PRINTED: 09/28/2020 FORM APPROVED

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING CA950000040 08/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST COUNTRY OAKS CARE CENTER POMONA, CA 91768 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY C 000 C 000 Initial Comments Country Oaks Care Center submits this response and Plan of Correction as part The following reflects the findings of the California of the requirements under state and Department of Public Health during a COVID-19 federal law. The plan of correction is SKILLED NURSING FACILITY MITIGATION submitted in accordance with specific PLAN IMPLEMENTATION MONITORING regulatory requirements. It shall not be SURVEY. construed as admission of any alleged deficiency cited or any liability. The A COVID-19 Mitigation Plan Implementation and Infection Control Surveys was conducted by the provider submits this plan of correction California Department of Public Health on 8/24/20 with the intention that it is inadmissible by any third party in any civil, criminal The facility was found not to be in compliance action of proceedings against the with Title 22 California Code of Regulations provider or its employees, agents, section 72523(c) patient care polices and officers, directors, or shareholders. The procedure regulations, and has not implemented their Skilled Nursing Facility Mitigation Plan for provider reserves the right to challenge COVID-19. the cited findings if at any time the provider determines that the disputed Representing the California Department of Public findings are relied upon in a manner Health: adverse to the interests of the provider either by the governmental agencies or Health Facilities Evaluator Nurse: 36290 third party. Total Residents: 78 C4190 C4190 T22 DIV5 CH3 ART5-72523(c)(3) Patient Care C4190 Policies and Procedures a) The facility has ensured that (c) Each facility shall establish and implement there are 40 hours of coverage policies and procedures, including but not limited of infection prevention each week. (3) Infection control policies and procedures. b) Other residents have the potential to be affected by this This Statute is not met as evidenced by: deficient practice and facility Based on interview and record review, the facility failed to implement the Coronavirus (COVID-19, will maintain 40 hours of IP a serous respiratory illness caused by a virus that coverage weekly. can spread from one person to person) Mitigation Plan and the COVID 19 Infection Control policy Licensing and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE O(B) DATE

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California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING CA950000040 08/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST **COUNTRY OAKS CARE CENTER POMONA. CA 91768** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X4) ID PREPIX (D PREFIX COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C4190 C4180 Continued From page 1 c) On September 21, 2020, the and procedure. The facility failed to have a facility hired an Infection full-time, dedicated Infection Preventionist (IP). **Prevention Nurse dedicated** solely to infection prevention. This deficient practice had the potential to result One other nurse in the facility in the IP duties and responsibilities not being fulfilled and could have resulted in the spread of completed the IP course COVID 19 amongst residents and staff. through the CDC on October 6. 2020 to serve as a backup IP Findings: nurse. Also, the DSD is currently On 8/24/20 at 10:50 am., a survey visit was taking the course online in conducted to ensure the facility was implementing order for the facility to have 2 the Coronavirus Disease 2019 (COVID-19) Mitigation Plan. backup IP nurses. d) Infection prevention is a topic On 9/24/2020 at 13:03 pm, during telephone at our monthly QAPI meeting. interview, the Director of Nursing (DON) stated the Director of Staff Development (DSD) has a The IP nurse will be present to combine role of DSD and IP, for a total of 40 evaluate infection prevention hours per week. practices of the facility and report on best practices and On 8/24/2020 at 1:40 pm, during an interview, the Administrator stated the IP was out due to family areas of opportunity for the emergency, and there was no one with an IP facility to ensure the facility is certificate to cover this IP role. doing its best to safeguard the On 8/25/2020 at 11:40 am, attempted to conduct residents and staff. a telephone interview with facility's IP, but the e) The deficient practice has been Administrator stated the IP called off and the corrected and facility is in facility do not have anyone who had the training certificate to cover the IP role. compliance. A review of the Coronavirus Disease 2019 (COVID-19) SNF (skilled nursing facility) Mitigation Plan Glossary, attachment from All Facilities Letter 20-62, indicated that the definition of a full-time infection preventionist was: One or more individuals who are responsible for the facility's infection prevention and infection control program. The IP must: work 40 hours per Licensing and Certification Division

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California Department of Public Health										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		CA950000040	B. WING		08/2	1/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DETICIENCY)	LDBE	(XS) COMPLETE DATE				
C4190	Continued From pa	ge 2	C4190							
	emergency (COVID specialized training control. More than one staff however, only direct towards direct care staffing requirement direct caregiver onli services beyond the duties of the IP nursing hours are services of the facility (COVID-19) Mitigat under the infection category the facility	for the duration of the declare of 19) and have completed on infection prevention and if member can share this role; it care hours can be counted service hours per patient day its. An IP may be considered a y when providing nursing the hours required to carry out role, if these additional separately documented. by's Coronavirus Disease 2019 ion Plan (undated) indicated, and prevention control shall have a full time,								
	shall spend adequa	Preventionist (s). The IP/s ate time in the building and y on activities dedicated to								
	titled "Role of the Ir Long-term Care Fa qualified person sh	lity's policy and procedure nfection Preventionist in cility", indicated that one culd be assigned the task of ction control program.		•						
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 09/28/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	TE SURVEY MPLETED	
	055247		B. WING			OS	08/24/2020	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER				21	TREET ADDRESS, CITY, STATE, ZIP CODE 16 W PEARL ST OMONA, CA 91768			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	CTION CULD BE ROPRIATE	(XS) COMPLETION DATE		
F 000	The following reflection is California Department Focused Infection in Representing the California Health: Health Facilities Extended in the Inspection was control survey and findings of a full instance of the California California California Department in the California Depar	saith Facilities Evaluator Nurse: 36280 he inspection was limited to a focused infection ontrol survey and does not represent the addings of a full inspection of the facility. ne deficiency was written as a result of the		200				
F 880 88¤E	Inspection. 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 providing services under a contractual		F	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 a) The facility has ensured that there are 40 hours of coverage of infection prevention each week. b) Other residents have the potential to be affected by this deficient practice and facility will maintain 40 hours of IP coverage weekly.				

