STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A355	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA PAZ GEROPSYCHIATRIC CENTER	**8835 VANS STREET PARAMOUNT, CA 90723**

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.** Based on observations, interviews and record review, the facility failed to ensure infection preventive measures were initiated and followed in order to prevent the potential spread of COVID-19 (a highly contagious infection). a. One employee's body temperature was not taken before the start of their shift and 18 employees had their body temperatures taken before the end of their shift b. There was no process in place or assigned staff designated to clean and disinfect high-touch environmental surfaces (surfaces touched frequently such as hand railings, door knobs, telephones, keyboards/touch pads) during the night shift c. There were no signs posted in the dedicated yellow zone (area designated to quarantine residents who may have been exposed to COVID-19 or are under observation for COVID-19) to indicate that it was a separate resident care area designated specifically for residents under quarantine (observation to rule out infection from COVID-19) These deficient practices had the potential to expose the residents, staff, and community to possible symptomatic employees, cause cross contamination of germs and COVID-19 virus on high-touch environmental surfaces, and expose multidisciplinary staff to residents on quarantine for possible infections. Findings: a. During a concurrent interview and record review, on 7/30/30 at 12:15 p.m., with the infection preventionist (IP) stated it was the facility's expectation that staff should be screened for signs and symptoms of COVID-19 (such as fever, cough, shortness of breath, sore throat, chills, muscle pain, headache, new loss of taste and smell, stomach cramps, soft stools, or if exposed to COVID-19 in the last two weeks) before the start of their shift and again before the end of their shift. A review of the Daily Employee Screening Log, dated 7/29/20, revealed one employee did not have their body temperature taken before the start of their shift. The log also indicated 18 employees did not have their body temperatures taken before the end of their shift. When asked if the employees' temperatures were supposed to have been taken, the IP shook his head yes and stated, They missed the checks. On 7/22/20, the local county department of public health recommendations, via a virtual tour with the facility, indicated the facility should screen all employees for signs and symptoms of COVID-19 at the beginning of their shift and again before the end of the employee's shift. A review of the facility's undated mitigation plan indicated all staff would be screened and temperatures taken at the beginning and at the end of each shift. b. During an interview on 7/30/30 at 2:20 p.m., the housekeeping supervisor (HS) was asked the process for cleaning the high-touch environmental surfaces (surfaces touched frequently such as hand railings, door knobs, telephones, keyboards/touch pads). The HS stated she had dedicated staff to clean during the day and evening shift. When asked who cleaned the high-touch environmental surfaces during the night shift, the HS stated she did not know. On 7/30/20 at 2:40 p.m., during an interview, when asked who was responsible for cleaning the high-touch environmental surfaces during the night shift, the IP stated he did not know. When asked if there was a schedule or assignment for this task, the IP stated No. The IP stated the facility would work on that process. On 7/30/30 at 3 p.m., the administrator confirmed the facility did not have a standard process in place for cleaning the high-touch environmental surfaces on the night shift. A review of the facility's undated policy, titled, Pandemic: COVID 19 Prevention and Control of Outbreak (24-Hour programs), indicated to increase cleaning and disinfection of common areas and patient care areas, medication rooms, and staff rooms and that the cleaning should occur as frequently as possible. The policy indicated special attention should be paid to frequently touched environmental surfaces such as: door handles, hallway banisters, bed rail, computer keyboards, telephones, vending machines, and refrigerators /microwaves in lounge areas. c. During an observation and interview on 7/30/20 at 1:20 p.m., the infection preventionist (IP) stated the entrance to the dedicated yellow zone was outside and proceeded to walk outside to a locked gate. There were no signs to the entrance of the dedicated yellow zone, indicating it was a designated zone. A personal protective equipment ((PPE) clothing to protect the staff or the resident from infections) station was set up outside of the entrance. However, there were no signs posted to indicate the area was designated as a yellow zone. There were also no signs to indicate the staff's break room/charting room was a designated specifically for the yellow zone. When asked if there was supposed to be signs posted to indicate the entrance to the yellow zone, the IP stated yes, we will put them up now. The IP stated there were four residents currently in the yellow (quarantine rooms) and he would add the signs by the entrance to the residents' rooms as well. On 7/30/20 at 2:55 p.m., the administrator stated the facility had designated yellow zone signs posted several days before, but the facility had taken them down because they had been re-arranging some rooms. The administrator stated the signs would be posted back up today. A review of the facility's floor plan indicated rooms 14-19 had been designated as the yellow zone. On 7/22/20, the local county department of public health recommendations, via a virtual tour with the facility, indicated there were no signs posted anywhere in the designated yellow zone and recommended the facility post specific signs to indicate what zone the staff or other care givers were entering in to.

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