STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055074	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Coronado D/P Snf	233 Prospect Place Coronado, CA 92118

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to ensure a splint was applied as ordered to one of nine residents (46) reviewed for range of motion (ROM, the movement of joints or muscles). This failure had the potential to result in a decline of Resident 46's joint mobility. Findings: Resident 46 was admitted to the facility on [DATE], per the facility Facesheet. On 5/15/24 at 9:45 A.M., an observation of Resident 46 was conducted in his room. Resident 46 did not respond to questions asked. Both arms were visible, propped up on pillows. A sign over the head of the bed indicated Resident 46 was to have a splint applied to the left hand at 8 A.M., then off at 10 A.M. No splint was visible on Resident 46's arms. On 5/15/24 at 9:59 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated she was assigned to Resident 46. CNA 11 stated the splint was supposed to be applied at 8 A.M., to help stretch Resident 46's arm. CNA 11 stated she was behind on her work, and had not put the splint on yet that day. Per CNA 11, the CNAs were responsible for placing splints on as ordered. On 5/15/24 at 10:05 A.M., an interview was conducted with Licensed Nurse (LN) 12. LN 12 stated she was the nurse assigned to Resident 46. LN 12 stated CNAs were responsible for ensuring splints were applied to residents, but the nurses should make sure it was done, as it was a physician's order. LN 12 stated the splint benefited the resident by keeping the arm from contracting and having decreased range of motion. Per LN 12, the staff had fallen behind and had not applied the splint that day. On 5/15/24, a record review was conducted. A physician's order, dated 2/23/24, indicated Resident 46 was to have the splint applied from 8 A.M. to 10 A.M. daily. On 5/16/24 at 2:59 P.M., an interview was conducted with the unit manager (MGR). MGR 2 stated she expected CNAs and LNs to follow the physician's order for splints. MGR 2 stated the splint was necessary to help Resident 46 maintain his ROM and muscle tone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per a facility Guideline of Care, issued 10/2022, titled Guidelines of Care: Splints/Brace Application and Care, .It is the guideline of this facility to properly apply and manage splints/braces of the resident as ordered .Procedure: .6. Apply brace/splint/device as ordered by MD .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on observation, interview and record review, the facility failed to: 1. Prevent Resident 20 from falling when a staff member did not follow a provider order, and 2. Perform an elopement (leaving facility unsupervised) assessment for Resident 78, who eloped from the facility. These failures had the potential for Residents 20 and 78 to be injured. Findings: 1. Resident 20 was admitted to the facility on [DATE] with diagnoses that included Traumatic Brain Injury (an injury caused by a forceful blow or piercing wound to the head) and quadriparesis with spasticity (unusually stiff or tight muscles with loss of muscle control). On 5/13/24 at 9:30 A.M., an observation of Resident 20 was conducted. Resident 20's head was touching the padded upper right bed rail and feet were at the lower left edge of the mattress. Resident 20 was diagonal in his bed. On 5/15/24 at 8:03 A.M., an observation of Resident 20 was conducted. Resident 20's head was at the upper right bed rail and feet were at the lower left edge of the mattress. Resident 20 was diagonal in his bed. On 5/15/24 at 8:24 A.M., an interview and concurrent record review were conducted with Licensed Nurse (LN) 6. LN 6 stated, The reason (Resident 20) fell was because a rail was left down. A review of the provider order indicated, 4 side rails up with padding when in bed . On 5/16/24 a review of the facility policy dated 2024 entitled, Fall Prevention was conducted. The policy indicated, .Implement preventative strategies based on patient's assessed area of risk . A policy regarding requirement of staff to follow provider orders was requested from the facility, but not received. 47466 2. A review of Resident 78's Admission Record indicated that Resident 78 was admitted on [DATE] to the facility with diagnoses that included Depression (a mental health disorder) and History of Stroke with Left Sided Paralysis (the loss of the ability to move). A joint observation and interview was conducted on 5/14/24 at 9:30 A.M., with Resident 78. Resident 78 had a WanderGuard (a security bracelet that alarms at exits) placed on his right arm. Resident 78 stated he went out of the facility a few weeks ago. When he returned, the nurses told him he should not have left without telling anyone. Resident 78 stated he was gone for a few hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 78's Minimum Data Set (MDS- an assessment tool) indicated Resident 78 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. A joint interview and record review was conducted on 5/14/24 at 11:33 A.M., with LN 1. LN 1 stated while the LN on duty was making rounds on 5/5/24 at 6:15 P.M., they could not locate Resident 78 anywhere on the facility grounds. LN 1 stated staff was concerned because Resident 78 had difficulty walking. An interview was conducted with LN 1 on 5/15/24 at 2:33 P.M. LN 1 stated the facility does not have an elopement risk assessment on Resident 78's medical record, and it was not included on their admission assessment. LN 1 stated an elopement risk assessment should be done on admission to provide the necessary interventions for Resident 78's safety. An interview was conducted with the unit manager (MGR) 1 on 5/16/24 at 2:06 P.M. MGR 1 stated the facility did not have an elopement risk assessment. MGR 1 stated it was important for the facility to have an