STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055538	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BONNIE BRAE SKILLED NURSING	**420 SOUTH BONNIE BRAE ST. LOS ANGELES, CA 90057**

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 0620 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure new Residents (Resident 2 and 3) were not admitted to the facility per Public Health mandate during the Coronavirus outbreak ((COVID-19), an illness caused by [MEDICAL CONDITION] that can spread from person to person). This deficient practice caused an increased risk for residents and staff to acquire respiratory illness that could lead to serious harm and or death. Findings: During an observation on 7/16/2020 at 7:35 AM, Resident 2 and Resident 3 were in their room. A review of the admission record on 7/16/2020 at 10:35 AM, indicated Resident 2 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 7/15/2020 indicated Resident 2 was cognitively intact (independently makes decisions) and required limited assistance with 1 person assist for activities of daily living (ADLs - transfers, personal hygiene, walking, and bathing) A review of Resident 2's physician's orders [REDACTED]. A review of the admission record indicated Resident 3 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 3's MDS dated [DATE] indicated Resident 3 was cognitively intact (independently makes decisions) and required limited assistance with 1 person assist for activities of daily living. A review of Resident 3's physician's orders [REDACTED]. During an observation and concurrent interview on 7/16/2020 at 8:56 AM, Resident 2 stated CNA 1 came into his room and took his vitals. Resident 2 stated he has been at the facility since 7/8/2020. During an interview on 7/16/2020 at 2:02 PM with Director of Staff Development (DSD) she stated she did not get confirmation from Public Health for new admissions. She stated the facility can not admit new residents without a clearance from Public Health. During an interview on 7/17/2020 at 10:59 AM, the Public Health Nurse (PHN) stated she informed in the email dated 6/25/2020 at 10:40 AM that if any staff or resident test positive during any of the two rounds of mass testing more than 4 weeks after the COVID-19 outbreak was originally closed then re-open outbreak and close to admissions. She stated the facility was not supposed to admit new residents. During an interview on 7/17/2020 at 11:15 AM, the Administrator (Admin) stated an email from Public Health Nurse (PHN) indicated if residents test positive from response testing then facility will close to new admissions. The Admin stated the facility was not supposed to admit Resident 2 and 3 on 7/8/2020, per Public Health mandate. A review of the PHN email dated June 25, 2020 at 10:40 AM to facility, indicated if residents test positive from response testing more than 4 weeks after the outbreak was originally closed then re-open the outbreak and close to admission. A review of the facility polices and procedures titled, Admissions Policies, indicated it shall be the responsibility of the Administrator, through the admissions department, to assure that the established admission policies are followed by the facility and resident.
F 0880 **Level of harm** - Immediate jeopardy **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 provide a safe and sanitary environment to help prevent the development and transmission of COVID-19 (Coronavirus disease 2019, a highly contagious [MEDICAL CONDITION] infection that spread from person-to-person affecting the respiratory system) for two of two residents (Residents 2 and 3) quarantined (restricted movement of people intended to prevent the spread of disease) for possible COVID-19 infection out of a total of 47 residents in the facility. The facility also failed to provide a safe environment for four nursing staff (Certified Nursing Assistants 1, 2, 3 (CNAs 1, 2, and 3) and Licensed Vocational Nurse 1 (LVN 1) and three kitchen staff (KSs 1, 2 and 3) out of 30 facility staff, who required to be quarantined and off work. The facility failed to: a. Ensure LVN 1 and CNAs 1 and 3 donned (put on) Personal Protective Equipment (PPE - protective clothing, goggles, head/shoe covers, mask, gown, gloves or other garments or equipment designed to protect the wearer's body from infection) while caring for Residents 2 and 3, who were potentially COVID-19 positive (Persons Under Investigation (PUI)) quarantined for 14 days since admission to rule out COVID-19. b. Ensure there were PPE supplies and a signage outside the room of Residents 2 and 3, indicating the type of isolation needed and the PPE to use to enter the room. c. Ensure newly admitted Residents 2 and 3 were quarantined for 14 days as PUI for potential COVID-19. d. Ensure the Infection Preventionist (IP) nurse was knowledgeable on cohorting (imposed grouping of people, such as residents, potentially exposed to designated diseases) residents as per recommendation from the Public Health Nurse (PHN). e. Ensure only assigned dedicated healthcare staff to care for Residents 2 and 3 who were PUIs and for Residents 1 and Resident 4 (was not in the facility at the time) who were positive for COVID-19. f. Ensure CNA 1, LVN 1, KS 1 and KS 2 were off work and quarantined, as per PHN recommendation. These deficient practices had the potential to result in the spread of COVID-19 placing remaining residents in the facility and the staff at risk to be infected with COVID-19 and