STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555132	A. BUILDING _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA NURSING AND TRANSITIONAL CARE LLC	6120 N. VINELAND AVE NORTH HOLLYWOOD, CA 91606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL. A COVID-19 Focused Infection Control Survey was conducted by the California Department of Public Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on 9/15/2021. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 53 Representing the California Department of Public Health: Surveyor 43323, Health Facilities Evaluator Nurse One deficiency was identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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

Jennifer Administrator 10/13/21

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 880	Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 2 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement coronavirus disease-2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection) infection control practices by failing to: 1. Ensure Certified Nursing Assistant 1 (CNA 1) appropriately discarded her contaminated N95 respirator (respiratory protective device designed to achieve a very close facial fit and efficiently filter airborne particles) after providing care for Resident 1 and switching back to her surgical mask. 2. Ensure the trash bin for doffed (removed) personal protective equipment (PPE - equipment worn to minimize exposure to hazards like infections that cause serious workplace injuries and illnesses) was located inside Resident 2's room near the exit. 3. Monitor Resident 3's oxygen saturation (the amount of oxygen in the bloodstream) at least	F 880		

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F 880	Continued From page 3 once per day. 4. Screen Dietary Staff 1 (DS 1), Registered Nurse 1 (RN 1), and Staff 1 for COVID-19 symptoms, international travel within the last 14 days to a restricted country, and contact with someone with or under investigation for COVID-19. These deficient practices increased the risk of spreading COVID-19 infection to residents and staff within the facility. Findings: a. During a concurrent observation and interview, on 9/14/2021 at 1:12 p.m., with Certified Nursing Assistant 1 (CNA 1), observed CNA 1 removing her N95 respirator (respiratory protective device designed to achieve a very close facial fit and efficiently filter airborne particles) upon leaving Resident 1's room located in the yellow zone (cohorted area reserved for newly admitted residents on observation and residents who are symptomatic or exposed to COVID-19) and putting the contaminated N95 back into her pocket in the presence of the Infection Preventionist (IP). During a concurrent observation and interview, on 9/14/2021 at 1:12 p.m., with the IP, the IP witnessed and verified that CNA 1 removed her contaminated N95 and placed it inside her pocket. Observed the IP instructing CNA 1 that she is supposed to discard the used N95 and wear a new one if she were to reenter an isolation room in the yellow zone. When the IP asked why she was pocketing the used N95, CNA 1 stated she was saving for later when she has to return to	F 880		

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F 880	Continued From page 4 Resident 1's room. During an interview, on 9/14/2021 at 4:41 p.m. with the IP, the IP stated that CNA 1 should not have pocketed the contaminated N95 for reuse. The IP confirmed that the N95 should be discarded once used and removed, and staff should be getting a new N95 from the personal protective equipment (PPE - equipment worn to minimize exposure to hazards like infections that cause serious workplace injuries and illnesses) cart. The IP stated staff are allowed to switch between N95 and surgical masks but they must adhere to and follow proper donning and doffing of appropriate PPE. The IP stated CNA 1 should have discarded the used N95, performed hand hygiene, and put on a new surgical mask. The IP further stated the CNA had told him that she was saving the N95 in her pocket for later to which the IP responded by providing in-service and telling her that she cannot keep her contaminated N95 in her pocket for reuse. The IP stated it important for all staff to properly don (put on) and doff (remove) PPE to observe proper infection control measures and make sure staff do not contaminate themselves and spread infection to residents and staff. A review of the facility's COVID-19 Mitigation Plan (identifies policies and procedures taken to reduce risk and minimize loss in the event of disasters/emergencies), revised 9/13/2021, indicated, "If staff will be shared across sections in any way, the staff will fully doff all PPE and leave all dirty PPE in designated receptacles, perform hand hygiene, and don new PPE in accordance with Centers for Disease Control and Prevention (CDC) guidance for the area they are entering."	F 880		

