Statement of Deficiency

Centinela Grand, Inc. (2225 N Perris Blvd Perris)

Riv. SNF COVID-19 Mitigation

Managers	Inspection Date	Status
Maricris Rizzo	Dec 1, 2020	Done

Report Sent Date	Done Date	Reference ID
Dec 9, 2020	Dec 30, 2020	Y00Z11

Notes

Dear Administrator:
Enclosed is a Statement of Deficiencies, which resulted from a recent COVID-19 Mitigation Survey visit to your facility. Please use the Risk and Safety Solutions program to prepare an electronic plan of correction for each deficiency within ten (10) calendar days from receipt of this Statement of Deficiencies. You can download a PDF copy of the Statement of Deficiencies and your Plan(s) of Correction or access the electronic record at any time.
The Plan of Correction for each deficiency must contain the following:
a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice?
b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.
c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.
e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.
If your Plan of Correction is unacceptable to the Department you will be notified in writing through the Risk and Safety Solutions program. You are ultimately accountable for compliance, and responsibility is not alleviated where notification of the acceptability of the plan of correction is not timely. You are responsible for submitting a timely acceptable Plan of Correction. Your plan of correction will serve as the facility's allegation of compliance.
If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.
If you have any questions, please contact Health Facilities Evaluator Supervisor, Maribeth Dela Cruz Health Facilities Evaluator Supervisor], at (909)-388-7170 or Dela Cruz, Maribeth@cdph.ca.gov.

The following reflects the findings of the California Department of Public Health during a COVID-19 SKILLED NURSING FACILITY MITIGATION PLAN IMPLEMENTATION MONITORING SURVEY.

A COVID-19 Mitigation Plan Implementation Survey was conducted by the California Department of Public Health on December 1, 2020.

Representing the Department of Public Health: Surveyor Federal ID # 36038,
Health Facilities Evaluator Nurse (HFEN)

Total Residents: 85

The facility was found not to be in compliance with the California Code of Regulations, title 22 section(s) outlined below related to implementation of the Skilled Nursing Facility Mitigation Plan for COVID-19.

§ 72321. Nursing Service -Patients with Infectious Diseases.
(a) Patients with infectious diseases shall not be admitted to or cared for in the facility unless the following requirements are met:
(1) A patient suspected of or diagnosed as having an infectious or reportable communicable disease or being in a carrier state who the attending officer determines is a potential danger, shall be accommodated in a room, vented to the outside, and provided with a separate toilet, hand-washing facility, soap dispenser and individual towels.
(2) There shall be:
(A) Separate provisions for handling contaminated linens.
(B) Separate provisions for handling contaminated dishes.
(b) The facility shall adopt, observe and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as necessary.
(c) The following shall be available in each nurse's station:
(1) The facility's infection control policies and procedures.
(2) Name, address and telephone numbers of local health officers.

§ 72523. Patient Care Policies and Procedures.
(c) Each facility shall establish and implement policies and procedures, including but not limited to:
(3) Infection control policies and procedures.
3 deficiencies were written at the below state regulation(s).

Mitigation-Testing and Cohorting *

The SNF will work with their local health department (LHD) and CDPH to develop a testing plan for regular testing of residents and staff through the identified testing sites able to meet the time requirements, including how test results will be used to inform resident and health care personnel (HCP) cohorting. This plan must be in place within 14 days of submission of the attestation

Survey Procedures:

- Request and review the facility’s testing plan for staff and residents. This plan must include information on methods and frequency, and it must specify how the facility will use testing results to inform resident and HCP cohorting decisions.
- Verify whether the testing plan complies with AFL-20-53.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Residents with active COVID-19 infection confirmed by testing, or those residents who are recovering from COVID-19 infection, have been separated from residents who are not infected or have unknown infection status. Where separation is not possible, the SNF is responsible for communicating with the LHD and CDPH and transferring the resident to the hospital or alternate care site following the guidance in AFL-20-48.1.

Survey Procedures:

- Observe how COVID-19 positive residents are cohorted.
- If separation is not possible, request for documentation of communication with LHD and CDPH.

