STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056063	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INFINITY CARE OF EAST LOS ANGELES	**101 S FICKETT STREET LOS ANGELES, CA 90033**

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 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly (means that results shall be relayed with little or no delay) report positive Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) laboratory reports for 27 of 27 residents (Residents 1, 8, 10, 12, 13, 16, 18, 22, 25, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50). The Clinical Laboratory Scientist (CLS, is a licensed healthcare professional who performs laboratory analyses) reported the COVID-19 positive laboratory results on 6/23/20 at 10:24 a.m. to the facility's Administrator (ADM) and the ADM did not intervene until the Department questioned him on 6/24/20 at 11:42 a.m., (more than 25 hours later). This deficient practice had the potential for the residents not to receive prompt care. *cross reference F880 Findings: During an interview on 6/24/20 at 11:42 a.m., the ADM stated he received positive COVID-19 results for more than 20 residents. The ADM stated he received the results on 6/24/20 around 9 or 10 a.m., and he was trying to gather all the information. During an observation on 6/24/20 at 11:45 a.m., Resident 1's room door was opened no isolation (the state of being alone or away from others) signs and Resident 1 was lying in bed with no face covering, the resident had a plastic nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) with oxygen at 2 liters per minute (LPM, velocity at which air flows). The plastic tubing was touching the floor. Resident 1 had her eyes closed and the Department was not able to interview the resident. A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 3/19/19 and readmitted her on 2/3/20 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 5/8/20 indicated the resident was severely impaired for cognitive skills (never/rarely made decisions) and requires extensive assistance for bed mobility, toilet use, and personal hygiene. A review of Resident 1's Laboratory Report with a release date of 6/23/20, indicated the resident tested positive for COVID-19. During an interview and a review of the facility's Daily Roster Census on 6/24/20 at 12:18 p.m., the ADM stated Residents 1, 8, 10, 12, 13, 16, 18, 22, 25, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50 had tested positive for COVID-19 and the staff and physician were not aware. The ADM stated the following Residents tested positive for COVID-19 and were not separated from the residents who tested negative: a. Resident 1 had symptoms of shortness of breath tested positive for COVID-19 is sharing a room with Resident 2 who tested negative for COVID-19. b. Resident 8 tested positive for COVID-19 is sharing a room with Resident 9 who tested negative for COVID-19. c. Resident 13 tested positive for COVID-19 is sharing a room with Resident 14 and Resident 15 who both tested negative for COVID-19. d. Resident 18 tested positive for COVID-19 is sharing a room with Resident 19 who tested negative for COVID-19. e. Resident 22 tested positive for COVID-19 is sharing a room with Resident 23 who tested negative for COVID-19. f. Resident 25 tested positive for COVID-19 is sharing a room with Resident 26 who tested negative for COVID-19. g. Resident 33 tested positive for COVID-19 is sharing a room with Resident 35 who tested negative for COVID-19. During a telephone interview on 7/1/20 at 1:11p.m., the laboratory CLS stated she reported to the ADM on 6/23/20 at 9:50 a.m. that more than 20 residents were tested positive for COVID-19. The CLS stated she told the ADM he had an outbreak in his facility and that he should begin to implement the proper protocol. The CLS stated she also emailed to the ADM on 6/23/20 at 11:30 a.m., and that she received a receipt that indicated ADM opened the email on 6/23/20 at 5:43 p.m. During an interview on 7/2/20 at 11:27 a.m., the ADM stated on 6/23/20, he was aware that 27 residents were tested positive. The ADM stated he did not take any actions to separate the residents who tested positive from the residents who tested negative for COVID-19. The ADM stated he did not intervene and he did not inform the physician and staff until the Department questioned him on 6/24/20. The ADM stated COVID-19 is very contagious and it is a deadly virus that could spread to other residents. A review of the facility's policy and procedure, titled Test Results, with a revised date of 2007 indicated the resident's Attending Physician would be notified of the results of diagnostic tests and should the test results be provided to the facility, the Attending physician should be promptly notified of the results.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct the Quality Assessment and Assurance (refers to identification, assessment, correction and monitoring of important aspects of patient care designed to enhance the quality of health consistent with achievable goals and within available resources) meeting to implement its policy and procedure by failing to: 1. Identify issues and concerns related to COVID 19 (an illness caused by [MEDICAL CONDITION] that can spread from person to person) Infection such as cohorting (grouping) positive COVID 19 residents from negative COVID 19 residents. 2. Notify and consult with the Medical Director and conduct a QAA meeting with staff to address issues and concern regarding COVID 19 outbreak in the facility. 