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PRINTED: 09/16/2020

California	Department of Pub	ilc Health			NO DATE O	1101101
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE 8 COMPL	
,,			TE BOILDING.			
		CA910680065	B. WING		09/16	/2020
NAME OF S	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		1
		301 CENT	NELA AVE	् टा 		
CENTUR	y villa, inc	INGLEWO	OD, CA 903		· · · · · · · · · · · · · · · · · · ·	
(X4) (D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D RE I	(X8) COMPLETE DATE
C 000	The following reflect Department of Publis KILLED NURSING PLAN IMPLEMENT SURVEY. A COVID-19 Mitigate Survey was conducted Department of Published		C 000	C000 — Please accept this Plan Correction as our Credible Alleg Package. The deficiencies cited be corrected as specified and the will be monitored to prevent reconcited that I are not later than 12/22/2020. Prepared for execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficient and plan of correction. The Prosubmits this Plan of Corrections the intention that it is inadmissible any third party in any civil or critaction or proceedings against the Provider, its employees, agents officers, directors, or shareholde Plan of Correction is submitted meet requirements established state and federal law.	ention	
C4190	Health: Health Facilities Ev Total Residents: 75	75-72523(c)(3) Patlent Care	C4180	C4190 - Patient Care Policies Procedures	and	
	policies and proced to: (3) Infection control	il) establish and Implement lures, including but not limited policies and procedures. met as evidenced by:	-	A. The 2 residents (resident 2 a resident 3) who were readm the facility that were not colwith non suspected COVID-immediately moved to the q zone for residents suspecte having COVID-19 on 7/29/2	nitted to norted -19 were uarantine d of	9/25/2020

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IMME OF PROVIDER OR SUPPLIER SINGLEWOOD, CA 90302 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE VILLA, INC SUMMARY STATEMENT OF DEFIDENCIES (EACH DEPICIENCY MUST BE PRECEDED OF PLAIL TAG CONTINUED From page 1 Based on observation, interview, and record review the facility falled to implement their mitigation plan as part of their infection control program when a. Two Residents (Resident 2 & resident 3) who were readmitted to facility did not cohorted with non-euspected covid-19 (a viral respiratory) disease that spreads from person to person). (residents b. Ensure two residents' in the quarantine (separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick) rooms (Resident 3 & resident 4) had personal protective equipment (PPE) signage and PPE outside their room. c. Ensure staff used environment protective agency (EPA) registered disinfecting products to clean the resident's room. d- The mitigation plan was not aligned with local, state, and federal guidelines This falture increased the risk of transmission of COVID-19 to non-infected patients. e- During an interview with the Director of Nursing DON on 7828/20, at 11:17 a.m., she stated the facility did not have any residents in quarantine. The DON stated for precisions in the last 14 days. She stated Resident 2 was readmitted on 8/22/20, at 11:28 a.m., he stated patients who were readmitted were considered	STATEMENT	a Department of Pul T of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CENTURY VILLA, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL.) REGULATORY OR LOS DEMITIFYING INFORMATION) CA190 COntinued From page 1 Based on observation, interview, and record review the facility felled to implement their mitigation plan as pert of their infection control program when a. Two Residents (Resident 2 & resident 3) who were readmitted to facility did not cohorted with non-suspected covid-19 (a viral respiratory disease that spreads from person to person). (residents) b. Ensure two residents in the quarantine (separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick) rooms (Resident 3) as resident 4) had personal protoctive equipment (PPE) signage and PPE outside their room door, and staff wore the proper PPE to enter the room. c. Ensure staff used environment protective egency (EPA) registered disinfecting products to clean the resident's room. d- The mitigation plan was not aligned with local, state, and federal guidelines This failure increased the risk of transmission of COVID-19 to non-infected patients. a- During an interview with the Director of Nursing DON on 7828/20, at 11:17 a.m., she stated the facility did not have any residents in quarantine, the last 14 days. She stated Resident 2 was readmitted on 8/22/20. During an interview with the Director of Staff Development on 8/28/20, at 11:28 a.m., he stated patients who were readmitted were considered.		. CA910000068		B. WING		09/16/2020	
