PRINTED: 10/26/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 555897 R WING 10/26/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1267 SAN GABRIEL BLVD MONTEREY HEALTHCARE & WELLNESS CENTRE, LP ROSEMEAD, CA 91770 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) ID (X4) ID PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY "Preparation and/or execution of INITIAL COMMENTS F 000 F 000 this Plan of Correction does not The following reflects the findings of the Constitute admission or California Department of Public Health during an agreement by the Provider of investigation of complaint allegation conducted on the truth of the 10/14/2020. facts alleged or conclusions set Complaint Number: CA00708795 forth in this statement of Representing the California Department of Public deficiencies. This Plan of Health: Correction is prepared and/or Health Facilities Evaluator Nurse: 43495 Health Facilities Evaluator Nurse: 28074 executed solely because it's Health Facilities Evaluator: 16279 required by the provision of Federal and State law," The inspection was limited to the specific focused survey conducted and does not represent the findings of a full inspection of the facility. This Plan of Correction constitutes Monterey Healthcare & Two deficiencies were issued for Complaint Wellness Centre Credible Number: CA00708795 Infection Prevention & Control F 880 F 880 allegation of compliance for the SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f) alleged deficient practices. §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 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP				1:	STREET ADDRESS, CITY, STATE, ZIP CODE 267 SAN GABRIEL BLVD ROSEMEAD, CA 91770		
SUMMARY STATEMENT OF DEFICIENCIES			ID.	ــــــــــــــــــــــــــــــــــــــ	PROVIDER'S PLAN OF CORRECTION		(XS) COMPLETION
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	Continued From page §483.80(a)(1) A syster reporting, investigating and communicable distaff, volunteers, visit providing services un arrangement based us conducted according accepted national states \$483.80(a)(2) Written procedures for the facility (ii) When and to who communicable disease reported; (iii) Standard and trart to be followed to previous forces and how iscresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected significant with residents contact with residents.	en for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to \$483.70(e) and following indards; a standards, policies, and ogram, which must include, liance designed to identify the diseases or ean spread to other in possible incidents of the or infections should be assession-based precautions that incition should be used for a thought incidents of the isolation, infectious agent or organism at the isolation should be the bie for the resident under the sunder which the facility the swith a communicable din lesions from direct the disease; and procedures to be followed		880	F 880: Infection Prevention Control (CFR(s): 483.80(a)(1)(2)(4) Corrective Actions for cite practice: On 10/14/2020, antibacter Sanitizer was placed in the Zones immediately at don Doffing stations as the final part of infection prevention On 10/14/20, clear signage was immediately placed directly on plastic barrier to distinguish areas separating the Green zone from yello zone and Red zone. On 10/14/20, clear signage was immediately posted on doors to indicate appropriate infection control & prevention preceived to the prevention preceived to the prevention preceived the prevention prevention preceived the prevention prevent	n & (e)(f) d rial hand yellow ning & al n plan.	
	§483.80(a)(4) A syste	em for recording Incidents			room.		

NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP SIMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WAIT BE PRECEDED BY FULL PROPERTY TAG FROUD INTEREM (EACH DEFICIENCY WAIT BE PRECEDED BY FULL PROPERTY TAG CONTINUED FROM THE PROPERTY IN THE PROPERTY OF LOCAL CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FROM CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FROM CROSS-REFERENCED TO TH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP MONTEREY HEALTHCARE & WELLNESS CENTRE, LP SIMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 2 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 provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) as indicated in the							C		
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIBED BY FILL) PREFEX TAG F 880 Continued From page 2 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 mat as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to help prevent the spread from person to person) as indicated in the	. 555897			B. WING			10/26/2020		
F 880 Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility falled to provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) as indicated in the					1267	san gabriel blvd			
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 provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) as indicated in the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFD	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE AFFRO			COMPLETION COMPLETION	
