STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW VISTA NURSING AND REHABILITATION CENTER	**8647 FENWICK STREET. SUNLAND, CA 91040**

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 by not posting Isolation Precautions signs outside the rooms for three of three sampled residents. (Residents 1, 2, and 3) This deficient practices has the potential for the spread of infection and cross contamination among residents. Findings: On 6/10/2020, at 1:50 p.m., during an observation tour of the facility, Residents 1, 2 and 3's rooms had a cart, outside the door, containing protective personal equipment (PPE). There was no sign indicating the type of isolation the residents required and what PPE were needed to enter the room. At the time of the observation, an interview with Director of Staff Development/Infection Preventionist (DSD/IP) indicated Residents 1, 2, and 3 were on isolation (quarantined) due to possible Coronavirus Disease 2019 (COVID-19, a [MEDICAL CONDITION] infection easily transmitted from person to person affecting the respiratory system) because they were recently readmitted from acute hospitals. DSD/IP stated there should be signs posted outside the doors for Droplet Isolation Precautions (used for diseases or germs that are spread in tiny droplets caused by coughing, talking, and sneezing. Healthcare workers should wear a face mask while in the room) A review of the Admission Record (Face Sheet) indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Admission Record, indicated Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

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.