SHAMARY STATEMENT OF DEFICIENCES SHAMARY STATEMENT OF DEFICIENCES PREFICE	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, 81	TATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCY MUST BE PRECREDED BY PILL. TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTIVE ACTION) FRETEX TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTIVE ACTION) FRETEX TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTIVE ACTION) FRETEX TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTIVE ACTION) PRETEX TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTION) PRETEX TAG PROVIDERS PLAN OF CORRECTION (ACCHIECTIVE ACCHIECTION) PRETEX TAG PROVIDERS PLAN OF CORRECTIVE ACTION (ACCHIECTION) PRETEX TAG PROVIDERS PLAN OF CORRECTIVE ACTION (ACCHIECTION) PRETEX TAG			301 CEN	TINELA AVE			
C4190 Continued From page 1 Based on observation, interview, and record review the facility felled to Implement their mitigation plan as part of their infection control program when a. Two Residents (Resident 2 & resident 3) who were readmitted to facility did not cohorted with non-suspected covid-19 (a viral respiratory disease that spreads from person to person). (residents b. Ensure two residents' in the quarantine (separates and restricts the movement of people who were expected to a contagious disease to see if they become sick) rooms (Resident 3 & resident 4) had personal protective equipment (PPE) signage and PPE outside their room door, and staff wore the proper PPE to enter the room. d- The mitigation plan was not aligned with local, state, and federal guidelines This failure increased the risk of transmission of COVID-19 to non-infected patients. a- During an interview with the Director of Nursing DON on 7828/20, at 11:17 a.m., she stated the facility had readmissions in the last 14 days. She stated Resident 2 was readmitted on 8/22/20. During an interview with the Director of Staff Development on 8/22/20, at 11:28 a.m., he stated patients who were readmitted were considered	CENTURY	y villa, inc	INGLEW	DOD, CA 9030	12		
Based on observation, interview, and record review the facility falled to implement their mitigation plan as part of their infection control program when a. Two Residents (Resident 2 & resident 3) who were readmitted to facility did not cohorted with non-suspected covid-19 (a viral respiratory disease that spreads from person to person). (residents b. Ensure two residents' in the quarantine (separates and restricts the movement of people who were exposed to a contaglous disease to see if they become sick) rooms (Resident 3 & resident 4) had personal protective equipment (PPE) signage and PPE outside their room door, and staff wore the proper PPE to enter the room. d. The mitigation plan was not aligned with local, state, and federal guidelines This falture increased the risk of transmission of COVID-19 to non-infected patients. a- During an interview with the Director of Nursing DON on 7828/20, at 11:17 a.m., she stated the facility did not have any residents in quarantine. The DON stated the facility had readmissions in the last 14 days. She stated Resident 2 was readmitted on 8/22/20. During an interview with the Director of Staff Development on 8/28/20, at 11:28 a.m., he stated patients who were readmitted were considered to resident and no other resident's and no other resi	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A	SHOULD BE	(X6) COMPLETI DATE
under investigation for COVID-19. Readmitted patients were put in the guarantine room and		Based on observation review the facility far mitigation plan as a program when a. Two Residents (were readmitted to non-suspected covidisease that spread (residents b. Ensure two residents b. Ensure two residents who were exposed she if they become resident 4) had persident 4) register that the persident for the persident for the persident for the mitigation plastate, and federal grant federa	on, interview, and record alled to implement their art of their infection control. Resident 2 & resident 3) who facility did not cohorted with d-19 (a viral respiratory is from person to person). Bents' in the quarantine ricts the movement of people to a contagious disease to sick) rooms (Resident 3 & sonal protective equipment PPE outside their room door, proper