

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2024
NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd Tujunga, CA 91042	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's dignity and respect in full recognition of their individuality by staff members by failing to knock prior to entering a resident's room for three of three sampled residents (Resident 29, 30, and 33).</p> <p>This deficient practice had the potential to affect Resident 29, Resident 30, and Resident 33's self-esteem and self-worth.</p> <p>a. A review of Resident 29's Admission Record indicated the facility admitted the resident on 9/22/2023 with diagnoses that included heart failure (a condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance.</p> <p>A review of Resident 29's Minimum Data Set (MDS- an assessment and screening tool) dated 3/31/2024, indicated that Resident 29's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were moderately impaired. The MDS indicated that Resident 29 required partial/moderate assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.</p> <p>b. A review of Resident 30's Admission Record indicated the facility admitted the resident on 9/12/2022 and readmitted the resident on 5/10/2023 with diagnoses that included Parkinsonism (a disorder of the central nervous system [makes up of the brain and spinal cord] that affects movement, often including tremors [involuntary shaking or movement]), neurocognitive disorder with Lewy bodies (a type of progressive dementia [impaired ability to remember, think, or make decisions that interferes with doing everyday activities] that leads to a decline in thinking, reasoning and independent function), and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness).</p> <p>A review of Resident 30's MDS dated [DATE], indicated that Resident 30's cognitive skills for daily decision making were intact. The MDS indicated that Resident 30 required supervision or touching assistance with eating and oral hygiene and required partial/moderate assistance with toileting hygiene, and personal hygiene.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/15/2024 at 8:48 a.m., observed Certified Nursing Assistant 3 (CNA 3) enter Resident 29 and Resident 30's room and did not knock prior to entering their room.</p> <p>During an interview on 6/15/2024 at 8:51 a.m., with CNA 3, CNA 3 stated that she did not knock prior to entering Resident 29 and Resident 30's room. CNA 3 continued to state that she should have knocked prior to entering Resident 29 and Resident 30's room and should have informed the residents that she was entering prior to entering the room. CNA 3 further stated that she forgot to knock and announce her entering. When asked about the importance of knocking prior to entering Resident 29 and Resident 30's room, CNA 3 stated that knocking prior to entering is importance to show respect to the residents.</p> <p>c. A review of Resident 33's Admission Record indicated the facility admitted the resident on 6/23/2020 and readmitted the resident on 6/12/2024 with diagnoses that included heart failure, atrial fibrillation, difficulty in walking, and history of falling.</p> <p>A review of Resident 33's MDS dated [DATE], indicated that Resident 33's cognitive skills for daily decision making were moderately impaired. The MDS indicated that Resident 33 required partial/moderate assistance with oral hygiene, upper body dressing, and personal hygiene. The MDS also indicated Resident 33 required substantial/maximal assistance with toileting hygiene and shower.</p> <p>During an observation on 6/15/2024 at 8:52 a.m., observed CNA 4 enter Resident 33's room and did not knock prior to entering Resident 33's room.</p> <p>During an interview on 6/15/2024 at 8:53 a.m., with CNA 4, CNA 4 stated that he did not knock prior to entering Resident 33's room. CNA 3 stated that he should have knocked prior to entering Resident 33's room. CNA 4 stated he should have knocked prior to entering Resident 33's room as a sign of respect.</p> <p>During an interview on 6/16/2024 at 10:08 a.m., with the Director of Nursing (DON), the DON stated that all staff should knock and introduce themselves prior to entering a resident's room for resident's dignity and to show resident's respect.</p> <p>A review of the facility's policy and procedure titled, Dignity, revised date 2/2022, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. Staff are expected to knock and request permission before entering residents' room.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>38549</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for one of 14 sampled residents (Resident 16).</p> <p>This deficient practice had the potential to cause a delay in resident care and for the resident's needs to remain unmet.</p> <p>Findings:</p> <p>A review of Resident 16's Admission Record indicated the facility admitted the resident on 9/16/2021 with diagnoses including breast cancer (a disease that occurs when breast cells mutate and grow out of control, forming tumors [solid mass of tissue that forms when abnormal cells group together]) and bone cancer (growth of cells that start in a bone).</p> <p>A review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/18/2024, indicated the resident had intact cognition (thought processes) and required moderate assistance from staff for some activities of daily living (ADLs - activities related to personal care).</p> <p>A review of Resident 16's care plan (a document that outlines the goals, interventions, and outcomes for a resident's health condition) for risk for fall, initiated on 2/16/2024, indicated a goal for the resident to have no fall incidents for the next 3 months. Among some of the interventions listed included to place belongings within reach and to instruct and remind the resident to use the call light for help and wait for assistance.