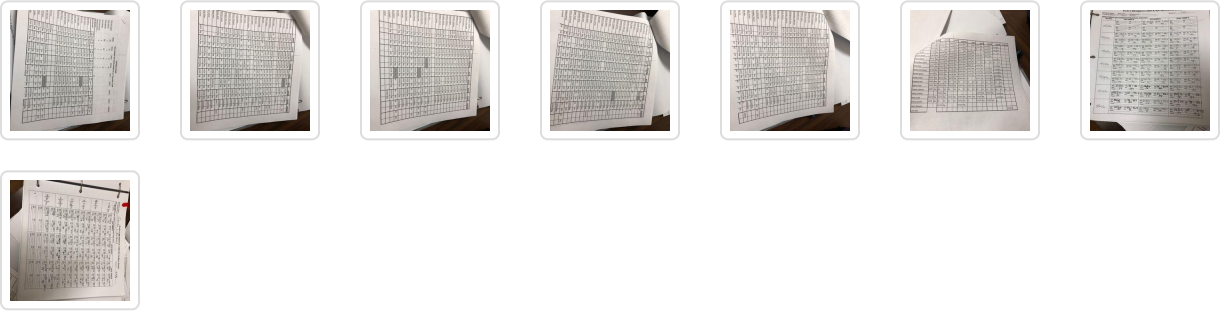
Public Comments:

Tags: § 72321 (b)

Status: Compliant

Incident Attachments:

Images:



Resident cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following surveillance testing (if available), temperature checks, and symptom screening in accordance with the Centers for Disease Control and Prevention's (CDC) recommendations.

Survey Procedures:

Interview the infection control lead and clinical staff responsible for reevaluating resident cohorting.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

Incident Attachments:

Images:

All residents are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks at least daily and documented in the clinical record.

Survey Procedures:
Observe their screening process and request to see their screening documentation for all residents.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Residents with any suspected respiratory or infectious illness are assessed (including documentation of respiratory rate, temperature and oxygen saturation) at least twice during each shift, during the day and evening shifts, to quickly identify residents who require transfer to a higher level of care. The SNF will monitor CDC guidance and modify these procedures to stay consistent with the most current guidance on an ongoing basis.

Survey Procedures:
- Request to see documentation of resident assessments.
- Verify their procedures are consistent with CDC guidance.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

The SNF has implemented a staffing plan to limit transmission, including dedicated, consistent staffing teams who directly interact with residents that are COVID-19 positive.

Survey Procedures:

Review the staffing plan and ensure that the facility has implemented all requirements in accordance with their staffing plan.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

The SNF has implemented a staffing plan to limit transmission, including limiting clinical and other staff who have direct resident contact to specific floors or wings. There should be no rotation of staff between floors or wings during the period they are working each day. wings during the period they are working each day. Limit staff to staff interactions assigned to different cohorts.

Survey Procedures:
Review the staffing plan and ensure that the facility has implemented all requirements in accordance with their staffing plan.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

The SNF has implemented a staffing plan to limit transmission, including an established policy to minimize the number of staff interacting with each resident.

Survey Procedures:
Review the staffing plan and ensure that the facility has implemented all requirements in accordance with their staffing plan.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

The SNF has implemented a staffing plan to limit transmission, including if these measures cannot be met the SNF will work with their LHD and CDPH to evacuate all positive residents to the nearest healthcare facility or alternate care site that can meet these requirements. The SNF is responsible for the transfer and any associated costs.

Survey Procedures:
Review the staffing plan and ensure that the facility has implemented all requirements in accordance with their staffing plan.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

Mitigation-Infections Prevention Control *

The SNF has a full-time, dedicated Infection Preventionist(s). This can be achieved by more than one staff member sharing this role, but a plan must be in place for infection prevention quality control. SNF will list the names and positions of staff assigned to infection prevention for the facility.

Survey Procedures:

- Interview staff identified as dedicated infection preventionist to discuss the training and infection control practices at the facility.
- Review documentation of the training for staff serving as he SNFs infection preventionist.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

An infection control lead has been designated to address and improve infection control based on public health advisories (federal and state) and spends adequate time in the building focused on activities dedicated to infection control.

Survey Procedures:
Interview the infection control lead and ask for information about the time spent focused on infection control activities and what activities were completed (i.e. surveillance, education adherence monitoring).

