

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2020
NAME OF PROVIDER OF SUPPLIER LAKEWOOD HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 12023 LAKEWOOD BLVD. DOWNEY, CA 90242	
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 interview and record review, the facility failed to ensure three of three residents (Resident 10, 20 and 30) who were receiving [MEDICAL TREATMENT] (removal of waste products and excess fluid from the body with the use of a [MEDICAL TREATMENT] machine) were cohorted (grouped) per Centers for Disease Control (CDC) guideline, to prevent the potential transmission of COVID-19 (an illness caused by [MEDICAL CONDITION] that can spread from person to person) infection. Findings: During an interview with the Infection Control and Prevention (ICP) nurse on 9/8/2020 at 2:15 p.m., the ICP nurse stated [MEDICAL TREATMENT] residents were all currently in the green zone (rooms or units that do not include confirmed or suspected COVID-19 cases, but may include COVID-19 recovered individuals). A review Resident 10, 20 and 30's records indicated these residents were residing with roommates who were Covid-19 infection free in the green zone. Residents 20, 20 and 30 were not cohorted in the yellow zone (separated, exposed and observation areas with single-occupancy rooms or multi-occupancy room with 6 ft. or as far as possible, between beds and curtains closed). A review of Resident 10's face sheet (admission record) indicated the resident was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. sheet indicated the resident was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. sheet indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. (number of residents in the facility) and bed placement on 9/08/2020, Residents 10, 20, and 30 were placed in the green zone during [MEDICAL TREATMENT] treatment days and were not placed on transmission-based precautions in the yellow zone. A review of the facility's Mitigation Plan dated 9/08/2020, indicated for residents on [MEDICAL TREATMENT] should be placed in the yellow zone of the facility on transmission-based precautions. During an interview with director of nursing (DON) on 09/08/2020 at 2:56 p.m., she stated the [MEDICAL TREATMENT] residents were cohorted in the yellow zone last week, but currently are in the green zone, we will move them now. A review of The Coronavirus Disease 2019 Guidelines for preventing and managing COVID-19 in Skilled Nursing Facilities, updated on 8/4/20, indicated residents who undergo regular [MEDICAL TREATMENT] treatments outside of the facility should be housed in the quarantine (yellow) cohort together. In the yellow cohort, contact and droplet precautions, with gown and glove changes between each patient is required, post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required personal protective equipment (PPE).</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.