| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055457 | A. Building<br>B. Wing | 08/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Intercommunity Healthcare & Rehabilitation Center | 12627 Studebaker Road<br>Norwalk, CA 90650 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382<br><br>Based on observation, interview, and record review, the facility failed to report change of condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) for one of eight sampled residents (Resident 60) with limited range of motion (ROM, full movement potential of a joint [where two bones meet]) concerns by failing to:<br><br>1.Report Resident 60's decline in ROM of both wrists and both hands to the physician in accordance with the facility's job description titled, Restorative Nursing Assistant, and policy and procedure tilted, Change in a Resident's Condition or Status.<br><br>This failure resulted in Resident 60 from not receiving interventions to improve ROM, including intervention to prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness).<br><br>Findings:<br><br>During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function).<br><br>During a review of Resident 60's OT's Joint Mobility Screening ([OT JMS, a brief joint mobility assessment of a resident's ROM in both arms and both legs completed by an OT), dated 1/5/2023, the OT JMS indicated Resident 60 had full PROM in both wrists, hands, fingers, and elbows and had moderate (26-50 percent [%] ROM loss) ROM limitations in both shoulders.<br><br>During a review of Resident 60's OT's Evaluation and Plan of Treatment (OT Eval), dated 1/8/2023, the OT Eval indicated Resident 60's ROM in both elbows, forearms, wrists, and hands were within functional limits ([WFL]a sufficient movement without limitation). The OT Eval indicated Resident 60 had no contractures in both arms and was at risk for contracture development.<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
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| NAME OF PROVIDER OR SUPPLIER Intercommunity Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 12627 Studebaker Road Norwalk, CA 90650 | |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 60's OT Discharge Summary, dated 3/3/2023, the OT Discharge Summary indicated the OT recommended Resident 60 to have a Restorative Nursing Assistant program (RNA, nursing aide program that helps residents maintain their function and joint mobility) to provide PROM exercises and apply splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to both elbows, four (4) to six (6) hours daily or as tolerated.<br><br>During a review of Resident 60's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/3/2023, for RNA to provide PROM exercises to Resident 60's both arms and both legs and apply splints to both elbows, 4 to 6 hours daily or as tolerated.<br><br>During a review of Resident 60's Minimum Data Set ([MDS], a standardized assessment and care-screening tool), dated 7/11/2024, the MDS indicated Resident 60 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 60 was dependent (full staff performance) on staff with eating, oral hygiene, toilet hygiene, bathing, dressing, rolling to both sides, and transfers (moving from one surface to another). The MDS indicated Resident 60 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs.<br><br>During a review of Resident 60's Annual OT JMS, dated 1/28/2024, the OT JMS indicated Resident 60 had severe (greater than 50 % ROM loss) ROM limitations in both wrists, both hands, both fingers, and both shoulders. The OT JMS indicated Resident 60 had minimal (less than 25% ROM loss) ROM limitations in both elbows. The OT JMS indicated Resident 60 had a minimal to severe loss of PROM to both arms and recommended a skilled OT evaluation.<br><br>During a review of Resident 60's OT Eval, dated 1/30/2024, the OT Eval indicated Resident 60 was referred to OT services due to a decline in ROM and strength of both arms. The OT Eval indicated Resident 60 had contractures in both arms which affected Resident 60's functional skills (basic or everyday skills necessary for daily living) and required skilled therapy (services that require specialized training and experience of a licensed therapist or therapy assistant) to address the contractures. The OT Eval indicated Resident 60's ROM in the right arm was impaired at the shoulder, elbow, forearm, wrist, and hand. The OT Eval indicated Resident 60 had a right claw hand contracture (condition of the hand where the fingers of the hand are in a hyperextended position [the extension of a body part beyond it's normal limits] at the knuckle joints and bent at the fingertips) and had zero degrees of PROM (normal is 70 to 90 degrees ROM) at the right wrist in an upward position. The OT Eval indicated Resident 60's ROM in the left arm was impaired at the shoulder, wrist, and hand. The OT Eval indicated Resident 60 was unable to straighten the fingers of the left hand and indicated a two-inch gap between the fingertips of the left hand and crease in the palm of the hand. The OT Eval indicated Resident 60 had zero degrees of PROM at the left wrist into an upward position. The OT Eval indicated OT recommended Resident 60 wear splints to both hands.<br><br>During an interview with RNA 1 on 8/20/2024 at 12:59 p.m., RNA 1 stated the Director of Nursing (DON), all available RNAs, and the Director of Rehabilitation (DOR) met monthly to discuss any concerns with residents receiving RNA services, including if any resident experienced a decline in ROM or mobility. RNA 1 stated any concerns or declines observed during RNA sessions should be immediately reported to charge nurse and the Rehabilitation Department (Rehab) for re-assessment.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the DOR on 8/20/2024 at 1:49 p.m., the DOR stated the facility monitored residents for changes and declines in ROM by JMSs conducted upon admission and quarterly by the rehab department and quarterly by the MDS nurses along with report from staff of any observable changes or declines. The DOR stated the DOR, RNAs, Director of Staff Development (DSD), and DON met monthly to discuss any concerns (in general) with residents receiving RNA services, including any declines, changes, or problems requiring re-assessment or intervention. The DOR stated any declines discussed in the monthly meeting would initiate a COC and the physician would be notified.<br><br>During an observation of RNA session with Resident 60 in Resident 60's room on 8/21/2024 at 10:53 a.m., the resident was lying in bed with her right arm wrapped in a towel covering the hand, wrist, forearm, elbow, and lower half of the upper arm. Resident 60's right arm was held out in front of her body with the right elbow bent and the wrist bent downwards. Resident 60's left arm was resting at the side of her body with the elbow slightly bent, the wrist straight, and the fingers of the hand bent into a fist position. RNA 1 was observed attempted to assist Resident 60 with PROM exercises to the right arm, but Resident 60 reported increased pain and refused exercises. RNA 1 moved to the left side of the bed and provided PROM exercises to Resident 60's left shoulder, elbow, wrist, and hand. RNA 1 was unable to straighten all of Resident 60's fingers on the left hand and moved the left wrist in small motions side to side. Resident 60 stated she had pain with PROM exercises to the left wrist and hand with exercises. RNA 1 was observed attempted to place a hand splint (splint secured from the hand to the forearm to position the hand and wrist in a functional position) onto Resident 60's left arm but Resident 60 refused and stated the splint hurt. RNA 1 observed to bend the left-hand splint at the wrist and removed a cylindrical portion of the splint that supported the fingers of the hand. Resident 60 agreed to wear left hand splint after it was modified by RNA 1. RNA 1 placed the modified hand splint on Resident 60's left arm by securing the splint with straps around the wrist and forearm. The left-hand splint was observed not straightening or supporting the fingers of the hand. RNA 1 observed moved to the right side of the bed and tried to place a hand splint on Resident 60's right arm. Resident 60 refused and stated she wanted the cylindrical piece of the splint that supported the fingers removed because it hurt her hand. RNA 1 removed the cylindrical piece of the right-hand splint and placed it onto Resident 60's right arm by securing the splint with straps around the wrist and forearm. Observed the right-hand splint not straightening or supporting the fingers of the right hand.<br><br>During an interview on 8/21/2024 at 11:15 a.m. with RNA 1, RNA 1 stated Resident 60 had been occasionally complaining of pain in both hands and wrists during exercises and when trying to place splints on both hands for a long time but did not recall when it started. RNA 1 stated he modified both hand splints by bending the wrist portion of the left-hand splint and removing the cylindrical portion of both splints that stretched the fingers because Resident 60 was unable to tolerate the stretch the splints provided due to tightness and pain in both hands and wrists. RNA 1 stated he had been providing exercises to Resident 60's both arms since last year, noticed both hands and wrists were intermittently (irregular intervals) getting tighter and more painful with exercises, and did not report the changes in ROM to the charge nurse or DOR. RNA 1 stated he should have informed the charge nurse and DOR and discussed the decline in Resident 60's ROM of both hands and both wrists in the RNA monthly meetings but did not. RNA 1 stated he thought he told the DOR at some point but was unsure and stated he had no documented evidence to indicate the charge nurse or DOR was informed of the ROM changes.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/21/2024 at 12:04 p.m. with the Director of Staff Development (DSD), the DSD stated the facility monitored for changes in ROM by the JMSs conducted by Rehab and nursing, communication with the RNAs in the monthly RNA meetings, and reports from any staff of any noticeable changes or declines in function. The DSD stated RNAs must notify the charge nurse of any changes in a resident's function such as increased pain, decrease in ROM, or if a splint was not fitting correctly to ensure the proper protocol was followed to ensure the resident received the appropriate services he or she needed. The DSD stated once the charge nurse was notified, the charge nurse will complete a COC evaluation and notify the physician and licensed therapist for re-assessment.<br><br>During a concurrent interview and record review of Resident 60's clinical record with the DOR on 8/21/2024 at 2:59 p.m., the DOR who was an OT stated Resident 60 was admitted to the facility on [DATE] with no ROM limitations and contractures to both wrists, hands, and fingers. The DOR reviewed Resident 60's Admission OT JMS, dated 1/5/2023, and confirmed Resident 60 had full ROM of both wrists, hands, and fingers. The DOR reviewed Resident 60's OT Eval, dated 1/8/2024, and confirmed Resident 60 had WFL ROM in both elbows, wrists, and hands which meant Resident 60 had sufficient ROM to perform ADLs. The DOR reviewed Resident 60's OT Discharge Summary, dated 3/3/3023, and stated Resident 60 was discharged from OT services with recommendations for an RNA program for PROM to both arms and application of splints to both elbows for four to six hours, daily. The DOR reviewed Resident 60's Annual OT JMS, dated 1/28/2024, and confirmed Resident 60 had severe ROM limitations in both wrists and both hands and recommended an OT evaluation for skilled therapy services. The DOR reviewed Resident 60's OT evaluation, dated 1/30/2024, and confirmed Resident 60 had contractures to both hands and both wrists and recommended resting hand splints to both hands for contracture management. The DOR stated Resident 60 had a decline in ROM and developed contractures to both hands and both wrists while in the facility. The DOR stated she was never notified by RNA or nursing of any declines in Resident 60's ROM of both arms. The DOR stated a COC was never initiated and the physician was not notified since RNA did not report any declines to nursing and/or Rehab and was unaware Resident 60 was experiencing a decline in ROM.<br><br>During an interview with the Physician on 8/22/2024 at 12:06 p.m., the Physician stated any change of condition which included a decline in ROM, splints not fitting correctly, and pain due to ROM must be reported to the physician. The Physician stated she must be notified of any changes of condition to provide the appropriate intervention and ensure the resident receives the services or medical treatment he or she needs. The Physician stated she did not recall if she was notified about Resident 60's decline in ROM of both hands and both wrists. The Physician stated if she was not notified of any changes in condition, she would not know there was a problem and would not be able to provide the appropriate interventions.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 8/23/2024 at 1:11 p.m., the DON stated the facility monitor for changes in ROM by multiple JMSs performed by nursing or Rehab upon admission, quarterly, and annually and by staff observation and report of any declines to the appropriate staff. The DON stated any change of condition noticed during routine nursing care or during RNA sessions such as a decline in ROM must be reported to the charge nurse who then completed a COC evaluation and notified the physician and licensed therapist for re-assessment. The DON confirmed Resident 60 had a decline in ROM and developed contractures to both hands and wrists while in the facility. The DON stated she was never notified by RNA or nursing of any declines in Resident 60's ROM of both arms. The DON stated RNA should have notified the change nurse or discussed Resident 60's decline in ROM in the monthly RNA meetings to ensure a COC was completed, the physician was notified, and therapy re-assessed Resident 60 to ensure the proper interventions were provided to prevent the contractures. The DON stated the physician was never notified because the RNA never notified the Charge Nurse to initiate a COC.<br><br>During a review of the facility's job description titled, Restorative Nursing Assistant, dated 1/27/2022, the job description indicated RNA assisted residents in reaching their maximal potential in collaboration with the Therapy Department and under the supervision of the Charge Nurse. The RNA job description indicated the RNA's essential duties and responsibilities included reporting and charting significant changes in a resident's condition.<br><br>During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 3/2023, the P&P indicated the facility would promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. |

