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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 055104 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/23/2020 |
| NAME OF PROVIDER OF SUPPLIER SUNSET MANOR CONV HOSP | | STREET ADDRESS, CITY, STATE, ZIP 2720 NEVADA AVENUE EL MONTE, CA 91733 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | |
| F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview and record review, the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of communicable disease and infections during the Coronavirus (COVID-19 - an illness caused by [MEDICAL CONDITION] that can spread from person to person) crisis as evidenced by failing to monitor residents temperature and oxygen saturation at a minimum of twice per shift for one of three sampled residents. These deficient practices had the potential to result in the spread of COVID-19 that could cause respiratory illness that could lead to hospitalization and death to other residents and staff. Findings: On 9/23/20, a Mitigation Plan Survey and Focused Infection Control Survey was conducted at the facility. A review of Resident 1, 2 and Resident 3's vital signs monitoring and monitoring of signs and symptoms COVID-19. Resident 1 did not have monitoring of temperature and oxygen saturation. On 9/23/20 at 4:10 p.m., during a concurrent record review and interview, The Infection Prevention Nurse stated Resident 1 only had monitoring of blood pressure and heart rate on the Medication Administration Record. The Infection Prevention Nurse stated monitoring of vital signs would be charted on the Medication Administration Record [REDACTED]. A review of the Nurse's Notes for the month of September indicated there were only the following dates written on the Nurse's Notes; 9/2/20 at 3 p.m., and at 3:15 p.m., 9/11/20 at 9 a.m. and 3 p.m., 9/17/20 at 4:30 p.m., and 9/20/20 at 12 p.m. There was only one entry on the Nurse's Notes indicating vital signs was monitored including the temperature but did not indicate oxygen saturation was monitored. On 9/23/20 at 4:50 p.m., during an interview, the Director of Nursing (DON) stated Resident 1's oxygen saturation and temperature was not monitored. The DON stated the staff would know when the resident felt hot with fever and would report to the licensed nurse. On 9/23/20 at 5:12 p.m., during an interview, the IP Nurse stated the facility would implement the process of checking the temperature and oxygen saturation of all residents. The IP Nurse stated an elevated temperature and low oxygen saturation could be signs and symptoms of COVID-19 infection. A review of Resident 1's Admission Record indicated the resident was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's Admission Record indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 3's Admission Record indicated the resident was readmitted on [DATE], with [DIAGNOSES REDACTED]. Plan indicated all residents in the yellow and green zones will be screened for symptoms of COVID-19 and have their oxygen saturation and temperature checks at a minimum of two times per day and documented in the medical record. A review of QSO 20-38 updated 8/25/20, indicated on one of the checklist under Infection Surveillance if the facility had established/implemented a surveillance plan, based on a facility assessment, for identifying (i.e., screening), tracking, monitoring and/or reporting of fever, respiratory illness, and/or other signs/symptoms of COVID-19, and immediately isolate anyone who is symptomatic.</p> | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE (X6) DATE | |

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.