STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055845	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEISURE GLEN POST ACUTE CARE CENTER	**330 MISSION ROAD GLENDALE, CA 91205**

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** - 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 follow infection control practices during the [MEDICAL CONDITION] 2019 (COVID-19, a respiratory illness that can spread from person to person) crisis as indicated in the facility's policy by failing to: 1. Screen all Health Care Providers (HCP) at the beginning of the shift for possible COVID-19 symptoms. 2. Screen staff's temperature at the end of their shift. 3. Screen all visitors before entering the facility. 4. Maintain social distancing amongst residents and staff. 5. Ensure staff did not cross over between different isolation zones (Red zone-this area is only for residents who have laboratory-confirmed COVID-19. Yellow zone-this area is for the following residents: those who have been in close contact with known cases of COVID-19; newly admitted or readmitted residents; those who have symptoms of possible COVID-19 pending test results; and for residents with indeterminate tests. Green zone-this area is reserved for residents who do not have COVID-19 These deficient practices had the potential to spread infection between residents, staff, and visitors. Findings: On 9/12/20, at 2:14 p.m., in the facility's parking lot, the facility's receptionist met the Surveyor and walked the Surveyor directly inside the facility's yellow zone without screening the Surveyor for signs and symptoms of COVID-19. During an interview on 9/12/20, at 2:26 p.m., in the yellow zone, Registered Nurse 1 (RN 1) stated, in the yellow zone they did not screen staff or visitors. RN 1 stated, screening process was done in the green zone. During an interview and concurrent record review, on 9/12/20, at 2:30 p.m., at the green zone entrance, RN 1 stated, he did not know who was responsible to screen visitors and staff. A review of the facility's screening logs for COVID-19 titled, Staff Log Yellow Zone, dated 9/11/20, 7 a.m. to 3:30 p.m., shift, only one of nine staff were screened for their temperature at the end of their shift. A review of the, Staff Log Yellow Zone and Staff Log Green Zone, log dated 9/12/20, 7 a.m. to 3:30 p.m., two of thirteen staff failed to complete their screening information. During an observation and concurrent interview, on 9/12/20, at 2:43 p.m., RN 1 was sitting in the nurses' station in the green zone close to other staff. RN 1 stated, he crossed over from the yellow zone to the green zone throughout the day. During an observation and concurrent interview, on 9/12/20, at 2:53 p.m., residents were sitting next to each other in their wheelchairs. Licensed Vocational Nurse 1 (LVN 1) stated, the residents were too closed to each other and staff should remind the residents to social distance from each other. During an interview, on 9/12/20, at 2:55 p.m., in the green zone area, the Janitor stated, he went to the red zone first to clean on 9/12/20, at 6 a.m. He then went to the yellow zone, and lastly to the green zone to clean. The Janitor stated, he would clean in that sequence when he worked. During an interview, on 9/12/20, at 3:10 p.m., the Administrator (ADM) stated, staff should not cross over different isolation zones to prevent the spread of infection. A review of the facility's COVID-19 Mitigation Plan with a revised date of 8/17/20, indicated: 1. All HCP were screened at the beginning of the shift for possible COVID-19 by: monitoring symptoms of COVID-19 (fever, cough, shortness of breath, malaise (a general feeling of discomfort, illness, or lack of well-being), headache, myalgia (muscle pain), dizziness, and diarrhea, loss of taste or smell, and sore throat). 2. Staff's temperature was monitored at the beginning and end of shift and documented on a log. 3. Avoid rotation of HCP between floors, wings, or units during the period they were working each day (no crossover of staff). 4. Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria [MEDICAL CONDITION] in a healthcare environment) would monitor the proper screening and documentation of all individuals entering the facility including staff for COVID-19 symptoms such as temperature. 5. Entry and access into facility would be limited and monitored. 6. Encourage residents to remain in their rooms and to maintain social distancing from other residents and HCPs when possible.

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