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889

Based on observation, interview, and record review, the facility failed to ensure an accurate Minimum Data Set Assessment (MDS, a standardized assessment and care screening tool) for restraint who is using full side rails for one of one sampled resident (Resident 14).

This deficient practice has the potential to result in Resident 14 not receiving the necessary care and treatment.

Findings:

During a review of the Face sheet dated 8/23/24 indicated Resident 14 was admitted on ,d+[DATE]/ 20, and readmitted 11/ 20/20, with diagnosis including Epilepsy (a brain disorder that causes recurring, unprovoked seizures), intellectual disabilities, convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles)

During a review of the History & Physical (H&P) dated 10/13/23, indicated Resident 14 does not have the capacity to understand and make decisions.

During a review of the Active Order Summary Report dated 8/1/24 indicated Resident 14 had an order for [Restraint] Bilateral full side rails up when in bed.

During a review of the MDS dated [DATE], the MDS section C indicated Resident 14 was severely impaired for daily decision making. The MDS Section P Restraints also indicated Resident 14 was not using siderails on the bed.

During an observation on 8/19/24 at 9:23 a.m. Resident 14 was in bed with bilateral full side rails in the up position.

During an observation on 8/20/24 12:12 p.m. Resident 14 was in bed with bilateral full side rails in the up position.

During a concurrent interview and record review on 8/23/24 at 08:58 a.m. with the MDS nurse, MDS nurse stated I miscoded the MDS section P restraints. Resident 14 does use bilateral full side rails. MDS stated inaccurate assessment has the potential for Resident 14 to not receive the appropriate care.

During a concurrent interview and record review on 8/23/24 at 9:10 a.m. with the Director of Nurses (DON) the DON stated The MDS nurse should have coded Resident 14 as having siderails. This inaccurate assessment has the potential for a negative outcome in patient safety. DON stated injuries could happen if residents are not assessed properly.

During a review of the facility's policy and procedure, titled Resident Assessment, revised October 2023 indicated it is the facility's policy that all personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment.

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

PASARR screening for Mental disorders or Intellectual Disabilities

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573

Based on interview, and record review, the facility failed to follow through with the Preadmission Screening and Resident Review (PASARR-a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) recommendation for three of three sampled residents. Facility failed to

a. Obtain a PASARR Level II evaluation for Residents 54 and 36 and Level I evaluation for Resident 4 during admission.

This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for three of three sampled residents (Resident 36,54 and 4).

Findings:

a. During a review of Resident 54's Admission Record (face sheet), the face sheet indicated Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 54's diagnoses included metabolic encephalopathy (chemical imbalance in the blood affecting the brain), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), dementia (a decline in thinking skills), major depressive disorder (sad mood disorder), anxiety (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation

During a review of Resident 54's History and Physical (H/P), dated 7/26/2024, the H/P indicated Resident 54 does not have the capacity to understand and make decisions.

During a review of Resident 54's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/2/2024, the MDS indicated Resident 54 had moderate cognitive (thought process) impairment and was dependent on self-care abilities such as oral hygiene, toileting, dressing, and personal hygiene.

During a review of Resident 54's physician orders, dated 7/29/2024, the physician orders indicated buspirone oral tablet 5 milligram ([mg], units of measure) give one tablet three times a day for anxiety and trazodone oral tablet 150 mg give 0.5 tablet at bedtime for depression manifested by inability to sleep.

b. During a review of the admission record indicated Resident 36's original admitted was 5/1/24, and was readmitted [DATE], with diagnoses that included schizophrenia, (a chronic and severe mental disorder that effects how a person thinks, feels, and behaves) bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

During a review of Resident 36's PASARR completed on 5/17/24, indicated the need for a level II PASARR evaluation.

During a review of Resident 36's MDS dated [DATE], indicated Resident 36's was unable to complete the interview. The MDS also indicated Resident 36 was receiving antipsychotic and antidepressant medications.

