

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 055760	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2020
NAME OF PROVIDER OF SUPPLIER ALHAMBRA HEALTHCARE & WELLNESS CENTRE, LP		STREET ADDRESS, CITY, STATE, ZIP 415 SOUTH GARFIELD ALHAMBRA, CA 91801	
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 - Some	<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 follow infection control practices during the [MEDICAL CONDITION] 19 (COVID-19, a respiratory illness that can spread from person to person) crisis for residents and staff as indicated in the facility's mitigation plan and the most updated infection control/prevention guidelines by failing to:</p> <p>1. Screen staffs and visitors upon entering the facility for possible signs and symptoms of COVID-19.</p> <p>2. Screen staff's temperature at the end of their shift. These deficient practices had the potential to spread infection between residents, staff, and visitors.</p> <p>Findings: During an observation and interview in the facility's main entrance on 10/20/20 at 10:40 a.m., the facility's Director of Nursing (DON) stated the screening log dated 10/19/20 did not have the staff's temperature screening after their shift. The DON stated the facility needed to check the staff's temperature for infection control surveillance. During an observation and interview in the facility's yellow zone (area where patients under investigation for COVID-19 are allocated) on 10/20/20 at 11:40 a.m., the DON stated the screening log was incomplete and did not indicate the screening for possible signs and symptoms of COVID-19 for all staff and visitors. The DON stated the Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria [MEDICAL CONDITION] in a healthcare environment) was responsible to monitor the proper screening and documentation of all individuals entering and exiting the facility. A review of the facility's COVID-19 Mitigation Plan with a revised date of September 14, 2020, indicated the facility screened and documented every individual entering the facility including staff for COVID-19 per CDC guidelines including signs and symptoms of COVID-19 infection, questions to determine risk and temperature reading. The Mitigation Plan indicated active screening of staff should include signs and symptoms of COVID-19 infection including temperature at the beginning of the shift and at the end of the shift.</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.