STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055077	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA BELMONT HEIGHTS	1730 GRAND AVE LONG BEACH, CA 90804

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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 19 of 19 residents by: a. To ensure staff properly re-used disposable personal protective equipment ((PPE) clothing or equipment to protect the resident and staff from infections) gowns when caring for the residents who were in the Coronavirus ((COVID-19) an illness caused by [MEDICAL CONDITION] that can spread from person to person) quarantine (separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick) area b. To monitor the vital signs (measures how well the body is functioning) and pulse oximeter (for monitoring the blood oxygen saturation) for 14 of 92 residents (R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, R13, R14, R15) at least twice a day c. To properly perform hand hygiene (applying an alcohol-based handrub to the surface of hands or washing hands with the use of a water and soap or a soap solution, either non-antimicrobial or antimicrobial) after delivering food to the resident's rooms d. To follow their Mitigation Plan (community mitigation measures are actions taken to slow the spread of infectious diseases, addressing testing and cohorting, infection prevention and controls, PPEs, staffing shortage, designation of space, and communication) to cohort staff that worked in the quarantine area e. To follow the Mitigation Plan when caring for five of 5 residents (R16, R17, R18, R19, R20) who were confirmed COVID-19 positive, and to isolate them for 10 days from the date of the test result, and if after baseline testing there was only a small number of individuals identified in one cohort, consider before relocating this minority to another facility These deficient practices had the potential to result in a wide-spread infection of COVID-19 in the facility and the community. Findings: a. During an observation and concurrent interview with the Maintenance Supervisor (MS) on 8/5/20 at 11:10 a.m., while in the dining room, stated the PPEs were temporarily stored in the room. The dinning room had may boxes of gowns, gloves, and masks. MS stated the facility had plenty of disposable gowns in stock and the staff did not need to re-use the disposable gowns. During an observation on 8/5/20 at 12:09, in the quarantine zone, room [ROOM NUMBER] had a disposable gown hanging on top of the door without it being visibly identified to which staff member it belonged to. During an observation on 8/5/20 at 12:10 p.m., in the quarantine zone, room [ROOM NUMBER] had two disposable gowns, one on top of the other, hanging on top of the door, without any visible identification to indicate which staff member it belonged to. During an observation and concurrent interview on 8/5/20 at 12:15 p.m., in the quarantine unit by room [ROOM NUMBER], two disposable gowns were hanging on the door, on top of each other. During an interview with a certified nursing assistant (CNA 1) stated the gowns did not have any labels to indicate which staff member it belonged to. CNA 1 stated she knew which disposable gown was hers because she hung in on the hook, behind the door, and pock a hole in the sleeve to identify the gown. During an observation and interview with Registered Nurse 1, on 8/5/20 at 12:25 p.m., in the quarantine area, stated the reusable gowns were hung on the hook behind the resident's door. RN 1 stated she knew which one was her gown because she wrote her name on the gown. However, a disposable gown was hanging on top of the door of room [ROOM NUMBER], without any identification as to which staff member it belonged to. RN 1 stated the gown should not be on top of the door mingling with other gowns. RN 1 stated the practice could spread the infections. During an interview with licensed vocational nurse (LVN 1) on 8/5/20 at 12:42 p.m., stated the disposable gown stayed in the room and was re-used to care for the residents in that same room. LVN 1 stated she was not sure if was acceptable to use the same gown for more than one resident in the room. During an interview with the Director of Nursing (DON), on 8/5/20 at 12:52 p.m., stated the reusable gown should be labeled, not mingled with other gowns, and hung behind the patient's door. The facility's policy Guidance for Infection Prevention and Control of Residents with Suspected or Confirmed COVID-19 dated 3/16/20, indicated disposable gowns were worn when entering the resident room and discarded before leaving the room. The policy indicated if there was a shortage of disposable and cloth gowns, a resident gown may be worn. If there was a shortage of all types of gowns, the equipment should be prioritized for aerosol-generating procedures, high contact resident care activities like activities of daily living and wound care. b. During an interview with LVN 3, on 8/5/20 at 11:20 a.m., stated the resident's vital signs were taken every shift and the CNAs reported when the resident had a fever. During an interview and concurrent record review with LVN 4, on 8/5/20 at 11:35 p.m., was not able to find the vital signs for Resident 10. LVN 4 stated the vital signs were kept in a binder, on station 1. LVN 4 walked to station 1 and asked the DON for the binder, but the binder was not there. During an interview and record review with the director of nursing (DON) on 8/5/20 at 11:40 p.m., stated Resident 10 did not have any of the vital signs documented on 8/4/20. The DON stated the resident's vital signs should have been documented in the vital signs log book, but it was not there. During an interview with the DON, on 8/5/20 at 1:23 p.m., stated the vital signs were taken twice