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 36's History & Physical dated 5/28/24, indicated Resident 36 did not have the capacity to understand and make decisions.<br><br>During a review of Active Order Summary Report dated 8/1/24, indicated Resident 36 was currently on these medications.<br><br>1.(Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125mg. Give 4 capsule by mouth in the morning for mood disorder manifested by (MB) intense mood swings).<br><br>2.(Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125mg. Give 6 capsule by mouth at bedtime for mood disorder manifested by (MB) intense mood swings).<br><br>3.(Geodon Oral Capsule 40mg. Give 1capsule by mouth two times a day for schizophrenia M/B auditory hallucination talking to self).<br><br>4.(Seroquel oral tablet 100mg. Give 1 tablet by mouth in the morning for schizophrenia M/B delusional thinking resulting to self-inflicting behavior).<br><br>5.(Seroquel oral tablet 300mg. Give 1 tablet by mouth at bedtime for schizophrenia M/B delusional thinking resulting to self-inflicting behavior).<br><br>c. During a review of Resident 4's face sheet, the face sheet indicated Resident 4 was admitted to the facility on [DATE] and readmitted [DATE]. Resident 4's diagnoses included, depression (sad mood disorder), anxiety, paranoid schizophrenia (a serious mental health condition that affects how people think, feel, and behave), dementia, hypertension, and anemia (low blood count).<br><br>During a review of Resident 4's H/P, dated 7/3/2024, the H/P indicated Resident 4's main contact and primary decision maker was the grandson, who was the responsible party (RP).<br><br>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severe cognitive impairment and was dependent on self-care abilities such as eating, oral hygiene, toileting, dressing and personal hygiene.<br><br>During a review of Resident 4's physician orders, dated 7/26/2024, the physician orders indicated abilify oral tablet 5 mg give 0.5 tablet by mouth one time a day for schizophrenia manifested by auditory hallucination resulting to angry outbursts and Cymbalta oral capsule delayed release (medication delivered slowly over a period) give 30 mg by mouth two times a day for depression manifested by decreased motivation.<br><br>During an interview on 8/21/24, at 1:17 p.m. with Registered Nurse Supervisor (RNS)1 RNS 1 stated registered nurses are responsible for the PASARR II upon admission. PASARR'S are important because the facility needs to ensure the resident is getting all required services. RNS 1 stated not having a PASARR II could jeopardize the resident's care. It could harm the resident mentally and physically.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 8/22/24, at 12:40 p.m. with Director of Nurses (DON), the DON stated the RN, or the DON is responsible for overseeing the PASARR. The DON stated she did not follow up with a PASARR representative regarding Resident's 4,36,54 PASARR II evaluation. With out the PASARR II evaluation there could be a potential for improper placement to a facility and there is the potential for the residents to decline.<br><br>During a review of the facility's policy and procedure (P&P) titled Preadmission Screening and Resident Review (PASARR) dated 6/ 3/24, indicated If the Department of Health Care Services / Department of Developmental Services (DHCS/DDS) contractor deems a level II evaluation is necessary, the facility will assist the DHCS contractor with additional information face to face visit for further evaluation as indicated.<br><br>The facility's designated staff will review the available information from the PASARR online system regularly, follow up with the DHCS/DDS contractor.<br><br>49889 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on interview and record review, the facility failed to ensure a plan of care was formulated for two of three sampled residents:<br><br>a.Resident 50 who was prescribed an anticoagulant medication (a medication used to lower the risk of stroke or blood clot in people); and<br><br>b.Resident 68 who was prescribed an anti-anxiety medication (a medication used to treat excessive worry and feelings of fear, dread, and uneasiness).<br><br>These failures have the potential for delayed in the delivery of care and services to Resident 50 and Resident 68.<br><br>Findings:<br><br>a. During a review of Resident 50's Admission Record (Face sheet), the face sheet indicated Resident 50 was admitted at the facility on 2/21/2024 and was readmitted on [DATE] with a diagnosis including chronic respiratory failure (a condition that usually happens when the airways that carry air to the lungs become narrow and damaged), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread and uneasiness) and long-term use of anticoagulant therapy (the use of a substance that prevent and treat blood clots in the blood vessels and the heart).<br><br>During a review of Resident 50's Physician Order Summary dated 8/1/2024, the Physician Order Summary indicated Resident 50 was prescribed Eliquis (an anti-coagulant medication, which is used to lower the risk of stroke or blood clot in people) 5 (five) mg (a unit of weight that is equal to a thousandth of a gram) 1 (one) tablet by mouth two times a day for deep vein thrombosis prophylaxis (prevention of a blood clot forming in one or more deep veins in the body, usually in the legs) on 5/16/2024.<br><br>During a review of Resident 50's comprehensive plan of care, the plan of care did not indicate a specific plan of care for an anticoagulant therapy was formulated for Resident 50.<br><br>b.During a review of Resident 68's Admission Record (Face sheet), the face sheet indicated Resident 68 was admitted at the facility on 9/12/2023 and was readmitted on [DATE] with a diagnosis including malignant neoplasm of the tongue (a form of cancer in the tongue that can spread into or invade the nearby tissues of the body) and tracheostomy (an opening surgically created through the neck in to the trachea [also known as windpipe] to allow air to fill the lungs).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Intercommunity Healthcare & Rehabilitation Center | 12627 Studebaker Road<br>Norwalk, CA 90650 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the Resident 68's Medication Administration Record dated 8/1/2024 to 8/31/2024, the Medication Administration Record indicated Resident 68 was prescribed Lorazepam (an anti-anxiety medication) tablet 0.5 mg 1 (one) tablet through the gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach to allow air and fluid to leave the stomach and can be used to give drugs, liquids, including food) every 6 hours as needed for anxiety manifested by hyperventilating (rapid deep breathing caused by anxiety or panic) causing shortness of breath for 14 days.<br><br>During a review of Resident 68's comprehensive plan of care, the plan of care did not indicate a specific plan of care for an anti-anxiety therapy was formulated for Resident 68.<br><br>During a concurrent interview and record review on 8/21/2024 at 1:21 p.m., Licensed Vocational Nurse 2 (LVN 2) stated a care plan was necessary to be implemented for:<br><br>a. Resident 68 who was taking an anti-anxiety medication to ensure all interventions were collaborative including non-pharmacological behavior management, monitoring of manifestations every shift, effectivity of the medication to upgrade or downgrade his medications and expedite his treatment, as necessary, and<br><br>b. Resident 50 who was taking an anti-coagulant medication, to educate Resident 50, her family and the nursing staff to ensure detection of any complications such as bleeding, which if missed could cause delay of care and services.<br><br>During an interview and record review on 8/22/2024 at 12:23 p.m., the Director of Nursing Services (DON) stated a plan of care was important for residents taking anti-anxiety drugs such as Lorazepam to monitor their behavior every shift, thereby allowing reassessment and/or evaluation to determine if the resident truly need the medication and/ or need adjustment of their dosages. The DON stated the care plan is also necessary to ensure the adverse reactions and/ or side effects of the medication to the resident is readily identified thus preventing complications and immediately address a change of condition as necessary.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Care Plans, comprehensive Person-Centered revised 3/2023, the P&P indicated a comprehensive, person-centered care plan include:<br><br>a. measurable objectives to meet the residents' physical, psychological and functional needs,<br><br>b. description of the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being,<br><br>c. professional services for each aspect of care, provided by competent and qualified persons,<br><br>d. residents' stated goals upon admission and desired outcome,<br><br>e. residents' capabilities and strength,<br><br>f. recognized standards of practice for problem areas and conditions,<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | g. care plan interventions after data gathering, problem areas, causes and relevant clinical decision making, and interventions that address the underlying sources of the problem areas, not just the symptoms or triggers, and<br><br>h. ongoing assessments of residents and revision of care plans based on the residents' ongoing care and changes in condition. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269<br><br>Based on observation, interview, and record review the facility failed to provide foot care to one of four sampled residents(Resident 38) by:<br><br>1.Failing to check and monitor if a podiatry service ( diagnose and treat any foot or ankle problem) is needed for Resident 38 's toenails who had thick and overgrown toenails.<br><br>This failure had the potential to cause discomfort and for Resident 38's toenails to cut into the skin due to their length.<br><br>Findings:<br><br>During a review of Resident 38's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included unspecified dementia(loss of cognitive functioning such as thinking, remembering and reasoning which can affect and interfere with daily life and activities), history of traumatic brain injury(brain dysfunction caused by an outside force usually a violent blow to the head) and polyneuropathy( condition in which person's peripheral nerves are damaged).<br><br>During a review of Resident 38's History and Physical( H&P) dated 3/1/2024, the H and P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 38's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 6/14/2024, the MDS indicated the resident required substantial/ maximal assistance( helper does more than half the effort) with bathing, toileting hygiene, dressing, personal hygiene, and bed mobility.<br><br>During a review of Resident 38's Physician Order Summary Report dated 1/24/2018, the Order Summary Report indicated an order for Podiatry care every two months and prn (as needed) for mycotic( nail fungus causing thickened, brittle, or ragged nails), hypertrophic nails (thickened toenails),corns and calluses.<br><br>During a review of Resident 38's Podiatry Note the resident was seen by the podiatrist(doctors who specialize in disorders of the feet and ankle) on 4/24/2024 and indicated the resident refused trimming of toenails.<br><br>During a review of Resident 38's Podiatry Consult dated 6/18/2024 indicated the resident refused evaluation and the podiatrist will attempt to evaluate patient again in two months or as allowable or emergent.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 8/21/2024, at 2:00 p.m. with Certified Nursing Assistant (CNA2) in Resident 38's room, Resident 38 was laying with a sheet covering his body, but bilateral feet were exposed. Observed Resident 38 's toenails on both feet were thick, ragged, and long. CNA2 stated Resident 38 had a shower today and his toenails are still okay. CNA2 stated he did not tell Licensed Vocational Nurse (LVN 4) about his long toenails and if a resident required toenail clipping , the charge nurse needs to be notified.<br><br>During an interview on 8/21/2024, at 2:49 p.m. with CNA3, CNA3 stated he had noticed Resident 38's long toenails and had notified LVN 4 yesterday.<br><br>During an interview on 8/21/2024, at 2:10 p.m. with LVN 4, LVN 4 stated CNA 2 did not notify her regarding Resident 38's long toenails today. LVN 4 stated CNA 2 should have notified her about the long toenails of Resident 38 so she could call the physician to get a podiatry consult and would notify the social worker to arrange for a podiatrist to come and see the resident. LVN4 stated residents who need podiatry service did not need to wait for 2 months if their toenails are long and had to be trimmed because long and thickened nails could cause discomfort and could cut into their skin.<br><br>During a concurrent interview and record review of Resident 38's feet digital picture on 8/21/2024, at 4:39 a.m. with Social Service Director(SSD), SSD stated she did not receive any referral for podiatry consult for Resident 38. SSD stated the licensed nurse would notify her or communicate to her about podiatry service or toenails trimming. SSD stated the podiatrist could accommodate emergency care as long the licensed nurse will notify her to get a referral for podiatry consult. SSD agreed Resident 38's toenails were long, thick, and a podiatrist need to see the resident to prevent discomfort and toenails getting into the skin.<br><br>During an interview on 8/22/2024, at 1:10 p.m. with Director of Nursing (DON),DON stated Resident 38's long toenails could dig into his skin could cause discomfort or infection.<br><br>During a review of facility's policy and procedure (P&P) titled Activities of Daily Living, Supporting revised 3/2003, the P&P indicated appropriate care and services will be provided to the residents who are unable to carry out activities of daily living (ADL, basic personal care tasks people need to do on their own to live independently). The P&P indicated if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or a different time or having another staff member speak to the resident may be an appropriate approach. |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382<br><br>Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 60) received appropriate services, did not acquire a decline (reduction) in range of motion (ROM, full movement potential of a joint) and did not develop a contracture (chronic loss of joint motion associated with deformity and joint stiffness) to both hands and both wrists.<br><br>The facility failed to:<br><br>1. Provide appropriate monitoring of Resident 60's ROM on a quarterly basis to determine any changes in ROM in accordance with the facility's policy titled Joint Mobility Assessment, ([JMS] a brief assessment of a resident's ROM in both arms and both legs) which indicated, all residents shall be assessed for joint mobility limitations upon admission and reviewed every three months thereafter.<br><br>2. Ensure Restorative Nursing Assistant ([RNA 1] certified nursing aide program that helps residents to maintain their function and joint mobility) reported Resident 60's decline in ROM during restorative program ( nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible ) sessions to the charge nurse (a licensed nurses in charge) in accordance with the facility's job description titled, Restorative Nursing Assistant.