STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. BUILDING _____ B. WING _____	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WALK VILLA CONVAL. HOSP.	12350 ROSECRANS NORWALK, CA 90650

(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 the investigation of a Complaint Investigation. Complaint Incident Number: CA00805360 Representing the Department of Public Health: Health Facilities Evaluator Nurse: 36331, HFEN, RN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the Complaint Incident: CA00805360 (F-tag 880)	F 000		
F 880 SS=D	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 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	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin | (X6) DATE 10/28/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1 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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. BUILDING _____ B. WING _____	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 2 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 their infection control policy and procedure and mitigation (plan to slow down the spread of Covid-19 [a highly contagious viral infection], and to reduce the peak in health care demand) plan to designate a separate yellow zone (used for resident ' s who may have been exposed to COVID-19 or are symptomatic but have not gotten the test results yet) for 2 of 2 residents (Resident 1 and Resident 2). This failure had the potential to spread COVID-19 to residents, staff and community. Findings: On 10/25/2022 at 12 noon, an unannounced visit was made to the facility to investigate a complaint regarding Infection Control/COVID-19 Noncompliance. During a concurrent observation and interview on 10/25/2022 at 12:25 p.m. with the Infection Control Preventionist (ICP) in the green zone (an area of the facility for residents without Covid-19), a yellow zone room (Room 2's) door was wide open and there were no barriers, to contain the virus , with Resident ' s 1 and 2 occupying the room. The ICP acknowledged, having the door to the yellow zone room open may expose residents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 3 and staff to COVID-19. During a review of Resident 1 ' s admission record (AR) dated 10/25/2022, the AR indicated Resident 1 was re-admitted on 10/19/2022 with diagnoses of end stage renal disease (a medical condition in which kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), muscle weakness, iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells). During a review of Resident 1 ' s Minimum Data Set (MDS-a comprehensive assessment and care planning tool) dated 10/26/2022, the MDS indicated Resident 1 had clear speech, limited ability to express ideas and wants, and sometimes understands. The MDS further indicated Resident 1 required extensive staff assistance with dressing, eating, and personal hygiene. During a review of Resident 1 ' s care plan titled "Infection", dated 10/18/2022, the care plan indicated Resident 1 is at risk of getting COVID-19 related to recent hospitalization. The care plan goal indicated Resident 1 will not have a negative outcome from Coronavirus. Nursing interventions included to follow current policy and procedures for management of Coronavirus, encourage hand hygiene During a review of Resident 2 ' s AR dated 10/27/2022, the AR indicated Resident 2 was admitted to the facility on 10/20/2022 with diagnoses of difficulty walking, fracture of right femur (a broken thighbone), and asthma (a chronic condition that affects the airways in the	F 880		

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F 880	Continued From page 4 lungs). During a review of Resident 2 ' s MDS dated 10/27/2022, the MDS indicated Resident 2 had clear speech, the ability to express ideas and wants, and clear comprehension (understands). The MDS further indicated Resident 2 required extensive staff assistance with dressing, toilet use, and personal hygiene. During a review of the facility ' s policy and procedure titled "Infection Control Manual-Coronavirus (COVID-19)" revised 6/14/2022, the Infection Control Manual-Coronavirus (COVID-19) indicated residents who are unvaccinated, or who have completed their primary series and are booster eligible but not yet boosted and have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine (yellow exposed status) for 7 days after their exposure, even if viral testing is negative. During a review of the facility ' s policy and procedure titled "COVID-19 Mitigation Plan, dated 2022. The COVID-19 Mitigation plan indicated resident cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on the results of any of the following: surveillance testing, temperature checks, and symptom screening in accordance with the Centers of Disease and Prevention ' s (CDC) recommendations Cohorting efforts will be a collaboration involving the ICP, director of nursing, administrator, and the director of staff development.	F 880		

ATTESTATION

Facility Name: North Walk Villa

Facility Address: 12350 Rosecrans Avenue Norwalk CA 90650

Director of Nursing: _____

Administrator: _____

Infection Preventionist: _____

Director of Staff Development: _____

We, hereby certify that we are the Director of Nursing, Infection Preventionist and Director of Staff Development of North Walk Villa and that the information provided accurately reflects the policies in effect at nursing facility for the safe care and treatment of residents. We also certify that we provided trainings and education to the staff on Infection Prevention with an emphasis on Zoning.

Norwalk Villa Convalescent submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action of proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.

Corrective action for residents found to have been affected by this deficiency:

Yellow zone room door immediately closed on 10/25/2022.

Yellow zone immediately placed a barrier between green and yellow zone on 10/25/22.

Inservice education to all staff was given on 10/25/22 and 11/2/22 by Director of Staff Development.