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

The SNF must ensure HCPs receive infection prevention and control training.

Survey Procedures:
Review documentation of staff training records

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

The SNF screens and documents every individual entering the facility (including staff) for COVID-19 symptoms. Proper screening includes temperature checks.

Survey Procedures:
Observe their screening process and request to see their screening documentation for all staff and visitors to the facility.

F000 – Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence no later than 12/19/2020. Preparation and /or 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 Deficiencies and plan of correction. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. Plan of Correction is submitted to meet requirements established by state and federal law.

Signage Posting

The signage for rooms 21,23, and 25 was immediately posted on 12/1/20 to instruct staff on what PPEs to wear when entering the rooms.

To ensure that no other resident is affected by this practice the DON assessed all the other residents in the facility and no other residents were noted to be affected by this practice.

To ensure that this practice does not reoccur All staff were in-serviced on 12/1/20 by the Infection Preventionist regarding the mitigation plan and the facilities infection prevention policy ie. what PPEs to wear in a yellow zone isolation room vs a green zone room.

To ensure that these solutions are sustained the Infection Preventionist also monitor all nurses daily for compliance with the donning and doffing policy and the mitigation plan.

All negative findings will be reported by the DON and IP to the Administrator immediately. The Administrator will report all negative findings to the QAA committee quarterly for review and recommendation.

This corrective action will be completed by 12/19/20.

Public Comments: Based on interview and record review the facility failed to follow their mitigation plan in preventing transmission of COVID-19 (corona virus- an illness caused by a virus that can be transmitted from person to person) when they failed to ensure that a staff member was screened for COVID-19 symptoms prior to entering and working at the facility. This failure had the potential to spread infection to the residents and staffs in the facility.
Findings:
On December 1, 2020, at 9:25 a.m., an unannounced visit to the facility was conducted to investigate implementation of the facility mitigation plan.

On December 1, 2020, at 1:10 p.m., Certified Nurse Assistant (CNA) was interviewed. She stated they were screened for COVID-19 symptoms prior to coming in to work.

On December 1, 2020, at 1:40 p.m., the Infection Preventionist (IP) was interviewed. She stated all staff were screened for signs and symptoms for COVID-19 prior to coming in to work.

In a concurrent record review of facility's document titled, "Daily Staff Checks," dated December 1, 2020. The document did not indicate the CNA was screened.

In a concurrent interview with the IP, she stated, the CNA's name was not included in the list of staff who were screened the day of December 1, 2020.

On December 1, 2020, at 4:10 p.m., the Administrative Assistant (AA) was interviewed, and stated that she works from 7a.m., to 7 p.m. The AA stated that she is responsible in ensuring that every staff were screened prior to entering the facility to work. She stated the Registered Nurse Supervisor is responsible in screening the CNA who comes in before 7 a.m.

On December 2, 2020, at 3:40 p.m., the Registered Nurse Supervisor was interviewed. She stated if the screening was not documented then it was not done.

A review of the facility document titled, "Corona virus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities (SNF)," with the approved date of June 3, 2020, indicated, "...The SNF screens and documents every individual entering the facility (including staff) for COVID-19 symptoms..."

Tags: § 72523(c)(3)

Status: Not Compliant

Resolution:

Resolved

Resolved on Dec 30, 2020
Updated on Dec 30, 2020
APOC 12/24/2020. Copy of in-services were submitted on 12/14/2020 (pages 1-35).

Ready For Verification

Updated on Dec 24, 2020
Please see Plan of Correction for Screening Staff. Thank you.

Documents:

POC CG Finding 1 SCREENING.docx

Download

Not Resolved

Updated on Dec 24, 2020

Added Plan of Correction for Screening. Thank you.

Documents:

POC CG Finding 1 SCREENING.docx
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Updated on Dec 23, 2020

UPOC- as discussed, re-submit the POC addressing the deficient practice. Thanks

Ready For Verification

Updated on Dec 14, 2020

Plan of correction. Please see attachment. Thank you.

Documents:

CENTINELA GRAND PLAN OF CORRECTION.pdf
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Updated on Dec 14, 2020

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The designated infection control lead maintains a line list of all patients who have been confirmed to meet clinical criteria of presumed COVID-19 including testing and results.