PPE to enter the room. I environment protective tered disinfecting products to room. In was not aligned with local, uidelines and the risk of transmission of fected patients. Bow with the Director of Nursing 11:17 a.m., she stated the any residents in quarantine, a facility had readmissions in the stated Resident 2 was 20. With the Director of Staff 18/20, at 11:28 a.m., he stated eadmitted were considered for COVID-19. Readmitted		To identify other resist the potential to be affisame practice, the Laupervisor and DON all in house resident's were be affected by this properties in the tast this properties in the all licensed staff to make the quarantine for 14 Also, that all new admission and will be placed in a sir in the quarantine are 14 days from the date admission and will not released without a netest result. The DON will conduct weekly rounds to ensure that all new admission are placed in the appropries in yellow zone admissions with negaresults. All negative findings to the Administrator will pre negative findings to the committee quarterly fand recommendation.	fected by the VN assessed s and no noted to actice. ractice does 20 the CQI DON and lake sure will be placed in days. missions a for e of ot be egative at the complete of the	
isolated for 14 days. During an interview with the DON on 7/28/20, at 11:42 a.m., she stated residents who were	į	isolated for 14 days. During an interview	with the DON on 7/28/20, at				
nsing and Certification Division				<u> </u>			

	<u>a Deparment of Pul</u> IT of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILITIPL	E CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 * *		COMPLETED
	•		,		
			B. WING		00149/2020
		CA910000065			09/18/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 8	STATE, ZIP CODE	
		301 CENT	inela ave		
CENTUR	Y VILLA, INC	INGLEWO	OD, CA 903	302	
(X4) ID	· SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTI	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	
TAG	REGULAIORTORL	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
			0.4400		
C4190	Continued From pa	ge 2	C4190	B. On 7/28/20 the 2 yellov	v zone 9/25/2020
	admitted and readr	nitted were quarantine in the		rooms 30,31 had their closed by the LVN sup	
	yellow zone.			PPE carts were placed	ervisor.
	, 011.011			each room and signs for	or proper
	During an interview	with Certified nurse assistant		PPE use were placed	on all
	(CAN 1) on 8/28/20	, at 12:23 p.m., she stated		the doors on 7/28/20.	
	residents who were	in the yellow zone were		PPE isolation carts inc	
	quarentine for 14 d	ays.		masks, face shields, di	sposable,
1	. *			gowns, and gloves. The signs indicated approp	
	During an interview	with licensed registered nurse		infection control proces	dures
	(LVN 1), on 8/28/20), at 1:20 p.m he stated	į	for droplet isolation of	
	residents in the yel	ow zone staff wear gown,		COVID-19 and approp	riate
	ehleid, mask, glove	s, and shoe covers.		donning and doffing of	i
				the PPEs.	
	During an interview	with CAN 2, on 7/28/20, at	ľ		;
	1:50 p.m., sne stat	ed room 12 had two residents.			Ì
		dent 3 went to the hospital on		To identify other reside	
_	8/27/20.	,	}	having the potential to affected by the same p	De :
·	During on interview	and concurrent record review	•	the LVN supervisor and	
		/27/20, at 2:17 p.m., she]	assessed all in house	
		and Resident 3 were	•	and no other resident's	were
		quarantine, refused to stay in	İ	noted to be affected by	this
1		and refused to stay in their	ŀ	practice.	• •
		she could not find any care		To once that this are	ation 1
		ent 2 and Resident 3 being		To ensure that this pra does not reoccur, the [
	non-compliant with	quarantine. DON stated if		in-serviced all staff reg	
		confirmed with COVID-19, he		infection control guideli	ines to
	would comply with	isclation. DON agreed that		prevent the spread and	
	readmissions shou	ld be separated from		transmission of all	
		ents. The DON stated		communicable disease	
		come out of quarantine after		including COVID-19 or	1 //29/20. :
		ative COVID-19 test results.		The DON will conduct	: weekiv
		mission had a 60% chance of		rounds to ensure that a	
	being infected with			quarantine rooms have	their
		the Medical Records for		doors closed, have app	propriate ·
		ce Sheet indicated Resident 2		signage displayed outs	
		the facility on 8/22/20. the Medical Records for		room, and have fully st	ocked (
		ne medical records for est Pack Labs, indicated		PPE/isolation carts out each room.	. i
		ted for COVID-19 on 8/25/20		Caon toom.	