Identification of others at risk:

IP Nurse conducted rounds on 10/25/22. There were no other resident was affected by the deficient practice.

Measures that will be put into place to ensure that this deficiency does not recur:

Director of Nursing along with the IP and DSD and or designee will observe staff during daily routine Infection Control rounds to ensure proper practice is being followed with emphasis on closing doors in yellow zone and proper zoning. Facility will follow guidance of Infection Control and COVID 19 policy and procedure. Including guidance from CMS, CDPH and Center for Disease Control.

Department Managers and dedicated IP coaches each shift to assist facility with the observation of facility rounds to ensure facility is compliant with COVID-19 Infection Control Practices with an emphasis on closing the door and proper zoning. Any findings will be corrected immediately.

In-service with staff on the alleged deficient practices identified with emphasis on closing door in yellow zone and proper zoning by the Infection Preventionist and Director of Staff

Development on 10/25/22 and again on 11/2/22.

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

The DNS and or IP or designee will provide a summary of the QA findings to the monthly CQI Steering Committee for further evaluations and recommendations for 3 months.

Completion date: 11/10/2022

North Walk Villa Convalescent Hospital submits the response and Directed Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors or shareholders.
The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.

F880 Infection Prevention & Control

Corrective action for residents found to have been affected by this deficiency:

1. **Corrective action to be implemented and an appropriate infection prevention and intervention consistent plan with the requirements of CFR 483.80 for the affected residents identified in the deficiency**

   Facility administration reviewed current Infection Control and COVID 19 policy and procedure. Policy and procedure include guidance related to COVID-19 from CMS, CDPH and Center for Disease Control.

   Facility staff and leadership team are responsible to adhere to the facility's COVID-19 policy to ensure mitigation of COVID-19 in addition to adhering with proper infection control measures to prevent the alleged deficient practices do not recur.

2. **Governing Body - QAPI Committee**

   2a. The Infection Preventionist in collaboration with the Director of Staff Development and Director of Nursing will conduct routine rounds of the facility to ensure compliance with the alleged deficient practices. DON/IP/Designee will provide a summary trend analysis of the facility compliance on a monthly basis to the QA Committee on a monthly basis for a period of 3 months then quarterly thereafter for further evaluation and recommendations.

   2b. The Infection Preventionist and Director of Staff Development will provide staff re-in service on their scheduled shift regarding COVID-19 Policy and Procedure, Infection Prevention & Control with emphasis on closing door in yellow zone and placing a barrier between green zone and yellow zone on 10/25/2022.

   The staff who are not able to attend the training will be in-service prior to the start of their shift by Infection Preventionist or Director of Staff Development.

   Any identified issues found by any department supervisor, Infection Preventionist, Director of Staff Development and or designee will be corrected immediately and reported to DON and Administrator for appropriate measures.

2c. Facility failed to close the door in the yellow zone and failed to place barrier between yellow zone. Root cause analysis due to staff unaware of surroundings, lack of attention and lack of education.
The DON will oversee the IP to ensure Infection prevention and control program and protocols are followed.

3. Specific staff involved in implementing the corrective action

The Medical Director, Administrator, DON, Infection Preventionist and Director of Staff Development collaborated on the implementation of the correction plan of action for the deficient practice.

4. Identify other residents having the potential to be affected by the same deficient practice:

Other residents throughout entire facility were checked to ensure compliance with Infection Prevention and Control by the DON and Infection Preventionist on 10/25/22. No other residents or staff were affected by the alleged deficient practice.

5. Systemic changes and actions that need to be taken

5a. The Director of Nursing along with the IP and DSD and or designee will observe staff during daily routine Infection Control rounds to ensure proper practice is being followed. Facility will follow guidance of Infection Control and COVID 19 policy and procedure. Including guidance from CMS, CDPH and Center for Disease Control.

Facility has dedicated and educated staff on each shift to assist facility with the observation of facility rounds to ensure facility is compliant with COVID-19 Infection Control Practices with an emphasis on closing the door and proper zoning. Any findings will be corrected immediately. In-service and assessment completed with staff on the alleged deficient practices identified with emphasis on Human Coronavirus by the Infection Preventionist and Director of Staff Development on 10/25/22 and again on 11/2/22.

5b. By 11/2/22, the Infection Preventionist along with the Director of Staff Development provided a training and evaluation of competencies the staff on the deficient practices identified in addition to transmission-based precautions.
Training on the following topics provided to the staff on 11/2/22 by the Infection Preventionist on the following topics:

- Guidance from Long Beach Public Health Department: Healthcare Providers (longbeach.gov)
- Center for Disease Control- Infection Prevention Training in Nursing Homes- https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
- County of LA Public Health- http://publichealth.lacounty.gov/acd/ncorona2019/healthcarefacilities/snf/
- CDPH AFL 20-25.2 Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19 Infection as it provides guidance for residents in the Red Zone: "Review facility processes for monitoring vital signs (including pulse oximetry) every shift for all residents and every 4 hours for residents with COVID-19 infection."

