STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWEST HEALTHCARE CENTER	6740 WILBUR AVE RESEDA, CA 91335

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 -** 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 spread of infections during the Coronavirus ((COVID-19), an illness caused by [MEDICAL CONDITION] that can spread from person to person) crisis for affected one (1) of 18 (residents assigned to be cared by Licensed Vocational Nurse (LVN1)) sampled residents (Resident 1) and placed the 17 of 18 residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18) at risk for acquiring respiratory illness that could lead to serious harm and or death by failing to: a. Ensure LVN 1 who was caring for a positive COVID-19 (Resident 1) resident did not also care for residents who are negative for COVID-19 (17 of the 18 residents cared by LVN 1). b. Ensure LVN 1 was wearing the required Personal Protective Equipment (PPE - protective clothing, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) including an N95 mask, while caring for Resident 1. c. Ensure there was proper signage of required PPE for droplet (infection with germs that can be spread to others by speaking, sneezing, or coughing) precaution posted outside of a COVID-19 positive room. d. Ensure LVN 1 did not cross over from red zone (area dedicated to COVID-19 positive residents) to the green zone (area dedicated to COVID-19 negative residents). e. Ensure Business Office Manager 1 (BOM 1) updated the facility census (a daily list reflecting room and bed numbers, and names of residents using the specific beds in those rooms) to accurately reflect the current residents in their own beds in the rooms. f. Ensure the Infection Preventionist (IP) Nurse was able to properly cohort (place residents with same COVID19 status together) residents based on provided Public Health Nurse (PHN) guidelines. g. Ensure LVN 1 was informed of Resident 1's diagnosis. h. Ensure Certified Nurse Assistant 1 (CNA 1) was dedicated to either a COVID-19 positive area or a COVID-19 negative area during his shift from 7:00 a.m. until 7:00 p.m. These deficient practices had the potential to result in the spread of infections related to COVID-19 that could lead to death to other residents and staff. On 6/9/20 at 5:25 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 Assistant Director of Nursing (ADON), IP Nurse, and Director of Staff Development (DSD) for the facility's failure to implement measures to prevent infection related to COVID-19 that threatened the health and safety for 17 of 18 COVID-19 negative Residents. On 6/12/20 at 11:17 a.m., after the facility submitted an acceptable plan of action (POA), the surveyor verified and confirmed on-site the implementation of the POA by observation, interviews, and record review confirmed the removal of the immediate jeopardy in the presence of the ADON and the Clinical Resource Nurse (CRN). The ADON provided an acceptable POA as follows: 1. LVN 1 and CNA 1 who went in to Resident 1's room with regular mask and face shield were given written disciplinary action and 1:1 educational in-services on 6/9/20 and 6/11/20 by the ADON and CRN on infection control prevention with emphasis on proper use of protective equipment; transmission-based precautions (second level of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission) on cohorting positive with positive and negative with negative. 2. LVN 1 and CNA 1, whom were both assigned to care for Resident 1, were informed by ADON on 6/9/20 Resident 1 was identified to have COVID-19 positive diagnosis. 3. DSD and designee staff to work on the COVID-19 unit exclusively on 6/9/20, and provided staff with required PPE, including N95 masks(a type of respirator mask capable of filtering out all types of very small particles including bacteria [MEDICAL CONDITION]) gloves, gowns, and face shields. 