<br><br>3. Provide Resident 60 with passive range of motion ([PROM] a movement of a joint through the ROM with no effort from resident) exercises to both arms daily from March 2023 to October 2023 per physician's order and in accordance with the Occupational Therapy ([OT], profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) discharge recommendation made on 3/3/2023.<br><br>4. Ensure RNA 1 did not modify Resident 60's splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to both hands without notifying OT.<br><br>These deficient practices resulted in Resident 60 developing contractures to both hands and both wrists, causing pain and placing Resident 60 at risk for physical, emotional, and psychosocial decline. Resident 60 was placed at risk to have a decline in ROM, improper fitting splints, ineffective interventions to maintain ROM, pain, and skin breakdown.<br><br>Findings:<br><br>During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function).<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 60's OT's Joint Mobility Screening ([OT JMS, a brief joint mobility assessment of a resident's ROM in both arms and both legs completed by an OT), dated 1/5/2023, the OT JMS indicated Resident 60 had full PROM in both wrists, hands, fingers, and elbows and had moderate (26-50 percent [%] ROM loss) ROM limitations in both shoulders.<br><br>During a review of Resident 60's OT's Evaluation and Plan of Treatment (OT Eval), dated 1/8/2023, the OT Eval indicated Resident 60's ROM in both elbows, forearms, wrists, and hands were within functional limits ([WFL]a sufficient movement without limitation). The OT Eval indicated Resident 60 had no contractures in both arms and was at risk for contracture development.<br><br>During review of OT's Discharge Summary dated 3/3/2023, the OT's Discharge Summary indicated the OT recommended for Resident 60 to have RNA to provide PROM exercises to both arms and apply splints to both elbows, four to six hours daily or as tolerated.<br><br>During a review of Resident 60's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/3/2023, for RNA to provide PROM exercises to Resident 60's both arms and both legs and apply splints to both elbows, four to six hours daily or as tolerated.<br><br>During a review of Resident 60's RNA Survey Report (record of nursing assistant tasks) for March 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X (resident was not seen for RNA treatment that day) on the following days: 3/4/2023, 3/5/2023, 3/11/2023, 3/12/2023, 3/18/2023, 3/19/2023, 3/25/2023, and 3/26/2023.<br><br>During a review of Resident 60's RNA Survey Report for April 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 4/1/2023, 4/2/2023, 4/8/2023, 4/9/2023, 4/15/2023, 4/16/2023, 4/22/2023, 4/23/2023, 4/29/2023, and 4/30/2023.<br><br>During a review of Resident 60's RNA Survey Report for May 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 5/6/2023, 5/7/2023, 5/13/2023, 5/14/2023, 5/20/2023, 5/21/2023, 5/27/2023, 5/28/2023.<br><br>During a review of Resident 60's RNA Survey Report for June 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 6/3/2023, 6/4/2023, 6/10/2023, 6/11/2023, 6/17/2023, 6/18/2023, 6/24/2023, and 6/25/2023.<br><br>During a review of Resident 60's RNA Documentation Survey Report for July 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 7/1/2023, 7/2/2023, 7/8/2023, 7/9/2023, 7/15/2023, 7/16/2023, 7/22/2023, 7/23/2023, 7/29/2023, and 7/30/2023.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 60's RNA Survey Report for August 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 8/5/2023, 8/6/2023, 8/12/2023, 8/13/2023, 8/19/2023, 8/20/2023, 8/26/2023, and 8/27/2023.<br><br>During a review of Resident 60's RNA Survey Report for September 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The squares on the RNA Survey Report had the letter X on the following days: 9/2/2023, 9/3/2023, 9/9/2023, 9/10/2023, 9/16/2023, 9/17/2023, 9/23/2023, 9/24/2023, and 9/30/2023.<br><br>During a review of Resident 60's RNA Survey Report for October 2023, the RNA Survey Report indicated for the RNA to provide the resident with PROM exercises to both arms and both legs and apply splints to both elbows for four to six hours, daily or as tolerated. The square on the RNA Survey Report was blank on 10/2/2023. The squares on the RNA Survey Report had the letter X on the following days: 10/1/2023, 10/7/2023, 10/8/2023, 10/14/2023, 10/15/2023, 10/21/2023, 10/22/2023, 10/28/2023, and 10/29/2023.<br><br>During a review of Resident 60's Minimum Data Set ([MDS], a standardized assessment and care-screening tool), dated 7/11/2024, the MDS indicated Resident 60 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 60 was dependent (full staff performance) on staff with eating, oral hygiene, toilet hygiene, bathing, dressing, rolling to both sides, and transfers (moving from one surface to another). The MDS indicated Resident 60 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs.<br><br>During a review of Resident 60's Annual OT JMS, dated 1/28/2024, the OT JMS indicated Resident 60 had severe (greater than 50 % ROM loss) ROM limitations in both wrists, both hands, both fingers, and both shoulders. The OT JMS indicated Resident 60 had minimal (less than 25% ROM loss) ROM limitations in both elbows. The OT JMS indicated Resident 60 had a minimal to severe loss of PROM to both arms and recommended a skilled OT evaluation.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 60's OT Eval, dated 1/30/2024, the OT Eval indicated Resident 60 was referred to OT services due to a decline in ROM and strength of both arms. The OT Eval indicated Resident 60 had contractures in both arms which affected Resident 60's functional skills (basic or everyday skills necessary for daily living) and required skilled therapy (services that require specialized training and experience of a licensed therapist or therapy assistant) to address the contractures. The OT Eval indicated Resident 60's ROM in the right arm was impaired at the shoulder, elbow, forearm, wrist, and hand. The OT Eval indicated Resident 60 had a right claw hand contracture (condition of the hand where the fingers of the hand are in a hyperextended position [the extension of a body part beyond it's normal limits] at the knuckle joints and bent at the fingertips) and had zero degrees of PROM (normal is 70 to 90 degrees ROM) at the right wrist in an upward position. The OT Eval indicated Resident 60's ROM in the left arm was impaired at the shoulder, wrist, and hand. The OT Eval indicated Resident 60 was unable to straighten the fingers of the left hand and indicated a two-inch gap between the fingertips of the left hand and crease in the palm of the hand. The OT Eval indicated Resident 60 had zero degrees of PROM at the left wrist into an upward position. The OT Eval indicated OT recommended Resident 60 wear splints to both hands.<br><br>During a concurrent observation and interview on 8/20/2024 at 10:43 a.m., in Resident 60's room, Resident 60 was lying in bed. Resident 60's right arm was held out in front of her body at shoulder level with the elbow bent, wrist fully bent in a downward position, and fingers of the hand in a hyperextended (the extension of a body part beyond it's normal limits) position at the knuckles with the fingertips bent. Resident 60's left arm moved upwards to shoulder height, the elbow was slightly bent, and the hand was partially closed with the fingers bent at the knuckles and the fingertips. Resident 60 was observed shouting and asking for staff to assist in wrapping her right arm in a towel. Resident 60 stated she wanted her right arm wrapped in a towel because her arm was in pain, liked the warmth the towel provided to help with the pain, and needed the towel wrapped around the right forearm so she could use it to wipe her mouth since her both hands does not work. Licensed Vocational Nurse (LVN 5) was observed entering the room and wrapping Resident 60's right arm with a towel. LVN 5 stated Resident 60 constantly asked for her right arm to be wrapped in a towel and was unsure why. LVN 5 stated she thought Resident 60 liked her arm wrapped because the right arm was painful, and it helped her wipe her mouth since she could not bring her forearm to her mouth. LVN 5 stated Resident 60 was unable to use both hands for activities of daily living (ADLs, basic activities such as eating, bathing, and dressing) because they were contracted and required total care for mobility and ADLs.<br><br>During an interview with RNA 1 on 8/20/2024 at 12:59 p.m., RNA 1 stated the Director of Nursing (DON), all available RNAs, and the Director of Rehabilitation (DOR) met monthly to discuss any concerns with residents receiving RNA services, including if any resident experienced a decline in ROM or mobility. RNA 1 stated any concerns or declines observed during RNA sessions should be immediately reported to charge nurse and the Rehabilitation Department (Rehab) for re-assessment.<br><br>During an interview with the DOR on 8/20/2024 at 1:49 p.m., the DOR stated the facility monitored residents for changes and declines in ROM by JMS conducted upon admission and quarterly by the rehab department and quarterly by the MDS nurses along with report from staff of any observed changes or declines. The DOR stated the DOR, RNAs, Director of Staff Development (DSD), and the DON met monthly to discuss any concerns (in general) with residents receiving RNA services, including any declines, changes, or problems requiring re-assessment or intervention.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an observation of RNA session with Resident 60 in Resident 60's room on 8/21/2024 at 10:53 a.m., the resident was lying in bed with her right arm wrapped in a towel covering the hand, wrist, forearm, elbow, and lower half of the upper arm. Resident 60's right arm was held out in front of her body with the right elbow bent and the wrist bent downwards. Resident 60's left arm was resting at the side of her body with the elbow slightly bent, the wrist straight, and the fingers of the hand bent into a fist position. RNA 1 was observed attempted to assist Resident 60 with PROM exercises to the right arm, but Resident 60 reported increased pain and refused exercises. RNA 1 moved to the left side of the bed and provided PROM exercises to Resident 60's left shoulder, elbow, wrist, and hand. RNA 1 was unable to straighten all of Resident 60's fingers on the left hand and moved the left wrist in small motions side to side. Resident 60 stated she had pain with PROM exercises to the left wrist and hand with exercises. RNA 1 was observed attempted to place a hand splint (splint secured from the hand to the forearm to position the hand and wrist in a functional position) onto Resident 60's left arm but Resident 60 refused and stated the splint hurt. RNA 1 observed to bend the left-hand splint at the wrist and removed a cylindrical portion of the splint that supported the fingers of the hand. Resident 60 agreed to wear left hand splint after it was modified by RNA 1. RNA 1 placed the modified hand splint on Resident 60's left arm by securing the splint with straps around the wrist and forearm. The left-hand splint was observed not straightening or supporting the fingers of the hand. RNA 1 observed moved to the right side of the bed and tried to place a hand splint on Resident 60's right arm. Resident 60 refused and stated she wanted the cylindrical piece of the splint that supported the fingers removed because it hurt her hand. RNA 1 removed the cylindrical piece of the right-hand splint and placed it onto Resident 60's right arm by securing the splint with straps around the wrist and forearm. Observed the right-hand splint not straightening or supporting the fingers of the right hand.<br><br>During an interview on 8/21/2024 at 11:15 a.m. RNA 1 stated Resident 60 had been occasionally complaining of pain in both hands and wrists during exercises and when trying to place splints on both hands for a long time but did not recall when it started. RNA 1 stated he modified both hand splints by bending the wrist portion of the left-hand splint and removing the cylindrical portion of both splints that stretched the fingers because Resident 60 was unable to tolerate the stretch the splints provided due to tightness and pain in both hands and wrists. RNA 1 stated he had been providing exercises to Resident 60's both arms since last year and noticed both hands and wrists were intermittently (irregular intervals) getting tighter and more painful with exercises. RNA 1 stated he did not report the changes in Resident 60's ROM to a charge nurse. RNA 1 stated he should have informed the charge nurse and DOR and should have discussed the decline in Resident 60's ROM of both hands and both wrists in the RNA monthly meetings but did not. RNA 1 stated he thought he told the DOR at some point but was unsure and stated he had no documented evidence to indicate the charge nurse or DOR was informed of Resident 60's ROM changes. RNA 1 stated he should not have modified the splints without notifying the DOR. RNA 1 stated he should have stopped trying to put the splints on Resident 60's both hands when they did not fit properly and Resident 60 complained of pain, notified the Rehab Department (Rehab), and waited for the OT to reassess the resident to check for any changes and modify the splints if needed. RNA 1 stated if RNAs modified splints without notifying the licensed therapist (OT), the resident could potentially be harmed since RNAs did not have the proper training and qualifications to modify splints and determine the type of splint a resident need.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 8/21/2024 at 11:50 a.m., the DOR who, was an OT, confirmed OT fitted and issued a hand-splints to Resident 60. The DOR stated the purpose of splints was for contracture management and to increase ROM. The DOR stated Rehab issued splints to residents in the facility. The DOR stated the licensed therapist assessed the resident to determine the appropriate type of splint, set goals to determine if a resident tolerated the splint, established the splint wear schedule (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits), and eventually transitioned the resident to the RNA program. The DOR stated if the splints prescribed by the therapist were no longer fitting appropriately or no longer tolerated by the resident due to issues such as pain, the RNA should inform Rehab department, and charge nurse for OT to re-assess the resident splint. The DOR stated licensed therapists were the only staff members who should modify splints. The DOR stated she was unaware Resident 60 had a decline in ROM in both wrists and hands and was not informed by RNA Resident 60's hand splints were not fitting appropriately. The DOR stated if RNAs modified splints without notifying Rehab, the splint may not fit appropriately, and the splinting intervention may not be effective.