STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMPERIAL CREST HEALTH CARE CENTER	**11834 INGLEWOOD AVENUE HAWTHORNE, CA 90250**

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 interview and record review, the facility failed to ensure one of one residents (Resident 1) who was receiving [MEDICAL TREATMENT] (removal of waste products and excess fluid from the body with the use of a [MEDICAL TREATMENT] machine) was cohorted (grouped) per Centers for Disease Control (CDC) guidelines, to prevent the potential transmission of COVID-19 (an illness caused by [MEDICAL CONDITION] that can spread from person to person) infection. Findings: During an interview on 8/27/20 at 1:44 p.m., the Director of Nursing (DON) stated, We do not have persons under investigation ((PUIs) a person who has been in close contact with a person with confirmed infection and may have been to a place where there is an outbreak). We only have [MEDICAL TREATMENT] residents. During an interview on 8/28/20 at 10:08 a.m., licensed vocational nurse (LVN 1) stated PUI's consist of [MEDICAL TREATMENT] residents, symptomatic residents (exhibits signs and symptoms of covid-19), residenrs who have been re-admission to the facility and newly admitted residents. LVN 1 stated the risks of not following infection control procedures could put others at risk of being affected and increased the risk of transmission of COVID-19. A review of the admission face sheet indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical (H&P) assessment form dated 7/31/20 indicated Resident 1 had the capacity to understand and make own decisions. A review of laboratory results dated [DATE] indicated Resident 1 was negative for COVID-19 upon admission to the skilled nursing facility. A review of the laboratory results indicated Resident 1 had a specimen for COVID-19 collected on 8/14/20 with results showing the resident was positive for COVID-19 on 8/18/20. A review of the Change of Condition dated 8/19/20 indicated Resident 1 was transferred to the hospital for evaluation for failure to thrive and weakness. A review of the Admission Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, indicated Resident 2 was unable to make decisions. A review of the laboratory result dated 8/3/20 indicated Resident 2 was negative for COVID-19. A review of the Notification of Room Change dated 8/19/20 indicated Resident 2 had a room change because of being identified as a PUI due to [MEDICAL TREATMENT] treatments. During an interview on 9/3/20 at 2:52 p.m., the DON stated Resident 1 had been in room [ROOM NUMBER]B since admission to the facility. The DON stated Resident 2 was discharged , came back and was admitted to room [ROOM NUMBER]A with Resident 1 because they were both under quarantine status. The DON stated when the facility had a new an admission or readmission, the staff placed the residents in a single room. The DON stated Resident 2 was a [MEDICAL TREATMENT] resident and was considered PUI, that was why the resident was moved to room [ROOM NUMBER]A. The DON stated, They did not say we could not put a [MEDICAL TREATMENT] and readmission resident together; they were both in quarantine. During an interview on 9/10/20 at 9:14 a.m., the DON stated only one COVID-19 test was done for Resident 2 on 7/31/20, which showed to be negative on 8/3/20, but no second testing was done. The DON stated, Resident 2 was positive in the GACH, not here. The DON stated Resident 2 went to the hospital on [DATE] and we were informed Resident 2 was positive for COVID-19 on 8/25/20. The DON stated Resident 2 was admitted to room [ROOM NUMBER]A on 8/11/20. The DON stated Resident 1 was admitted on [DATE] but was transferred to the GACH. The DON stated We isolate the new admissions and readmissions for 14 days and retest them on the last day of the isolation. During a concurrent interview with the Social Services Designee (SSD) on 9/10/20 at 9:32 a.m., stated Resident 1 was admitted to room [ROOM NUMBER]B on 7/24/20 with no roommate and went back out to the GACH on 7/27/20. The DON stated Resident 1 was readmitted to room [ROOM NUMBER]B for a 14 day isolation. The DON stated Resident 1 was off the isolation on 8/12/20. When asked why Resident 2 was placed with Resident 1 when her isolation period was not completed, the DON stated, they were both on quarantine. When asked if a repeat COVID-19 test was done for Resident 1 on 8/12/20, which was the last day of isolation, the DON stated, No, the retest was done on 8/14/20. The DON stated [MEDICAL TREATMENT] residents should be kept separated from others as they are at higher risk for COVID-19 due to frequency of leaving the facility. A review of the Guidelines for Preventing and Managing COVID-19 in Skilled Nursing Facilities dated 8/4/20 indicated newly admitted and readmitted patients must stay in quarantine in the yellow cohort for 14 days. The guidelines indicate the resident(s) must be tested on admission and again at the end of quarantine. The guidelines indicated residents who regularly leave the facility for [MEDICAL TREATMENT] treatments should be housed in the yellow cohort together.

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.