1. To ensure antibacterial hand sanitizer/ handwashing station is available at the doffing station for the facility's two Yellow zones (The Yellow Zone is the unit where residents are located who are undergoing hemodialysis, readmission and/ or residents waiting for the test results to determine if they have COVID-19 or not). 2. To ensure the plastic barriers (provide some limited protection for individuals sharing the same space, first by preventing people from getting too close and by preventing particles or droplets exhaled by one person from entering the breathing zone of another) separating the Green zone, (Green Zone is the unit where residents are located who do not have COVID-19) Yellow zone and Red zone (Red Zone is the area where		identified under the facorrective actions take \$483.80(e) Linens. Personnel must handle transport linens so as infection. \$483.80(f) Annual revious The facility will conduct IPCP and update their This REQUIREMENT by: Based on observation review, the facility failed sanitary environment to finfections during the (COVID-19, a respirate from person to person facility's policy and profession for the facility's Yellow Zone is the unit located who are under readmission and/or reresults to determine if the interest of the plast limited protection for in space, first by preventing exhaled by one person breathing zone of anot zone, (Green Zone is the located who do not have located who do not have located who do not have leading the protection for in space, first by preventing zone of anot zone, (Green Zone is the located who do not have leading the protection for the space, first by preventing zone of anot zone, (Green Zone is the located who do not have leading the protection for the space, green Zone is the located who do not have leading the protection for the space, green Zone is the located who do not have leading the protection for the space.	clitty's IPCP and the en by the facility. e, store, process, and to prevent the spread of lew. et an annual review of its program, as necessary. is not met as evidenced in interview, and record at to provide a safe, to help prevent the spread in coronavirus-19 ory illness that can spread in as indicated in the locature by failing: erial hand sanitizer/ si available at the doffing two Yellow zones (The interview and interview are residents are going hemodialysis, sidents waiting for the test they have COVID-19 or its barriers (provide some adividuals sharing the same ling people from getting too in granticles or droplets in from entering the ther) separating the Green the unit where residents are ve COVID-19) Yellow zone	F	80	cart was replaced with iso cart with wheels to ensure not directly touching or resting on the floor to prevent contamination from dust picked up by staff and risk of contamination. How Facility will identify other residents having the potential to be affected by the same deficient practice & what corrective action will be taken: No other residents were found to be affected	ff	11/20 po	

STATEMENT OF DEFICIENCIES (X1) PROVIDERS UPPLIERCILA AND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	!	665897	B. MNG			10/	/26/2020
	PROVIDER OR SUPPLIER LEY HEALTHCARE & WEL	LNESS CENTRE, LP		1	Street Address, City, State, ZIP Code 1287 San Gabriel BLVD ROSEMEAD, CA 91770		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(%) COMPLETION DATE
	COVID-19 positive para spread of the disease; the types of Zone in the spread of the disease; the types of Zone in the spread of the disease; the types of Zone in the spread of the spr	atients reside to prevent the a) had a posters identifying these areas. ediately outside of resident opriate infection control and ired PPEs (personal needed to enter room. Its (storage for gowns, e shields are stored) are not sting on the floor. 2:37 PM, during concurrent and interview with the t (IP -a nurse that ling the spread of infectious as and bacteria), iP showed aske off) station at west wing, indicating doffing station Personal Protective stated, for proper doffing oremove their gown, hygiene before removing agies, and then perform moving their face shield or are was no antibacterial and washing station available. and washing station available. alk to the donning (putting e antibacterial hand e. IP verbalized for cross contamination other microorganisms another) by doing such will immediately provide	F	880	What measures will be purinto place to ensure practides not reoccur: DSD & Admin Inserstaff on 10/19/20, 11/3/20, 11/4/20 on the importance of signage, imports of isolation carts in working condition and functioning plabarrier. This will be ongoing education Staff will notify maintenance immedor use maintenance of any areas needin upkeep.	rviced ance e an to staff ediately e log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
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			Di Villia		TROOT INDOOR AND OWEN TO ARR	1 70	/26/2020
NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP				1:	itreet address, city, state, zip code 267 San Gabriel BLVD ROSEMEAD, CA 91770		_
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				BE	OS) COMPLETION DATE	
	On 10/14/2020, at 2:4 observation of the facility the IP there was sanitizer nor hand wait doffing station. A review of the facility revised 2/1/2013, India always the final step a of PPE. Hand hygiene readily accessible and encourage compliance 2. On 10/14/2020, at a observation of the facilizone with the IP the pl Green zone from Yello signage distinguish the zone. On 10/14/2020, at 2:23 the facility's South wing the plastic barrier separed zone did not had distinguish the Yellow and India the Yellow and	O PM, during an illity's east wing, Yellow zone no antibacterial hand shing station available at the stated, hand hygiene la fiter removing and disposal products and supplies are convenient for staff use to a with hand hygiene policy. 2:14 PM, during lity's North wing- Green astic barrier separating we zone did not have a clear exception of green zone with the IP trating Green zone from Green so a clear signage to zone from Green zone from a clear signage to zone from Red zone. PM during observation of with the IP, the plastic zone from Yellow zone did ge to distinguish the Yellow zone did ge to distinguish the Yellow	F	880	Monitoring system to make sure solutions are sustained: Department Manawill perform daily to identify any are that need replaced or barriers that need replaced or barriers that need be reinforced. Daily rounds are brought to stand ustand down to revareas to be addressed. Findings to be brought to Comonthly and result to be brought to Comonthly and for 3 months thereafted to track/trend that deficient practices not reoccur.	rounds as ment ed up and iew sed. ught of Comn ts	ittee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	QC) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	107	ZVIZVZV
