

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 055872	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2020
NAME OF PROVIDER OF SUPPLIER CITRUS NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 9440 CITRUS AVENUE FONTANA, CA 92335	
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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure: 1. staff correctly donned personal protective equipment (PPE) when in a droplet precautions (staff wear gown, gloves and a mask to prevent exposure to infection) room. 2. staff disposed of PPE correctly after use in a droplet precautions room. This failure had the potential to spread infection to patients and staff. Findings: 1. During an observation tour of the facility on August 12, 2020 at 1:55 PM, a Certified Nursing Assistant (CNA 1) was observed coming out of a droplet precautions room. The gown CNA 1 was wearing to prevent the spread of infection was not tied in the back, and the gown was open in the back exposing her clothing. During a second observation on August 12, 2020 at 2:10 PM with the Director of Staff Development (DSD), CNA 1 put on a gown preparing to go into the same droplet precautions room and did not tie the gown in the back exposing the back of her clothing. In a concurrent interview with the DSD she acknowledged the gowns worn by staff should be closed in the back. And acknowledged the exposed clothing could contribute to the spread of infection. In an interview with the Administrator on August 12, 2020 at 2:45 PM, he stated that the staff should tie the gowns in the back to cover their clothing and they use the CDC guidelines for using PPE. A review of the information by the Center for Disease Control (CDC) showed the following: Sequence For Putting On Personal Protective Equipment (PPE) 1. Gown Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back Fasten in back of neck and waist 2. During an observation on August 12, 2020 at 1:55 PM, CNA 1 left a droplet precautions room and properly removed her gown. She then carried it down the hallway past a second patient room and also the nurse's station and deposited the gown into a dirty linen hamper. In an interview with the DSD on August 12, 2020 at 2:10 PM, she acknowledged the CNA should have disposed of the gown in a hamper that was closer to the patient's room to prevent possible spread of infection. In an interview with the Administrator on August 12, 2020 at 2:45 PM, he stated the CNA should have deposited the gown in the hamper that was by the door in 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.