</p> <p>During a concurrent observation and interview on 6/14/2024 at 7:53 p.m., with Certified Nursing Assistant 1 (CNA 1), observed Resident 16 awake in bed. Resident 16 stated she did not know where her call light was. Observed Resident 16's call light on the floor. CNA 1 confirmed by stating that Resident 16's call light was on the floor and stated it should have been within reach of the resident.</p> <p>During an interview on 6/16/2024 at 12:38 p.m., with the Director of Nursing (DON), the DON stated it was important for residents' call lights to be within reach so that they could alert staff when they needed something, and staff can respond timely. The DON stated there was a potential for the resident to have a fall if they were unable to call for help.</p> <p>A review of the facility's policy and procedure titled, Answering the Call Light, last revised on 9/2022, indicated that the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>39550</p> <p>Based on interview and record review, the facility to implement their policy and procedure for resident council (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) by failing to ensure residents had a private space to conduct resident council meetings for five of five sampled residents (Resident 11, 12, 39, 38, and 4).</p> <p>This deficient practice had the potential of violating residents' rights of holding a resident council meeting privately.</p> <p>Findings:</p> <p>During an interview on 6/15/2024 at 10:15 a.m., with the Activity Director (AD), the AD stated that resident council meetings are arranged monthly, on the second Wednesday of the month, and are held in the activity room. When asked if the resident council has a private space to meet, the AD stated the resident council does not have a private space to meet. The AD stated that a table is placed in the middle of the activity room and the residents attending the resident council meetings sit around that table. The AD continued to state that during the resident council meeting, there are other residents in the activity room and staff that are not participating in the resident council meeting. When asked what other residents do in the activity room while the resident council conducted their meeting, the AD stated that the other residents present in the activity room were doing activities such as coloring or drawing. The AD stated that the resident council meeting is an activity. The AD further stated that the facility does not have a designated area to hold resident council meetings and should have a private room to conduct resident council meetings for residents' privacy and residents' rights.</p> <p>A review of the facility's policy and procedure titled, Resident Council, undated, indicated it is the policy of the care center to support and assist the formation of a resident council; Provide the council with private space in which to meet; Assume the responsibility to support the ongoing functioning of the resident council; Designate a staff member- often the Activities Director or social service designee, who will be responsible for organizing, facilitating, recording, and filing all recorded minutes from the resident council meetings.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>39550</p> <p>Based on interview and record review, the facility failed to implement the facility's policy on changes of condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses], behavioral, or functional domains) by failing to notify a resident's responsible party (RP) and the resident's physician after a fall incident for one of three sampled residents (Resident 30).</p> <p>This deficient practice had the potential outcome to have had a negative effect on Resident 30's treatment if any decisions were needed at the time of the change of condition.</p> <p>Findings:</p> <p>A review of Resident 30's Admission Record indicated the facility admitted the resident on 9/12/2022 and readmitted the resident on 5/10/2023 with diagnoses that included Parkinsonism (a disorder of the central nervous system [makes up of the brain and spinal cord] that affects movement, often including tremors [involuntary shaking or movement]), neurocognitive disorder with Lewy bodies (a type of progressive dementia [impaired ability to remember, think, or make decisions that interferes with doing everyday activities] that leads to a decline in thinking, reasoning and independent function), and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness).</p> <p>A review of Resident 30's History and Physical (H&P - a formal assessment of a patient and their problem) dated 5/20/2024, indicated Resident 30 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 30's Minimum Data Set (MDS- an assessment and screening tool) dated 3/22/2024 indicated that Resident 30's cognitive skills for daily decision making were intact. The MDS indicated that Resident 30 required supervision or touching assistance with eating and oral hygiene and required partial/moderate assistance with toileting hygiene, and personal hygiene.</p> <p>A review of Resident 30's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) for actual fall dated 3/21/2024, indicated to notify the physician and family member of the fall.