Survey Procedures:
Request to see the list of confirmed patients

Public Comments:

Tags: § 72321 (b)

Status: Compliant

The facility must submit a copy of the facility's infection prevention quality control plan.

Survey Procedures:
Review the facility's infection prevention quality control plan and verify that the facility is implementing the plan.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Mitigation-Personal Protective Equipment (PPE) *

The SNF has a plan for adequate provision of PPE, including types that will be kept in stock, duration the stock is expected to last. The SNF will provide information on the supply network it plans to use.

Survey Procedures:
Review the plan for PPE and verify the facility is implementing the plan.

Public Comments:
Tags: § 72523(c)(3)
Status: Compliant

The SNF has initiated measures for procuring their own PPE supply (e.g., facemasks, respirators, gowns, gloves, and eye protection such as face shield or goggles) across all PPE items. If a two-week supply is not available, the SNF has evidence that it has orders arriving to ensure minimal PPE supplies.

Survey Procedures:
If the SNF has less than a two week supply on hand, request documentation reflecting PPE orders.

Public Comments:
Tags: § 72523(c)(3)
Status: Compliant

The SNF has existing contracts or relationships with PPE vendors to facilitate the replenishment of stock.

Survey Procedures:
Request to see documentation or contract for PPE.

Public Comments:
Tags: § 72523(c)(3)
Status: Compliant

The SNF has a contingency plan to address PPE supply shortages.

Survey Procedures:
Request documentation of the contingency plan.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Staff have been trained on selecting, donning and doffing appropriate PPE and demonstrate competency of such skills during resident care.

Survey Procedures:
Request documentation of the in-service training provided on use of PPE.

F000 – Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence no later than 12/19/2020. Preparation and /or 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 Deficiencies and plan of correction. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. Plan of Correction is submitted to meet requirements established by state and federal law.

Mitigation-Personal Protection Equipment (PPE)

The CNA that doffed and left the reusable gown on the back of the patient's door was educated by the DON on 12/1/20 to always place all reusable gowns in the barrel for washing after each use and to only use disposable gowns in the yellow zone patent rooms and remove them before exiting the room.

All reusable gowns were immediately washed on 12/1/20 to prevent the spread of infection to the residents.

To ensure that no other resident is affected by this practice the DON assessed all the other residents in the facility and no other residents were noted to be affected by this practice.

To ensure that this practice does not reoccur All staff were in-serviced on 12/1/20 by the Infection Preventionist regarding the Donning and Doffing policy and to only use the reusable gowns in yellow zone rooms and to remove the gown before exiting, also, to never hang a reusable gowns anywhere for reuse.

To ensure that these solutions are sustained the Infection Preventionist also monitor all nurses daily for compliance with the donning and doffing policy and the mitigation plan.

All negative findings will be reported by the DON and IP to the Administrator immediately. The Administrator will report all negative findings to the QAA committee quarterly

for review and recommendation.

This corrective action will be completed by 12/19/20.

Public Comments: Based on observation, interview and record review, the facility failed to implement their mitigation plan in preventing transmission of COVID-19 (corona virus - an illness cause by virus that can be transmitted from person to person), when the facility staff were reusing their washable isolated gowns prior to being laundered. This failure had the potential to spread infection to the residents and staffs in the facility.

Findings:

On December 1, 2020, at 9:25 a.m., an unannounced visit to the facility was conducted for the facility Mitigation plan survey.

On December 1, 2020, at 1:10 p.m., a Certified Nurse Assistant (CNA) was interviewed. She stated she would doff (remove) the gown she used in providing care for the patient in the yellow zone (unit dedicated for the patient with unknown COVID-19 status) at the back of the door of the patient's room. The CNA stated she would be using the gown the entire shift prior to washing.

On December 1, 2020 at 1:20 p.m., the House keeper Manager was interviewed. She stated the facility has 432 pieces of washable yellow gowns in stock. The Housekeeper Manager stated there is no shortage of gowns. She stated the washable gowns were washed every after change of shift. In addition, the facility is not tracking the times the isolation gowns were being washed.

On December 1, 2020, at 2 p.m., during the tour of the yellow zone with the Infection Preventionist (IP), there were two isolation gowns hanging on the door of Room 21 (in the yellow zone).