becoming seriously ill, leading to hospitalization and/or death. On 7/16/2020 at 4:25 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 Administrator, the Director of Nursing (DON), and the Infection Preventionist (IP) Nurse for the facility's failure to implement measures to prevent the transmission of COVID-19 infection that threatened the health and safety of the residents and staff. On 7/18/2020 at 1 p.m., after the facility submitted an acceptable plan of action (POA), the survey team verified and confirmed on-site the implementation of the POA through observation, interview and record review. The IJ situation was removed in the presence of the Administrator, DON, and IP. The accepted POA included the following actions: 1. In-service education to all staff on infection control prevention with emphasis on proper use of PPE, signage outside the residents rooms, PPEs outside resident rooms, transmission-based precautions, cohorting and zoning, dedicated staff for positive COVID-19, PUIs and not infected residents, and mandatory 14 days quarantine of residents and staff who were potentially infected. 2. The DON informed LVN 1 and CNA 2 on 7/18/2020 Resident 4 was identified to have COVID-19 positive diagnosis. 3. The Director of Staff Development (DSD) and DSD Designee assigned trained staff to work on the COVID-19 positive residents Red Zone unit exclusively and provided staff with necessary PPEs (N95 masks, gloves, gowns, and face shields). 4. On 7/17/2020, proper signages were posted, infection control carts with the necessary supplies and PPEs were placed outside the rooms. 5. Dedicated staff would continue to care for residents in the COVID-19 unit and PUI unit until residents completes 14 days without symptoms and are moved to the general population, per PHN recommendation on 7/14/2020 as they had been exposed to positive COVID-19. Findings: A review of the facility's census dated 7/16/2020, indicated facility had 47 residents in-house. A review of Resident 1's Admission Record (Face Sheet) indicated an admission on 5/4/2016 and a re-admitted d 7/11/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's the Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 7/18/2020 indicated Resident 1 was unable to make decisions, and required limited assistance with one person assist with activities of daily living (ADLs - transfers, personal hygiene, dressing, and toilet use). A review of Resident 1's COVID-19 test result collected 7/9/2020 indicated positive for COVID-19. A review of Resident 4's Admission Record (Face Sheet) indicated an

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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BONNIE BRAE SKILLED NURSING	**420 SOUTH BONNIE BRAE ST. LOS ANGELES, CA 90057**

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) admitted d 12/22/15 and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 4's MDS, dated [DATE] indicated Resident 4 was able to make decisions, and required extensive assistance with one person assist with activities of daily living (ADLs - personal hygiene, and dressing). A review of Resident 4's COVID-19 test result collected 7/9/2020 indicated positive for COVID-19. A review of Resident 4's physician's orders [REDACTED]. A review of Resident 2's Admission Record (Face Sheet) indicated an admitted d 7/8/2020 with [DIAGNOSES REDACTED]. A review of Resident 2's the Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 7/15/2020 indicated Resident 2 was able to make decisions, had no memory problems, and required limited assistance with one person assist with activities of daily living (ADLs - transfers, personal hygiene, walking, and bathing). A review of Resident 2's physician's orders [REDACTED]. A review of the facility's COVID-19 Mitigation Plan indicated newly admitted residents would be placed in droplet isolation (quarantined) for potential COVID-19 for a 14-day period. A review of Resident 3's Admission Record indicated the facility admitted the resident on 7/8/2020 with [DIAGNOSES REDACTED]. A review of Resident 3's MDS dated [DATE] indicated Resident 3 was cognitively intact and required limited assistance with one-person assist with ADLs. A review of Resident 3's physician's orders [REDACTED]. On 7/16/2020 at 7:35 a.m., Residents 2 and 3 were observed in their room without any signage indicating they were on droplet isolation precautions. The two residents' room did not have outside the door, a cart containing supplies and equipment dedicated to use with them only (PPEs, stethoscope (medical device for listening to internal sounds of human body), blood pressure cuff, etc.). At the time of the observation, Certified Nursing Assistant 1 (CNA 1) entered Resident 3's room to provide care. CNA 1 did not put on PPE. On 7/16/2020 at 7:50 a.m. during an interview, CNA 1 stated he was assigned to care for Residents 2 and 3, who were not in isolation precautions because there were no isolation signs outside the rooms or isolation carts (with PPE and equipment) by the entrance of their rooms. CNA 1 stated he was also assigned to other residents (non-quarantined residents). On 7/16/2020 at 7:57 a.m., during an observation and concurrent interview on CNA 2 was observed exiting Resident 1's room, who was on droplet isolation precaution for COVID-19 (there was a sign posted outside the room and a cart with PPEs and supplies). CNA 2 stated she was assigned to provide care to resident with COVID-19 and residents who did not have COVID-19. CNA 