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STATEMEN	a <u>Department of Pul</u> IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		uction (X	3) DATE 8 COMPL	
		CA910000085	B. WING			09/1	6/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 8	STATE, ZIP	CODE		
CENTUR	Y VILLA, INC	· · ·	'inelaave Ood, ca 903	302			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	i ⟨€/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
C4190	on 8/26/20. During a review of it Resident 2, the Res 8/28/20, indicated r isolation/quarantine During a review of it Resident 3, the Spe 8/20/20, indicated F COVID-19 During a review of it Resident 3, the Fact was readmitted to it During a review of it Resident 3, the We Resident 3 was test and the negative Co on 8/26/20. During a review of it Resident 3, the Resident 3 was test and the negative Co on 8/26/20, indicated r isolation/quarantine The facility mitigation facilities. The plan it test the resident, the quarantine upon ad residents who were would be tested prior to admission of transfer from hospificallities. The plan it test the resident, the quarantine upon ad residents who were would be tested prioresidents who were would be tested prioresident and then retested. It be released from quite facility would en new and readmitted COVID-19 status woccupancy room or wing, or building.	he Medical Records for sident Care Plan dated con-compliance to order for the Medical Records for the Sheet indicated Resident 2 the facility on 8/23/20 the Medical Records for the Medical Records f	C4180	C.	All negative findings will be addressed by the Administr to be presented to the QAA committee quarterly for revi and recommendation. Corrective actions were completed on 9/26/20 On 8/28/20 the housekeepe was immediately given the correct bottle of EPA registed disinfectant effective against COVID-19 and educated in use to prevent the spread of COVID-19 infection. To identify other residents having the potential to be affected by the same practithe LVN supervisor and DO assessed all in house resident and no other resident's wernoted to be affected by this practice. To ensure that this practice not reoccur, on 8/29/20 the housekeeping supervisor in-serviced the housekeeping staff regarding the use of El registered disinfectants to us which are effective against COVID-19. The housekeeping superviswill conduct weekly rounds ensure that all housekeeper are using the proper disinfe for use against the COVID-virus.	ew er ered st its if ce, N ent's e does ppA use	9/25/2020
·}	The facility's policy	litled "Cohorting of Residents"		-			
ansing and ATE FORM	Certification Division		C\$ D9 L	AZY011			ion sheat 4 of

STATEMEN	a Department of Put IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		CA910000065	B. WING		09/10	8/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	***************************************	ŀ
APMITTER	AZ SZELE A LIMP	***************************************	INELA AVE			ì
CENTOR	y Villa, inc	INGLEWO	OD, CA 903			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHIC CROSS-REFERENCED TO THE APPI DEFICIENCY)	NJLD BE I	(X6) COMPLETE DATE
C4190	Continued From pa	ige 4	C4190	All negative findings wi	ll be	
	undated indicated	the yellow unit or quarantine		brought to the Adminis	trator's	ŀ
	was for residents w	the have been in close contact		attention by the housel	ceeping :	
	with one or more k	nown cases of COVID-19 or		supervisor. The Admin		ľ
ł	for newly admitted	or readmitted residents.		will present all negative	i findings]
	Patients in this are:	a should be placed in a private		to the QAA committee		
١.	room if possible. In	dividuals should be kept in		for review and recomm	eriuation.	
