STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055464	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWO PALMS NURSING CENTER, INC	**2637 E. WASHINTON BLVD PASADENA, CA 91107**

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 0725 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to limit transmission of COVID-19 by failing to have a dedicate nursing team to provide directed care and respond to the needs 20 of 20 residents with COVID-19 (red zone area) and another dedicate nursing team to provide direct care to eight residents with suspected COVID-19 (yellow zone area). This deficient practice resulted in Resident 1's needs were not met and placed other residents at risk for the transmission of COVID - 19 which can cause serious respiratory illness and death. On 6/28/2020 at 7:31 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Facility's Administrator for the facility's failure to have sufficient staff to ensure the health and safety of the residents and staff. On 7/2/2020 at 4:47 p.m., the Temporary Manager (TM) provided an acceptable facility's Plan of Action (POA). On 7/2/2020 at 5:35 p.m. the IJ was removed in the presence of the TM, Administrator, and Director of Nursing after the implementation of POA was verified and confirmed on onsite through observation, interview, and record review. The accepted POA included the following actions: 1. Facility hired the following full-time employees on 7/1/20: 1 Registered Nurse (RN), 5 Licensed Vocational Nurses (LVNs), and 1 Certified Nursing Assistant (CNA). 2. Facility will develop their staffing and recruitment plan for the facility to have staffs that can provide the proper care and treatment to the residents. 3. The facility Temporary Manager provided the Administrator and the Interim Director of Nursing (DON) in-service on general staffing requirements and staffing based on current resident acuity (level of care required). Findings: A review of the facility census dated 6/27/2020 indicated 29 residents on the list. The actual resident count was 28, with one resident transferred out in the early morning of 6/28/20. On 6/27/2020 at 9:37 a.m., during an observation, the facility staffing included the Director of Staff Development (DSD), Licensed Vocational Nurse 1 (LVN 1), LVN 4 and Certified Nursing Assistant 4 (CNA 4) for the 7 am to 7 pm shift (1 RN/DSD, 2 LVNs and 1 CNA). The DSD who was acting as Registered Nurse Supervisor (RN Supervisor) stated there was only 1 CNA so she needed to enter the COVID area to assist the CNA and would have to go back to the main hallway (non COVID area) from time to time. The DSD stated there was no Director of Nursing, because he submitted his resignation on 6/26/20. A review of the Staff Assignment for the 7 AM to 7 PM shift dated 6/27/2020 indicated the DSD, LVN 1, LVN 4 and CNA 4 were the staff for the shift. A review of the letter dated 6/23/2020, the Director of Nursing submitted his resignation effective 7/6/2020, but will no longer be working physically on an actual scheduled shift. On 6/27/2020 at 10:30 a.m., during an interview, the Administrator stated staffing for the 7 PM to 7 AM shift on 6/27/2020, would be 1 LVN and no CNA. The Administrator further stated the facility needed staffing assistance. On 6/27/2020 at 3:30 p.m., during an interview, the Administrator stated she did not want to request the assistance from CAL MAT (California Medical Assistance Team - a group of highly trained medical professional and other specialists organized and coordinated by the state emergency medical services authority for rapid field medical response in disasters). She stated that she heard CAL MAT would take over the facility after being informed for staffing assistance. On 6/27/2020 at 3:37p.m., during an interview, the Administrator stated one LVN, one RN and 2 CNAs would report to work tonight and the facility would not be needing staffing assistance from CAL MAT for the 7 PM to 7 AM shift. On 6/27/2020 at 7:18 p.m., during an observation, CNA 4 left the facility, and there was no CNA came to