STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555494	A. BUILDING _____ B. WING _____	**10/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDAR MOUNTAIN POST ACUTE	**11970 4TH STREET YUCAIPA, CA 92399**

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** - Many	**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 properly prevent an infection control breach of COVID-19 (Disease caused by the [DIAGNOSES REDACTED]-CoV-2 virus, a highly contagious and potential fatal respiratory infection), when the facility did not subject two Emergency Medical Technicians (EMTs) to COVID-19 screening procedures (including, but not limited to, verifying an individual's body temperature for fever, and verifying if an individual has any other indications of COVID-19 infection, such as cough, sore throat, and shortness of breath) prior to them entering the facility for non-emergency resident transportation. This failure had the potential to expose 83 out of 83 vulnerable, non-COVID-19 positive residents in the facility to COVID-19, which could have resulted in resident harm and/or death, as the two unscreened EMTs had the capability to enter the facility with signs and/or symptoms of COVID-19, without intervention nor restriction from the facility. Findings: During an observation on September 11, 2020, at 11:15 a.m., at the facility's modified entrance due to COVID-19 restrictions, two emergency medical technicians (EMTs) were observed to enter the facility, but were not subjected to COVID-19 screening by any facility staff members. The two EMTs were observed to walk into the facility, with a gurney in-tow, while no apparent emergency in the facility was taking place at the time of the observation. During an interview on September 11, 2020, at 11:40 a.m., with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON and IP stated EMTs that enter the facility for non-emergent resident transport were not exempt from the facility's COVID-19 screening procedures. The DON and IP further stated the two EMTs should have been screened for COVID-19 prior to entering the facility. The DON and IP further stated that the resident pending transport by the two EMTs was being transported for a follow-up procedure, and was not being transported for emergent, nor urgent needs. During an interview on September 11, 2020, at 12:31 p.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated she observed and was aware of the two EMTs who entered the facility, without being subjected to COVID-19 screening procedures. CNA 1 further stated the two EMTs should have been screened for COVID-19 prior to entering the facility, and it is the expectation that all individuals are screened for COVID-19 prior to entering the facility. During a review of the facility's Coronavirus Disease 2019 (COVID-19) Mitigation Plan, (undated), the mitigation plan indicated, Facility Name: Cedar Mountain Post Acute . COVID-19 Mitigation Plan Requirements: . 2. Infection and Prevention Control: . 2.4 Facility screening process for every individual entering the facility (including staff) for COVID-19 symptoms. Proper screening includes temperature checks .
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the execution of COVID-19 (Disease caused by the [DIAGNOSES REDACTED]-CoV-2 virus, a highly contagious and potential fatal respiratory infection) testing of applicable staff in the facility, according to the residing county's COVID-19 positivity rate, for three out of three sampled staff members (Infection Preventionist, Certified Nurse Assistant 1, & Lead Respiratory Therapist). This failure had the potential for resident harm and/or death, for 83 out of 83 vulnerable, non-COVID-19 positive residents in the facility, as the absence of the required COVID-19 testing frequency, per the facility's residing county's COVID-19 positivity rate, had the potential to allow an unknown, insidious COVID-19 outbreak to develop within the facility. Findings: During an interview on September 11, 2020, at 1:15 p.m., with the Director of Nursing (DON) and Infection Preventionist (IP), the IP stated the facility is testing all applicable staff members for COVID-19 every four weeks. The DON and IP further stated they were not aware of the requirements regarding routine testing of staff, according to the facility's residing county's COVID-19 positivity rate. During a review of Data.CMS.gov, the COVID-19 positivity rate for the facility's residing county of San Bernardino, between August 20, 2020 and August 26, 2020, was (9.7%), two weeks prior to the date of the Surveyor's on-site Infection Control Survey activity. This COVID-19 positivity rate was indicative of routine weekly facility staff testing for COVID-19. During a review of Data.CMS.gov, the COVID-19 positivity rate for San Bernardino County, between August 27, 2020 and September 2, 2020, was (8.8%). This COVID-19 positivity rate was indicative of routine weekly facility staff testing for COVID-19. During a review of Data.CMS.gov, the COVID-19 positivity rate for San Bernardino County, between August 27, 2020 and September 9, 2020, was (7.8%). This COVID-19 positivity rate was indicative of routine weekly facility staff testing for COVID-19. During a review of the facility's COVID-19 testing documentation for sampled staff members, including the IP, Certified Nurse Assistant 1 (CNA 1), and Lead Respiratory Therapist (RT 1), dated between July 2020 and August 2020, the COVID-19 testing documentation for the IP, CNA 1, and RT 1 indicated the following: - (IP): tested for COVID-19 on August 06, 2020; - (CNA 1): tested for COVID-19 on July 10, 2020 & August 10, 2020; - (RT 1): tested for COVID-19 on August 05, 2020; During a review of the facility's COVID-19 testing documentation for sampled staff members, including the IP, (CNA 1), and (RT 1), dated between July 2020 and August 2020, the COVID-19 testing documentation for the IP, CNA 1, and RT 1 indicated that the respective staff members were not subjected to the indicated routine weekly COVID-19 testing, according to San Bernardino County's COVID-19 positivity rates ranging between 5% & 10%. During a review of the QSO-20-38-NH . Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements ., dated August 26, 2020, the document indicated, . Routine Testing of Staff: Routine testing should be based on the extent of [MEDICAL CONDITION] in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency . County Positivity Rate in the past week: 5% - 10%, Minimum Testing Frequency: Once a week . The facility should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week . If the county positivity rate decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency .

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.