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/15/2024 at 5:05 p.m., with the MDS Nurse (MDSN), reviewed Resident 30's progress notes from 3/21/2024-3/22/2024. The MDSN stated that after any type of change in condition, licensed nurses are to call and inform the resident's responsible party and the resident's physician of the change in condition. The MDSN reviewed Resident 30's progress notes from 3/21/2024-3/22/2024 and stated that Resident 30 had a fall incident documented on 3/21/2024 at 3:48 a.m. The MDSN stated that there was no documented evidence that Resident 30's responsible party and physician were made aware of Resident 30's fall incident on 3/21/2024 at 3:48 a.m., The MDSN stated that Resident 30's responsible party should have been aware of Resident 30's fall incident on 3/21/2024 at 3:48 a.m. The MDSN stated when a resident has a change in condition, the resident's responsible party should be made aware so that the family will be aware and will be updated of any changes. The MDSN continued to state that it is important to inform Resident 30's physician of the fall incident so that the physician will be aware of the fall and may have ordered additional interventions for the resident. When asked who is responsible for informing Resident 30's responsible party and physician, the MDSN stated that the licensed nurse should have informed Resident 30's responsible party and physician.</p> <p>A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, revised 5/2017, indicated our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) The nurse will notify the resident's Attending Physician or physician on-call when there has been a(an): a. accident or incident involving the resident; i. specific instruction to notify the Physician or changes in the resident's condition. The policy further indicated a nurse will notify the resident's responsible party when: a. the resident is involved in any accident. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>38469</p> <p>Based on observation, interview, and record review, the facility failed to ensure the window screen was affixed to the frame and did not have any gaps or openings from top to bottom for one of 18 resident rooms (Room A).</p> <p>This deficient practice had the potential to result in insect infestation (a large number of animals or insects that carry disease) that could pose harm to the residents.</p> <p>Findings:</p> <p>During the initial facility tour and room observation on 5/28/2024 at 11:37 a.m., observed Room A occupied by three residents. Upon observation of the room environment, observed one panel of the window screen was not affixed on the window frame creating a gap or opening from top to bottom measuring half an inch.</p> <p>During a concurrent observation and interview on 5/29/2024 at 11:46 a.m., with the Assistant Director of Nursing (ADON), observed the gap on the window screen of Room A. The ADON stated staff frequently conduct room inspections to ensure the environment is safe for the residents. The ADON stated that they make sure rooms are clutter free and free from insect infestations. The ADON stated that if the screens are not tightly sealed to the frame or there are openings, it could pose a potential hazard to the occupants if insects can gain access to the inside of the rooms. The ADON stated that she will have maintenance fix the window screens.</p> <p>A review of the facility's policy and procedure titled, Maintenance Service, last reviewed on 10/17/2023, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38469</p> <p>Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a written document that summarizes a resident's needs, goals, and care/treatment) for antibiotic (medicines that fight infections caused by bacteria) use for one of two sampled residents (Resident 6).</p> <p>This deficient practice had the potential to result in failure to deliver the necessary care and services.</p> <p>Findings:</p> <p>A review of Resident 6's Admission Record indicated the facility initially admitted the resident on 9/7/2022 and readmitted the resident on 9/14/2023 with diagnoses that included muscle weakness, urinary tract infection (an infection in any part of the urinary system), and gastro-esophageal reflux disease (a common condition in which the stomach contents move up into the esophagus [muscular tube through which food passes from the throat to the stomach]).</p> <p>A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/17/2024, indicated the resident had the capacity to make self-understood and the capacity to understand others. The MDS indicated the resident required supervision and partial assistance for activities of daily living (ADLs- activities related to personal care).</p> <p>A review of Resident 6's physician's orders dated 3/15/2024, indicated order for fosfomycin (antibiotic that treats urinary tract infections) oral packet three (3) grams (gm, a unit of measurement), give one packet by mouth one time a day every three days for urinary tract infection prophylaxis (action taken to prevent disease) for three doses then weekly after.</p> <p>A review Resident 6's Physician's Order Summary Report (document summarizing the resident's physician's orders) indicated a changed in dose on 6/7/2024 for fosfomycin to one packet by mouth every seven (7) days.</p> <p>During a concurrent interview and record review on 6/16/2024 at 10:46 a.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 6's physician's orders and care plans dated 3/15/2024 to 6/16/2024. The IPN stated the order for fosfomycin was originally ordered on 3/15/2024 and the dose was changed on 6/7/2024. The IPN verified by stating that there was no care plan developed regarding Resident 6's antibiotic therapy. The IPN stated there should be a care plan for any antibiotic use. The IPN stated that a care plan will state the goal of treatment and the approaches or interventions to achieve the goals and periodically evaluated if the goal has been met.