work, LVN 1 and LVN 4 stayed over. The staffing included LVN 5 assigned at the yellow zone (suspected COVID-19 infection), LVN 1 was the designated staff in the red zone (COVID - 19 infection). There was no CNA staff, the DSD was moving medications cart to the red zone. During a concurrent interview, LVN 4 stated she stayed over to complete the documentation. On 6/27/2020 at 8:18 p.m., during an observation, no CNA staff in the COVID-19 unit. The DSD was moving charts from Non COVID-19 unit to COVID-19 unit. The DSD stated she was preparing the donning and doffing of PPE area, the nurse's station and breakroom in COVID-19 unit. On 6/27/2020 at 11:38 p.m. to 11:48 p.m., during an observation, there was no staff working in the COVID-19 unit after DSD left, a moaning sound was heard coming from Resident 1's room. On 6/27/2020 at 11:50 p.m., during an observation, CAL MAT provided 1 RN and 2 Medics (person involved in medicine such as a medical doctor, medical student and sometimes a medically trained individual participating in an emergency such as a paramedic or an emergency medical responder) who would provide direct patient (as CNAs). A review of the Staff Assignment on 6/28/2020 for the 7 AM to 7 PM shift, facility staffing included the DSD who was also the (RN Supervisor and the designated Charge Nurse in the Covid-19 unit), 1 LVN, and 4 CNAs. There was no DON at the facility. On 6/28/2020 at 9:20 a.m., during an interview, the Administrator stated she did not have the staffing assignment for the 7 PM to 7 AM and had other tasks to do this morning. On 6/28/2020 at 11:00 a.m., during a concurrent interview and record review of the Medication Flowsheet, the DSD stated Resident 1 had episodes of occasional moaning. The DSD stated she worked until 11:00 p.m. last night (6/27/20) and did not hear any moaning from the Resident 1. A review of Resident 1's Medication Flowsheet indicated the following: 1. Vital signs (temperature, pulse, blood pressure, and respiratory rate) were not monitored at 8:00 p.m. 2. Signs and symptoms of COVID-19 such as cough, shortness of breath, sore throat, loss of taste, loss of smell, temperature, respiratory rate, oxygen saturation, and level of pain for 3 PM to 11 PM were not monitored. 3. House snack was not offered at 8 p.m. 4. Side effects of [MEDICATION NAME] and Quetiapine [MEDICATION NAME] use was not monitored. 5. Behavior for fear of dying, panic/worry regarding medical condition was not monitored 6. Behavior monitoring for recurrent outburst of anger, persistent extreme fear, persistent talking, nausea and vomiting, and potential side effects of Quetiapine [MEDICATION NAME] was not monitored. 7. Vitamin C tablet, 250mg scheduled at 5p.m. was not administered during the 3 PM to 11 PM shift. The DSD stated that Registered Nurse 1 (RN 1) came in at 8:30 p.m. On 6/27/20 at 2:15 p.m., during an interview, the Administrator stated she sent the facility's staffing plan on the Mitigation Plan attachments. The Administrator stated she would resend the documents. On 6/28/20 at 11:55 a.m., during an interview, the Administrator stated the facility initiated a contract with a staffing registry as of today (6/28/20) but the registry would not be able to provide nursing staffing for this weekend. A review of the Mitigation Plan attached documents which were sent through electronic mail on 6/28/20, indicated the facility sent Strategies to Mitigate Staffing Shortages but it was not the facility's staffing plan, it did not indicate the name of the facility. On 7/2/20, the facility sent an electronic mail communication of the facility's Emergency Staffing Strategies and Policy and Procedure on General Staffing, these documents were dated 7/2/20. A review of the Center for Disease Control and Prevention (CDC) Strategies to Mitigate Healthcare Personnel Staffing Shortages dated 4/30/20, indicated healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with anxiety and stress. There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations.

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.