1	EY HEALTHCARE & WEL	LNESS CENTRE, LP		1	267 san gabriel blyd Rosemead, ca 91770		
(X4) ID PREFIX TAG	SLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Plan revised 09/14/20 will separate distinct and green zone with the with clear signage to lareas. 3. On 10/14/2020, at tour observation with the posted immediately of indicate appropriate in prevention precaution protective equipment the lareas, gloves, face facemasks and/or residents in the Yellow contact and droplet is germa that are spread coughing and sneezing or reminders are important and place signs outside infection control precaution control precaution control precaution control precautions accordance with CDPI 4. On 10/14/2020, at an observation of the total control precaution of the infection control precautions accordance with CDPI 4. On 10/14/2020, at an observation of the total control precaution of the infection control precaution of the infection control precautions accordance with CDPI 4. On 10/14/2020, at an observation of the infection control precaution control precaution of the infection control precaution control preca	areas red zone, yellow zone emporary physical barrier be used to distinguish these are used to resident rooms to uticide of resident rooms to uticide of resident rooms to uticide control and so and required personal (PPE, protective clothing, shields, goggles, pirators or other equipment e wearer from injury or the illiness). The IP stated, or Red Zones are on clation (used for diseases or in tiny droplets caused by g). The IP stated, signages of in tiny droplets caused by g). The IP stated, signages of the rooms to indicate utions and required PPE. S COVID-19 Mitigation 20, it indicated, signs are utions and required PPE in and guidance. 2:15 p.m., to 3 p.m., during facility's Yellow zone with a in the Yellow Zone and 1 d Zone containing required usting directly on the int interview with the	F	880			Whipo

NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP STREET ADDRESS, CITY, STATE, ZIP CODE 1287 SAN GABRIEL BLVD ROSEMEAD, CA 91770 PRIEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 6 wheels were broken. IP stated that she will make sure that all isolation carts had solld bottom to prevent contamination. IP also stated that she would have them replaced immediately. F 921 Safe/Functional/Sanitary/Comfortable Environ F 921 CFR(s): 483.90(i):			DENTIFICATION AS IMPED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP C(4) ID PREFIX TAG C(4) ID PREFIX REGULATORY OR LSC EMENTLYING INFORMATION) F 880 Continued From page 6 wheels were broken. IP stated that she will make sure that all isolation carts had solid bottom to prevent contamination. IP also stated that she would have them replaced immediately. F 921 Safe/Functional/Sanitary/ Comfortable Environ F 921 Safe/Functional/Senitary/Comfortable Environ F 921 Safe/Functional/Senitary/Comfortable Environ F 921 CFR(s): 483.90(i):			7. 55,00				C		
MONTEREY HEALTHCARE & WELLNESS CENTRE, LP 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770	555897			B. WING		10/26/2020			
F 880 Continued From page 6 wheels were broken. IP stated that she will make sure that all isolation carts had solid bottom to prevent contamination from dust kicked up by staff and risk of contamination. IP also stated that she would have them replaced immediately. F 921 Safe/Functional/Sanitary/Comfortable Environ F 921 CFR(s): 483.90(i): CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPR	,		lness centre, LP		126	7 san gabriel blvd		•	
wheels were broken. IP stated that she will make sure that all isolation carts had solid bottom to prevent contamination from dust kicked up by staff and risk of contamination. IP also stated that she would have them replaced immediately. F 921 Safe/Functional/Sanitary/Comfortable Environ F 921 CFR(s): 483.90(i):	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			¢		(X6) COMPLETION DATE		
S483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This RECUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility falled to provide a safe and functional environment for the residents, staff, and public, regarding emergency signs on plastic barriers (provide some limited protection for individuals sharing the same space, first by preventing people from getting too close and also by preventing particles or droplets exhalled by one person from entering the breathing zone of another) used to separate the facility's different zones during COVID-19 (COVID-19, a respiratory litness that can spread from person to person). This deficient practice had the potential to result in negative effects to the health status, safety, and welfare of the residents, staff and public. Findings: During observation of the facility's north winggreen zone with the infection Preventionist (IPnurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment) on 10/14/200 at 2:14	F 921 SS=E	wheels were broken. sure that all isolation of prevent contamination staff and risk of contain that she would have the Safe/Functional/Sanith CFR(s): 483.90(i) \$483.90(i) Other Environmental Sanitary, and