</p> <p>A review of the facility's policy and procedure titled, Care Plan, Comprehensive Person-Centered, last revised on 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who required assistance with nail trimming were provided care and services to maintain good personal hygiene for two of two sampled residents (Resident 23 and 33) investigated under activities of daily living (ADL- activities related to personal care).</p> <p>This deficient practice has the potential to result in a negative impact on the resident's self- esteem due to an unkempt appearance.</p> <p>Findings:</p> <p>a. A review of Resident 23's Admission Record indicated the facility admitted the resident on 10/7/2023 and readmitted the resident on 11/1/2023 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A review of Resident 23's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/15/2024, indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and required moderate assistance for toileting, shower, dressing and personal hygiene.</p> <p>During an observation on 6/15/2024 at 9:09 a.m., observed Resident 23 in bed, awake and incoherent (expressed in a way that is not clear) when interviewed. Observed Resident 23's fingernails to be long, dirty, and with black substances under the tip of the nails.</p> <p>During an observation and interview on 6/15/2024 at 10:03 a.m., with the Director of Nursing (DON), observed Resident 23's fingernails. The DON stated Resident 23's fingernails look dirty and that there were black substances under the tip of the nails. The DON stated that the nursing staff provide grooming services to the residents to make sure they are clean and well-groomed. The DON stated that part of grooming is to ensure nails are trimmed and cleaned. The DON stated that dirty and long fingernails can cause skin to be opened when a resident scratches themselves and could lead to infection.</p> <p>A review of the facility's policy and procedure titled, Activities of Daily Living, Supporting, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>39550</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. A review of Resident 33's Admission Record indicated the facility admitted the resident on 6/23/2020 and readmitted the resident on 6/12/2024 with diagnoses that included heart failure (a condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), difficulty in walking, and history of falling.</p> <p>A review of Resident 33's MDS dated [DATE], indicated that Resident 33's cognitive skills for daily decision making were moderately impaired. The MDS indicated that Resident 33 required partial/moderate assistance with oral hygiene, upper body dressing, and personal hygiene. The MDS also indicated Resident 33 required substantial/maximal assistance with toileting hygiene and shower.</p> <p>During a concurrent observation and interview on 6/15/2024, at 10:30 a.m., with Resident 33, observed Resident 33 have long and untrimmed fingernails. Resident 33 stated that his nails were long and stated that he would like his nails to be trimmed. When asked if anyone had offered to cut his nails, Resident 33 stated that no one has offered to trim his nails.</p> <p>During a concurrent observation and interview on 6/15/2024 10:52 a.m., with Certified Nursing Assistant 4 (CNA 4), observed Resident 33's nails. CNA 4 stated that Resident 33's nails are long and untrimmed. CNA 4 stated that CNAs are assigned to cut residents' nails. When asked why Resident 33's have not been trimmed, CNA 4 stated that Resident 33 was readmitted recently and had not been able to trim his nails.</p> <p>During an interview on 6/16/2024 at 10:08 a.m., with the DON, the DON stated that licensed nurses and CNAs are responsible for the trimming of residents' nails. The DON stated that residents' nails should be kept clean and trimmed and not long. When asked of the importance of keeping residents' nails short, the DON stated that residents' nails should be kept trimmed to avoid the risk of infection and to be hygienic.</p> <p>A review of the facility's policy and procedure titled, Activities of Daily Living, Supporting, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p>		

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NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd Tujunga, CA 91042	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>During an interview and record review, the facility failed to implement the facility's fall policy, by failing to ensure a post-fall evaluation was conducted for two of two sampled residents (Resident 29 and Resident 30).</p> <p>This deficient practice placed the residents at risk of not receiving appropriate care and services after a fall incident.</p> <p>Findings:</p> <p>a. A review of Resident 29's Admission Record indicated the facility admitted the resident on 9/22/2023 with diagnoses that included heart failure (a condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance.</p> <p>A review of Resident 29's Minimum Data Set (MDS- an assessment and screening tool) dated 3/31/2024, indicated that Resident 29's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were moderately impaired. The MDS indicated that Resident 29 required partial/moderate assistance with eating, oral hygiene, toileting hygiene, and personal hygiene.</p> <p>A review of Resident 29's Fall Risk assessment dated [DATE], indicated Resident 29 was a high risk for falls.</p> <p>A review of Resident 29's [NAME] of Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains)/Interact Assessment Form dated 3/12/2024, indicated Resident 29 had a fall in the room.