4. On 6/10/20, residents who were cared for by LVN 1 and CNA 1, identified as potentially exposed were placed on Person Under Investigation (PUI) monitoring per PHN recommendations and guidelines. Per PHN, residents were maintained in their assigned rooms; rooms were updated to reflect PUI designated (yellow zone), cohorting map updated to reflect new PUI assigned rooms, proper signage was posted, infection control carts were placed outside designated rooms, dedicated staff were provided appropriate PPE, including N95 masks, gloves, gowns, and face shields, dedicated staff were assigned to PUI rooms to provide medication pass, patient care and housekeeping services, and initiated monitoring of vital signs, including monitoring of oxygen saturation every four hours. 5. Dedicated staff will continue to care for residents in the COVID-19 unit and PUI unit until resident completes 14 days without symptoms onset and is moved to the general population per PHN recommendations. 6. Dedicated staff in the COVID-19 and PUI units will observe hand hygiene before and after each resident's care and throughout the shift, as well as proper use of PPE. 7. IP Nurse immediately re-posted proper signage of required Enhanced Droplet and Contact Precautions outside of COVID-19 positive room. 8. BOM 1 updated the facility census to accurately reflect the room and bed numbers to match the residents staying in the specific room and beds for the 17 residents placed in PUI and one resident in the COVID-19 unit. 9. IP Nurse or IP Designee will report any COVID-19 suspects/PUI to CDPH during daily COVID-19 mandatory daily e-reporting (report transmitted to an electronic format) and CDPH monitoring calls. 10. On 6/9/20 & 6/10/20, IP Consultant provided in-service to licensed nurses, CNAs, housekeepers, Respiratory Therapists, rehabilitation staff, activities personnel, and managers on cohorting residents designated to red, yellow and green zones. 11. Nursing assignments were reviewed to identify those resident who were cared for by LVN 1, those residents were placed on PUI monitoring for COVID-19 related signs/symptoms. Findings: 1. A review of the facility's census, dated 6/9/20, indicated facility had 69 residents residing in the facility. a. During an interview with the ADON, on 6/9/20 at 11:40 a.m., she stated she was not aware Resident 1 was positive for COVID-19. During a follow-up interview and record review with the ADON on 6/9/20 at 12:20p.m., the ADON verified that the facility's daily census dated 6/9/20 (official count of total residents admitted at the facility including resident names and assigned room numbers) indicated five residents are placed in the COVID-19 unit however, only one resident (Resident 1) was currently inside the COVID-19 unit. The ADON was unable to explain how come the daily census indicated multiple rooms that did not accurately represent current room assignments of their residents verified during the tour. During an interview with LVN 1, on 6/9/20 at 12:20 p.m., he stated Resident 1 was a Non-COVID resident. LVN 1 stated Resident 1 was supposed to be on a Non-COVID area upon re-admission however the bed was broken and instead was placed in a room inside the COVID-19 unit. A review of Resident 1's Admission Record, dated 6/8/20, indicated the facility admitted Resident 1 with an admitting [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a care and screening tool), dated 3/31/20, indicated Resident 1 was able to make self-understood and had the ability to understand others. A review of Resident 1's laboratory result dated 5/28/20 indicated a positive result for COVID-19. During an interview and concurrent record review with the IP Nurse, on 6/9/20 at 1:45 p.m., she verified Resident 1's laboratory result for COVID-19 indicated a positive result. When IP Nurse was asked why the nursing staff including the IP nurse, the ADON and LVN1 were unaware of Resident 1's COVID-19 positive status, the IP Nurse stated the laboratory results goes to the facility's marketing department. The IP Nurse stated Resident 1's laboratory result dated 5/28/20 was not relayed to the Nursing Department including the IP nurse, ADON, and LVN1. b. During an observation on 6/9/20 at 12:20 p.m., LVN 1 was seen walking out of Resident 1's room (inside the designated COVID-19 Unit). LVN 1 stated Resident 1 was readmitted from the hospital last night on 6/8/20.

