STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055504	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA SOUTH CONV CTR	**3515 OVERLAND AVENUE LOS ANGELES, CA 90034**

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 follow the recommendations by the Los Angeles County Department of Public Health when presented with Certified Nursing Assistant 2 (CNA 2) who tested positive for Coronavirus Disease 2019 (COVID-19 - a highly contagious and deadly virus transmitted easily from person to person). These deficient practices had the potential to place all 75 residents of the facility at risk of contacting the COVID-19 virus and increased the risk that residents and staff could have experienced serious health complications such as respiratory distress or life-threatening infection (invasion of the body by disease causing organisms) likely resulting in hospitalization or death. Findings: A review of the facility's reported incident (FRI) indicated on 3/25/20, the facility was notified that CNA 2 tested positive for COVID-19 and the last date worked for CNA 2 was [DATE]. The intake report indicated the Administrator (ADM) and Director of Nursing (DON) had gone home sick. Resident 1 and Resident 2 had passed away but were not confirmed for having COVID-19. During a phone interview with the Administrator (ADM) on 3/25/20 at 5:30 PM, he stated and verified that he and the DON went home sick. The ADM stated CNA 2 was confirmed positive earlier that day on 3/25/20 and the ADM confirmed that CNA 2's last work day in the facility was [DATE]. On 3/25/20 at 7:30 PM during observation, there were no signs regarding isolation precautions at the door to five isolated rooms, which had a total of nine residents. There was Personal Protective Equipment (PPE, protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) outside the isolation room doors, which had the potential to cause confusion to the Department of Health and staff regarding the type of isolation residents required, such as contact (any substance that can be transmitted to others by touch), droplet (a small drop, such as a particle of moisture discharged from the mouth during coughing, sneezing, or speaking; these may transmit infections), or both. In addition, during a concurrent observation, there were no signs on the appropriate use of donning (putting on) and doffing (removing) PPE. During an observation, on 3/25/20 at 7:35 PM, the doors to the droplet isolation rooms were observed open. This had the potential to affect other staff and residents walking past the room. During an observation with CNA 1, on 3/25/20 at approximately 8:15 PM, CNA 1 was observed doffing (removal of) the PPE. CNA 1 was first observed in the resident room removing the faceshield, then the mask, then rolled the gown and gloves into a ball and disposed inside a trash receptacle inside the room. According to the Centers for Disease Control (CDC) document titled, Sequence for Donning (putting on) and Doffing, (https://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf) this was the incorrect way to doff PPE. The order was from dirtiest to cleanest which would be gloves, gown, goggles (or faceshield) inside the resident's room and the mask after leaving the room and closing the door. A review of the CDC document titled, PPE Sequence(https://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf), indicated the order for removal of PPE was gloves, gown, goggles (or faceshield) inside the resident's room and the mask after leaving the room and closing the door. The document indicated that except for mask or respirator, remove PPE at doorway and to remove mask after leaving an isolated patient's room and closing the door. During an observation on 3/25/20 at approximately 8:16 PM, CNA 1 was going to a resident bathroom inside the room to wash hands after removal of all PPE. According to the CDC, this would be not adhering to the rule of removing mask after leaving patient room and closing door. During an interview on 3/25/20 at 8:17 PM, with CNA 1, after doffing the PPE, she stated she had been assigned to provide care for residents on isolation as well as non-isolation residents. A review of the Los Angeles County Department of Public Health document titled, COVID-19 Long-Term Care Facility Preparedness Checklist, dated 3/11/20, indicated there should be designated staff who will be responsible for caring for suspected or known COVID-19 patients. The document indicated there should be signs on the appropriate use of donning and doffing PPE. During an interview with Licensed Vocational Nurse 1 (LVN 1) and LVN 2 on 3/25/20 8:30 PM, they stated and confirmed CNA 1 was caring for both isolated rooms suspected of having COVID-19 and also for non-isolation rooms. A review of the facility's CNA Daily Assignment for 3/25/20 from 3 PM to 11 PM, indicated there was another staff, (CNA 4) who provided care to the same room CNA 1 provided care for. A review of the Daily CNA Assignment sheet for 3/25/20 indicated there were 9 CNAs working which would allow staff to be dedicated to the cases that were rule -out or actual COVID-19 positive. During an interview with LVN 1 and LVN 2 on 3/25/20 at 8:30 PM, a line listing (a table in which important information is recorded on each person who is ill or has signs or symptoms) of COVID-19 suspected residents was requested. LVN 2 stated there was no line list available at the time as it was being compiled but was not ready to be presented. LVN 2 stated the line listing should have been started as soon as the first resident room was placed on isolation. There was no available line listing of residents or staff suspected of having COVID-19 on 3/25/20, after nine residents were placed on droplet isolation. A review of the facility's Resident Line Listing, dated 3/25/20 at 10 PM, indicated there were 21 residents on isolation to rule out COVID-19. As of 3/31/20 there were seven residents and nine staff diagnosed with [REDACTED]. During a phone interview with LVN 2 on 3/26/20 at 8:31 AM, she stated CNA 3 went home sick on 3/25/20. LVN 2 stated CNA 3 worked the 7 AM to 3 PM shift and the temperature was checked at the entrance to the facility. LVN 2 stated CNA 3's temperature was 100.2 at the start of the shift and was immediately sent home. A review of the sign-in sheets for 3/25/20 did not indicate CNA 3's name or temperature as being recorded. A review of the facility sign-in sheets for [DATE] indicated two sheets had no date, some sheets had faded numbers and were illegible. During an interview with CNA 2 on 3/31/20 at 4:46 PM, she stated she last worked in the facility on Friday [DATE]. CNA 2 stated she called in sick on the morning of 3/23/20 and had not returned to the facility since [DATE]. CNA 2 stated she first had a temperature of 101.4 approximately 2 AM or 3 AM. CNA 2 stated she called in sick the morning of 3/23/20 telling staff she did not feel well. A review of the facility's policy and procedure titled, Guidance for Infection Prevention and Control for Residents with Suspected or Confirmed COVID-19, created [DATE], indicated the facility was to verify that staff members can correctly don and doff PPE. The policy indicated, as much as possible, maintain consistent staff assignments to limit the number of staff members providing care to the dedicated cohort of residents with COVID-19 or residents with history of exposure to COVID-19. A review of the Center for Medicare and Medicaid Services (C[CONDITION]) ref: QSO-20-20-All, dated 3/23/20, indicated there was a COVID-19 Focused Survey for Nursing Homes checklist. The document indicated staff were to perform appropriate hand hygiene before and after contact with residents. The document indicated staff were to remove and discard PPE appropriately after resident care and leaving the room. The document indicated the facility needs to have the appropriate signage on the usage of specific PPE posted in appropriate locations in the facility such as outside a resident's room. The document indicated the facility needs to have infection surveillance that address the following: 1. How many residents or staff in the facility have signs/symptoms related to COVID-19. 2. How many residents and staff have been diagnosed with [REDACTED]. 3. Establishing a surveillance plan for identifying, tracking, monitoring and/or reporting of fever, respiratory illness, and/or other signs/symptoms of COVID-19. A review of the facility's policy and procedure titled, Infection Control, revised 1/1/12, was general in scope. The policy did not indicate any measure to track data for trends.

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