</p> <p>During a concurrent interview and record review on 6/16/2024 at 8:41 a.m., with the Director of Nursing (DON), reviewed Resident 29's physical chart and electronic chart for rehabilitation evaluation notes post-fall, 3/12/2024. The DON stated that after a fall incident the rehabilitation department will assess the resident to see if the resident is a candidate for rehabilitation services. The DON stated that she was unable to find documented evidence that a rehabilitation evaluation was conducted after Resident 29's fall on 3/12/2024.</p> <p>During a concurrent interview and record review on 6/16/2024 at 11:40 a.m., with the Physical Therapy Assistant (PTA), reviewed Resident 29's physical chart and electronic chart for rehabilitation evaluation notes post-fall, 3/12/2024. The PTA stated there was no documented evidence that a rehabilitation assessment was conducted after Resident 29's fall on 3/12/2024.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. A review of Resident 30's Admission Record indicated the facility admitted the resident on 9/12/2022 and readmitted the resident on 5/10/2023 with diagnoses that included Parkinsonism (a disorder of the central nervous system [makes up of the brain and spinal cord] that affects movement, often including tremors [involuntary shaking or movement]), neurocognitive disorder with Lewy bodies (a type of progressive dementia [impaired ability to remember, think, or make decisions that interferes with doing everyday activities] that leads to a decline in thinking, reasoning and independent function), and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness).</p> <p>A review of Resident 30's MDS dated [DATE], indicated that Resident 30's cognitive skills for daily decision making were intact. The MDS indicated that Resident 30 required supervision or touching assistance with eating and oral hygiene and required partial/moderate assistance with toileting hygiene, and personal hygiene.</p> <p>A review of Resident 30's Fall Risk assessment dated [DATE], indicated Resident 30 was a high risk for falls.</p> <p>A review of Resident 30's Progress Notes dated 3/21/2024 at 3:58 a.m., indicated Resident 30 was found slid down on the mat next to the bed.</p> <p>A review of Resident 30's Care Plan for actual fall related to inability to understand physical limitation dated 3/21/2024, indicated an intervention for Physical Therapy (PT- the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery) screening status post (after) fall.</p> <p>During a concurrent interview and record review on 6/16/2024 at 12:40 p.m., with the PTA, reviewed Resident 30's physical chart and electronic chart for rehabilitation evaluation notes post-fall, 3/21/2024. The PTA stated there was no documented evidence that a rehabilitation assessment was conducted after Resident 30's fall on 3/21/2024.</p> <p>During an interview on 6/16/2024 at 2:30 p.m., with the Rehabilitation Director (RD), the RD stated that a rehabilitation evaluation is important to be conducted after a fall to assess a resident for safety and to provide any recommendations that will prevent future falls. When asked if rehabilitation services in the facility was contracted, the RD stated that rehabilitation services is contracted with the facility. When asked if the RD was aware of the policies related to falls, the RD stated that he was not aware of the facility's policies related to fall and follows his company's fall protocols.</p> <p>A review of the facility's policy and procedure titled, Assessing Falls and Their Causes, review date 3/2018, indicated the purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Under performing a post-fall evaluation: 1. After a first fall a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and returned to sitting, and will document the results of this effort.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>38549</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (prn) opioid pain medication (a class of drugs that are used to treat moderate to severe pain) for one of 14 sampled residents (Resident 43).</p> <p>This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention).</p> <p>Findings:</p> <p>A review of Resident 43's Admission Record indicated the facility originally admitted the resident on 8/14/2023 and readmitted the resident on 4/30/2024 with diagnoses including malignant neoplasm of prostate (a cancerous tumor [solid mass of tissue that forms when abnormal cells group together] that forms in the tissues of the prostate gland [gland in the male reproductive system]).</p> <p>A review of Resident 43's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/7/2024, indicated the resident had moderately impaired cognition (thought processes) and required maximum assistance from staff for most activities of daily living (ADLs - activities related to personal care).</p> <p>A review of Resident 43's physician's order, dated 4/30/2024, indicated to give oxycodone with acetaminophen (medication used to treat moderate to severe pain) 5-325 milligrams (mg - unit of measurement) by mouth (PO) every six (6) hours as needed for severe pain 7-10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain).</p> <p>A review of Resident 43's Medication Regimen Review (a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) dated 5/2024, indicated a recommendation from the pharmacist for nurses to document non-pharmacological interventions prior to administering prn pain medication.