STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAYA DEL REY CENTER	**7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293**

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 designated to provide a safe environment by: The MDS nurse was in the COVID-19 (highly contagious [MEDICAL CONDITION] infection) donning (putting on) and doffing (taking off) room without wearing appropriate Personal Protected Equipment ((PPE) protective clothing and mask). Ensured all the residents and health care providers (HCP) were mass tested , and when determined to be negative for COVID-19, they were systematically retested because the results of [MEDICAL CONDITION] testing could inform care decisions, infection control interventions, and placement decisions (e.g., cohorting decisions) relevant to that resident. Designate one section of the facility for the yellow zone. These deficient practices had the potential to result on wide-spread infection of COVID-19 in the facility and the community. Findings: 1a. During a concurrent observation and interview on 7/2/20 with MDS coordinator, in the patio area there was a COVID designated area. The room had multiple PPE gowns hanging on the walls. The MDS coordinator was working inside the room without wearing a mask, face shield, and a protective gown. The MDS coordinator walked outside the patio door and stated the room was designated as a donning and doffing station and he was working in the room. During an interview with the Director of Nursing (DON) and Assistant DON (ADON) on 7/2/20, ADON stated the room with PPE gowns were used by the staff working in the COVID-19 unit. The DON did not have an answer for the MDS coordinator not wearing a mask, a face shield, and a gown while working in COVID designated donning and doffing area. The DON and ADON acknowledge there was a risk for cross contamination to occur by the MDS coordinator, while working in the designated COVID donning and doffing area, without wearing proper PPEs. During an interview with the ADON and Infection Control Practitioner (ICP 1) on 7/2/20 at 4 p.m., ICP 1 acknowledged MDS coordinator was working in the donning and doffing area. ADON stated COVID designated donning and doffing area inside the MDS coordinator's office could cause cross contamination and infections to spread. During an interview with the DON on 7/8/20 at 3:30 p.m., stated she educated the MDS coordinator about the risk of infections working in an office that was designated as COVID donning and doffing station, and when not wearing proper PPEs. DON stated the MDS coordinator told her he was using the computer in the room which was storing reusable gowns. The DON stated the reusable gowns were moved to a different area. During a review of in-service dated 7/6/20, indicated the staff was trained on how to prevent COVID-19 infection. During a record review, the in-service dated 7/6/19, indicated the facility trained staff about the donning and doffing in the COVID-19 area and the use of PPEs when in the facility. A review of the facility's policy titled Personal Protective Equipment (PPE): Use, Reuse and Extended Use of PPE for All Staff dated 5/13/20 indicated building where COVID-19 was confirmed staff must wear a standard face mask and eye shield at all times, even in non-patient areas such as the office. The policy guidance for extended use of isolation gowns during a COVID-19 outbreak, gowns must be worn by all employees, in patient care areas who are entering patient rooms. Used washable gowns that had reached their maximum number of laundering and remained in good shape should be bagged and put to the side. The policy indicated when staff cared for residents with the same infectious process staff, could wear the same gown between patients. Gown must be removed in the room and discarded after leaving that room, unless going directly to the room of another patient with the same infectious process. 