<br><br>During an interview on 8/21/2024 at 12:04 p.m. the Director of Staff Development (DSD) stated the facility monitor residents for changes in ROM by the JMS's conducted by Rehab and nursing, communication with the RNAs in the monthly RNA meetings, and reports from any staff of any noticeable changes or declines in function. The DSD stated RNAs must notify the charge nurse of any changes in a resident's function such as increased pain, decrease in ROM, or if a splint was not fitting correctly to ensure the proper protocol was followed to ensure the resident received the appropriate treatment. The DSD stated RNAs were not allowed to modify splints because RNAs did not have the qualifications or training to determine the type of splint the residents needed. The DSD stated if a splint was not fitting correctly, it could indicate an area of concern that may require re-assessment. The DSD stated if RNAs modified splints without notifying Rehab department, it could cause skin breakdown and decline in ROM leading to further contracture development. The DSD stated once the charge nurse was notified, the charge nurse will complete a Change of Condition ([COC] a major decline or improvement in a resident's status that will not resolve itself without intervention) evaluation and notify the physician and licensed therapist for re-assessment.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review of Resident 60's clinical record with the DOR on 8/21/2024 at 2:59 p.m., the DOR stated Resident 60 was admitted to the facility on [DATE] with no ROM limitations and no contractures to both wrists, hands, and fingers. The DOR reviewed Resident 60's Admission OT JMS, dated 1/5/2023, and confirmed Resident 60 had full ROM of both wrists, hands, and fingers. The DOR reviewed Resident 60's OT Eval, dated 1/8/2023, and confirmed Resident 60 had WFL ROM on both elbows, wrists, and hands which meant Resident 60 had sufficient ROM to perform ADLs. The DOR reviewed Resident 60's OT Discharge Summary, dated 3/3/3023, and stated Resident 60 was discharged from OT services with recommendations for an RNA program for PROM to both arms and application of splints to both elbows for four to six hours, daily. The DOR stated daily meant seven times a week. The DOR stated she recommended elbow splints to both arms at the time of discharge from OT services because Resident 60 had tightness from increased muscle tone (amount of tension in the muscles) in both elbows. The DOR stated any additional splinting to both arms were unnecessary because Resident 60 had no ROM limitations to both wrists and both hands at the time. The DOR reviewed Resident 60's Annual OT JMS, dated 1/28/2024, and confirmed Resident 60 had severe ROM limitations in both wrists and both hands and recommended an OT evaluation for skilled therapy services. The DOR reviewed Resident 60's OT evaluation, dated 1/30/2024, and confirmed Resident 60 had contractures to both hands and both wrists and recommended resting hand splints to both hands for contracture management. The DOR stated Resident 60 had a decline in ROM and developed contractures to both hands and both wrists while in the facility. The DOR stated she was never notified by RNA or nursing staff of any declines in Resident 60's ROM of both arms. The DOR stated Resident 60's contractures to both hands and both wrists could have been prevented if nursing staff or RNA notified Rehab once they noticed a decline in Resident 60's ROM and if there were more frequent JMSs conducted to detect declines in ROM since Rehab only performed JMSs upon admission and annually.<br><br>During a concurrent interview and record review of Resident 60's clinical record with the DSD on 8/22/2024 at 2:03 p.m., the DSD stated the purpose of RNA services was to maintain a resident's current functional ability and prevent any declines in ADLs, mobility, and ROM. The DSD reviewed Resident 60's physician's orders and RNA Survey Reports for the months of March 2023 to October 2023. The DSD confirmed Resident 60 had physician's orders for RNA to provide PROM exercises to both arms and apply splints to both elbows, four to six hours daily, from March 2023 to October 2023. The DSD stated daily meant seven times a week. The DSD stated a blank square and the letter X on the RNA Survey Report indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 60 missed the following number of scheduled RNA services for the following months:<br><br>1. Nine days for the month of March 2023.<br><br>2. Ten days for the month of April 2023.<br><br>3.Eight days for the month of May 2023,<br><br>4. Eight days for the month of June 2023.<br><br>5. Ten days for month of July 2023.<br><br>6. Eight days for the month of August 2023,<br><br>7. Nine days for the month of September 2023.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 8. Ten days for the month of October 2023.<br><br>The DSD stated Resident 60 did not receive RNA treatments as ordered by the physician for unknown reasons. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline and contractures.<br><br>During a concurrent interview and record review on 8/23/2024 at 10:39 a.m., with the Minimum Data Set Nurse (MDSN) on 8/23/2024 at 10:39 a.m., Resident 60's clinical record was reviewed. The MDSN stated the facility monitor for changes in joint ROM through JMSs performed by nursing and Rehab. The MDSN stated Rehab performed a detailed JMS of a resident's arms and legs upon admission and annually. The MDSN stated the MDSN and Minimum Data Set Assistant performed quarterly JMSs to assess a resident's general ROM in both arms and both legs to check for declines and checked the effectiveness of the services the resident was receiving such as RNA or skilled therapy. The MDSN stated any declines in ROM found in the nursing quarterly JMS were reported to Rehab for further assessment and a COC process would be initiated. The MDSN reviewed Resident 60's clinical record and confirmed no nursing quarterly JMS to monitor for ROM declines were conducted for Resident 60 between Resident 60's admission on 1/4/2023, on OT JMS, dated 1/4/2024, and the annual OT JMS, dated 1/28/2024. The MDSN stated Resident 60 should have had nursing quarterly JMSs to check Resident 60's ROM declines and completed in the months of 4/2023, 7/2023, and 10/2023 but did not. The MDSN stated the only JMSs Resident 60 received in the year of 2023 was by the Rehab upon admission (1/4/2023) and was not monitored quarterly throughout the year per facility policy. The MDSN stated the facility had three opportunities in 2023 when the nursing quarterly JMSs were due to detect a decline in Resident 60's arms and check if the current RNA program was effective but did not because the quarterly nursing JMSs were not done. The MDSN stated it was important to complete JMSs upon admission, quarterly, and annually to monitor for any declines in ROM and to ensure the facility could identify and provide the appropriate services the resident needs. The MDSN stated if joint ROM was not monitored routinely, the resident could have a functional decline and develop contractures.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 8/23/2024 at 1:11 p.m., the DON stated the facility monitor for changes in ROM by multiple JMSs performed by nursing or Rehab upon admission, quarterly, and annually and by staff observation and report of any declines to the appropriate staff. The DON stated any change of condition noticed during routine nursing care or during RNA sessions such as a decline in ROM must be reported to the charge nurse who then completed a COC evaluation and notified the physician and licensed therapist for re-assessment. The DON reviewed Resident 60's Admission OT JMSs, dated 1/5/2023, and confirmed Resident 60 had full ROM of both wrists, hands, and fingers upon admission to the facility. The DON reviewed Resident 60's OT Evaluation, dated 1/8/2024, and confirmed Resident 60 had WFL ROM in both elbows, wrists, and hands upon admission to the facility. The DON reviewed Resident 60's OT Discharge Summary, dated 3/3/3023, and confirmed Resident 60 was discharged from OT services with recommendations for an RNA program for PROM to both arms and application of splints to both elbows for four to six hours, daily. The DON stated daily meant Resident 60 should be receiving RNA services seven times a week. The DON reviewed Resident 60's RNA Survey Reports from March 2023 to October 2023 and confirmed Resident 60 did not receive RNA services 7 days a week as ordered from March 2023 to October 2023. The DON reviewed Resident 60's Annual OT JMS, dated 1/28/2024, and confirmed Resident 60 had severe ROM limitations in both wrists and both hands and a skilled OT evaluation was recommended. The DON reviewed Resident 60's OT Eval, dated 1/30/2024, and confirmed Resident 60 had contractures to both hands and both wrists and OT recommended hand splints to both hands for contracture management. The DON reviewed Resident 60's clinical record and confirmed no quarterly JMSs were completed by nursing or the Rehab to monitor for ROM declines between the admission, OT JMS, dated 1/4/2024, and the annual OT JMS, dated 1/28/2024. The DON stated Resident 60 had a decline in ROM and developed contractures to both hands and wrists while in the facility. The DON stated she was never notified by RNA or nursing of any declines in Resident 60's ROM of both arms. The DON stated RNA should have notified the change nurse or discussed Resident 60's decline in ROM in the monthly RNA meetings to ensure a COC was completed, the physician was notified, and OT re-assessed Resident 60 to ensure the proper interventions were provided to prevent the contractures. The DON stated the quarterly JMSs should have been done every three months after admission to monitor for declines in ROM and ensure the appropriate services were provided to prevent contractures but were not done. The DON stated the facility could have caught the decline in ROM of Resident 60's both hands and both wrists earlier if quarterly JMSs were done and could have prevented the contractures. The DON stated the development of Resident 60's both wrists and both hands contractures was avoidable. The DON stated Resident 60's contractures could have been prevented if RNA reported the decline in Resident 60's ROM to both hands and both wrists to the charge nurse, if the quarterly JMSs were completed to monitor for ROM declines, and if RNA provided RNA services for PROM and splinting seven times a week as ordered by the physician.<br><br>During an interview on 8/23/2024 at 1:11 p.m., the DON stated Rehab assessed and issued splints to the residents in the facility. The DON stated Rehab was the only staff in the facility who should modify splints since it was their expertise. The DON stated Rehab assessed splints specific to each resident and determined the appropriateness of the splint, resident's tolerance to the splint, and made any adjustments as necessary. The DON stated RNAs cannot modify splints because they did not have the knowledge and qualifications to determine what residents need. The DON stated if splints were not fitting correctly and required modification, the RNA should notify Rehab and charge nurse, a Change of Condition (COC, major decline or improvement in a resident's status that will not resolve itself without intervention) evaluation would be completed, the physician would be notified, and Rehab would re-assess the resident and modify the splint as needed.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of the facility's Policy and Procedure (P&P) undated, titled, Joint Mobility Assessment, the P&P indicated the purpose of the Joint Mobility Assessment was to determine a resident's ROM for all major joints and to implement plans of care to increase, maintain, or reduce a decline in joint mobility. The P&P indicated all residents shall be assessed for joint mobility limitations upon admission and reviewed every three months thereafter. The P&P indicated limitations in the joint mobility shall be defined in the following terms: WNL describes full ROM, no limitations, resident has access to 100% normal ROM .and severe which represented limitations in joint mobility greater than 75% to approximately 100% of the normal ROM. The P&P indicated the licensed nurse shall assess the program's effectiveness and the resident response to treatment on a weekly basis in the licensed weekly summary. The P&P indicated therapy evaluations may be requested if programs provide ineffective or complications occur requiring therapy expertise.<br><br>During a review of the facility's undated P&P titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated nursing would identify the resident's current ROM of his or her joints and limitations in movement as part of the comprehensive assessment and develop a plan of care to include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve ROM.<br><br>During a review of the facility's job description titled, Restorative Nursing Assistant, dated 1/27/2022, the job description indicated RNA assisted residents in reaching their maximal potential in collaboration with the Therapy Department and under the supervision of the Charge Nurse. The RNA job description indicated the RNA's essential duties and responsibilities included reporting and charting significant changes in a resident's condition and notifying the OT and Physical Therapy of any referrals and reassessment needs.<br><br>During a review of the facility's undated Policy and Procedure (P&P) titled, S [TRUNCATED] |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on observation, interview, and record review the facility failed to ensure measurement of siderails to the bedframe and mattress were implemented and documented prior to installation of a full side rails to the bed of four of four sampled residents (Resident 55 and Resident 69, 14 and 80).<br><br>This failure had the potential to physical harm from possible entrapment (when a person is trapped by the bed rail in a position they cannot move from) from the use of bed rails for Resident 55 and Resident 69, 14 and 80.<br><br>Findings:<br><br>a.During a record review of Resident 55's Admission Record (Face sheet), the face sheet indicated Resident 55 was admitted at the facility on 4/26/2022 and was readmitted on [DATE] with diagnoses including chronic respiratory failure (a condition that usually happens when the airways that carry air to the lungs become narrow and damaged) and traumatic brain injury (a condition that occurs when a sudden trauma, such as a blow or jolt to the head, causes damage to the brain).<br><br>During a review of Resident 55's Physician Order Summary dated 8/1/2024, the Physician Order Summary indicated Resident 55 had the following orders:<br><br>1. Bilateral (both) full siderails up when in bed for safety and protection secondary to involuntary movement to gravity due to elevated head of the bed for management of the tracheostomy (an opening surgically created through the neck in to the trachea [also known as windpipe] to allow air to fill the lungs) and provision of enteral feeding (a form of liquid nutrition/food fed through a tube into the stomach), ordered 1/6/2023, and<br><br>2. Low Airloss Mattress (a type of medical mattress designed to reduced pressure on the skin by air which is continuously operated by electric power) for skin integrity and management every shift, ordered 1/10/2024.