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) LVN 1 stated Resident 1 was supposed to be readmitted into a room in the non-COVID designated area, however, the bed was broken so Resident 1 was placed in a room inside the designated COVID-19 Unit instead. LVN 1 did not wear any isolation precaution PPE when entering the COVID-19 unit and did not wear any PPE when entering Resident 1's room. LVN 1 stated Resident 1 was not positive for COVID-19. During a subsequent observation on 6/9/12 at 1:05 p.m., LVN 1 walked out of a room in the Non-COVID area and to the hallway of the non-COVID designated area and to the nursing station to perform hand hygiene. LVN 1 stated he was assigned to administer medications (Medication Cart Number 2) in the skilled nursing side (including Resident 1 and Non-COVID area) from 7:00 a.m. to 7:00 p.m for 1 day on 6/9/20. During an interview and concurrent record review with the IP Nurse, on 6/9/20 at 1:45 p.m., she verified Resident 1's laboratory result, dated 5/28/20, for COVID-19 indicated a positive result. During an interview and concurrent record review on 6/9/20 at 2:43 p.m., the ADON verified the staffing assignment dated 6/9/20 indicated LVN 1 was assigned as a medication nurse and cared for residents in both the COVID-19 unit and Non-COVID designated area. The ADON also verified that CNA 1 was assigned and provided care for residents in both COVID-19 unit and Non-COVID unit on 6/9/20. During a follow-up interview and concurrent record review on 6/9/20 at 3:25 p.m., the ADON verified LVN 1's physician notification dated 4/26/20 indicated LVN 1's COVID-19 test was positive. The IP Nurse verified LVN 1's most recent COVID-19 test result dated 5/14/20 indicated COVID-19 is detected in his laboratory result. The IP Nurse stated she did not know that a staff whom tested positive for COVID-19 test could not care for non-COVID residents unless the staff is subsequently tested negative for COVID-19. A review of the facility COVID mapping on 6/9/20 indicated a color coded separation of rooms indicating the following: Green color on map for Clear/COVID free rooms indicated for room numbers 19, 20, 21, 22, 23, 24, 25, 30, 31, 32, 33, 34, Yellow for PUI (person under investigation)/Symptomatic rooms indicated for rooms 26, 27, 28, 29, Red for COVID positive indicated for rooms 35, 36, 37, 38. A review of the facility's policy titled, Policy for Emergent Infectious Disease for Skilled Nursing Care Center, with unknown date, indicated, Suspected case in the care center - Activate quarantine (a strict isolation imposed to prevent the spread of disease by separating well persons from persons who may have been exposed to a communicable disease to see if they become ill) interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC. According to the Centers for Disease Control and Prevention (CDC), dated 6/22/20, facility needs to identify Health Care Personnel (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use. Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html c. During an observation on 6/9/12 at 12:20 p.m., LVN 1 was seen walking out of Resident 1's room (inside the designated COVID-19 unit). LVN 1 was seen wearing a black cloth mask over his nose and mouth. LVN 1 was not wearing any N95 (a type of respirator mask capable of filtering out all types of very small particles including bacteria [MEDICAL CONDITION]) mask, face shield, eye shield, or gown. During an interview on 6/9/20 at 1:20 p.m., LVN 1 verified he was wearing a cloth mask when entering Resident 1's room. LVN 1 stated he brought the cloth mask from home. LVN 1 stated at times he will double mask while indicating he will place a second cloth mask on top of the mask he was wearing. LVN 1 confirmed he did not wear an N95 mask while administering medications for Resident 1. LVN 1 stated he did not wear the N95 mask because he was not caring for any residents with precautions that required the N95 mask. LVN 1 stated N95 is required when caring for COVID-19 positive residents. LVN 1 stated Resident 1 was not COVID-19 positive. During a subsequent interview on 6/15/20 at 11:11 a.m., LVN 1 stated that he did not wear the appropriate PPE such as an N95 mask because he did not know that Resident 1 was positive for COVID-19. LVN 1 stated he should have worn N95 when caring for a COVID-19 positive resident. LVN 1 stated he would have if he knew that Resident 1 had a positive result to ensure safety of all residents and staff members. During an interview and record review on 6/9/20 at 1:45 p.m., the IP Nurse verified Resident 1 had a positive result for the COVID-19 test dated 5/28/20. The IP Nurse stated residents should be isolated for 14 days if they have a positive COVID-19 test result. The ADON further stated LVN 1 should have worn N95 when caring for a resident with positive result for COVID-19. A review of the facility's policy titled, Policy for Emergent Infectious Disease for Skilled Nursing Care Center, with unknown date, indicated, Suspected case in the care center - Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC. According to the CDC, dated 6/22/20, HCP should wear an N95 or higher-level respirator, eye protection, gloves and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated. Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html d. During an observation and concurrent interview inside the COVID unit on 6/9/20 at 5:00 p.m., LVN 1 verified that signs for isolation precaution were not posted on or near the entrance door of Resident 1's room (located inside the COVID-19 unit). LVN 1 stated there should have been a sign posted at Resident 1's door indicating the type of precaution and which personal protective equipment should be worn. LVN 1 was unable to explain how come there were no signs posted. A review of the facility's policy titled, Isolation-Initiating Transmission-Based Precaution dated January 2012, indicated When transmission-based precautions are implemented, the IP Nurse shall post the appropriate notice on the room entrance door and on the front of the resident's chart (resident's medical records) so that all personnel will be aware of precautions. The CDC dated 4/30/20, states Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html