- LA County Public Health useful links, resources, webinars: http://publichealth.lacounty.gov/acd/snf.htm#webinars
- CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://www.youtube.com/watch?v=7srwrF9MGdw-

Additional Training on the following topics provided to facility staff by the Infection Preventionist on 11/2/22:

- Clean Hands (youtu.be/xmYMUly7qiE)
- Closely Monitor Residents (youtu.be/1ZbT1Njv6xA

5c. Trainings and education provided by the Infection Preventionist and Director of Staff Development

5d. Daily, a Department room rounds will be conducted and documented by the Department Managers in addition to daily rounds of the facility utilizing the Infection Prevention Surveillance Audit tool ensuring appropriate infection control practice is followed with an emphasis on closing door in yellow zone and placing barrier in yellow zone. Findings of non-compliance will be reported to the IP/DON for appropriate action. The Licensed Nurses of each shift will also conduct a Licensed Nurse rounds checklist which will be turned into the Director of Nursing. Any concerns will be identified and corrected immediately and reported to DON immediately. DON and IP to randomly make rounds daily to identify concerns in the unit and correct them immediately if warranted.

6. **Monitoring of approaches to ensure infections are controlled going forward**

Weekly, the IP will track and trend the QA observation rounds and Licensed Nurse Rounds checklist and bring it the IP Committee meeting for discussion and develop an action plan to address the issues. DON and DSD to also conduct facility round throughout facility to ensure employees are facility policy and procedure and mitigation plan to designate a separate yellow zone for residents. Re-education will be provided to staff who is not correctly observing infection prevention/control practices especially those related to the deficient practices identified.

The Director of Nursing and or designee will provide a summary trend analysis of the facility compliance on a monthly basis to the QA committee on a monthly basis for a period of 3 months then quarterly thereafter for further evaluation and recommendations.

7. **Conduct a Root Cause Analysis (RCA)**

Root cause analysis determined there was no attention to detail/surroundings and lack of education from facility staff with regard to closing door in yellow zone and designating a separate yellow zone for residents who may have been exposed to COVID-19 or are symptomatic but have not gotten the test results yet to prevent potential spread of Covid-19 to residents, staff and community.

8. **Completion date of DPOC: 11/15/2022**

North Walk Villa Convalescent Hospital submits the response and Directed Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors or shareholders.
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1. **Corrective action to be implemented and an appropriate infection prevention and intervention consistent plan with the requirements of CFR 483.80 for the affected residents identified in the deficiency**

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2. **Governing Body - QAPI Committee**

   2a. The Infection Preventionist in collaboration with the Director of Staff Development and Director of Nursing will conduct routine rounds of the facility to ensure compliance with the alleged deficient practices. DON/IP/Designee will provide a summary trend analysis of the facility compliance on a monthly basis to the QA Committee on a monthly basis for a period of 3 months then quarterly thereafter for further evaluation and recommendations.

   2b. The Infection Preventionist and Director of Staff Development will provide staff re-in service on their scheduled shift regarding COVID-19 Policy and Procedure, Infection Prevention & Control with emphasis on closing door in yellow zone and placing a barrier between green zone and yellow zone on 10/25/2022.

   The staff who are not able to attend the training will be in-service prior to the start of their shift by Infection Preventionist or Director of Staff Development.

   Any identified issues found by any department supervisor, Infection Preventionist, Director of Staff Development and or designee will be corrected immediately and reported to DON and Administrator for appropriate measures.

2c. Facility failed to close the door in the yellow zone and failed to place barrier between yellow zone. Root cause analysis due to staff unaware of surroundings, lack of attention and lack of education.
The DON will oversee the IP to ensure Infection prevention and control program and protocols are followed.

3. Specific staff involved in implementing the corrective action

The Medical Director, Administrator, DON, Infection Preventionist and Director of Staff Development collaborated on the implementation of the correction plan of action for the deficient practice.

4. Identify other residents having the potential to be affected by the same deficient practice:

Other residents throughout entire facility were checked to ensure compliance with Infection Prevention and Control by the DON and Infection Preventionist on 10/25/22. No other residents or staff were affected by the alleged deficient practice.

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- CDPH AFL 20-25.2 Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19 Infection as it provides guidance for residents in the Red Zone: "Review facility processes for monitoring vital signs (including pulse oximetry) every shift for all residents and every 4 hours for residents with COVID-19 infection."