<br><br>During an observation on 8/19/2024 at 10:03 a.m., Resident 55 was lying in her bed on top of a low air loss mattress, in 45 (forty-five) degrees head of bed elevation and there were two full padded siderails on attached to each side of her bed. On the left side of the bed, there was a volleyball sized hole in between the lower rail of the siderail and the topside of the low airloss mattress.<br><br>b. During a review of Resident 69's Admission Record (Face sheet), the face sheet indicated Resident 69 was admitted at the facility on 10/13/2023 and was readmitted on [DATE] with diagnoses including chronic respiratory failure and epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]).<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 69's Physician Order Summary dated 8/1/2024, the Physician Order Summary indicated Resident 69 had an order of bilateral (both) full siderails up when in bed for safety and protection secondary to involuntary movement to gravity due to elevated head of the bed for management of the tracheostomy and provision of enteral feeding, ordered 2/27/2024.<br><br>49889<br><br>c. During a review of Resident14's Face sheet indicated Resident 14 was admitted on ,d+[DATE]/ 2020, and readmitted 11/ 20/2020, with diagnoses including epilepsy, and intellectual disabilities chronic condition that affects a person's intellectual and adaptive functioning.<br><br>During a review of Resident 14's History & Physical (H&P) dated 10/13/23, indicated Resident 14 does not have the capacity to understand and make decisions.<br><br>During a review of the Physician Order Summary dated 8/1/24 indicated Resident 14 had an order for bilateral full side rails up when in bed.<br><br>During a review of the Minimum Data Set Assessment (MDS, a standardized assessment and care screening tool), dated 6/19/2024, the MDS indicated Resident 14 was severely impaired for daily decision making.<br><br>45269<br><br>d. During a review of Resident 80's Admission Record (Face Sheet) , the Face Sheet indicated Resident 80 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage ( caused by a significant head injury where blood leaks out of a torn blood vessel below the space of brain and skull), gastrostomy (tube inserted through the wall of the abdomen directly into the stomach used to give medicine and liquid nutrition).<br><br>During a review of Resident 80's H & P dated 7/17/204, the H & P indicated Resident 80 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 80's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 80 was dependent on staff with bed mobility, toileting, bathing, dressing and personal hygiene.<br><br>During a review of Resident 80's Physician Order Summary dated 8/6/2024 indicated an order of bilateral full side rails up when in bed for safety and protection secondary to involuntary movement by gravity due to elevated head of bed for management of tracheostomy and provision of enteral feeding.<br><br>During an observation on 8/19/2024, at 11:05 a.m. in Resident 80's room, observed Resident 80's bed had a regular mattress and bilateral full padded siderails up.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/22/2024 at 10:00 a.m., the Maintenance Director (MD) stated the full siderails of the residents' beds were installed by him and he did not measure the bedrails and mattress/bedframe to determine compatibility, prior to installing the full siderails on the bed. MD stated the measurement of the bedrails, and the mattress/bedframe was necessary to identify the gap between siderail and the mattress/bedframe to prevent entrapment of the residents' arm/leg and any other part of their body.<br><br>During an interview on 8/23/2024 at 10 a.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 55 was at 45 degrees laying with a low air loss mattress for wound management and there was a gap on the left side of Resident 55's bed between the last rail of the siderail and the mattress/bed frame. CNA 1 stated a part of the resident's body can pass through the gap because the low airloss mattress can get deflated by accident causing the gap in between the siderail and the mattress/ bedframe of the bed to become wider/bigger that can cause an accident or injury to Resident 55.<br><br>During an interview on 8/23/2024 at 10:12 a.m., Registered Nurse Supervisor 1 (RNS 1) stated there could be a risk of entrapment for Resident 55 if the low air loss mattress deflates accidentally. RNS 1 stated the siderails and bed/mattress compatibility needed to be determined by the MD for the residents' safety.<br><br>During an interview on 8/23/2024 at 10:40 a.m., the Administrator (ADM) stated longer/ full siderails pose risks for injury to residents due to entrapment, the reason why regulations were on point as to the requirement of ensuring the residents' bed/ mattress was compatible with the siderails. The ADM stated the safety and well-being of the residents was part of MD's and all the staff's responsibility in the facility.<br><br>During a review of the facility's Policy and Procedure (P/P) on Bed Safety and Bed Rails revised 3/2023, the P/P indicated the following:<br><br>1.Residents beds must meet the safety specifications and regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or any part of their body and any gap in the bed system are within the safety dimensions established by the FDA.<br><br>2. Bed frames, mattresses and bedrails are checked for compatibility and size prior to use.<br><br>3. Bedrails are properly installed and used according to the manufacturer's instructions, specifications, and other pertinent safety guidance to ensure proper fit; and<br><br>4. Maintenance staff must routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Intercommunity Healthcare & Rehabilitation Center | 12627 Studebaker Road Norwalk, CA 90650 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130<br><br>Based on observation, interview, and record review, the facility failed to accurately account for the use of a controlled substance (a medication with a high potential for abuse) on Controlled Drug Record (CDR- a log signed by the nurse with the date and time each time a controlled substance is given to a resident) for one resident (Resident 44) in one out of three medication carts reviewed (Middle Medication Cart Sub-Acute).<br><br>This failure had the potential to result in unintended use of Tramadol (a controlled substance used to relieve and manage pain) and placed the facility and Resident 44 at risk for medication errors, drug loss and diversion.<br><br>Findings:<br><br>During a review of Resident 44's Admission Record (a document containing demographic and diagnostic information), dated 8/22/2024, the admission record indicated Resident 44 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis including, but not limited to, polyneuropathy (a medical term to describe weakness, numbness and burning pain due to damage of peripheral (areas outside of brain and spinal cord) nerves throughout the body.<br><br>During a review of Resident 44's History and Physical, dated 11/28/2023, the document indicated Resident 44 does not have the capacity to understand and make decisions.<br><br>During a review of Resident 44's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 7/24/2024, the MDS indicated Resident 44 was rarely or never understood. The MDS indicated Resident 44 was dependent for eating and required full assistance from the facility staff for other activities of daily living (tasks of everyday life that include oral hygiene, dressing, bathing, toileting, and personal hygiene).<br><br>During a review of Resident 44's Order Summary Report (a list of all currently active medical orders), dated 8/20/2024, the order summary report indicated the following medication order:<br><br>Ultram [generic name - Tramadol] Oral Tablet 50 milligrams (mg - a unit of measure for mass) (Tramadol Hydrochloride [HCl]) Give 1 tablet via gastrostomy tube ([G-tube] a soft tube surgically placed directly into the stomach for administration of medication and nutrition) every 12 hours for pain management related to (r/t) tracheostomy and gastrostomy, order date: 1/18/2024<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent observation and interview on 8/20/2024 at 2:34 p.m. with Licensed Vocational Nurse (LVN) 1, of the Middle Medication Cart Sub-Acute, Resident 44's medication card / bubble pack for Tramadol 50 mg indicated handwritten words 9 PM on label and showed 24 tablets remaining in the medication card / bubble pack. The CDR indicated 25 tablets remaining with the last dose administered on 8/18/2024 at 8:08 p. m. LVN 1 stated she did not document in the CDR after one tablet of Tramadol 50 mg was given to Resident 44 in the morning. LVN 1 stated the morning dose for Tramadol 50 mg was taken from PM (evening) medication card / bubble pack. LVN 1 stated the dose (1 tablet) from PM medication bubble pack was documented in the electronic medical record in the morning, but it was not documented on PM CDR.<br><br>During a concurrent interview and record review on 8/20/2024 at 3:05 p.m. with LVN 1, Resident 44's Administration Details for Ultram oral tablet 50 mg (Tramadol HCl), dated 8/20/2024 were reviewed. The administration details indicated tramadol 50 mg, 1 tablet was administered on 8/20/2024 at 11:23 a.m. LVN 1 stated the controlled substances should be documented in the book (CDR) and electronic medical record to keep track of them. LVN 1 stated controlled substances can be addicting so they are closely monitored. LVN 1 stated it was very important to document tramadol in CDR after it was administered to prevent drug diversion and misuse.<br><br>During an interview on 8/21/2024 at 2:34 p.m. with the Director of Nursing (DON), the DON stated after a controlled substance is administered to the resident, the electronic medical record should be documented because of the specific documented time. DON stated there would be a risk for drug diversion if a controlled substance was not documented in the CDR. DON stated, the book (controlled drug record) should also be signed and documented by the nurse after a controlled substance was administered to ensure that the medication was not stolen and to maintain patient safety. DON stated, the documentation in book is preventing medication errors, double-dosing, unintended use, medication theft and drug diversion.<br><br>During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, dated 3/2023, the P&P indicated, the facility complies with all laws, regulations, and other requirements related to administration, handling, storage, disposal, and documentation of controlled medications .Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift Upon administration, the nurse administering the medication is responsible for recording: name of the resident receiving the medication .signature of nurse administering medication. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on interview and record review the facility failed to ensure non-pharmacological interventions (intervention that does not primarily use medication) were ordered for three of three sampled residents (Resident 50,68, and 75) who were prescribed psychotropic (any drug or substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications.<br><br>This failure had the potential to result in use of unnecessary psychotropic drugs for Resident 50, 68, and 75 that can lead to side effect (effect of a drug or other type of treatment that is in addition to or beyond its desired effect) and adverse drug reaction (unintended, harmful events attributed to the use of medicines).<br><br>Findings:<br><br>a. During a review of Resident 50's Admission Record (Face Sheet) the face sheet indicated Resident 50 was admitted on [DATE] and was readmitted on [DATE] at the facility with diagnoses including chronic respiratory failure (a condition that usually happens when the airways that carry air to the lungs become narrow and damaged), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread and uneasiness).<br><br>During a review of Resident 50's Medication Administration Record (MAR) dated 8/1/2024 to 8/31/2024, the MAR indicated Resident 50 was:<br><br>1.On Ativan (an anti-anxiety medication) 0.5 milligram (mg-a unit of measurement) one tablet by mouth every eight hours as needed for anxiety as manifested by hyperventilating (rapid deep breathing caused by anxiety or panic) causing shortness of breath for 30 days, and<br><br>2.No non-pharmacological interventions were ordered and documented in Resident 50's MAR.<br><br>b.During a review of Resident 68's Admission Record (Face sheet), the face sheet indicated Resident 68 was admitted on [DATE] and was readmitted on [DATE] with diagnoses including malignant neoplasm of the tongue (a form of cancer in the tongue) and tracheostomy (an opening surgically created through the neck into the trachea [also known as windpipe] to allow air to fill the lungs).<br><br>During a review of the Resident 68's MAR dated 8/1/2024 to 8/31/2024, the MAR indicated Resident 68:<br><br>1.On Lorazepam (an anti-anxiety medication) tablet 0.5 mg one tablet through the gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach to give drugs, liquids, including food) every six hours as needed for anxiety as manifested by hyperventilating (rapid deep breathing caused by anxiety or panic) causing shortness of breath for 14 days, and<br><br>2.No non-pharmacological interventions were ordered and documented in Resident 50's MAR.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. During a review of Resident 75's Admission Record (Face sheet), the face sheet indicated Resident 75 was admitted at the facility on 4/12/2024 and was readmitted on [DATE] with diagnoses including chronic respiratory failure and anxiety disorder.<br><br>During a review of Resident 75's MAR dated 8/1/2024 to 8/31/2024, the MAR indicated Resident 75 was:<br><br>1. On Ativan 0.5 mg one tablet thru gastrostomy tube every six hours as needed for anxiety as manifested by hyperventilating causing shortness of breath for 14 days; and<br><br>2.No non-pharmacological interventions were ordered and documented in Resident 50's MAR.<br><br>During a concurrent interview and record review on 8/21/2024 at 1:21 p.m., Licensed Vocational Nurse 2 (LVN 2) confirmed Resident 50, Resident 68, and Resident 75, were not provided non-pharmacological interventions prior to administering psychotropic medications. LVN 1 stated it was important for non-pharmacological interventions to be provided for Resident 50, Resident 68, and Resident 75 to educate and/or provide ways to control the behavioral episodes rather than psychotropic medications, which can cause side effects and adverse reactions.<br><br>During an interview on 8/22/2024 at 12:23 p.m., the Director of Nursing Services (DON) stated non-pharmacological interventions must be provided to the residents prior to giving the psychotropic medications because the psychotropic medications are not necessary if the residents are relieved by the non-pharmacological interventions.<br><br>During a review of the facility's policy and procedure (P&P) on Psychotropic Medication Use revised 3/2023, the P/P indicated the residents of the facility will not receive medications that are not clinically indicated, and non-pharmacological approaches must be used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuing of the medications when possible. |