3. Ensure an Infection Preventionist (an experts on practical methods of preventing and controlling the spread of infectious diseases, typically within a specific population, the patients, staff, and visitors at a hospital or other health care setting) Nurse was available to manage, control and prevent the spread of COVID 19. This deficient practice resulted in 45 residents and 27 staff had tested positive for COVID 19 and and had the potential for the [MEDICAL CONDITION] to spread to other residents and staff. Cross Reference F 880 Findings: A review of the facility's COVID 19 and Respiratory Outbreak Line List for Long Term Care Facilities form, dated 6/24/20, indicated the facility had 19 residents and 27 staff tested positive for COVID 19. A review of the facility's floor plan indicated Rooms 106, 107, 108, 109, and 110 were in the red zone (COVID area for positive COVID 19 residents) and Rooms 102, 103, 104, and 105 were in the yellow zone (Quarantine area for persons under investigation (PUI, residents who suspect to have COVID 19). During an interview On 6/24/20, at 11:35 AM with the DON, she stated as today (6/24/20), there were 19 residents had tested positive for COVID 19. The DON stated there were 18 residents awaiting COVID 19 test results. During an observation of the 1st floor and concurrent interview with the DON on 6/24/20 at 11:38 AM, she stated five residents who had tested positive for COVID 19 were in the red zone. The DON stated PUI residents reside in the green zone (non COVID 19 area for residents with negative COVID 19). The DON stated she did not know about the yellow zone. The DON stated residents who were waiting for COVID 19 test results reside in the green zone. During an observation of the facility 2nd floor and concurrent interview with the DON on 6/24/20 at 11:45 AM, she stated the 2nd floor was designated for residents who had tested negative for COVID 19 (green zone). During an observation on 6/24/20 at 11:48 AM, room [ROOM NUMBER] had an sign for contact isolation (infections, diseases, or germs that are spread by touching the resident or items in the

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 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) room). The DON stated she did not know the reason for the contact isolation. During an interview with the Licensed Vocational Nurse 1 (LVN 1), on 6/24/20 at 12:30 PM, he stated there was no designated breakroom and restroom for staff assigned in the red zone. LVN 1 stated that the red zone does not have donning and doffing areas for Personal Protective Equipment (PPE, masks, gowns, gloves and face shields worn to limit exposure to COVID 19). During an interview with the Administrator on 6/24/20 at 12:35 PM, he stated the facility used one entrance and one exit for staff that worked in the COVID and non-COVID areas. The Administrator stated the facility did not had a designated breakroom and restroom for staff who works in the red zone. The Administrator stated there was no PPE donning and doffing area for staff assigned in the red zone. During an interview with the DON on 6/24/20 at 2:56 PM, she stated that as of today (6/24/20) he received an additional 22 resident with positive test results for COVID 19 including the residents in the green zone. During an interview with the DON on 6/24/20 at 3:30 PM, she stated that the facility did not had an IPN. The IPN last day of work was 6/10/20. The DON could not provide the facility's COVID 19 Infection Control surveillance (a tool used for ongoing, systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status). During an interview with the Administrator on 6/26/20 at 4:10 PM, he stated that the facility has not conducted a QAA meeting to discuss an issues and concern regarding the implementation of the COVID 19 Infection Control care policies. The Administrator stated the last time facility conducted QAA meeting was on February 2020. The Administrator stated the facility did not conduct meeting with the members of the committee regarding the plan and implementation of potential COVID 19 outbreak in the facility. During an interview with the Medical Director on 6/26/20 at 4:23 PM, he stated the facility did not had recent QAA meeting to address the plan of care and how to address the outbreak. The Medical Director stated he was not aware of the COVID 19 outbreak. The Medical Director stated was not notify regarding the increase in the number of residents who had tested positive for COVID 19. A review of facility's policy and procedure, titled Quality Assessment & Assurance Program, dated 8/4/2007, indicated for the facility to make continual effort to provide quality care to residents within available resources. The policy indicated in order to assist in providing such care, the Quality Assessment and Assurance Program is developed as a mechanism by which to identify and correct resident care problems. The facility Administrator or designee shall be responsible for overseeing the Quality Assessment and Assurance Program in order to meet the needs, goals and objectives of the resident population that it serves and meet the Standards of Care established within the Infinity Care Quality Improvement Program. The identified problems should be established to determine amount of resources necessary to address and resolve identified problem. The corrective action plans should be evaluated for their effectiveness in resolving problem area.