On December 1, 2020, at 3:57 p.m., the Director of Nursing (DON) was interviewed, regarding the use of washable gowns. She stated they were used only once, and then they will wash it.

On December 1, 2020, at 4:12 p.m., a Charge Nurse (CN) was interviewed. She stated the washable gowns should be use once per visit to the patient.

The facility undated document, titled, "Washing Processing Guidelines Polyester Non-Surgical Isolation Gown," indicated, "...Polyester Isolation gowns must be laundered prior to use..."

A review of the facility's mitigation plan, with an approved date on June 3, 2020, indicated, "...Personal Protective Equipment (PPE)...Facility may move to extended use of PPE per CDC guidance..."

According to the Centers for Disease Control and Prevention (CDC) online publication titled, " Coronavirus Disease 2019 (COVID-19): Strategies for Optimizing the Supply of Isolation Gowns," dated October 9, 2020, it indicated: "...Once PPE supplies and availability return to normal, healthcare facilities should promptly resume conventional practices...Conventional Capacity Strategies....Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered after each use according to routine procedures and reused..."

Tags: § 72523(c)(3)

Status: Not Compliant

Resolution:

Resolved

Resolved on Dec 30, 2020

Updated on Dec 30, 2020

APOC submitted on 12/24/2020. Copy of in-services were submitted on 12/14/2020.

Ready For Verification

Updated on Dec 24, 2020

Please see plan of correction for PPE. Thank you.

Documents:

POC CG Findings 2 PPE.docx
Download

Not Resolved

Updated on Dec 23, 2020

UPOC- resubmit POC addressing each deficient practice

Ready For Verification

Updated on Dec 14, 2020

Plan of correction. Kindly see attached. Thank you.

Documents:

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Signs are posted immediately outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE in accordance with CDPH guidance.

Survey Procedures:
Observe whether the facility has posted signage.

F000 – Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence no later than 12/19/2020. Preparation and /or 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 Deficiencies and plan of correction. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. Plan of Correction is submitted to meet requirements established by state and federal law.

Mitigation-Infections Prevention Control

The CNA who's name was not included on the list of staff screened for December 1st was educated by the Infection Preventionist on December 1 to always sign in and fill out the form for screening including taking a temperature and screening for symptoms.

The CNA who's name was not included on the list of staff who were screened for the day of December 1st was screened

immediately after discovering that she was not screened.

On 12/1/2020, all staff were reeducated on the importance of temperature/symptom screening before and after their shift.

The Administrator and DON assessed all the other residents and staff in the facility
and noted that no other residents or staff were affected by this practice.

To ensure that this practice does not reoccur the DSD and Infection Preventionist (IP) will in-service all staff on infection control monthly and prevention of COVID 19 transmission including taking temperature and symptoms upon signing in and out for the day

On 12/1/2020 the DON in-serviced all staff on the mitigation plan to include screening process of temperature/symptom screening before and after their shift.

On a daily basis, the Director of Nursing (DON) and Infection Preventionist (IP) will randomly check the staff screening log to ensure all staff have logged in their temperatures/symptoms before and after their shift.

To ensure that the solutions are sustained the (IP) will conduct weekly rounds to review the staff screening logs for all staff and ensure facility is in compliance with the mitigation plan.

The DON will have a daily AM and PM huddle with all nurses to remind them to screen and log their temperatures/symptoms before and after their shift.

The Administrator will be notified of any negative findings. Any significant findings will be addressed at the QA&A Committee for further review and recommendation quarterly.

Completion Date: December 19, 2020

Public Comments: Based on observation, interview and record review, the facility failed to follow their mitigation plan in preventing the transmission of COVID-19 (corona virus- an illness caused by the virus that can be transmitted from person to person), when the facility failed to ensure signs were posted to indicate the appropriate personal protective equipment (PPE) required in managing care for the patients in the yellow zone (unit dedicated for the patients of unknown COVID-19 status). This failure had the potential to result in staff not knowing the appropriate PPE to use while providing care to the patients in the yellow zone, which could result in spread of infection to the patients and staffs in the facility.

Findings:

On December 1, 2020, at 10: 25 a.m., during the tour of the yellow zone, the signage posted by the patient's door did not indicate the instruction on what PPE should the staff be using prior to entering the patient's room.