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F 0725 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1)

F 0880

Level of harm - Immediate jeopardy

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 provide a safe, sanitary environment to help prevent the development and transmission of communicable disease and infections during the Coronavirus (COVID-19 - an illness caused by [MEDICAL CONDITION] that can spread from person to person) crisis for 5 of 31 sampled residents (Resident 2, 5, 6, 8, and 10) as evidenced by failing to: a. Cohort (practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of b particular case together as a group) five positive residents for COVID-19 (Residents 1, 3, 4, 7, and 9) with positive residents and cohort five negative residents for COVID-19 (Residents 2, 5, 6, 8, and 10) with negative residents and have designated staff care for residents with COVID-19. c. Have an Infection Preventionist (IP) available to manage, prevent and control the spread of COVID-19 in the facility. d. Ensure positive resident (Resident 4) for COVID-19 wearing face covers while being out of her room. Licensed Vocational Nurse (LVN 1) was not wearing gown and gloves when wheeling Resident 4. e. Have a designated staff to care for only positive residents for COVID 19. These deficient practices had the potential to result in the transmission of COVID-19 by person to person contact, which placed the residents at high risk to be infected with COVID - 19 and become seriously ill with respiratory illness which could lead to hospitalization and/or death. On 6/26/2020 at 12:51PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Facility's Administrator for the facility's failure to implement measures to prevent infection that threatened the health and safety of the residents and staff. On 7/2/2020 at 4:47 p.m., the Temporary Manager (TM) provided an acceptable facility's Plan of Action (POA). On 7/2/2020 at 5:30 p.m. the IJ was removed in the presence of the TM, Administrator, and Director of Nursing after the implementation of POA was verified and confirmed on onsite through observation, interview, and record review. The accepted POA included the following actions: 1. Completing a cohorting plan for COVID-19 positive residents to be place in an area in the red zone, Persons Under Observation (PUI) residents in the yellow zone, and COVID-19 negative in the green zone. 2. In-service education to the all facility staffs on the cohorting, facility infection control practices, and personal protective equipment (PPE). 3. The facility will have a full-time certified Infection Preventionist (IP) Licensed Vocational Nurse and was hired on 7/2/20. The main job function and responsibilities included providing a safe, sanitary environment to help prevent the spread of infections during the COVID-19 crisis. Findings: a. On 06/25/20 at 09:41 PM, during an interview, Certified Nursing Assistant 1 (CNA 1) stated the residents who were confirmed positive for COVID-19 were in the rooms behind the barrier. CNA 1 showed her assignment that included three resident rooms. Room A had Residents 1, 2, 3, 4 sharing the same room (Resident 2 was negative for COVID- 19). Room B had Residents 5, 6 and 7 sharing the same room (Residents 5 and 6 were negative). Room C had Residents 8, 9, and 10 sharing the same room (Resident 8 and 10 were negative). CNA 1 stated she was scheduled to work from 7 pm - 7 am shift. CNA 1 stated she worked last night on 06/24/20 and she was informed the residents who were confirmed with COVID-19 were behind the barrier. CNA 1 stated she was not informed on this shift that there were new residents that tested positive. On 06/25/2020 at 09:45 p.m., during an observation, CNA 2, who was also the team leader, made a printout of the residents confirmed with positive COVID-19 and wrote the updated room numbers of these residents and handed it over to CNA 1. A review of resident room printout indicated the residents who tested positive with COVID-19 were cohorting (sharing the same room) with residents that tested negative. Residents who were cohorting behind the barrier were all confirmed positive with COVID-19 from the previous testing. The following residents were in Room A. Resident 1, confirmed positive for COVID-19 on test date 6/23/20 Resident 2, tested negative for COVID-19 on test date 6/23/20 Resident 3, confirmed positive for COVID-19 on test date 6/23/20 Resident 4, confirmed positive for COVID-19 