comforter residents, staff and the This REQUIREMENT by: Based on observation review, the facility failed functional environmentand public, regarding barriers (provide some individuals sharing the preventing people from by preventing people from by preventing particles person from entering the another) used to separate another) used to separate that can spread This deficient practice in negative effects to the and welfare of the resident process. During observation of green zone with the Innurse who helps preven of infectious agents like	IP stated that she will make carts had solld bottom to a from dust kicked up by mination. IP also stated hem replaced immediately. ary/Comfortable Environ ronmental Conditions de a safe, functional, tible environment for a public, is not met as evidenced at to provide a safe and at for the residents, staff, emergency signs on plastic a limited protection for a same space, first by a getting too close and also so or droplets exhaled by one he breathing zone of rate the facility's different 19 (COVID-19, a respiratory I from person to person). The health status, safety, dents, staff and public, the facility's north wingfection Preventionist (IP-ent and identify the spread e bacteria and viruses in a			Comfortable Environment CFR9s): 483.90(i): Corrective Actions for cited practice: Immediate action taken on 10/14/20 and signs to "TEADOWN IN CASE OF EMERGING were placed/posted on plate barriers. How Facility will identify other residents having the potential to be affected by the same deficient practice & what corrective action will be taken: No other residents were found to be affected	d IR ENCY" stic	1/26/20	

PRINTED: 10/26/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	000001		STREET ADDRESS, CITY, STATE, ZIP CODE	ן זע	/26/2020	
Monterey Healthcare & Wellness Centre, LP				1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULE CROSS-REPERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
F 921	from yellow zone (The where residents are k COVID-19. The Yellow residents are located hemodialysis, readmis waiting for the test reshave COVID-19 or not that indicates to tear demergency. During observation of green zone with the IPPM, the plastic barrier from yellow zone does indicates to tear down emergency. During observation of yellow zone with the IPPM, the plastic barrier from red zone (The Recovident) positive paragraph spread of the disease) that indicates to tear demergency. During observation of the IP on 10/14/2020, separating red zone from have signage that indicates of emergency. During interview with A 10/18/2020 at 1:22 PM put up the signage to the locate, but some of the it. But after the visit from the signage to the locate of the l	r separating green zone a Green Zone is the unit becated who do not have by Zone is the unit where who are undergoing ssion and/ or residents suits to determine if they t.) does not have signage flown plastic in case of the facility's south wing- on 10/14/2020, at 2:23 reparating green zone is not have signage that plastic in case of the facility's east wing- on 10/14/2020, at 2:45 separating yellow zone and Zone is the area where lients reside to prevent the does not have signage	F	What measures will be pinto place to ensure prace does not reoccur: DSD & Admin Insestaff on 10/19/20 11/3/20, 11/4/20 on the importance "TEAR DOWN SIGNATE CASE OF EMERGENCY" posplaced on plastic. This will be an ongoing education	erviced e of N IN ted/ parriers.		

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STATEMENT OF DEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		OCZ) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		555897	B. WING			18/	26/2020
NAME OF PROVIDER OR SUFPLIER MONTEREY HEALTHCARE & WELLNESS CENTRE, LP			1	itreet address, city, state, zip code 267 San Gabriel Blvd Rosemead, ca 91770			
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC (Dentifying Information)	(D PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	rie E	(X6) COMPLETION DATE
F 921	again. During interview with a (DON) on 10/19/2020 they have received the putting up plastic barriet via email. During interview of fact (PHN) on 10/19/2020 she gave guidelines to via teleconference reg to distinguish the differ signs indicating to tear case of emergency. A record review of the regarding the Fire Ret indicated, staff shall be the barriers in case of in accordance with the and Pianning Develop access to quality health OSHPD ensures hosp offers financial assistate the aithcare data) regar indicated the following 1. The facility needs to barriers that indicate "Emergency, Emergency instructed to tear down	the Director of Nursing at 3:45 PM, DON stated, e guidelines regarding lers and will send a copy of cility's Public Health Nurse at 08:15 AM, PHN stated, the facility last 10/13/2020 garding putting up signages rent zones and to put up a down plastic barrier in email sent by the DON gardant Plastic Barriers, it is instructed to tear down a fire or emergency exit. Diffice of Statewide Health ment (OSHPD, improves theare for Californians. it is buildings are safe, and collects and publishes ding plastic barrier, it: Diffice of Statewide Health ment (OSHPD, improves theare for Californians. it is buildings are safe, and collects and publishes ding plastic barrier, it:	F	921	Monitoring system to make sure solutions are sustained: Department Mgrs of perform daily round and brought to state up and stand down Immediate signage posted as needed of rounds occur. Findings to be brought to Infection Control Committee monthly and result to be brought to QA monthly and for 3 months thereafted to track/trend that deficient practice does not reoccur.	nds nd n. e is when ught ol es	1/ple po