STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555780	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA DEL RIO GARDENS	**7004 EAST GAGE AVENUE BELL GARDENS, CA 90201**

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 establish, and maintain an infection prevention and control program, designed to provide a safe, sanitary environment, that can help prevent the development, and transmission of communicable diseases, and infections by not monitoring: a. One of 10 healthcare workers, who had long, sharp, fake nails, was caring for one COVID-19 (an illness caused by [MEDICAL CONDITION] that can spread from person to person), and non-COVID-19 residents. The facility did not establish and implement a policy on how to manage employees long, fake nails. b. Two of the three residents (2, 3), who were exposed to a roommate that was confirmed positive for COVID-19, were not cohorted (keeping residents who are COVID-19 positive or are suspected to have COVID-19 in the same space (wing, floor, etc.) that is separate from those who are COVID-19 negative or do not have exposure to COVID-19) with other suspected residents, but were placed in two separate rooms that housed non-COVID residents. These deficient practices had the potential to result in wide-spread of COVID-19 infections in the facility and the community. Findings: a. During a concurrent observation and interview with certified nurse assistant (CNA 2), on 7/1/20 at 4:22 p.m., was observed with long, sharp nails. During interview CNA 2 stated she had fake nails but the facility allowed her to have long, fake nails. However, CNA 2 immediately retracted her answer and stated she did not know if she could have fake nails. During an interview with the Director of Nursing (DON), on 7/1/20 at 4:31 p.m., stated the healthcare workers could not have long nails. The DON stated the charge nurses were responsible for monitoring the nails of healthcare workers. During an interview with Infection Preventionist (IP 1) on 7/1/20 stated the healthcare workers were not allowed to have long, fake nails. IP 1 stated fake nails trapped particles inside the nail and could spread COVID-19 to other residents. IP 1 stated the facility did not establish a policy on how to manage employees long, fake nails. b. During an observation with the Director of Nurses (DON) on July 1, 2020 at 4 p.m., of the hallway with rooms 80-84 (designated as COVID area/red zone), the observed room [ROOM NUMBER] had an isolation cart (cart to put and organize gowns, face shield, gloves and alcohol sanitizer, to protect individuals from exposure to the germs) outside, by the door. There was also signage for donning and doffing of Personal Protective Equipment ((PPE) materials worn to protect from exposure to germs), and droplet and contact precaution signs (signs to indicate the level of protection needed) posted above the isolation cart. The door of the room was closed. During a interview with the DON on July 1, 2020 at 4:09 p.m., stated Resident 1, who was confirmed Covid-19 positive during the latest testing done by the facility, was placed in room [ROOM NUMBER] bed C. The DON also stated the roommates of Resident 1 were placed in room [ROOM NUMBER] bed C (Resident 2), and 76 bed C (Resident 3). However, during an observation of the hallway 70 to 79 along with the DON, Resident 2 was housed in room [ROOM NUMBER] bed C with another resident in bed A. Bed B in room [ROOM NUMBER] was empty and not occupied by any other residents. Resident 3 was placed in room [ROOM NUMBER] bed C with 2 other residents. During a review of the facility's map indicated the cohorting zones for the COVID-19 cases, were rooms 70 to 79, and 90 to 95, designated for confirmed non-COVID residents (green zone). Rooms 60 to 67 were designated as a yellow zone which was dedicated for the residents on isolation/quarantined (new admits or readmission, where the Covid-19 status was unclear, or for the residents possibly exposed to COVID-19). The red zone was designated rooms 80 to 84 for confirmed COVID-19 positive residents only. During an interview with IP 1 on July 1, 2020 at 4:40 p.m., acknowledged and stated Resident 2 and 3 should have been placed in the yellow zone, which was designated for isolation and not with the residents who were tested , and confirmed as non-COVID. During a review of an undated facility's policy and procedures titled Cohorting of Residents, indicated: Patients who are close contacts of COVID+ patient (roommates): should be placed in quarantine (yellow) unit, ideally in single rooms if space allows.

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