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130

Based on observation, interview, and record review, the facility failed to remove an expired insulin (a medication used to treat high blood sugar) per manufacturer's requirements, affecting one resident (Resident 56) in one of three inspected medication carts (Medication Cart 3 Back Cart.)

This failure had the potential to result in hyperglycemia (a medical term used to describe high blood sugar) and/or hospitalization for Resident 56 because of receiving an expired insulin that could have been ineffective or toxic due to improper storage conditions.

Findings:

During a review of Resident 56's Admission Record, dated 8/21/2024, the admission record indicated Resident 56 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis including, but not limited to, Type 2 Diabetes Mellitus (a medical condition characterized by the inability to control blood sugar) without complications.

During a review of Resident 56's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 7/19/2024, the MDS indicated Resident 56 was rarely or never understood. The MDS indicated Resident 56 was dependent for eating and required full assistance from the facility staff for other activities of daily living (tasks of everyday life that include oral hygiene, dressing, bathing, toileting, and personal hygiene).

During a review of Resident 56's Order Summary Report (a list of all currently active medical orders), dated 8/21/2024, the order summary report indicated the following list of medications:

Insulin Lispro (a medication in the category of insulin used to treat high blood glucose level) Injection Solution, Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 3; 201-250 = 4; 251-300 = 5; 301 - 350 = 6; 351 - 400 = 7; 401 - 450 = 8 Call Medical Doctor (MD), subcutaneously every Mon for DM Notify MD if blood sugar greater than 450 milligrams (mg - a unit of measure for mass) / deciliters (dL - a unit of measure for volume) or less than 70 mg/dL.

Insulin Glargine (a medication in the category of insulin used to treat high blood glucose level) Solution 100 units (a unit of measurement for insulin) / milliliters (mL - a unit of measure for volume) Inject 30 units subcutaneously in the morning for diabetes Hold if blood sugar is less than 110. Rotate injection site, order date: 7/5/2024, start date: 7/6/2024

Insulin Glargine Solution 100 units/mL Inject 42 units subcutaneously at bedtime for diabetes Hold if blood sugar is less than 110, order date: 12/13/2022, start date: 12/13/2022

During an observation and inspection on 8/21/2024 at 1:37 p.m. of Medication Cart 3 Back Cart with the Licensed Vocational Nurse (LVN) 6, the insulin listed below for Resident 56 was found expired, which was not in accordance with manufacturer's requirements and facility's policy and procedure.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
|---|---|---|---|
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Insulin Lispro 100 units/mL, 3 mL prefilled insulin delivery device for Resident 56, labeled with an opened date of 7/8/2024.<br><br>According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature (up to 77 Fahrenheit [( F) is a unit of temperature] or 25 Celsius [( C) is a unit of temperature]), Insulin Lispro pen must be used within 28 days or be discarded. Resident 56's Insulin Lispro expired on 8/5/2024.<br><br>During an interview on 8/21/2024 at 1:37 p.m. with LVN 6, LVN 6 stated the insulin should have been removed from the medication cart because it expired on 8/5/2024. LVN 6 stated the insulin would not be effective and blood sugar would not be well controlled, increasing the risk for hospitalization for Resident 56 due to hyperglycemia and other health complications. LVN 6 stated the instructions for the insulin order were to inject insulin subcutaneously (a medical term for under the skin) per sliding scale (a dosing schedule where the dose of insulin varies based on blood glucose level) every Monday.<br><br>During a review of Resident 56's Medication Administration Record (MAR - log of all medications given to resident), dated 8/1/2024 - 8/31/2024, the MAR indicated Insulin Lispro was administered as following:<br><br>8/5/2024: 3 units at 0600<br><br>8/12/2024: 3 units at 0600<br><br>8/19/2024: 3 units at 0600<br><br>During an interview on 8/21/2024 at 2:34 p.m., with the Director of Nursing (DON), the DON stated a medication should be removed from the medication cart immediately once it was discontinued or expired. DON stated licensed nurses should check to ensure no expired medications were administered to residents. DON stated if the expired insulin was administered to the resident, it would not be effective and safe to treat high blood sugar increasing the risk for hyperglycemia, coma, and hospitalization for Resident 56.<br><br>During a review of the facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures, dated 4/2008, the P&P indicated, Check expiration date on package/container .when opening a multi-dose container, place the date on the container.<br><br>During a review of the facility's P&P titled, Insulin Storage Guidelines, dated 9/2017, the P&P indicated, Humalog (insulin lispro) is to be used within 28 days if it is opened, stored at refrigerated temperature 36-46 F or at room temperature below 86 F.<br><br>During a review of the facility's P&P titled, Labeling of Medication Containers, dated 3/2023, the P&P indicated, labels for individual resident medications include all necessary information, such as: appropriate accessory and cautionary statements when applicable, the expiration date when applicable.<br><br>During a review of the facility's P&P titled, Administering Medications, dated 3/2023, the P&P indicated, the expiration/beyond use date on the medication label is checked prior to administering. |

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F 0801

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.

45269

Based on observation, interview and record review, the facility failed to ensure a dietary aide was knowledgeable on how to identify the amount of chlorine level in the dish washing machine by failing to:

a. Ensure the chlorine level is 50 to 100 parts per million (PPM, concentration of chlorine used to sanitize dishes) of the dishwashing machine after the final rinse.

b. Ensure the dish washing machine was checked and monitored for the right temperature of water and correct amount of chlorine before using.

These failures had the potential to place residents at risk for food-borne illnesses due to improper testing of chlorine level of the dishwashing machine.

Findings:

a. During a concurrent kitchen tour observation and interview on 8/19/2024, at 8:45 a.m. with Dietary Aide (DA 1), observed DA 1 ran the dishwashing machine and took a test strip to check the chlorine level of the water on the surface of a pitcher and resulted to 100 ppm. DA 1 stated the facility is using low temperature dish washing machine and she stated the chlorine level should be 200 ppm. DA 1 took another test strip to recheck the chlorine level after the final rinse and stated the chlorine level reading was still 100 ppm. DA 1 stated she had to change the solution so the test strip would read 200 ppm because it was almost empty.

During an interview on 8/20/2024, at 11:35 a.m. with DA 2, DA 2 stated they follow 100 ppm of chlorine not 200 ppm when dishwashing machine is checked for chlorine level after the final rinse.

b.During a concurrent interview and record review of kitchen's Dish Machine Temperature Log on 8/19/2024, at, 8:48 a.m. with DA 1, the Kitchen's Dish Machine Log indicated the dish washing machine was checked 8/18/2024 and the temperature was 120 degrees Fahrenheit (F, unit of measurement) and the chlorine level was 50 ppm for breakfast, lunch, and dinner and no documentation for 8/19/2024. DA 1 stated the dishwashing machine was not yet checked today for temperature or chlorine level.

During a subsequent interview on 8/19/2024, at 8:50 a.m. and on 8/21/2024, at 10:31 a.m. with DA 3 stated the dishwashing machine should be checked first for chlorine level and temperature before using it to wash dishes to ensure the machine had the right temperature and is working properly. DA 3 stated the chlorine level should be 50 to 100 ppm and the temperature should be 135 degrees F. DA 3 stated they checked the chlorine level at the final rinse of the dish washing machine cycle. DA 3 stated she checked the dish washing machine on the beginning of her shift for temperature and chlorine level for 50 to 100 ppm to kill the bacteria present on the dirty dishes. DA 3 stated right temperature and correct chlorine level will prevent food-borne illnesses which can cause diarrhea or vomiting among the residents.