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 living environment to prevent the spread of Coronavirus (COVID-19, a respiratory illness that can spread through respiratory droplet from an infected person a non-infected to person) for 61 of 61 residents as indicated in the facility's infection control policies and COVID-19 mitigation plan (plan to reduce loss of life and limit the impact of COVID-19 in the facility) during the COVID-19 pandemic (spread of a disease worldwide) when the facility's administrative staff failed to: 1. Cohort (to group) residents who tested positive for COVID-19 from residents who tested negative for COVID-19. 2. Ensure there were designated breakrooms, restrooms, entrances, exits, personal protective equipment (PPE, gown, gloves masks worn to minimize exposure to COVID) donning (putting on) and doffing (taking off) areas for staff who were taking care the COVID-19 positive residents (COVID staff). 3. Ensure Resident 1, who tested positive for COVID 19, was wearing a face cover while sharing the same room with Resident 2 who tested negative for COVID-19. 4. Designate an interim (temporary) Infection Prevention Nurse (IPN who helps prevent and identify the spread of infectious agents like bacteria [MEDICAL CONDITION] in a healthcare environment) to manage, prevent and control the spread of COVID-19 in the facility while the full time IPN was out sick. 5. Ensure staff perform hand hygiene (wash or sanitize hands) after contacting with objects in the room of a COVID-19 positive resident. 6. Ensure Quality Assurance meeting (meeting to review and improve care and services to the residents) was conducted with staff regarding the COVID-19 outbreak. These deficient practices resulted in the spread of COVID 19 that led to 45 residents had tested positive for COVID 19. These deficient practices also had the potential to result in further spread of COVID-19 to other residents and staff. On 6/24/20 at 3:40 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation had 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 (ADM) and Director of Nursing (DON) for the facility's failure to implement measures to prevent infection that threatened the health and safety of 61 residents and staff. On 6/27/20 at 5:36 p.m., the immediate jeopardy was lifted after the facility submitted an acceptable plan of action (POA, actions to correct deficient practices), the survey team verified the implementation of the POA by observation, interview and record review then confirmed the removal of the immediate jeopardy in the presence of the ADM and the DON. The POA included the following actions: 1. On 6/24/20 and 6/25/20, facility's staff moved all confirmed positive COVID-19 residents to the second floor (Station 2, designated area for positive COVID-19 residents) and all non-COVID-19 residents to the 1st floor (Station 1, designated area for negative COVID-19 residents). Facility's staff moved persons under investigations (PUI, residents suspect to have COVID-19) to room [ROOM NUMBER]. The provided inservice regarding green zone (non COVID area), yellow zone (PUI area) and red zone (COVID area). 2. On 6/26/20, The Fire Department Operator #175 approved the use of the fire exit door. Staff who were taking care of COVID positive residents had their own entrance and exit into the red zone. Dining room on the 1st floor was converted to Nursing Station and break room for COVID staff. Signages were put in-place to remind staff to wash their hands, to don and doff their PPE. Staff in the yellow zone has designated restroom. The IPN provided in services for donning and doffing of PPE. The ADM and the DON provided in services for staff to ensure non-COVID staff must not use the breakrooms and restroom dedicated for COVID staff. 3. On 6/24/20 and 6/25/20, the ADM and the DON provided in services for staff to provide face masks to positive COVID-19 residents. 4. On 6/27/20, the administrator hired an interim IPN to work 40 hours a week. 5. On 6/24/20, the ADM and DON provided in services for staff to perform hand hygiene before and after contact with residents or objects in the residents' environment. 