</p> <p>During a concurrent interview and record review on 6/16/2024 at 12:32 p.m., with the Director of Nursing (DON), reviewed Resident 43's Medication Administration Record (MAR - document that serves as a legal record of the drugs administered to a resident at a facility by a health care professional) dated 6/2024. The DON confirmed by stating the following:</p> <ul style="list-style-type: none"> - Oxycodone with acetaminophen 5-325 mg was administered to Resident 43 from 6/1/2024 - 6/4/2024, and there were no documented non-pharmacological interventions. - Oxycodone with acetaminophen 5-325 mg was administered to Resident 43 from 6/6/2024 - 6/8/2024, and there were no documented non-pharmacological interventions. - Oxycodone with acetaminophen 5-325 mg was administered to Resident 43 from 6/10/2024 - 6/12/2024, and there were no documented non-pharmacological interventions. <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Oxycodone with acetaminophen 5-325 mg was administered to Resident 43 on 6/14/2024, and there were no documented non-pharmacological interventions.</p> <p>The DON stated it was important for nurses to attempt non-pharmacological interventions prior to administering pain medication because it's possible residents may be in pain for reasons such as needing to go to the bathroom or needing to be repositioned. The DON stated it was generally not good to have residents rely on medications because it can cause them to experience adverse side effects such as constipation and addiction to the medication.</p> <p>A review of the facility's policy and procedure titled, Pain Assessment and Management, last revised on 3/2020, indicated the purposes of this procedure are to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Non-pharmacological interventions may be appropriate alone or in conjunction with medications.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>39550</p> <p>Based on interview and record review, the facility failed to complete a post-dialysis (the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) assessment for one of two sampled residents (Resident 5).</p> <p>This deficient practice placed Resident 5 at risk for complications of dialysis such as redness at the dialysis access site (way to reach the blood for hemodialysis), edema (too much fluid trapped in the body's tissues), excessive bleeding, and a change in vital signs (clinical measurements that indicate the state of a patient's essential body functions).</p> <p>Findings:</p> <p>A review of Resident 5's Admission Record indicated the facility admitted the resident on 6/27/2020 and readmitted the resident on 9/19/2023 with diagnoses that included end stage renal disease (chronic irreversible kidney failure), dependence on renal (kidney) dialysis, and diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]).</p> <p>A review of Resident 5's Minimum Data Set (MDS- an assessment and screening tool) dated 5/13/2024, indicated that Resident 5's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were severely impaired. The MDS indicated that Resident 5 required supervision or touching assistance with eating, oral hygiene, and personal hygiene.</p> <p>A review of Resident 5's care plan (a written document that summarizes a patient's needs, goals, and care/treatment) for need for dialysis, initiated 9/19/2023, indicated under approach and plan: Take vital signs pre- and post-dialysis days.</p> <p>A review of Resident 5's Dialysis Communication Record dated 5/29/2024, indicated the post-dialysis assessment was blank and there was no documentation for post-dialysis monitoring for an assessment for cognitive status, vital signs, and assessment of the access site.</p> <p>During a concurrent interview and record review on 6/16/2024 at 9:29 a.m., with the Director of Nursing (DON), reviewed Resident 5's Dialysis Communication Record dated 5/29/2024. The DON stated that for pre and post-dialysis, licensed nurses are to assess residents for vital signs and to assess the residents' dialysis access site. The DON stated that there is no documented evidence that Resident 5's post dialysis assessment was completed. The DON stated that post-dialysis assessment is important to be done and documented to see if Resident 5 veered from her baseline (initial set of critical observations or data used for comparison) pre-dialysis. The DON further stated that post-dialysis assessments are done to make sure there are no changes in the resident's condition and to ensure resident safety post-dialysis.</p> <p>A review of the facility's policy and procedure titled, End-Stage Renal Disease, Care of a Resident with, revised 9/20/20, indicated resident with end stage renal disease (ESRD) will be cared for according to currently recognized standards.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure licensed nurses administered blood pressure (the force of blood pushing against the walls of the arteries) medications within prescribed parameters (a set of defined limits) for one of 14 sampled residents (Resident 16). <p>This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from the medication.</p> <ol style="list-style-type: none"> 2. Ensure the Medication Count Sheet (MCS- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Record (MAR, a report detailing the drugs administered to a patient by the licensed nurses) for one of 14 sampled residents (Resident 5). <p>These deficient practices had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 16's Admission Record indicated the facility admitted the resident on 9/16/2021 with diagnoses including atrial fibrillation (a-fib, an irregular and often very rapid heart rhythm), cardiomegaly (a condition where the heart is larger than normal), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), and hypotension (low blood pressure [the force of the blood pushing on the blood vessel walls is too low]). <p>A review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/18/2024, indicated the resident had intact cognition (thought processes) and required moderate assistance from staff for some activities of daily living (ADLs - activities related to personal care).