STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46247 Based on observation, interview, and record review the facility failed to implement transmission-based infection control measures when personal protective equipment (PPE, protective garments worn to prevent exposure to infection hazards) was not readily available for staff when entering the room of a resident (2) on transmission-based precautions (TBP, control measures put in place to prevent the spread of disease). This failure increased the risk of MRSA transmission to all susceptible residents, staff, and visitors at the facility. Findings: Resident 2 was admitted to the facility on [DATE] with a diagnosis of a sacral pressure ulcer (injury to the skin and tissue at the base of the spine), per the facility's Admission Record. A review of Client 2's physician orders, dated 4/18/24, indicated Resident 2 was on enhanced barrier precautions (EBP, intervention to decrease risk of disease transmission during resident contact that requires use of a gown and gloves) for a history of Methicillin-resistant Staphylococcus aureus (MRSA, a bacteria that is resistant to many antibiotics). On 4/18/24 at 12:16 PM, an observation outside of Resident 2's room was conducted. An orange dot was located next to Resident 2's name outside the door to Resident 2's room. There was a sign hanging next to Resident 2's name panel indicating EBP, and gloves and a gown should be worn for high contact activities. There was no PPE available for immediate use outside or inside Resident 2's room. On 4/18/24 at 12:49 PM, a concurrent observation and interview was conducted with licensed nurse (LN) 2 outside of Resident 2's room. LN 2 stated the orange dot and the sign outside Resident 2's room indicated Resident 2 was on EBP and gloves and a gown should be worn if having physical contact with Resident 2. LN 2 stated she did not know why Resident 2 was on EBP and there were no gloves or gowns available outside the room, and that there should be. LN 2 stated not having EBP PPE outside Resident 2's room was an infection control problem. (continued on next page)

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

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(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	On 4/18/24 at 12:58 PM, a concurrent observation and interview was conducted with medical doctor (MD) outside Resident 2's room. The MD stated she was going to enter Resident 2's room but could not enter because the EBP PPE was not available outside the room. The MD stated Resident 2 was on EBP for a history of MRSA and a lack of PPE for protection at the door of a resident on EBP increased the risk of spreading infection to others. On 4/18/24 at 1:02 PM, an interview was conducted with the infection prevention (IP) nurse. The IP stated when a resident is on EBP there should be a gown and gloves hanging on the door or in a cart outside the room of that resident. Stated staff should not provide care to residents on EBP if PPE is not available because it increases the risk of infection transmission to other residents. On 4/18/24 at 1:23 PM, an interview was conducted with certified nursing assistant (CNA) 1. CNA 1 stated she had contact with Resident 2 this morning while turning resident. CNA stated she was not wearing a gown or gloves when moving Resident 2. A review of the facility policy & procedure, revised 9/2022, titled, Infection Preventionist, did not indicate the policy and procedure for enhanced barrier precautions.