

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Pomona Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 651 N Main St Pomona, CA 91768	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34273</p> <p>Based on observation, interview, and record review, the facility failed to implement its infection prevention and control program for a census of 52 residents by failing to ensure Certified Nursing Assistant (CNA) 1 and CNA 2 performed hand hygiene (cleaning hands by either washing them with soap and water, or by using alcohol-based hand rub [ABHR- liquid, gel, or foam which contains alcohol and applied to hands to kill most bacteria and viruses]) in accordance with the hand hygiene in-service (ongoing employee educational and training program) provided to all staff by the Infection Prevention Nurse (IPN- responsible for coordinating infection prevention and control program activities to prevent, detect, and mitigate communicable diseases and infections within the facility) on 5/5/2024.</p> <p>This failure had the potential to spread infection to all residents and staff in the facility.</p> <p>Findings:</p> <p>During an observation on 7/2/2024 at 11:51 am, CNA 1 removed CNA 1's soiled gloves after CNA 1 provided care to Resident 3. CNA 1 did not wash CNA 1's hands or used ABHR after removing gloves. CNA 1 exited Resident 3's room, walked to the clean linen cart, and lifted the blue cover on the clean linen cart, without washing hands and/or using ABHR.</p> <p>During an interview on 7/2/2024 at 12 pm with CNA 1, CNA 1 stated CNA 1 changed Resident 3 because Resident 3 was wet. CNA 1 stated after changing Resident 3, CNA 1 went outside Resident 3's room to look for a plastic bag. CNA 1 stated the linen inside the clean linen cart with the blue cover was used by staff for all residents. CNA 1 stated CNA 1 was supposed to wash CNA 1's hands and sanitize CNA 1's hands after removing dirty gloves to prevent the spread of infection.</p> <p>During an interview on 7/2/2024 at 12:09 pm with Licensed Vocational Nurse (LVN) 2, LVN 2 stated after removing dirty gloves, staff (in general) were supposed to perform hand hygiene to prevent the spread of infection.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 7/2/24 at 12:23 pm, CNA 2 was observed picking up Resident 6's tray on top of Resident 6's table. CNA 2 touched Resident 6's table while CNA 2 picked up Resident 6's tray. CNA 2 went outside Resident 6's room and put Resident 6's tray on top of the food cart that was in the hallway. CNA 2 did not use ABHR or wash CNA 2's hands after CNA 2 left Resident 6's room. CNA 2 then got another tray from the food cart and set the tray down on Resident 7's table inside Resident 7's room. CNA 2 touched the privacy curtain when CNA 2 set the tray down on Resident 7's table. CNA 2 left Resident 7's room and still have not used ABHR or washed CNA 2's hands. CNA 2 then went towards the kitchen, touched the doorknob to open the door to the kitchen, and talked to a dietary staff. CNA 2 then got another tray from the food cart, went inside Resident 8's room, touched Resident 8's wheelchair and table, and set the tray on Resident 8's table. CNA 2 removed the lid from the plate on Resident 8's tray and removed the plastic wrap covering Resident 8's dessert. CNA 2 left Resident 8's room and still have not used ABHR or washed CNA 2's hands. CNA 2 got another tray from the food cart, placed the tray on top of Resident 9's table, then CNA 2 pulled Resident 9's privacy curtain close. CNA 2 left Resident 9's room and still have not performed hand hygiene. CNA 2 walked towards the kitchen, opened the kitchen door, spoke to a dietary staff, then went inside Resident 10's room and asked Resident 10 if Resident 10 wanted Resident 10's tray. CNA 2 left Resident 10's room without performing hand hygiene and walked towards the kitchen and opened the kitchen door. CNA 2 came back from the kitchen with two bowls, went inside Resident 7's room, and handed the two bowls to Resident 7.</p> <p>During an interview on 7/2/2024 at 12:34 pm with CNA 2, CNA 2 was informed CNA 2 was observed delivering food to Resident 7, Resident 8, and Resident 9, touching tables, a wheelchair, and privacy curtains in the residents' rooms without performing hand hygiene. CNA 2 stated, I'm supposed to use hand sanitizer when going in and out of residents' rooms. I forgot.</p> <p>During an interview on 7/2/2024 at 12:42 pm with LVN 3, LVN 3 stated staff (in general) needed to perform hand hygiene after removing gloves. LVN 3 stated when passing out food trays, staff (in general) were supposed to use ABHR if they (staff) touched something inside the resident's room. LVN 3 stated if staff did not touch anything in the resident's room while passing food trays out, staff did not have to use ABHR. LVN 3 stated it was important to perform hand hygiene to prevent the spread of germs (disease causing microbes).</p> <p>During an interview on 7/2/2024 at 1:04 pm with CNA 3, CNA 3 stated staff (in general) were supposed to use ABHR every time they (staff) go in and out of residents' rooms. CNA 3 stated staff were supposed to wash hands after providing resident care and after removing gloves. CNA 3 stated hand hygiene was performed to prevent the spread the infection.</p> <p>During an interview on 7/2/2024 at 4:10 pm with the Director of Staff Development (DSD), the DSD stated staff were supposed to use ABHR every time they go in and out of a resident's room and supposed to wash hands after providing resident care and after removing gloves. The DSD stated performing hand hygiene was important to prevent the spread of any infection in the facility.</p> <p>During a phone interview on 7/17/2024 at 1:57 pm with the IPN, the IPN stated staff were supposed to perform hand washing before and after providing resident care and were supposed to use ABHR before going inside and when exiting a resident's room. The IPN stated hand hygiene was important to prevent the spread of infection.</p> <p>(continued on next page)</p>		

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