a day to identify the resident who was symptomatic for COVID-19. The DON stated the vital signs were taken to identify changes in the residents condition and to provide intervention for their symptoms. During an interview with LVN 2, on 8/5/20 at 1:37 p.m., stated the CNAs were responsible to take the resident's vital signs. LVN 2 stated the licensed nurses tried to encourage the CNAs to take the residents' vital signs. LVN 2 stated she had notified the supervisor about the CNAs not doing the vital signs. LVN 2 stated the supervisors talked to the CNAs but they continued to not take the vital signs. LVN 2 stated the vital signs were important to identify when the residents had any change of condition or showed COVID-19 symptoms. LVN 2 stated completion of taking the resident's vital signs have been an issue for the facility. During an interview with CNA 1, on 8/10/20 at 1:13 p.m., stated the resident's vital signs were taken to monitor for COVID-19 symptoms, such as exhibiting signs of fever. During a review of the facility's vital signs clinical record, dated 8/4/20, indicated Residents 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, and 15 did not have their vital signs monitored. A review of the facility's policy titled Infection Control Surveillance revised 3/10/14, indicated a purpose to provide surveillance of healthcare associated infections ((HAIs) infection contracted in the healthcare setting during the course of receiving healthcare treatment for [REDACTED]. The policy indicated the surveillance would be used to capture certain epidemiologically important data. The policy indicated the surveillance data would include laboratory records, skin checks, infection control rounds or interviews, verbal reports from staff, infection surveillance sheets, temperature logs, pharmacy records, antibiotic reviews, and transfer summaries. The data would be used to analyze trends. c. During an observation and concurrent interview in the quarantine unit, on 8/5/20 at 12:18 p.m., certified nurse assistant (CNA 1) entered the quarantine unit, rolling the cart that had two food trays on it. CNA 1 entered room [ROOM NUMBER], put a food tray on the bedside table, exited the room, grabed a from the hallway, knocked on the door of room [ROOM NUMBER], delivered the tray, and exited the room without performing hand hygiene. During interview CNA 1 stated she forgot to perform hand hygeine upon entering and exiting the resident's rooms. During an interview with the Director of Nursing (DON), on 8/5/20 at 12:52 p.m., stated the staff should perform hand hygiene before delivering anything to the patient's room and when exiting the room, to help prevent the spread of infections. A review of the facility's policy titled Hand Hygiene dated 2/1/13, indicated the facility staff should follow hand hygiene procedures to help prevent the spread of infection to other staff, residents, and

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) visitors. The policy indicated alcohol-based hand hygiene products could and should be used to decontaminate hands immediately upon entering a resident occupied area regardless of glove used, immediately upon exiting a resident occupied area regardless of glove used, and before moving from one resident to another in a multiple bed room or procedure area regardless of glove used. A review of the facility's policy titled COVID-19-[MEDICAL CONDITION] disease 2019 dated 6/6/20, indicated diligent hand washing practices were an important step in prevention of COVID-19. The policy indicated if COVID-19 was suspected strict adherence to hand hygiene practices and cough etiquette shall be followed. d. During an interview with licensed vocational nurse (LVN 1), on 8/5/20 at 12:42 pm., stated the staff who worked in the non-COVID-19 unit and the quarantine unit shared the same breakroom and bathroom. LVN 1 stated she was assigned patients from non-COVID 19 unit and the quarantine unit during her shift. During an interview with the Director of Nursing (DON), on 8/5/20 at 12:52 p.m., stated the LVNs assignment included patient's in the non-COVID -19 unit and the quarantine unit. However, a review of the facility's Mitigation Plan dated 5/6/20, indicated staff, equipment, should be dedicated to the non-COVID-19, quarantine, or COVID-19 area. e. During an interview with the DON, on 8/5/20 at 10:37 a.m., stated the facility send any confirmed COVID-19 resident cases to the affiliated COVID-19 facility. The DON stated the facility transfer the confirmed covid-19 case right away and the transfer was processed from the receiving facility. During an interview with the administrator on 8/10/20 at 12 p.m., confirmed the facility's practice was to send any confirmed COVID-19 resident to a COVID-19 facility. During an interview with DON on 8/12/20 at 3:42 p.m., stated the facility notified the local health department where the resident was going when a resident was confirmed infected with Covid-19. DON stated the facility transferred the confirmed COVID-19 residents to a COVID-19 facility because it was better for the facility to contain the infection. A review of the facility's Mitigation Plan dated 5/26/20, indicated the residents who were tested positive with COVID-19 and were symptomatic should be isolated at least 10 days since symptoms first appeared. The plan indicated residents who tested positive and were asymptomatic should be isolated for 10 days from the date of the test result. The policy indicated if after baseline testing there was only a small number of individuals identified in one cohort, consider relocating this minority to another facility. The plan indicated given the risk of spreading infection, all transfers must first be cleared by the local health department.