

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056321	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2020
NAME OF PROVIDER OF SUPPLIER OLYMPIA CONVALESCENT HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP 1100 S. ALVARADO ST LOS ANGELES, CA 90006	
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 staff failed to follow the facility's policy and procedure regarding donning on gloves before entering an isolation room of one of three sampled residents (Resident 1). This failed practice had the potential to spread infection to the residents and impede resident's progress to wellness. Findings: On 8/5/2020 at 11:45, an unannounced visit was made to the facility to investigate their Mitigation Plan. During an observation and a concurrent interview on 8/5/2020 at 12:45 p.m., with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed entering the facility's red zone (isolation), for Coronavirus (COVID-19- ia a respiratory illness caused by [MEDICAL CONDITION] that can spread from person to person) positive resident (Resident 1). LVN 1 unzipped the plastic covering and reached inside the room to retrieve a pair of gloves and continued to attend to the task on the medication cart. LVN 1 confirmed the finding and stated she may have contaminated the clean medication cart, and spread bacteria [MEDICAL CONDITION]. A record review of Resident 1's Admission Record indicated Resident 1 was re-admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS-an assessment and care planning tool) dated July 29, 2020, indicated Resident 1 had unclear speech, unable to express ideas and wants, rarely/never understands. The MDS further assessed Resident 1 as requiring one person physical assistance with dressing, eating, and personal hygiene. A review of Resident 1's care plan dated 6/30/2020, indicated Resident 1 is at risk for recurrent of active COVID-19 infection secondary to having a positive COVID-19 test. The nursing interventions included following infection control pathways for admitting residents with COVID-19, observe standard, contact, and droplet precautions, and monitor for fever (99.4 or 1.1 over baseline, dry cough, or shortness of breath). The facility's policy and procedure titled Scope of Infection Control Program, dated July 2017, indicated, Staff will use isolation precautions for a resident; included but not limited to: the type and duration of the isolation, depending upon the infectious agent or organism involved, and a requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</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.