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- Closely Monitor Residents (youtu.be/1ZbT1Njv6xA

5c. Trainings and education provided by the Infection Preventionist and Director of Staff Development

5d. Daily, a Department room rounds will be conducted and documented by the Department Managers in addition to daily rounds of the facility utilizing the Infection Prevention Surveillance Audit tool ensuring appropriate infection control practice is followed with an emphasis on closing door in yellow zone and placing barrier in yellow zone. Findings of non-compliance will be reported to the IP/DON for appropriate action. The Licensed Nurses of each shift will also conduct a Licensed Nurse rounds checklist which will be turned into the Director of Nursing. Any concerns will be identified and corrected immediately and reported to DON immediately. DON and IP to randomly make rounds daily to identify concerns in the unit and correct them immediately if warranted.

6. Monitoring of approaches to ensure infections are controlled going forward

Weekly, the IP will track and trend the QA observation rounds and Licensed Nurse Rounds checklist and bring it the IP Committee meeting for discussion and develop an action plan to address the issues. DON and DSD to also conduct facility round throughout facility to ensure employees are facility policy and procedure and mitigation plan to designate a separate yellow zone for residents. Re-education will be provided to staff who is not correctly observing infection prevention/control practices especially those related to the deficient practices identified.

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7. Conduct a Root Cause Analysis (RCA)

Root cause analysis determined there was no attention to detail/surroundings and lack of education from facility staff with regard to closing door in yellow zone and designating a separate yellow zone for residents who may have been exposed to COVID-19 or are symptomatic but have not gotten the test results yet to prevent potential spread of Covid-19 to residents, staff and community.

8. Completion date of DPOC: 11/15/2022

NORTH WALK VILLA CONVALESCENT
RECORD OF INSERVICE

Life Care Centers of America

DATE: 10/25/22 To 11/2/22	**SPEAKER:** Chris Urrainer / Sandy Marmolejo
LENGTH OF PROGRAM: 1 hr.	
PROGRAM TITLE: Zones, Green, yellow, Red. Doors to remain closed (yellow, red), PPE in yellow, red, green. CDC – Infection prevention training, healthcare providers	
REFER TO LESSON PLAN:	

NAME	TITLE	SHIFT	SIGNITURE
Eva Rico	CNA	7-3	Eva Rico
Alma Rivas	Cook	10:630	Alma R
Gloria Ortiz	H-K	6:23	Gloria Ortiz
Marta Martinez	AID	1-	Marta Martinez
Rosy Acosta	HR	6:00	[illegible]
Jas Torres	Admiss	9-5	[illegible]
Alice Banaza	Marketing		[illegible]
Veronica Godfrey	BOM	9-5	[illegible]
Fibi Plazola	PR	9-5	[illegible]
Rose Morales	CNA	7-3	Rose Morales
Erik Drake	LVN	7-3	[illegible]
Janice Hermias	MDS	AM	Janice
Rachel Gonzalez	SSD	CM	AM	[illegible]
Saul Moros	H-K		
Diane Gallegos	CNA	7-3	Diane Gallegos
[illegible] C	LVN	11-7	[illegible]
Nicole Vasquez	AD	9-5	[illegible]
Albino [illegible]	CNA	11-7	[illegible]
Ruby Brown	CNA	7-3	[illegible]
Romelyn Gonzaga	CNA	7-3	[illegible]
Judy B	act	830-4-3	[illegible]

NORTH WALK VILLA CONVALESCENT
RECORD OF INSERVICE

Life Care Centers of America

DATE: 11/2/22 **SPEAKER:** Sandey Marmolejo / Magra Torres

LENGTH OF PROGRAM:

PROGRAM TITLE: Handwashing

ZONES; GREEN YELLOW RED

PPE DON & DOFFING

REFER TO LESSON PLAN:

NAME	TITLE	SHIFT	SIGNITURE
EVA Rico	CNA	7-3	Eva Rico
Alva Rivas	COOK	10-6:30	Alva R
Marta Martinez	AID	1-9	Marta M
Rosa Arreola	HK	6:230	Rosa Arreola
Jasmine Torres	Admiss	9-5	[signature]
Alice Barraza	Marketing		[signature]
Vernica Godfrey	BOM	9-5	[signature]
Fibi Plazola	PR	9-5	[signature]
Rocio Morales	CNA	7-3	Rocio Morales
Eric Duarte	LVN	7-3	[signature]
Jamie Hermas	MDS	AM	[signature]
Raquel Bonilla	SSD/CM	AM	[signature]
Diane Gallegos	CNA	7-3	
Soul [illegible]	HK	8-430	
[illegible], C	[illegible]	11-7	[signature]
Nicolle Vasquez	A.D	9-5	[signature]
Albina Ramirez	CNA	11-7	[signature]
[illegible] Guzman	RNA	73	[signature]
Ruby Bueno	CNA	7-3	[signature]

Lucky Bautista act 8:30-4:30 [signature]