STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056293	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALCOTT REHABILITATION HOSPITAL	**3551 WEST OLYMPIC BLVD. LOS ANGELES, CA 90019**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to place Resident 2 in a private room away from other residents during readmission back to the facility from acute care hospital during a Covid-19 (extremely contagious human coronavirus causing upper respiratory tract illness) outbreak at the facility. This failure has the potential for Resident 2 to spread infectious disease to other roommates. Findings: On 5/7/20, at 11:27 a.m., an unannounced complaint visit was conducted at the facility regarding infection control concerns. During an interview with the Administrator on 5/12/20 at 12:19 p.m., he stated that Resident 2 was the first Covid-19 positive resident at the facility. The Administrator stated Resident 2 may have exposed another resident from being in the same room. During an interview with the Infection Control Preventionist/Director of Staff Development (ICF/DSD), on 5/15/20, at 10:28 a.m., she stated if the residents were readmitted from the hospital, the resident should be in isolation for two weeks. A review of Resident 2's readmission record indicated, an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's History and Physical Record, dated 3/25/20, indicated Resident 2 did not have the capacity to understand and make medical decisions. A review of Resident 2's Nurses Notes Record, dated 3/27/20, at 8:40 a.m., indicated Resident 2 was observed with shortness of breath and transferred to ER (emergency room) for possible COVID-19 infection. A review of the facility's policy titled Infection Control, Standard Precautions, revised 5/17/18, indicated to place a resident who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room whenever possible.

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.