on test date 6/23/20 The following residents were in Room B. Resident 5, tested negative for COVID-19 on test date 6/23/20 Resident 6, tested negative for COVID-19 on test date 6/23/20 Resident 7, confirmed positive for COVID-19 on test date 6/23/20 The following residents were in Room C. Resident 8, tested negative for COVID-19 on test date 6/23/20 Resident 9, confirmed positive for COVID-19 on test 6/23/20 Resident 10, tested negative for COVID-19 0n test 6/23/20 On 6/26/2020 at 9:44 a.m., during an observation, Certified Nursing Assistant CNA 3) went inside Resident 1's room. On 6/26/2020 at 10:08 a.m., during a follow up interview, CNA 3 stated she was taking care of Residents 1, 3 and 4 , who were confirmed positive with COVID-19. CNA 3 stated she was also assigned to Resident 2 who tested negative for COVID-19. During an interview 6/26/2020 at 9:46 a.m., LVN 1 stated she was assigned to Resident 2 who tested negative for COVID-19, and Resident 3 was confirmed positive COVID-19. LVN 1 did not answer when asked regarding cohorting residents who tested negative for COVID-19 with residents who were confirmed positive for COVID-19. On 6/26/2020 at 10:03 a.m., during an interview, LVN 2 stated she was assigned to Residents 5 and 6, both tested negative for COVID-19. LVN 2 also stated she was assigned to Resident 7, who was confirmed positive for COVID-19. LVN 2 stated she would ask the Director of Staff and Development (DSD) if they were supposed to cohort residents confirmed positive COVID-19 with residents that tested negative COVID-19 On 6/26/2020 at 10:05 a.m., during an interview, the DSD stated we were supposed to move COVID-19 negative residents out from the rooms that had positive residents for COVID-19. The DSD stated she was busy and she would have to move the residents later. b. On 6/27/2020 at 2:15 p.m., during an interview, the Administrator stated the Director of Nursing (DON) was acting as the facility's Infection Preventionist (IP - expert on practical methods of preventing and controlling the spread of infectious diseases). The Administrator stated LVN 2 was on continuous training with the DON to be the facility's Infection Preventionist but did not get certification on Nursing Home Infection Preventionist Training Course. The Administrator stated the facility did not have a dedicated IP. The Administrator stated the information she provided during the previous onsite visit on 6/23/20, would be the time the DON would spend time to do Infection Control. A review of the hours reported during the previous onsite visit on 6/23/20 indicated the DON would spend 8 hours in a week for the responsibilities of an Infection Preventionist. c. On 6/26/2020 at 12:47 p.m., during an observation of Resident 4 who was confirmed positive for COVID-19, the resident was inside her room sitting in a wheelchair without a facemask or face covering. Resident 4 wheeled herself out of the room and went to the shared bathroom which was located outside her room. This observation was confirmed and verified by LVN 1. During an interview, LVN 1 stated Resident 4 must wear a face covering when she goes outside the room. LVN 1 stated Resident 4 must also wear face covering when inside the room because she was sharing the room with Resident 2 who tested negative for COVID-19. LVN 1 proceeded to wheel Resident 4 back to her room. LVN 1 was not wearing a gown and gloves. During this observation, facemask or face covering was not provided to Resident 4. 1. A review of Resident 1's Facesheet indicated Resident 1 was admitted on [DATE], with [DIAGNOSES REDACTED].) A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 3/5/2020, indicated moderate impaired cognitive skills for daily decision making. Resident 1 required extensive assistance for bed mobility, transfer, and dressing. A review of the facility's Line Listing (template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak) indicated the resident confirmed positive for COVID-19 2.A review of Resident 2's Facesheet indicated Resident 2 was admitted on [DATE], with [DIAGNOSES REDACTED].). A review of Resident 2's MDS, dated [DATE], indicated moderate impaired cognitive skills for daily decision making. Resident 2 required limited assistance in dressing, toilet use and personal hygiene. A review of the facility's Line Listing indicated Resident 2 tested negative for COVID-19. 3.A review of Resident 3's Facesheet indicated Resident 3 was admitted on [DATE] with [DIAGNOSES REDACTED].

