STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555862	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA SCALABRINI SPECIAL CARE	**10631 VINEDALE STREET SUN VALLEY, CA 91352**

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 to prevent the spread of Coronavirus Disease 2019 (COVID-19, a highly contagious [MEDICAL CONDITION] infection affecting the respiratory system and can be severe enough to cause death) for two of two sampled residents. The facility failed to ensure: 1. Certified Nursing Assistants 1 and 2 (CNAs 1 and 2) used the necessary Personal Protective Equipment (PPE) when assisting Residents 1 and 2, who were on isolation precautions. 2. Place Resident 1, who was recently admitted from an acute hospital, on contact and droplet precautions (used for germs that are spread in tiny droplets caused by coughing and sneezing) in the quarantine (isolation) Yellow Zone area. 3. The Intervebtion Preventionist (IP) Nurse and the Director of Nursing (DON) were knowledgeable of the current infection control guidelines related to cohorting newly admitted residents. These deficient practices increased the risks of spreading infections to other residents and staff members. Findings 1. A review of Resident 2's Admissions Record (Face Sheet) indicated an admitted d 8/6/2020 with the [DIAGNOSES REDACTED]. A of Resident 2's physician's orders [REDACTED]. On 8/14/2020 at 1:24 p.m., CNA 1 was assisting Resident 2 with care but was not wearing gown or gloves. At the entrance to Resident 2's room there was a cart with isolation PPE for staff to use. A sign posted on Resident 2's doorway indicated Contact Precautions, Everyone must: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Concurrent interview with CNA 1 confirmed that the proper PPE was not utilized when working with Resident 1. A review of facility's In-Service Training Meeting dated 6/11/2020, with the topic, Hand Hygiene, PPE donning and doffing (putting on and removing of PPEs) competency indicated CNA 1 attended training. On 8/14/2020 at 2:05 p.m., during an interview, the IP Nurse stated for Resident 1's isolation, staff needed to wear gown and gloves and for all residents, a mask, due to COVID-19. The purpose of wearing PPEs is to prevent the spread of infection. A review of an undated facility policy titled, Policy and Procedure Infection Control, indicated the facility is to implement infection control measures to prevent the spread of communicable diseases and conditions. 2. A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 8/13/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's physician's orders [REDACTED]. On 8/14/2020, at 1:05 p.m., Resident 1's room did not have signs outside the door or wall indicating Resident 1 was on isolation precautions and the necessary PPE to use to care for Resident 1. During an interview with the IP Nurse, present at the time of the observation, the IP Nurse stated the staff only needed to wear gloves, masks, and face shields while providing care for Resident 1. Resident 1 was admitted from a hospital with a negative COVID-19 test result. During an interview on 8/14/2020 at 1:39 p.m., CNA 2 stated she provided morning care (personal hygiene) for Resident 1 and did not wear an isolation gown. She was wearing only gloves, masks, and face shield while providing services for Resident 1. CNA 2 stated she was not informed wearing a gown was necessary. On 8/14/2020 at 1:45 p.m., Licensed Vocational Nurse 3 (LVN 3) stated staff should wear gloves, masks, face shields, and gown, in the Yellow Zone (a transitional space for symptomatic residents). LVN 3 stated she did not inform CNA 1 about the necessary PPE to use. During an interview on 8/14/2020 at 1:45 p.m., the DON stated residents admitted from a hospital with a negative COVID test result, did not need isolation precautions. During a review of the facility's COVID-19 Mitigation Plan Manual on Cohorting Unknown Yellow Zone, reviewed 6/19/2020, indicated residents in Yellow Zone will be treated with contact and droplet precautions until a negative test result can be achieved or the resident meets the time criteria to return to the green zone based on current CDC (Center's for Disease Control and Prevention) guidance for the removal of transmission-based precautions .Any new admission will be placed in Yellow Zone, quarantine for 14 days. A review of the CDC's Guidelines titled Preparing for COVID-19 in Nursing Homes, updated 6/25/2020, indicated to create a plan for managing new admissions and readmissions whose COVID-19 status was unknown: Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (Healthcare Personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. A review of the Los Angeles County Department of Public Health (LAC DPH) Guidelines for Preventing and Managing COVID-19 in Skilled Nursing Facilities, dated 8/4/2020, indicated Special PPE considerations in cohort areas: In the Yellow Cohort, contact and droplet precautions, with gown and gloves changes between each patient is required.

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