On December 1, 2020, at 10:30 a.m., the Licensed Vocational Nurse (LVN) was interviewed. He stated there was no posted instruction on what PPE to wear, before entering Rooms 21, 23 and 25. The LVN stated the staff who will be entering will not be guided on what PPE to wear in managing the patient in the yellow zone.

A review of the facility document titled, "Corona virus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities (SNF)," with approved date of June 3, 2020, indicated, "...Signs are posted immediately outside of resident rooms indicating appropriate...and required PPE in accordance with CDPH (California Department of Public Health) guidance..."

Tags: § 72523(c)(3)

Status: Not Compliant

Resolution:

Resolved

Resolved on Dec 30, 2020

Updated on Dec 30, 2020

APOC submitted on 12/24/2020. A copy of the in-services were submitted as an attachment on 12-14-2020.

Ready For Verification

Updated on Dec 24, 2020

Please see plan of correction attached. Thank you.

Documents:

POC CG findings 3 POSTING.docx
Download

Not Resolved

Updated on Dec 23, 2020

UPOC- re-submit POC addressing the specific deficient practice. Thanks

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Ready For Verification

Updated on Dec 15, 2020

Please see plan of correction below.

Documents:

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Individuals serving as PPE coaches, who are responsible for providing just-in-time education to direct care staff, have been designated for each shift to identify and support adherence with PPE policies.

Survey Procedures:
Interview designated PPE coaches.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Necessary PPE is immediately available outside of the resident room when there are units with separate cohorted spaces for both COVID-19 positive nd negative residents or in the corridor near rooms in dedicated COVID- 19 units and in other areas where resident care is provided.

Survey Procedures:
Request to see where PPE storage is located.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

Trash disposal bins are positioned as near as possible to the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room when there are units with separate cohorted spaces for both COVID-19 positive and negative residents.

Survey Procedures:
Observe location of trash disposal bins.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

If there are COVID-19 cases identified in the facility, health care professionals are provided and are wearing recommended PPE for care of all residents, in line with the most recent CDPH PPE guidance.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

Incident Attachments:

Images:

Residents are wearing a facemask (as they are able to tolerate) whenever they leave their room or are around others, including whenever they leave the SNF for essential medical appointments.

Survey Procedures:
Observe residents outside of their rooms to determine whether facemasks are worn.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

All SNF personnel are wearing a facemask while in the facility.

Survey Procedures:
Observe staff in the facility to determine whether facemasks are worn.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Mitigation-Staffing Shortages *

The SNF has policies in place to address HCP shortages, including contingency and crisis capacity strategies.

Survey Procedures:
Request and review the SNFs staffing contingency plan verify whether they are complying with the plan.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

The SNF can demonstrate that there has been advanced planning, in alignment with its emergency preparedness plans, for backup staffing using all resources (e.g., corporate resources, temporary staffing agencies, hospital partnerships, or other resources) in advance of staff testing to be able to cover shifts based on potential staff quarantines.

Survey Procedures:
Request documentation of the advanced planning to address staffing shortages.

Public Comments:

Tags: § 72551 (b)

Status: Compliant

The SNF has a plan for expediting training of new health care professional staff brought in from other locations to provide resident care in the event that the facility reaches a staffing crisis.
The infection preventionist must provide training to registry staff on facility infection control practices.

Survey Procedures:
Request documentation of the training plan for new or registry staff.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

A designated person has been assigned responsibility for conducting a daily assessment of staffing status and needs, and has implemented or is ready to implement backup plans as needed.

Survey Procedures:
Request documentation of the dedicated person responsible for conducting a daily assessment of staffing status and needs.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

The SNF's sick leave policies are non-punitive (i.e., they do not result in disciplinary actions or job performance reviews, and they do not require provider notes), flexible, and consistent with public health policies that do not dissuade health care professionals from staying home when they are sick.

Survey Procedures:
Request documentation of the SNFs sick leave policy.

Public Comments:
Tags: § 72523(c)(3)
Status: Compliant

Mitigation-Designation of Space *

The SNF has policies in place for dedicated spaces within the facility to ensure separation of infected patients and that the physical location of the designated area is located in an area to minimize foot traffic to common facility spaces in order to eliminate movement of HCP and visitors among those spaces to minimize transmission risk.