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F 880	Continued From page 5 A review of the facility's policy and procedures titled, "Personal Protective Equipment - Contingency and Crisis Use of N-95 Respirators (COVID-19 Outbreak)," under section "Procedure for Donning and Doffing N95 Respirator Masks," dated April 2020, indicated the following: To remove N95 respirator mask: - Front of mask/respirator is contaminated - do not touch. If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer. - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front. - Discard in a waste container. - Perform hand hygiene immediately. b. During an observation, on 9/14/2021 at 12:42 p.m., observed the trash bin for discarding doffed PPE located outside of Resident 2's room in the yellow zone (cohorted area reserved for newly admitted residents on observation and residents who are symptomatic or exposed to COVID-19). Upon opening the trash bin, doffed (removed) disposable gowns were noted to be inside. During a concurrent observation and interview, on 9/14/2021 at 1:12 p.m., with the Infection Preventionist (IP), the IP witnessed and verified that the trash bin for doffed PPE was outside of Resident 2's room. The IP confirmed that the trash bin should be positioned inside the resident's room near the exit for staff to doff their contaminated PPE prior to leaving the isolation room. The IP stated contaminated PPE should not be brought outside the room in the yellow zone since there is potential outcome of spreading infection.	F 880		

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F 880	Continued From page 6 A review of the facility's COVID-19 Mitigation Plan (identifies policies and procedures taken to reduce risk and minimize loss in the event of disasters/emergencies), revised 9/13/2021, indicated trash can to be located near exit for staff to discard PPE if moving out of designated area in the yellow zone. c. A review of Resident 3's coronavirus disease-2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection) and vital signs monitoring log indicated there were no documentation for oxygen saturation (the amount of oxygen in the bloodstream) from 9/10/2021 to 9/14/2021. During a concurrent interview and record review, on 9/17/2021 at 2:34 p.m., with the Infection Preventionist (IP), the IP reviewed Resident 3's vital sign log from 9/10/2021 to 9/14/2021 and confirmed that the oxygen saturation was not documented for Resident 3. The IP stated Resident 3 is currently in the green zone (cohort reserved for residents who do not have COVID-19 that have tested negative, cleared isolation, or are fully vaccinated without symptoms). The IP explained that the vital signs including oxygen saturation is monitored at least once per shift for green zone residents and should have been done. The IP stated the admitting nurse failed to add oxygen saturation monitoring for Resident 3 as part of the vital sign set when the resident was readmitted into the facility and staff consequently continued to miss checking and documenting Resident 3's oxygen saturation. The IP confirmed the oxygen saturation has not been checked for Resident 3 since his readmission on 7/21/2021. The IP	F 880		

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F 880	Continued From page 7 stated it is important to check vital signs including oxygen saturation to monitor for changes in the resident. During an interview, on 9/17/2021 at 3:40 p.m., with the Director of Nursing (DON), the DON verified that there is no policy for screening green zone residents for COVID-19 symptoms and monitoring vital signs specified in the facility's mitigation plan. However, the DON stated that the facility is monitoring for COVID-19 symptoms and vital signs once per shift for residents in the green zone. The DON confirmed there should be a policy for monitoring vital signs and COVID-19 symptoms of residents in the green zone and that the facility will add a policy into the mitigation plan. A review of the facility's COVID-19 Mitigation Plan (identifies policies and procedures taken to reduce risk and minimize loss in the event of disasters/emergencies), revised 9/13/2021, did not indicate a policy for monitoring vital signs and COVID-19 symptoms for residents in the green zone. d. A review of the staff screening log, dated 9/11/2021, indicated Registered Nurse 1 (RN 1) and Staff 1 were not completely screened upon entering facility and there were missing documentation for presence of coronavirus disease-2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection) symptoms, international travel within the last 14 days to a restricted country, and contact with someone with or under investigation for COVID-19. A review of the staff screening log, dated	F 880		