elopement risk assessment to ensure the residents safety. A record review was conducted on 5/16/24. On 5/7/24 following the elopement incident, a nursing assessment note indicated Resident 78 was at high risk for falls and injury. A review of the facility's policy titled, Elopement of a Non-Behavioral Health Patient from an Inpatient Care Area was conducted. The policy did not addressed the need for elopement assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49330 Based on observation, interview and record review, the facility failed to ensure medications given via feeding tube (a way to provide nutrition when a person cannot eat or drink safely by mouth) were administered separately for one of two residents (Resident 25) reviewed for tube feeding medication administration. As a result, there was the potential for the medications to be less effective and/or clogging of the feeding tube. Findings: On 5/15/24 at 8:27 A.M., a medication administration observation was conducted with Licensed Nurse (LN) 7. LN 7 prepared Resident 25's medications. LN 7 crushed four pills individually and mixed each of the crushed medication with 10 milliliters (ml) of water. LN 7 used a 60 cc (cubic centiliters) syringe to administer the medications through Resident 25's feeding tube. LN 7 administered 30 ml of water into the feeding tube using the syringe. LN 7 removed the plunger from the syringe and poured the first medication mixed with 10 ml of water into the chamber of the syringe. LN 7 immediately followed the first medication with 10 ml of water flush, then immediately poured the second medication, while the first medication and the 10 ml water flush were still in the chamber of the syringe. On 5/15/24 at 9:05 A.M., an interview with LN 7 was conducted. LN 7 stated medications given via feeding tube should be given separately, with 10 ml of water in between each medication. LN 7 stated he should have waited for the first medication to be completely administered prior to administering the water flush and the second medication to avoid any drug interactions. On 5/16/24 at 3 P.M., an interview was conducted with Manager (MGR) 1. MGR 1 stated it was her expectation that medications were administered separately via feeding tube to avoid any drug interactions and to avoid clogging the feeding tube. A review of the facility's policy titled Enteral Tube - Medication Administration, effective 5/4/23, indicated medications, .are to be given separately .and, when administering medications .pour .dissolved solids separately .and allow to flow by gravity into the tube .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38512 Based on observation, interview and record review, the facility failed to ensure kitchen staff stored and served food in a safe manner when: 1. The ice machine bin lid was open, exposing ice to potential contamination, and, 2. Breakfast trays were served to residents prior to food temperatures being documented. These failures had the potential to cause cross-contamination and expose residents to the risk of foodborne illness. Findings: 1. On 5/13/24 at 7:46 A.M., an observation of the kitchen was conducted with the General Manager (GM). A large ice machine and bin was located inside the kitchen entrance. The ice machine bin had a brown plastic cover, which was in an upright position, exposing the ice. On 5/13/24 at 7:48 A.M., an interview was conducted with the GM. The GM stated the lid to the ice machine should be kept closed to keep the ice from becoming contaminated. The GM stated leaving the lid open had the potential to contaminate the ice. Per a facility document, effective 3/1/24 and titled Hazard Management & Prevention, Ice Handling, Policy: The Food and Nutrition Services Department prepares and serves ice under strict procedures. Purpose: To prevent the transmission of disease .Cover the container properly. 2. On 5/13/24 at 7:58 A.M., a concurrent observation, interview and record review was conducted with [NAME] 1, and the Executive Chef (EC). [NAME] 1 had completed preparing breakfast trays on the trayline. The temperature log was reviewed for the foods which had been served, and the temperature log was blank. [NAME] 1 stated he had checked the temperatures prior to serving any food, but had written the temperatures on a piece of paper rather than the temperature log. [NAME] 1 stated he was unable to find the piece of paper. Per the EC, it was his expectation temperatures were documented on the temperature log prior to service. The EC stated it was not safe to serve foods without taking temperatures, as it could cause foodborne illness. On 5/16/24 at 2 P.M., an interview was conducted with the GM. The GM stated it was her expectation all food temperatures were documented on the temperature log prior to serving any foods, to prevent foodborne illness. Per a facility policy, revised 4/1/22 and titled Food Safety Management System, .Hot and Cold Holding . Classification: Critical .Monitoring Activity: Service - Take temperatures at the time food is placed in hot/cold holding for service .Forms and Record Keeping: Required: Hot/Cold Holding .Cold foods must be held and served at a temperature of 40 degrees or below, Hot foods must be held and served at a temperature of 140 degrees or above .