1b. During an interview and record review with ICP 1 on 7/2/20 at 1 p.m., stated the facility had mass testing done on 5/19/20 to detect [DIAGNOSES REDACTED]-CoV-2 infection among residents and HCP. During a review of Mass Testing Results, dated 5/19/20, indicated the residents and healthcare workers were tested . However, ICP 1 acknowledged not all the residents and HCP were tested . The ICP 1 indicated only 33 residents and 96 healthcare workers were tested . During an interview with IP 1 on 7/2/20 at 1:50 p.m., stated the residents who tested negative for COVID-19 had not been retested since the initial mass testing in May 2020. The IP 1 stated the Director of Staff development (DSD) was helping the facility to locate COVID-19 test kits. During an interview with the DON on 7/2/20 at 2:24 p.m., stated a total of 45 residents were never confirmed as positive or negative for COVID-19. During an interview with the IP 1 on 7/2/20 at 4 p.m., confirmed the facility did not complete baseline testing and did not complete retesting of all the negative residents and HCP, since the first testing on 5/19/20. During an interview with director of staff development (DSD) on 7/8/20 at 1:40 p.m., stated the facility was retesting the residents on the same day. DSD stated the prior Administrator 2 did not obtain the test kits. DSD stated she was assigned to find test kits for the facility and retest the residents on 6/24/20. DSD stated she was not aware of All Facilities Letter 20-53 or Department of Public Health testing guidelines regarding baseline and retesting. The DSD stated the facility was not aware of weakly retesting guidance. During an interview with the DON on 7/8/20 at 3:30 p.m., confirmed and stated mass retesting was important to prevent the spread of COVID-19 within the facility and community. During a review of in-services dated 7/6/20, indicated the staff was in-serviced about the mass testing guideline of the Department of Public Health. During a review of a note dated 7/2/20, indicated the facility ordered COVID-19 tests to conduct a retesting of residents and healthcare workers. During a review of an untilled records indicated the residents and healthcare workers were retested for COVID-19 on 7/8/20. A review of Center for Disease Control and Prevention (CDC), Testing Guidelines for Nursing Homes, dated 7/2/20, indicated all skilled nursing facilities (SNF) required a testing strategy to decrease the risk of COVID-19. The CDC indicated SNFs must conduct a baseline testing of all healthcare workers and residents. The guidelines indicated to continue repeat [MEDICAL CONDITION] testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of [DIAGNOSES REDACTED]-CoV-2 infection among residents or Healthcare Personnel (HCP) for a period of at least 14 days since the most recent positive result. If any HCP or resident tests positive, the SNF conducts response test (test all negative healthcare workers and negative residents) weekly. Once the SNF identifies two rounds of negative tests the SNF initiates surveillance test (testing 25% of healthcare workers and 10 % of residents) on a weakly basis until the retesting was completed. 1c. During an observation on 7/2/20 at 1:15 p.m., the first room [ROOM NUMBER], when entering the facility it was marked as a quarantine (separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick) room. However, during an observation on 7/2/20 at 2:35 p.m. room [ROOM NUMBER] and 8 were also designated for quarantine area, but only room [ROOM NUMBER] was occupied. During an observation on 7/2/20 at 4 p.m., the ICP stated the public health recommendation for the facility was to quarantine the residents in room [ROOM NUMBER] and 8, but the resident did not want to move to the quarantine zone. The ICP stated the resident had a 50% chance of being infected with COVID-19. During an interview with ICP 1 at 1:45 p.m., stated room [ROOM NUMBER] had two residents who were admitted from the hospital, were in COVID-19 observation for 14 days. The ICP 1 stated the two residents should have been in the quarantine zone by room [ROOM NUMBER] and 8 but the facility did not have any available rooms in the quarantine zone. During an interview with ICP 1 on 7/2/20 at 1:50 p.m., stated room [ROOM NUMBER] was made temporary as a quarantine room. However, on the other side of the building, the facility designated room [ROOM NUMBER] and room [ROOM NUMBER] as quarantine rooms. During an interview with DON on 7/8/20 at 3:30 p.m., stated room [ROOM NUMBER] was no longer being used as a quarantine room. DON stated the quarantine zone was designated as rooms [ROOM NUMBERS]. During a record review, the in-service dated 7/6/20, indicated the facility trained healthcare workers about COVID-19 cohorting of staff and residents. A review of 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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) County of Los Angeles Public Health, Acute Communicable Disease Control manual (B73), revised 7/14/20, indicated every SNF should have a three separate zones, a green, yellow, and red zone. The manual indicated the yellow zone was composed of residents who were exposed to COVID or admitted and readmitted to the facility.