2 stated she worked full time in the facility and during her shifts, she alternated between taking care of residents in quarantine and non-quarantine zones. On 7/16/2020 at 8:50 a.m., after taking care of Resident 1, who had COVID-19, CNA 2 proceeded to assist Resident 4 who was not on isolation precautions. CNA 2 was observed wheeling Resident 4 from the shower room to his room, after a shower. CNA 2 was not wearing PPEs. On 7/16/2020 at 8:55 a.m., CNA 1 was observed entering Resident 2's room to take Resident 2's vital signs (blood pressure, respiratory and heart rate and temperature) without putting PPEs. Upon leaving the room, in an interview, CNA 1 stated he did not need PPEs because Resident 2 was not in isolation precautions. On 7/16/2020 at 9 a.m. during an interview, Resident 2 confirmed CNA 1 took his vital signs without any personal protective equipment. Resident 2 stated he has been at the facility since 7/8/2020. During an interview on 7/16/2020 at 1:25 p.m. the Director of Nursing (DON) confirmed Residents 2 and 3 were admitted on [DATE] and were not placed on quarantine for 14 days as recommended by the PHN. The DON stated new admitted residents are tested for COVID-19 and the policy is to quarantine and isolate new Residents for 14 days regardless of initial COVID-19 test results. Then, re-test for COVID-19, and if negative the resident is removed from quarantine. The DON could not explain the reason the staff did not quarantine Residents 2 and 3. On 7/16/2020 at 4 p.m., during an interview, CNA 3 stated she had been assigned to Residents 2 and 3 and she did not wear any PPE because there was no signs outside the rooms indicating the residents were on isolation precautions and the licensed nurses did not advise her to wear PPEs. On 7/16/2020 at 4:10 p.m., during an interview, the IP confirmed Residents 2 and 3 were not placed in droplet isolation precautions since their admitted d 7/8/2020. The IP did not explain the reason the policy and the PHN recommendations were not followed. A review of the Staffing Assignments for 7/9 and 7/16/2020, indicated CNAs 1 and 3 and LVN 1 were assigned to quarantine and non-quarantined residents during the morning shift. On 7/17/2020 at 7:40 a.m., during an interview, LVN 1 he stated the facility had only Resident 1 in the Red Zone (for COVID-19 positive residents). LVN 1 stated Residents 2 and 3 were not on isolation. on 7/17/2020 at 11:15 a.m., during an interview, the Administrator stated the facility's policy and procedure on transmission-based precaution and COVID19 mitigation plan indicated new admitted residents are to be placed in isolation for 14 days in the Yellow Zone. The Red Zone was for COVID-19 positive residents and the Green Zone was for COVID-19 negative residents. b. During an observation on 7/16/2020 at 8:15 a.m. KS 1, KS 2 and Dietary Service Supervisor were working in the kitchen. KS 1 and KS 2 were observed preparing food and cleaning the kitchen. At the time of the observation, three kitchen staff (KS1, KS2, and KS3) stated they were scheduled to work on that day (7/16/2020) and they prepared and served breakfast. On 7/16/2020 at 8:30 a.m. during an interview, PHN stated KS 1, KS 2, LVN 1, and CNA 2 were last exposed to a COVID-19 positive Resident/Staff on 7/11/2020 and the recommendation was for them to quarantine for 14 days or allowed to work only on the Red Zone (COVID-19 positive residents) only if there was staffing shortage. A review of an email from the PHN, dated 7/14/2020, to the facility indicated PHN recommended exposed or positive staff should quarantine, but if staffing issues nursing staff could work on the Red Zone only, and kitchen staff to be quarantined. A review of facility's policy and procedures titled, Isolation - Initiating Transmission Based Precautions, revised April 2012 indicated if a resident is suspected of, or identified as, having a communicable infections disease, the charge Nurse or Nursing Supervisor shall notify the infection Preventionist and the resident's attending physician for appropriate Transmission Based precautions. When transmission-based precautions are implemented, the IP or designee shall ensure that protective equipment, gloves, gowns, masks, etc., is maintained near the resident's room ensuring everyone entering the room can access what they need. The policy indicated to post the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel will be aware of the precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. The facility's policy titled, Mitigation Plan, undated, indicated to test residents prior to admission or re-admission, including transfers from hospitals or other healthcare facilities. If the hospital does not test the resident, the facility will test and quarantine the resident upon admission. Residents admitted should be tested prior to admission and if they test negative, should be quarantined for 14 days and then re-tested . If negative, the resident can be released from quarantine. Place residents into three separate cohorts based on the test results. Facility will cohort all unknown asymptomatic and untested residents in the Yellow Zone and will be treated with contact and droplet precautions until a negative test result can be achieved or the resident meets the time criteria to return to the Green Zone based on current Centers for Disease Control (CDC) guidance for removal of transmission-based precautions. Residents positive for COVID-19 are cohorted on the Red Zone.