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F 880	Continued From page 8 9/12/2021, indicated Dietary Staff 1 (DS 1) was not completely screened upon entering facility and there were missing documentation for presence of COVID-19 symptoms, international travel within the last 14 days to a restricted country, and contact with someone with or under investigation for COVID-19. During a concurrent interview and record review, on 9/14/2021 at 3:35 p.m., with the Infection Preventionist (IP), the IP reviewed the staff screening log for 9/11/2021 and 9/12/2021 and verified the missing documentation for travel outside the country, COVID-19 symptoms, and contact with someone with or under investigation for COVID-19 for RN 1 on 9/11/2021, Staff 1 on 9/11/2021, and DS 1 on 9/12/2021. The IP was unable to identify who Staff 1 was that was screened on 9/11/2021. The IP stated there is a door monitor sitting in the front lobby at all times who checks and ensures the screening form is done accurately and completely. The IP stated if any of the screening questions are missed, the door monitor reminds the staff to answer all the questions completely. The IP stated he also reviews the screenings logs every three to four days to ensure the logs are complete. The IP stated it is important properly screen all visitors and staff to make sure they are not bringing COVID-19 infection with them into the facility and to protect the residents and staff. A review of the facility's policy and procedures titled, "Infection Prevention and Control," under section "Employee Screening," indicated "all staff members will be screened for symptoms associated with COVID-19 (e.g. cough, shortness of breath, elevated temperature >100) upon entering the facility/beginning of their scheduled	F 880		

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F 880	Continued From page 9 shift and before leaving the premises."	F 880		

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during a COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL. A COVID-19 Focused Emergency Preparedness Survey was conducted by the California Department of Public Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on 9/15/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6). Total residents: 53 Representing the California Department of Public Health: Health Facilities Evaluator Nurse: 43323 No deficiency was identified.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/13/21

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.

Valley Vista Nursing and Transitional Care (VVNTC) makes the best effort to operate in full compliance with Federal and State law. Nothing included in this plan of correction is an admission otherwise.

F880

How corrective action will be accomplished for those residents affected by the deficient practice

1. CNA 1 was given a one to one in-service on 9/11/21 regarding proper disposal of contaminated N-95 respirator after providing care for resident 1.
2. IP removed trash bin for doffed (removed) PPE outside of resident's 2 room and positioned inside the resident's room near the exit immediately for staff to doff (removed) their contaminated PPE prior to leaving the isolation room. In-service the Housekeeping Supervisor on (DATE) regarding the proper placement of all trash bins in the yellow zone.
3. DON and/or designee initiated in-service on(DATE) to all licensed staff regarding vital signs monitoring (including temperature, oxygen saturation, signs and symptoms of COVID-19 to green zone (every shift) and every 4 hours in the yellow zone.
4. Policy for monitoring vital signs and covid-19 symptoms for residents in the green zone were included in the facility's Covid-19 Mitigation Plan.
5. DON/designee gave an In-service to RN1 on (DATE), Dietary Staff 1 on (DATE), Staff 1 and receptionist/screener on (DATE) the importance of employee screening log, all staff members will be screened for symptoms associated with Covid-19 upon entering the facility/beginning of their scheduled shift and before leaving the premises.

How the facility will identify other residents having the potential to be affected by the same deficient practice

1. IP/DSD conducted a random verbal assessment of staff (LVN/CNA) on 9/11/21 regarding proper disposal of contaminated N95 respirator, no other deficient practice
2. IP did rounds on the yellow zone and all checked all trash bin, no other deficient practice observed.
3. DON/QA checked all physician order, no other resident affected by the deficient practice.
4. IP rechecked logs for September, no other deficient practice observed.

Measure and Systematic changes to be in place to ensure the deficient practice do not recur

1. IP/DSD gave an in-service to all staff on 9/11/21 regarding infection control and proper disposal of contaminated N95 respirator. DSD/IP will conduct an in-service to all staff regarding Infection Prevention and Control Program monthly x 3 months to ensure compliance.
2. Department managers and facility staff on their daily rounds will ensure all trash bin in the yellow/red zone used to doffed (removed) PPE is inside.
3. 11-7 Licensed nurse will do a 24 hour check on new admit resident to ensure vital signs monitoring is in place. DON/QA will check all new admit patient chart within 24 hours to ensure compliance.
4. Screener/receptionist will be responsible in asking questions and will document employee/visitors response to COVID 19 questionnaire.

How Facility plans to monitor its performance to make sure that solutions are sustained

1. Facility administrator will report to the QAA Committee during regular scheduled meetings any deficient practice x 3 months.

Completion Date: 10/31/2021