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to ensure the prevention and spread of infection when: 1. Family members (FM) of Resident 80 were not wearing Personal Protective Equipment (PPE, special equipment such as gowns, masks and gloves designed to protect staff and patients from infection risk) while in a room requiring PPE, 2. Staff entered a resident room identified as contact precaution (preventing the spread of germs by using PPE) without wearing PPE, 3. Staff brought a medication container inside a contact isolation room and returned the unsanitized container back in the medication cart, and, 4. Staff did not perform hand hygiene (handwashing with soap and water or use of alcohol-based hand rub) before putting on gloves and removing gloves These failures had the potential to spread infection to residents, staff, and/or visitors. Findings: 1. Resident 80 was admitted to the facility on [DATE], per the facility Facesheet. On 5/13/24 at 11:49 A.M., an observation of Resident 80's room was conducted. Outside of the room, a sign in English directed staff to wear PPE if they would touch the patient, her clothing or bedding. A small cart containing the PPE was located outside of the room. On 5/13/24 at 11:51 A.M., a concurrent observation and interview was conducted in Resident 80's room. Resident 80 was in bed, not responding to questions. Resident 80's FM's were sitting at the bedside, holding Resident 80's hands and touching Resident 80's hair. Neither FM was wearing PPE. FM 1 stated he had not been told to wear PPE while visiting his family member. FM 1 stated his English was not good and he had not read the sign on the door. On 5/13/24 at 12 P.M., an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 80 was assigned to him that day. LN 11 stated he was aware Resident 80 was in isolation due to an infection, and the sign outside the door applied to anyone who touched Resident 80, not just staff. LN 11 stated it was his responsibility to ensure visitors and staff wore PPE when touching Resident 80. LN 11 stated PPE was necessary to minimize the transfer of germs to and from Resident 80. LN 11 stated he had not educated the visitors before they entered Resident 80's room, but he should have. On 5/15/24, a record review was conducted. Resident 80's physician ordered Isolation Precautions to be initiated on 4/17/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 2:55 P.M., an interview was conducted with Manager 2 (MGR 2). MGR 2 stated she was responsible for oversight of Resident 80's care. MGR 2 stated it was her expectation that all staff members would help family understand the need for PPE and assist them as needed, in order to prevent the spread of infection. Per a facility policy, effective 11/14/23 and titled Standard Precautions and Transmission-Based Precautions for hospitalized Patients, .8 a. Educate patients and their families/visitors .about infection prevention strategies including isolation precautions as needed .d. Visitors are encouraged to wear isolation gowns and gloves . 49330 2. On 5/15/24 at 8:27 A.M., a concurrent observation and interview was conducted while in the hallway outside Resident 25's room. A sign was posted on the wall with Contact Precautions for the room, indicating staff and visitors were required to wear PPE. LN 7 was observed entering Resident 25's room without PPE. LN 7 stated he did not wear PPE because he had not touched anything in the room. On 5/15/24 at 8:40 A.M., an interview was conducted with LN 7. LN 7 stated he should have worn PPE into a contact precautions room to protect residents and staff from infections. 3. On 5/15/24 at 8:27 A.M., an observation was conducted of LN 7. LN 7 prepared Resident 25's medications and placed them on a tray. LN 7 entered Resident 25's room and administered medication. LN 7 exited with the medication and placed it back in the medication cart without sanitizing the medication container. On 5/15/24 at 8:40 A.M., an interview was conducted with LN 7. LN 7 stated he should have sanitized the medication container before returning it to the medication cart to prevent infections. 4. On 5/15/24 at 8:35 A.M., a medication administration observation was conducted inside Resident 25's room. LN 7 was observed administering Resident 25's medications. LN 7 removed his gloves and put on new gloves without performing hand hygiene. On 5/15/24 at 8:40 A.M., an interview was conducted with LN 7. LN 7 stated it was important to perform hand hygiene before and after removing gloves for infection control. On 5/15/24 a record review was conducted. Resident 25's Physician's Orders, dated 2/21/24 indicated Resident 25 was to be on contact precautions. On 5/15/24 at 9:46 A.M., an interview was conducted with the Infection Preventionist Nurse (IPN). The IPN stated PPE should be worn prior to entering a contact precaution room, no matter what purpose or care the staff will do inside the resident room. The IP further stated hand hygiene should be done before and after applying gloves at all times to avoid the exchange of germs. The IPN stated if a medication entered a contact isolation room, it should be sanitized before and after going in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 at 3 P.M., an interview was conducted with Unit Manager 1 (MGR 1). MGR 1 stated it was important for staff to wear PPE prior to entering a contact isolation room, and to perform hand hygiene before and after wearing gloves to protect residents and staff from the spread of infection. MGR 1 stated LNs should not return a medication container from a contact isolation room to the medication cart to avoid cross contamination. MGR 1 further stated if a medication container was brought in a contact isolation room, the LN should sanitize the container before placing it back into the medication cart to avoid contamination. A review of the facility's policy titled Standard Precautions and Transmission-Based Precautions for hospitalized Patients, effective 11/14/2023, indicated, .PPE Required: Isolation Gown and Gloves .Perform hand hygiene and don clean isolation gown and gloves upon entry into the patient room . and .Prior to exiting patient room or cubicle, doff isolation gown and gloves in a method to prevent self-contamination, and perform hand hygiene In addition, the policy indicated .re-usable medical equipment (RME) and devices must be cleaned and disinfected and maintained .to prevent patient-to-patient transmission of potentially infectious material