1	quarantina for 14 d	ays from the date of their		Corrective actions were	A	'
	exposure, or admit	tance date. Patients who		completed on 9/25/20		
	received two negat	ive test results at least 24	•			: 1
	hours a part can be	transfer to the non-COVID-19				
	patient care area.		ļ	D. On 8/31/20 the mitigati		9/25/2020
	The facility policy t	tled "Novel Coronavirus, Plan,	į.	was implemented to be		
	Prevention, and Re	esponse" revised 2020,	Į.	with the local, state, ar guidelines.	id rederai	i !
	Indicated interventi	ons to prevent the spread of		guidelines.		!
	respiratory germs t	or residents with undiagnosed	<u> </u>	To identify other reside	ents having	i I
	respiratory infection	n, the facility would use		the potential to be affe		
	standard, contact,	and droplet precaution with eye	1	same practice, the LVI		!
	protection. The pol	icy indicated residents who		supervisor and DON a	assessed	: {
}	were suspected of	having COVID-19 were the		all in house resident's		i · [
1	staff would implem	ent standard, contact, and	{	other resident's were r		i I
1	airbome. The polic	v indicated staff would wear	i	affected by this practic	e	, }
	gloves, gowns, gog	igles or face shields, and mask		To ensure that this pra	aech enits	i
1	(respirators) upon	entering room.	1	not reoccur, on 8/31/2		1
1	b-During an intervi	ew with the DON on 8/28/20, at	1	nurse in-serviced the		
	11:17 a.m., she sta	ated the facility did not have		Administrator regardin		!
	any residents in qu	arantine.	1	mitigation plan and to	make sure	,
	During an interview	with the Director of Staff		that it is aligned with t		;
	Development on 7	/28/20, at 11:28 a.m., he stated	1	state, and federal guid	eiines.	
	patients who were	in the yellow zone were		The administrator will	conduct	j
	considered under	investigation for COVID-19.		weekly rounds with the	DON to	•
	During an observa	tion on 7/28/20 in the hailway,		ensure that the mitigat	ion plan	1 .
1	room 30 and room	31 were marked as yellow		is followed and aligned	d with the	Į į
1	zone and were occ	cupied with one resident each.		local, state, and federa	al	'
	Room 30 and 31 d	cors were open. There was no		guidelines.		
	signage of PPE of	irt outside the door.				•
	Dunng an interview	with Certified nurse assistant				1
1	(UAN 1) OF 8/28/2	0, at 12:23 p.m., she stated e in the yellow zone were				
	quarantine for 14					ļ
1.	Deglararial of 14 C	aays v with Hoensed registered nurse	1	L		
Januarian -	d Certification Division	A Alth Modified 1980steled Haloc	<u> </u>			
STATE FOR		kajit kija (1900-1904) kun ila (1904) jalija kun ila (1904) kun ila mana kun dinadir ala din Amanda kana sa ma Kun jalija kun ila (1904) kun ila (1904) kun ila kun i Kun ila kun ila (1904)	6 888	MZY011.	if continu	elon sheet 5 of 8

California Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING CA910000085 09/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **301 CENTINELA AVE** CENTURY VILLA, INC INGLEWOOD, CA 80302 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C419D C4180 Continued From page 5 All negative findings will be brought to the Administrators (LVN 1), on 8/28/20, at 1:20 p.m., he stated attention by the housekeeping supervisor. The Administrator residents in the vellow zone staff wear gown. shield, mask, gloves, and shoe cover will present all negative findings During an interview with LVN 2, on 8/28/20, at to the QAA committee quarterly 1:57 p.m., he stated readmission residents and for review and recommendation. hemodialvsis residents were cohorted in the Corrective actions were vellow zone. completed on 9/25/20 During an interview with the DON, on 8/27/20, at 2:17 p.m., she stated hemodialysis residents were cohorted in the yellow zone. The DON stated the yellow zone rooms should have PPE cart and signage by the door, the door should be close, and the staff should wear mask, gloves, and a gown to go into the rooms in the yellow zone to prevent COVID-19 infection. The facility mitigation plan undated indicated the necessary PPE would be made available directly outside the resident's rooms in the red zone in accordance with current Center for Disease Control and Prevention (CDC) guidance. The plan indicated the facility would have an isolation set-up outside resident rooms when necessary to meet this requirement. The plan indicated all staff would wear recommended PPE while in the building per current California Department of Public Health (CDPH) guldance. The plan indicated signs were posted immediately outside the resident rooms indicating appropriate Infection control and prevention precautions and required PPE in accordance with CDPH guidelines. The plan indicated the facility designated space for safe care and treatment of COVID-19. The plan indicated the quarantine yellow space was designated for unknown asymptomatic residents and/or developed a safe plan The facility policy titled "Novel Coronavirus, Plan. Prevention, and Response revised 2020. Indicated interventions to prevent the spread of respiratory germs; residents with undlagnosed censing and Certification Division

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDINGS B. WING			(XS) DATE SURVEY COMPLETED	
,	•	CA910000065			09/16/2020		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, 81	TATE, ZIP CODE		•	
CENTUR	Y VILLA, INC		iinelaave Dod, Ca 803()2			
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies / Must be preceded by Full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X6) COMPLE DATE	
C4190	contact, and drople	n facility would use standard, t precaution with eye	C4190				
	use posting signs of the resident room to of precaution needs	oy indicated the facility would in the door or wall outside of hat clearly described the type and required PPE. The			•		
	protection, gowns, a immediately outside policy indicated res	PPE, including face mask, eye and gloves, available of the resident's room. The ident's who were suspected of vere placed in a private room					
	with the door closes d- during an observ with housekeeping						
	nursing station, and bottle with a purple	the resident's side table, I facility spills. HK 1 showed a liquid labeled brilloso and product he used to clean.					
į	Facility surfaces. His seconds contact tinused a yellow liquid	K 1 stated the liquid has a 20 ne. HK 1 stated the facility only when the bed was ved the bottle for brilloso					
	product and stated	he could not find a label that rona virus and EPA					
	housekeeping, on a facility should not us	1/28/20, 3 p.m., he stated the see the product called brilloso the facility and brilloso was			·		
	The facility's policy Plan, Prevention, as indicated the facility	titled "Novel Coronavirus, nd Response" revised 2020, would perform routine and			·		
	effective against en	sing disinfectants known to be nerging viral pathogens or ARS-CoV02 (EPA list N				!	
j	d- Buring an intervi	ew with the DON on 8/28/20,		-		!	
	Certification Division		J.,,,,,				

		CIES (X1) PROVIDER/SUPPLIER/CLIA N IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		CA91000065	B. WING		09/16/2020		
	PROVIDER OR SUPPLIER Y VILLA, INC	301 CENT	DRESS, CITY, 81 FINELA AVE DOD, CA 9030	·			
(X/) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X6) COMPLE DATE	
	cohorted symptoms confirmed with CON DON stated the mit The facility mitigation facility had developed and treatment of CO spaces. The policy confirmed positive is symptomatic suspenses. The facility's policy undated, indicated residents who have COVID-19 and indicated in symptoms of COVI results, or who have should be placed in The center for Dise dated 7/15/20, indicated 7/15/20, indicat	stated the facility did not allo residents who were not //ID-19 in the red zone. The igation plan was not correct. On plan undated indicated the ed procedures to safe care OVID-19 in designated indicated residents who were for COVID-19 and /or were cted would be in the red titled "Cohorting of Residents" the red unit or tsolation include been tested positive for viduals who developed D-19, who were walting test a tested negative a single time the quarantine area. The control and Prevention sated patients who had any be cohorted with patients iretory pathogen. The communicable disease 20, indicated The facility in area for the placement of					
<u> </u>	i Cerificellon Division					1	