6. On 6/29/20, the AMD conducted a Quality Assurance (QAA, refers to the identification, assessment, correction and monitoring of important aspects of patient care designed to enhance the quality of care) meeting to discuss about the COVID-19 outbreak with facility's staff. Findings: 1. During the observation and interview on 6/24/20 at 11:26 a.m., the facility did not have a define (specify) green zone, yellow zone, and red zone. The Administrator (ADM) stated there were more than twenty residents who tested positive for COVID-19. The ADM stated Residents 1, 8, 10, 12, 13, 16, 18, 22, 25, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50 had tested positive for COVID-19. The ADM stated he had not separated these positive residents from the resident who had tested negative for COVID-19. The ADM did not answer to why he failed to cohort these residents During a tour of the facility, a review of the facility's Daily Roster Census and a concurrent interview with the ADM on 6/24/20 at 12:18 p.m., he stated the following: a. Resident 1 was tested positive for COVID-19 and had symptoms of shortness of breath, sharing a room with Resident 2 who tested negative for COVID-19. b. Resident 8 was tested positive for COVID-19, sharing a room with Resident 9 who tested negative for COVID-19. c. Resident 13 was tested positive for COVID-19, sharing a room with Resident 14 and Resident 15 who both tested negative for COVID-19. d. Resident 18 was tested positive for COVI-19, sharing a room with Resident 19 who tested negative for COVID-19. e. Resident 22 was tested positive for COVID-19, sharing a room with Resident 23 who tested negative for COVID-19. f. Resident 25 was tested positive for COVID-19, sharing a room with Resident 26 who tested negative for COVID-19. g. Resident 33 was tested positive for COVID-19, sharing a room with Resident 35 who tested negative for COVID-19. A review of the laboratory reports dated 6/23/20, indicated on 6/23/20 at 11:30 a.m., the Laboratory Clinical Specialist (LCS, staff works in the lab) notified the ADM via email that the facility had more than 20 residents who tested positive for COVID 19. The LCS reminded the ADM that the facility is having an outbreak (a certain increase in the number of positive COVID 19 cases) and he needed to implement the proper protocols to prevent further spread of COVID-19. The CLS received an email receipt indicating the ADM opened the email on 6/23/20 at 5:43 p.m. (the survey team entered the facility on 6/24/20, 18 hours after). A review of the facility's Mitigation Plan, titled COVID-19 Testing & Cohorting, dated 6/1/20, indicated the facility would place the residents into three separate cohorts (red, green and yellow zones) based on the test results. According to the Centers for Disease Control and Prevention at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, indicated if the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. 2. During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 6/24/20 at 11:40 a.m., there was

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) no designated area for staff to don their PPE outside of the red zone. LVN 1 stated staff need to go inside the plastic barrier (the red zone) to don their PPE. During an observation inside the red zone, on 6/24/20 at 12:30 p.m., there were no posters/signages to remind staff to wash their hands or don and doff their PPE. There was no breakrooms or restroom designated for staff who worked in the red zone (COVID area). LVN 1 stated that: 1. Staff assigned to the red zone would don the PPE inside the plastic barrier. 2. There was no breakrooms or restroom designated for the staff who care for positive COVID-19 residents. 3. There was no doffing area in the red zone. 4. There were no specific entrance and exit for the COVID area. During an interview on 6/24/20 at 12:35 p.m., the ADM stated there were no designated donning and doffing area for the red zone. The ADM stated the red zone with confirmed COVID-19 positive residents was on the first floor. The ADM stated the ambulance entered and accessed the facility by the hallway in the red zone area. A review of the facility's Mitigation Plan, titled COVID-19 Testing & Cohorting, dated 6/1/20, indicated residents who tested positive with COVID-19 would have dedicated health care providers and staff would use separate break rooms and restrooms. A review of the facility's undated policy and procedure, titled Designation of Space, indicted for the facility to ensure separation of infected residents and for eliminating movement of health care workers among those spaces to minimize transmission risk. According to the Centers for Disease Control and Prevention at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, indicated to place signages at the entrance to the COVID-19 care unit to instruct health care professionals they must wear eye protection and an N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) or higher-level respirator or facemask if a respirator is not available at all times while on the unit. Gowns and gloves should be worn when entering resident rooms. 