</p> <p>A review of Resident 16's physician's orders indicated the following:</p> <ul style="list-style-type: none"> - Amiodarone hydrochloride (HCl) (antiarrhythmic medication - treats abnormal heart rhythms) 100 mg by mouth (PO) two times a day (BID) for a-fib. Hold for systolic blood pressure (SBP - the maximum pressure in the arteries when the heart contracts and pushes blood out) is less than 110 millimeters of mercury (mmHg - unit of measurement) or apical pulse (a pulse point on the left side of the chest that corresponds to the bottom tip of the heart) less than 60 beats per minute (BPM), ordered on 12/30/2023. - Metoprolol tartrate (beta blocker - relaxes blood vessels and slows the heart rate to improve blood flow and decrease blood pressure) 25 mg. Give 0.5 tablet by mouth two times a day for hypertension. Hold if SBP is less than 110 mmHg or heart rate (HR) is less than 60 BPM, ordered on 2/29/2024. <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Midodrine HCl (treats low blood pressure) 10 mg by mouth every eight (8) hours for hypotension. Hold if SBP is greater than 110 mmHg, ordered on 2/29/2024.</p> <p>A review of Resident 16's care plan (a written document that summarizes a resident's needs, goals, and care/treatment) for potential for complications related to hypertension, initiated on 2/16/2024, indicated to provide medication(s) as ordered.</p> <p>A review of Resident 16's care plan for potential for complications related to hypotension, initiated on 2/16/2024, indicated to provide medication(s) as ordered.</p> <p>During a concurrent interview and record review on 6/16/2023 at 12:38 p.m., with the Director of Nursing (DON), reviewed Resident 16's MAR dated 6/2024. The DON stated the following:</p> <ul style="list-style-type: none"> - On 6/3/2024 at 7:30 a.m., Resident 16's BP was 98/62 mmHg. Metoprolol was administered. - On 6/3/2024 at 9:00 a.m., Resident 16's BP was 107/68 mmHg. Amiodarone was administered. - On 6/3/2024 at 4:00 p.m., Resident 16's BP was 112/64 mmHg. Midodrine was administered. - On 6/4/2024 at 7:30 a.m., Resident 16's BP was 100/64 mmHg. Metoprolol was administered. - On 6/4/2024 at 9:00 a.m., Resident 16's BP was 107/59 mmHg. Amiodarone was administered. - On 6/5/2024 at 4:00 p.m., Resident 16's BP was 118/62 mmHg. Midodrine was administered. - On 6/6/2024 at 4:00 p.m., Resident 16's BP was 115/61 mmHg. Midodrine was administered. - On 6/9/2024 at 4:00 p.m., Resident 16's BP was 127/67 mmHg. Midodrine was administered. - On 6/11/2024 at 4:00 p.m., Resident 16's BP was 117/63 mmHg. Midodrine was administered. - On 6/12/2024 at 8:00 a.m., Resident 16's BP was 126/73 mmHg. Midodrine was administered. - On 6/13/2024 at 9:00 a.m., Resident 16's BP was 107/72 mmHg. Amiodarone was administered. - On 6/13/2024 at 5:30 p.m., Resident 16's BP was 107/72 mmHg. Metoprolol was administered. - On 6/14/2024 at 9:00 a.m., Resident 16's BP was 108/58 mmHg. Amiodarone was administered. <p>The DON stated that medications should be held or administered according to the physician's order. The DON stated that if the physician's orders are not followed and medications are given outside of parameters, then the resident can experience adverse side effects such as hypotension.</p> <p>A review of the facility's policy and procedure titled, Administering Medications, last revised on 4/2019, indicated that medications are prescribed in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. A review of Resident 5's Admission Record indicated the facility originally admitted the resident on 6/27/2020 and readmitted the resident on 9/19/2023 with diagnoses including neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet).</p> <p>A review of Resident 5's MDS, dated [DATE], indicated the resident had severely impaired cognition and required maximum assistance from staff for most ADLs.</p> <p>A review of Resident 5's physician's orders indicated an order for hydrocodone-acetaminophen (medication used to treat moderate to severe pain) 5-325 mg, give one tablet by mouth every four hours as needed for severe pain 7-10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered 9/19/2023.</p> <p>During a concurrent interview and record review on 6/15/2024 at 10:19 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 5's MCS for hydrocodone-acetaminophen 5-325 mg and MAR dated 3/2024. RN 1 stated that, according to the MCS, hydrocodone-acetaminophen 5-325 mg was administered on 3/1/2024 and 3/11/2024. When asked if they were also documented on Resident 5's MAR dated 3/2024, RN 1 stated that it was not documented as administered on 3/1/2024 and 3/11/2024.</p> <p>During an interview on 6/16/2024 at 12:47 p.m., with the DON, the DON stated that administered controlled substances should be documented in both the MCS and the MAR. The DON stated that, even if it was signed off on the MCS, it was also important to document it in the MAR so that the next nurse was aware of when the last pain medication was given. The DON stated this was important in order to avoid double dosing the resident, or just to get a more accurate representation of the resident's pain.</p> <p>A review of the facility's policy and procedure titled, Administering Medications, last revised on 4/2019, indicated that the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on observation, interview, and record review the facility failed to maintain infection control practices by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Certified Nursing Assistant 4 (CNA 4) donned (put on) gloves, gown, and goggles prior to entering a droplet isolation room (used to prevent the spread of pathogens that are passed through respiratory secretions) for one of three sampled residents (Resident 33). <p>This deficient practice had the potential for the spread of infection and cross contamination among residents.