This bulge can rupture and cause internal bleeding), diabetes mellitus (high blood sugar). A review of Resident 3's MDS, dated [DATE], indicated cognitive status and decision making skills were intact. Resident 3 required extensive assistance for, transfer, and toilet use. A review of the facility's Line Listing indicated Resident 3 confirmed positive for COVID-19. 4. A review of Resident 4's Facesheet indicated Resident 4 was admitted on [DATE], with [DIAGNOSES REDACTED]. One such condition is a [MEDICAL CONDITION] ([MEDICAL CONDITION] infarction - when cell death results in damaged or destroyed heart tissue), [MEDICAL CONDITION] disorder (a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations or states of awareness.) A review of Resident 4's MDS, dated [DATE], indicated cognitive status and decision making skills were intact. Resident 4 required limited assistance in transfer, dressing, and personal hygiene. A review of the facility's Line Listing indicated Resident 4 confirmed positive for COVID-19. 5. A review of Resident 5's Facesheet indicated Resident 5 was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 5's MDS, dated [DATE], indicated severely impaired cognitive skills for daily decision making. Resident 5 required total dependence for transfer, toilet use and personal hygiene. A review of the facility's Line Listing dated on 6/23/2020 indicated Resident 4 tested negative for COVID-19. 6. A review of Resident 6's Facesheet indicated Resident 6 was admitted on [DATE], with

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) [DIAGNOSES REDACTED]. A review of the MDS indicated Resident 6 had no cognitive impairment and totally dependent with transfers, locomotion and toilet use. The MDS indicated Resident 6 was independent with eating and personal hygiene. A review of the facility's Line Listing dated 6/23/2020 indicated Resident 6 tested negative for COVID-19. 7. A review of Resident 7's Facesheet indicated Resident 7 was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of the MDS indicated Resident 7 had no cognitive impairment and required extensive assistance with dressing, walking in corridor and toilet use. A review of the facility's Line Listing dated 6/23/2020 indicated Resident 7 confirmed positive for COVID-19. 8. A review of Resident 8's Facesheet indicated Resident 8 was admitted on [DATE] with [DIAGNOSES REDACTED]. The disease is called chronic because the damage to your kidneys happens slowly over a long period of time), diabetes mellitus (high blood sugar). A review of the MDS indicated Resident 8 had severe cognitive impairment and required limited assistance with dressing and personal hygiene. A review of the facility's Line Listing indicated Resident 9 tested negative for COVID-19. 9. A review of Resident 9's Facesheet indicated Resident 9 was readmitted on [DATE], with [DIAGNOSES REDACTED].) A review of the MDS indicated Resident 9 had no cognitive impairment and required limited assistance with dressing and personal hygiene and independent with other activities of daily living. A review of the facility's Line Listing indicated Resident 9 confirmed positive for COVID-19. 10. A review of Resident 10's Facesheet indicated Resident 10 was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of the MDS indicated Resident 10 was severely impaired for daily decision making and was totally dependent with all activities of daily living. A review of the facility's Line Listing indicated Resident 10 tested negative for COVID-19. On 6/27/20, during an interview, the Administrator stated she will e-mail the facility's Policy and Procedure on infection prevention plan for COVID-19. On 7/2/20, sent an e-mail communication to the Administrator to follow up on the Policy on Procedure on infection control. There was no Policy and Procedure on Infection Control sent by the facility. A review of the County of Los Angeles Department of Public Health Order of the Health Officer issued on 4/24/20 indicated the facility shall establish an area within the facility for residents/patients who have tested positive for COVID-19 or who are displaying symptoms associated with COVID-19. The area must be physically separated from the area for those who do not have confirmed or suspected COVID-19. All staff providing care to patients in the established COVID-19 area of the facility are not to work or enter into any other area of the facility until 14 days have passed from their last exposure to COVID-19 patients. A review of Centers for Disease Control and Prevention (CDC) Recommendation for Preparing for COVID-19 in Nursing Homes, updated 06/25/2020, indicated to identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Identify Healthcare Practitioners (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. A review of the Novel Coronavirus (COVID-19) Guidelines for Long Term Care Facilities updated on 5/1/20, indicated Los Angeles County Department of Public Health recommends employing a full-time, on-site infection preventionist who can help monitor compliance with infection control guidance based your facility and resident/patient population and assist with adherence to hand hygiene and correct use of PPE.