STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555416	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENDORA CANYON TRANSITIONAL CARE UNIT	**401 W. ADA AVE. GLENDORA, CA 91741**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices and precautions to prevent the spread of COVID-19 (an illness caused by [MEDICAL CONDITION] that can spread from person to person) by failing to: 1. Screen every individual entering the facility for signs and symptoms of COVID-19. 2. Check and document staff temperature twice daily, once prior to coming in to work and second at the end of the shift. 3. Have necessary Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that cause illnesses) available directly outside of resident rooms in the Yellow zone (residents suspected of COVID-19). 4. Placing a bin near the room door or exit for easy discarding of PPE after removal (i.e. washable gowns). 5. Post signs immediately outside of resident rooms indicating required PPE in accordance with current guidance. These deficient practices had the potential to spread [MEDICAL CONDITION] to residents, staff, and/or essential visitors. Findings: During an observation on 7/1/20 at 1:35 p.m., Receptionist 1 greeted Surveyor 1 upon entering the facility. Receptionist 1 checked Surveyor 1's temperature, but did not ask or screen Surveyor 1 for signs and symptoms of COVID-19, travel history, and/or any possible exposure to someone who tested positive for COVID-19. During an interview on 7/1/20 at 2:15 p.m., the Director of Nursing (DON) stated all staff and visitors should be screened for signs and symptoms of COVID-19 as soon as they enter the facility. The DON stated the receptionist should check the temperature and ask all the questions from the screening log. The DON stated the facility's screening log was not complete to include temperatures of the facility staff twice a day. The DON stated that the facility only checked staff temperatures at the beginning of the shift and asked staff to self-monitor after 12 hours. A review of the facility's Employee Screening Log, dated 6/25/2020, included the following questions: 1. Do you have any flulike symptoms (such as stuffy nose, fever or cough)? 2. Have you traveled outside of the United States (U.S.) around December to present? 3. Have you been in close contact with anyone who travelled outside the U.S. in the past 21 days? 4. Do you live in a community where community based spread of COVID-19 is occurring? 5. Comments/Temperature The Screening Log indicated temperatures documented once. During an observation of the facility's Yellow zone with the DON on 7/1/20 from 2:15 to 3:00 p.m., the following were observed: 1. Isolation carts/drawers containing required PPE were not directly outside of resident rooms in the Yellow zone on the 3rd floor. Facility was observed using linen carts with covering located in between two rooms to store clean washable gowns and linens. 2. Bins for used washable gowns were located outside resident rooms and not near the exit for easy discarding after removal. A nursing staff was observed doffing (removing) a used gown and walking out of the room to place the used gown in the bin. 3. Signs posted outside of resident rooms in the Yellow zone indicating required PPE did not include use of eye protection. During an interview on 7/1/20 at 2:45 p.m., the DON stated the facility was short of isolation carts and bins and was in the process of buying more isolation carts (carts holding PPE) to place directly outside and bins to place inside for every isolation room. The DON stated she will update the signs to include need to wear eye protection. A review of an Order of the Health Officer for Control of COVID-19 issued on 4/24/20, indicated the facility shall require permitted visitors entering the facility to have symptom screening prior to entry. Anyone who is experiencing any symptoms shall not be admitted entry into the facility. The facility should conduct daily temperature checks for staff and residents. All staff should be checked twice daily, once prior to coming to work and the second at the end of the shift. Records are to be kept of those temperature checks. A review of the facility's COVID-19 Mitigation Plan dated 5/27/20, indicated the facility has PPE plan for adequate provision of PPE. Signs are posted immediately outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE in accordance with California Department of Public Health guidance. Necessary PPE is immediately available outside of the resident room when there are units with separate cohorted (group of people put together as one group) spaces for both COVID-19 positive and negative residents and in other areas where resident care is provided. Trash disposal bins are positioned as near as possible to the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.