3. A review of Resident 1's Laboratory Report, dated 6/23/20, indicated the resident tested positive for COVID-19. A review of Resident 2's Laboratory Report, dated 6/24/20, indicated the resident tested negative for COVID-19. During an observation on 6/24/20 at 11:45 a.m., Resident 1 was lying in bed with no face covering. Resident 1 was sharing the same room with Resident 2. During an interview and a review of the facility's Daily Roster Census on 6/24/20 at 12:18 p.m., the ADM stated Resident 1 had symptoms of shortness of breath and was tested positive for COVID-19. The ADM stated Resident 1 was sharing a room with Resident 2 who tested negative for COVID-19. A review of the facility's Mitigation Plan, titled COVID-19 Infection Prevention and Control, dated 6/1/20, indicated all residents and staff are required to wear face covering while residing in the facility. 4. During an interview on 6/24/20, at 11:30 a.m., the DON stated the facility's IPN was out sick and there was no certified IPN available in the facility to perform the IPN's job functions. The DON stated she did not know which residents were tested positive for COVID-19. The DON stated she was not familiar with the process on how to cohort residents who tested positive for COVID 19. During an interview with the DON on 6/24/20 at 11:38 a.m., she stated five COVID-19 positive residents were the red zone on the first floor. The DON stated there were 18 other residents on the first floor waiting for their COVID-19 test results, but she could not identify these 18 residents nor the room where they resided. During an interview on 6/24/2020, at 12:35 p.m., the ADM stated the IPN's last day of work was on 6/10/20 and that he had not hired an interim IPN since 6/10/20. A review of the facility's Mitigation Plan, titled COVID-19 Infection Prevention and Control, dated 6/1/20, indicated the facility had a full-time dedicated IP nurse. 5. A review of Resident 1's Laboratory Report, dated 6/23/20, indicated the resident tested positive for COVID-19. During a concurrent observation on 6/24/20 at 11:45 a.m., Resident 1 had a plastic nasal cannula (flexible plastic tubing used to deliver oxygen through nostrils) with oxygen at 2 liters per minute (LPM, velocity at which air flows). The plastic tubing was on the floor. The DON stated the plastic tubing should not be on the floor. The DON proceeded to pick the plastic tubing from the floor with her bare hands and placed it on the resident's bed. The DON did not perform hand hygiene and left the room. The DON proceeded to use her contaminated bare hand touching the doorknob to open the door that lead to the stairs to the second floor. A concurrent interview was conducted; the DON stated she did not perform hand hygiene after she touched Resident 1's nasal cannula tubing. A review of the facility's undated policy and procedure, titled General Standard Precautions, indicated for staff to wash their hands aft her contact with objects and surfaces in the resident's environment. A review of the facility's Mitigation Plan, titled COVID-19 Infection Prevention and Control, dated 6/1/20, indicated for staff to wash their hands or use alcohol-based hand sanitizer. 6. During an interview on 6/24/20 at 11:26 a.m., the ADM stated Residents 1, 8, 10, 12, 13, 16, 18, 22, 25, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50 had tested positive for COVID-19 but he had not notified his staff. The ADM stated his staff did not know which residents were tested positive for COVID-19. During an interview on 6/26/20 at 4:10 p.m., the ADM stated the facility did conduct a Quality Assessment and Assurance meeting to discuss about the COVID-19 outbreak with his staff. During a telephone interview on 6/26/20 at 4:23 p.m., the facility's Medical Director 1 (MD 1, a physician who provides guidance and leadership on the use of medicine in a healthcare organization) stated he was not aware that the facility had a COVID-19 outbreak and was under an IJ related to infection control due to the spread of COVID-19 in the facility. During an interview on 6/26/20 at 4:31 p.m., the ADM stated he did not inform MD 1 regarding the IJ on infection control because he did not have a chance to call MD 1. A review of the facility's undated policy and procedure, titled Communication, indicated the facility will communicate the prevalence of confirmed cases of COVID-19 to staff, daily. A review of the facility's undated policy and procedure, titled Quality Assessment and Assurance Program, indicated the administrator or designee shall be responsible for overseeing the Quality Assessment and Assurance (QAA) Program in order to meet the needs, goals and objectives of the resident population that it serves and meet the standard of care. The policy indicated the QAA committee shall consist of the medical director and other key facility's staff members as may assigned or deemed appropriate.