</p> <ol style="list-style-type: none"> 2. Ensure a resident's nasal cannula (a medical device that provides supplemental oxygen or increased airflow to people who need respiratory help) was not touching the floor for one of 14 sampled residents (Resident 25). <p>This deficient practice had the potential to place the resident at increased risk of contracting an infection.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 33's Admission Record indicated the facility admitted the resident on 6/23/2020 and readmitted the resident on 6/12/2024 with diagnoses that included heart failure (a condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), difficulty in walking, and history of falling. <p>A review of Resident 33's Minimum Data Set (MDS- an assessment and screening tool) dated 5/6/2024, indicated that Resident 33's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were moderately impaired. The MDS indicated that Resident 33 required partial/moderate assistance with oral hygiene, upper body dressing, and personal hygiene. The MDS also indicated Resident 33 required substantial/maximal assistance with toileting hygiene and shower.</p> <p>A review of Resident 33's Order Summary Report indicated an order for droplet isolation for parainfluenza virus three (3) (one of a group of common viruses that cause a variety of respiratory illnesses) every shift for 14 days, ordered 6/12/2024.</p> <p>A review of Resident 33's Care Plan (a written document that summarizes a resident's needs, goals, and care/treatment) for presence of contagious infection indicated resident on isolation precautions related to respiratory droplet isolation. An intervention included to practice isolation precautions for infection control and follow infection control policy and procedures.</p> <p>During an observation on 6/15/2024 at 8:52 a.m., outside of Resident 33's room, observed signages indicating droplet precautions. Observed Certified Nursing Assistant 4 (CNA 4) not don gloves, gown, and goggles prior to entering Resident 33's isolation room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2024
NAME OF PROVIDER OR SUPPLIER Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd Tujunga, CA 91042	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/15/2024 8:54 a.m., with CNA 4, CNA 4 stated that Resident 33's room is a droplet isolation room. CNA 4 stated that when entering Resident 33's room staff are to wear a mask, gown, and gloves. CNA 4 continued to state that he did not don gloves and a gown because he was only in the room for a short period of time. CNA 4 stated that he should have worn a gown and mask when he entered Resident 33's room incase Resident 33 asked him to provide care and for infection control.</p> <p>During an interview on 6/16/2024 at 10:10 a.m., with the Director of Nursing (DON), the DON stated that anyone entering an isolation room should wear PPEs (Personal Protective Equipment - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illness) based on the type of precautions. The DON stated for droplet precautions, everyone entering a droplet precaution room should wear a mask, gown, and gloves prior to entering the room. The DON stated everyone entering an isolation room has to wear PPEs to decrease the risk of infection.</p> <p>A review of the facility's policy and procedure titled, Isolation-Categories of Transmission-Based Precautions, revised date 9/2022, indicated transmission-based precautions (steps taken to prevent spread of infection to others) are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or had laboratory confirmed infections; and is at risk of transmitting the infection to other resident. Droplet Precautions: 3. Masks are worn when entering the room; 4. Gloves, gown, and goggles are worn if there is a risk of spraying respiratory secretions.</p> <p>38549</p> <p>2. A review of Resident 25's Admission Record indicated the facility admitted the resident on 10/10/2023 with diagnoses that included congestive heart failure (a long-term condition that occurs when the heart can't pump enough blood to meet the body's needs) and atrial fibrillation.</p> <p>A review of Resident 25's MDS, dated [DATE], indicated the resident had severely impaired cognition (thought processes) and required moderate assistance with most activities of daily living (ADLs - activities related to personal care)</p> <p>A review of Resident 25's physician's order, dated 2/8/2024, indicated an order to administer oxygen via nasal cannula at two (2) liters (L, unit of measurement)/minute (min) as needed.</p> <p>During a concurrent observation and interview on 6/14/2024 at 8:04 p.m., with Certified Nursing Assistant 2 (CNA 2), observed Resident 25 awake in bed and had on a nasal cannula with oxygen running at 2 L/min. Observed Resident 25's oxygen tubing touching the floor. CNA 2 verified by stating that Resident 25's oxygen tubing was touching the floor and stated she would provide the resident with a new one.</p> <p>During an interview on 6/16/2024 at 12:45 p.m., with the DON, the DON stated that residents' oxygen tubing should be kept off the floor for infection control purposes. The DON stated, if not kept off the floor, then bacteria can be introduced to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated that floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.</p> <p>A review of the facility's policy and procedure titled, Standard Precautions, last revised on 9/2022, indicated that resident care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments.</p>