Survey Procedures:
- Request a copy of the dedicated space policy to ensure separation of infected patients and to limit the movement of HCP among those spaces.
- Does the facility have a separate breakroom for staff assigned to different cohorts? If no is there a schedule in place to allow for cleaning of the break area between use by staff in different cohorts?
- Does the facility have a separate supply area for the COVID positive cohort?

Public Comments:
Tags: § 72321 (b)
Status: Compliant

All residents with COVID-19 infection confirmed by testing, or those residents who are recovering from COVID-19 infection, have been separated from residents who are not infected or have unknown infection status are placed in dedicated COVID-19 positive wings.

Survey Procedures:
Request to see the location of any COVID-19 dedicated wings or space.

Public Comments:
Tags: § 72321 (b)
Status: Compliant

If dedicated COVID-19 positive wings are unavailable, infected or recovering residents are cohorted appropriately, either alone in single-occupancy rooms or cohorted into a multi-occupancy room with other confirmed cases.

Survey Procedures:
Observe how COVID-19 positive residents are cohorted.

Public Comments:
Tags: § 72321 (b)
Status: Compliant

Symptomatic residents with suspected COVID-19 infection may remain in their room (if multi-occupancy room, with 6ft, or as far as possible, between beds and curtains closed) while testing is pending.

Survey Procedures:
In rooms with multiple patients, verify that beds are 6 feet apart.

Public Comments:
Tags: § 72321 (b)
Status: Compliant

All residents who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases, unless they are already cohorted with a symptomatic on confirmed positive roommate.

Survey Procedures:
Observe how residents are cohorted.

Public Comments:
Tags: § 72321 (b)
Status: Compliant

Upon admission, new and readmitted residents with unknown COVID-19 status are placed in single-occupancy rooms or a separate observation unit, wing, or building.

Survey Procedures:
Observe where new and readmitted residents are placed.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

All congregate spaces have been closed and all group events involving close proximity ceased.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

There is no communal dining, or, in accordance with CMS guidance, eating in dining areas with appropriate social distancing is only used as a last resort; i.e., only allowed for residents without signs or symptoms of a respiratory infection, without a confirmed diagnosis of COVID19 and with cognitive needs that warrant such accommodation. The facility must perform terminal cleaning at the end of each meal.

Survey Procedures:
Request documentation of cleaning of communal dining areas.

Public Comments:

Tags: § 72321 (b)

Status: Compliant

In the event that the facility cannot safely designate space, staff, and supplies they will take immediate action to reduce the risk of the residents by any means necessary, up to and including evacuation of all suspect and confirmed COVID positive residents to the nearest facility which has been designated for the safe care and treatment of COVID.

Public Comments:

Tags: § 72551 (b)

Status: Compliant

The SNF will communicate any imminent or suspected need to evacuate with their local MHOAC and CDPH.

Public Comments:

Tags: § 72541. Unusual Occurrences

Status: Compliant

Mitigation-Communication *

The SNF has a plan for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility, including the prevalence of confirmed cases of COVID-19 in staff and residents as directed by CMS guidance.

This information must:
- Not include personally identifiable information
- Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered
- Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other

Survey Procedures:
- Request documentation of the facility's communication plan
- Request documentation of resident and family notifications
- Verify the plan complies with Title 42 CFR section 483.80
- The facility must inform residents, their representatives, and families of those residing in facilities by 5 P.M. the next calendar day following the occurrence of either:
  - A single confirmed infection of COVID-19, or
  - Three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Incident Attachments:

Images:

The SNF will provide regular updates to the staff about PPE.

Survey Procedures:
Interview facility staff about how they receive updates about PPE.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

A designated staff member has been assigned responsibility for daily communications with staff, residents, and their families.

Survey Procedures:
Interview the designated staff member responsible for communicating with staff, residents, and their families.

Public Comments:

Tags: § 72523(c)(3)

Status: Compliant

Title 22-Article 2. License

Title 22-Article 3. Required Services

Title 22-Article 4. Optional Services

Title 22-Article 5. Administration

Title 22-Article 6. Physical Plant

Title 22-Article 7. Violations and Civil Penalties