Any deficiency statishent ending with an asterisk (*) denotes a deficiency which the institution may be exceed 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.

FORM CMS-2567(02-99) Provious Versions Obsoleto

Event ID: 0J0311

Facility ID: GA950000040

If continuation sheet Page 1 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2020 FORM APPROVED QMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
055247		055247	B. WING			08/24/2020		
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 216 W PEARL ST POMONA, CA 91768					
(X4) (D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	280	c) On September 21, 2020, facility hired an Infection Prevention Nurse dedica solely to infection prevention Prevention Nurse dedical solely to infection prevention in the factorized the IP course through the CDC on Octorized 2020 to serve as a backunurse. Also, the DSD is contaking the course online order for the facility to his backup IP nurses. d) Infection prevention is a at our monthly QAPI means the IP nurse will be presevaluate infection preventices of the facility a report on best practices areas of opportunity for facility to ensure the facility is incompliance.	ted ntion. scility bber 6, p IP urrently in ave 2 topic eting. ent to ntion nd and the ility is rd the		

PRINTED: 09/28/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X8) DATE SURVEY COMPLETED A. BUILDING_ 055247 B. WING 08/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 216 W PEARL ST **COUNTRY OAKS CARE CENTER** POMONA, CA 91768 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PRÉFIX TAG CONFLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX TAG F 880 Continued From page 2 F 880 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 Based on interview and record review, the facility failed to implement the Coronavirus (COVID-19. a serous respiratory illness caused by a virus that can spread from one person to person) Mitigation Plan and the COVID 19 Infection Control policy and procedure. The facility failed to have a full-time, dedicated Infection Preventionist (IP). This deficient practice had the potential to result in the IP duties and responsibilities not being fulfilled and could have resulted in the spread of COVID 19 amongst residents and staff. Findings: On 8/24/20 at 10:50 am., a survey visit was conducted to ensure the facility was implementing the Coronavirus Disease 2019 (COVID-19) Mitigation Plan. On 9/24/2020 at 13:03 pm, during telephone interview, the Director of Nursing (DON) stated the Director of Staff Development (DSD) has a combine role of DSD and IP, for a total of 40 hours per week.

certificate to cover this IP role.

On 8/24/2020 at 1:40 pm, during an interview, the Administrator stated the IP was out due to family emergency, and there was no one with an IP

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Q(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X8) DATE SURVEY COMPLETED	
	0 55 247 B. Wing_						08/24/2020	
NAME OF PROVIDER OR SUPPLIER COUNTRY OAKS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W PEARL ST POMONA, CA 91788					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SKOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
F 880	On 8/25/2020 at 11 a telephone intervie Administrator state	:40 am, attempted to conduct sw with facility's IP, but the d the IP called off and the anyone who had the training	F8	80				
	(COVID-19) SNF (a Mitigation Plan Glos Facilities Letter 20-of a full-time infection on or more individual the facility's infection control program. To week at the facility emergency (COVID specialized training control. More than one staff	conavirus Disease 2019 skilled nursing facility) ssary, attachment from All 52, indicated that the definition on preventionist was: duals who are responsible for in prevention and infection he IP must: work 40 hours per for the duration of the declare 0 19) and have completed on infection prevention and f member can share this role; at care hours can be counted						
·	towards direct care staffing requirement direct caregiver onli services beyond the the duties of the IP	e care riours can be courned e service hours per patient day its. An IP may be considered a by when providing nursing e hours required to carry out role, if these additional separately documented.				·		
	(COVID-19) Mitigat under the infection category the facility dedicated Infection shall spend adequa	ty's Coronavirus Disease 2019 tion Plan (undated) indicated, and prevention control shall have a full time, Preventionist (a). The IP/s ate time in the building and y on activities dedicated to				·		
	titled "Role of the Ir	iity's policy and procedure nfection Preventionist in cility", indicated that one	l					

PRINTED: 09/28/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MILITIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 055247 8. WING 08/24/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 216 W PEARL ST **COUNTRY OAKS CARE CENTER POMONA, CA 91768** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) (D PREFIX TAG COMPLETION DATE PREFIX TAG F 880 Continued From page 4 F 880 qualified person should be assigned the task of overseeing the infection control program.