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/22/2024, at 9:32 a.m. with [NAME] (CK 2), CK 2 stated the kitchen staff had to ensure they follow chlorine level of 50 to 100 ppm to ensure they are using the correct amount of chlorine when washing the dishes. CK 2 stated if the dishwashing machine was using more chlorine than the recommended amount it could be dangerous to the resident and the dish washing machine should be checked first before using to ensure it is safe to use.<br><br>During an interview on 8/22/2024, at 10:14 a.m. with Registered Dietician (RD), RD stated the chlorine level in the dishwashing machine supposed to be 50 to 100 ppm to ensure the whole cycle was sanitizing the whole dishes. RD stated if the solution had too much chlorine meant the dish washing machine was not sanitizing the dishes properly.<br><br>During a review of facility's policy and procedure( P/P) undated, the P/P indicated a temperature and chlorine log will be kept and maintained by the dish washer to ensure that the dish machine is working properly. The P/P indicated the dishwasher will run the dish machine before washing of dishes until temperature and chlorine level is within manufacturer's guidelines. The P/P indicated temperature should be 120- 135 degrees F and chlorine level is 50 -100 ppm for low temperature dish machine.<br><br>During a review of facility's dishwashing machine manufacturer's guideline, the manufacturer's guideline indicated to use correct chlorine test strips to test for proper chlorine sanitizer levels at no less than 50 ppm and no higher than 100 ppm for low temperature dish machine.<br><br>During a review of facility's Job Description of Dietary Aide /Dishwasher dated 1/27/2022, the Job Description of Dietary Aide / Dishwasher indicated the responsibilities and duties included following all policies and procedures regarding sanitation, safety, procedures for proper method of dishwashing machine such as checking the temperature and chlorine level and reporting to Dietetic Service Supervisor if the machine is not operating properly. The Job Description of Dietary Aide / dishwasher indicated one of the essential duties of a Dietary Aide is to follow assigned cleaning / sanitizing schedules, sweeps and mops the kitchen floors. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269<br><br>Based on observation, interview and record review, the facility failed to:<br><br>a. Ensure staff's personal items were not stored in the refrigerator and dry storage area.<br><br>b. Ensure frozen food items were safely stored in the freezer.<br><br>c. Ensure open food items are stored properly in the storage area.<br><br>d. Ensure the [NAME] performed hand washing and change of glove after and before switching tasks in the kitchen.<br><br>e. Ensure the drain area of ice machine was clean and free of grime.<br><br>These failures had the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another).<br><br>Findings:<br><br>a. During an initial kitchen tour observation on [DATE], at 8:13 a.m. a tumbler was stored in the reach in refrigerator. [NAME] (CK2) stated the tumbler belonged to a kitchen personnel and should not be stored in the refrigerator.<br><br>During a concurrent observation and interview on [DATE], at 8: 16 a.m. with CK 2 in the dry storage area of the kitchen, two lunch bags, a purse and a cup of coffee were stored in the storage area. CK 2 stated the kitchen staff placed their bag and lunch bags most of the time in the storage area.<br><br>During an interview on [DATE], at 10:31 a.m. with Dietary Aide (DA 3), DA 3 stated lunch bags should not be stored in the dry storage area and should be kept in the break room because of infection control and could cause cross contamination of residents' food.<br><br>During an interview on [DATE], at 11:21 a.m. with Dietary Manager (DM) , DM stated kitchen staff personal belongings do not belong in the kitchen because of possible cross contamination and infection control issues.<br><br>During a review of facility's policy and procedure (P/P) titled Dietary-Infection Control undated, the P/P indicated employee personal belongings such as clothing, food, cell phone etc. should be stored in a separate area away from food or items used in for food service.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
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| NAME OF PROVIDER OR SUPPLIER Intercommunity Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 12627 Studebaker Road Norwalk, CA 90650 | |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. During a concurrent observation and interview on [DATE], at 8:33 a.m. with CK 2, an open bag of frozen corn was inside a brown box, open frozen hotdogs with ice crystals with an open date of [DATE], and frozen sliced ham with freezer burns without open date or received date on the bag were observed kept in the freezer.CK 2 stated the frozen hotdogs and sliced hams will be discarded because they are too old and expired. CK 2 stated the bag of frozen corns should be tied and closed to keep the bag sealed and frozen item fresh.<br><br>During an interview on [DATE], at 10:31 a.m. with DA 3, DA 3 stated all kitchen personnel is responsible in ensuring expired food items are removed and not kept in the freezer and refrigerator. DA 3 stated residents could get food borne illness if these expired food items were served to the residents.<br><br>During a review of facility's P/P titled Refrigerator/ Freezer Storage undated, the P/P indicated all items should be properly covered, dated, and labeled. The P/P indicated food items should have the following such as delivery date open date and thaw date. The P/P indicated frozen food taken from the original packaging should be labeled, dated and food with freezer burn should be discarded and no food item that is expired or beyond the best buy date should be stored.<br><br>c.During a concurrent observation and interview on [DATE], at 8:16 a.m. with CK 2, observed an open plastic bag of corn flakes cereal sealed by a tape and an open bag of cheerios cereal with a masking tape loosely securing the opening of the bag on the shelf of the dry storage area.<br><br>During an interview on [DATE], at 11:21 a.m. with DM, DM stated cold cereal is placed in a container with a lid , labeled with date received, name of item and expiration date or best by date.<br><br>During an interview on [DATE], at 9;32 a.m. with CK 2, CK 2 stated cold cereals should be transferred in a plastic container to keep them fresh. CK 2 stated the staff labeled the cold cereal by putting received date and open date.<br><br>During an interview on [DATE], at 10:14 a.m. with Registered Dietician(RD), RD stated presence of ice crystals on frozen meat meant the food could have been defrosted and was returned in the freezer. RD stated frozen items that have ice crystals should not be used because of the quality and residents could get sick of food borne illness.<br><br>During a review of facility's P/P titled Storage of Canned and Dry Goods undated, the P/P indicated plastic or metal containers with tight fitting lids or resealable plastic bags will be used for staples and opened packages like pasta, rice, cereal, flour and will be dated , labeled when placed in a container. The P/P indicated to remove food from packaging boxes upon delivery and loose items should be placed in a container or bins to minimize occurrence of pests.<br><br>d. During a tray line observation on [DATE], at 12:35 p.m. observed [NAME] (CK 1) chopping tomatoes with gloves and CK 2 handed him a plate of several pieces of turkey to be prepared for residents who are in mechanical diet (food that can be blended, mashed, or chopped using a kitchen tool like a blender or food processor). Observed CK1 placed the sliced turkeys on the blender without performing handwashing or change of gloves then he proceeded to the dishwashing area of the kitchen, washed a pitcher and crates with same gloves. Observed CK 1 went to the sink of the preparation area and washed the blender jar then went back into chopping tomatoes with same gloves and without handwashing performed after each task.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE], at 2:06 p.m. with CK 1, CK 1 stated he should have washed his hands and changed gloves every time he switched task because of cross contamination which could lead to food borne illnesses among residents.<br><br>During an interview on [DATE], at 11:21 a.m. with DM, DM stated CK 1 should have practiced hand washing and changed his gloves after each task to prevent cross contamination and spread of infection among residents.<br><br>During an interview on [DATE], at 10:14 a.m. with RD, RD stated CK 1 should perform hand washing and change gloves when switching to different tasks because it could spread cross contamination from the dirty gloves and spread infection among the residents.<br><br>During a review of facility's P/P titled Dietary -Infection Control undated , the P/P indicated to wash hands when beginning a different task, during food preparation, as often as necessary when it gets soiled and when changing task to prevent cross contamination. The P/P indicated disposables gloves are to be worn as single use item and should be discarded after each use.<br><br>e. During an initial tour observation and interview on [DATE], at 8:50 a.m. with CK 2, the floor at the back of the ice machine and area around the drainage tube of the ice machine had grime and dirt.CK 2 stated the floor and the area around the drainage of ice machine should not looked like that.<br><br>During an interview on [DATE], at 2:06 p.m. with CK 1, CK 1 stated nobody was cleaning the floor and the area where the ice machine was. CK 1 stated it was supposed to be done by the dishwasher or dietary aide who mopped the floor usually in the morning after washing the dishes. CK 1 stated preparation of food for the residents occurred in the kitchen so it should be clean and sanitary to prevent cross contamination that could get residents sick.<br><br>During an interview on [DATE], at 1:21 a.m. with DM, DM stated the surrounding area of the ice machine and where drainage tube was located should be clean because of possible cross contamination and infection control issues.<br><br>During an interview on [DATE] , at 9:32 a.m. with CK 2, Ck 2 stated all the people in the kitchen was responsible in keeping the kitchen clean. CK 2 stated housekeeping was not allowed to clean the kitchen and the person cleaning the kitchen's floor is gone. CK 2 stated the area around the ice machine looked bad and it should be clean to prevent cross contamination and spread of infection among the residents.<br><br>During a review of facility's P/P titled Dietary -Infection Control undated, the P/P indicated food service employees will follow infection control policies to ensure the department operates under sanitary condition. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on observation, interview, and record review, the facility failed to observe infection control measures on nine of 20 sampled residents (Resident 3,17, 20, 22, 33, 37, 60, 68 and 76) by failing to:<br><br>a.Ensure the soiled tracheostomy (an opening surgically created through the neck into the trachea [also known as windpipe] to allow air to fill the lungs) supplies of (Resident 68 was disposed properly by the licensed staff.<br><br>b.Ensure Certified Nursing Assistant (CNA) 3 wore personal protective equipment (PPE, specialized clothing or equipment worn by an employee for protection against infectious materials) who was on Enhanced Barrier Precaution (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms) during mealtime for Resident 33.<br><br>c.Ensure physician observed Contact Isolation precautions (precautions used for disease, germs and infection that are spread by touching the patient and items in the room) for Residents 3, 17, 37 and 76.<br><br>d.Ensure Restorative Nursing Assistant 1 ([RNA 1] certified nursing aide program that helps residents to maintain their function and joint mobility) used the appropriate cleaning agent to effectively clean and disinfect a cloth gait belt (safety device worn around the waist that can be used to help safely transfer a person from one surface to another or while walking) after completing RNA walking exercises with Resident 20.<br><br>e. Ensure RNA 1 wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while providing RNA services to Resident 60 who was on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms).<br><br>f. Ensure RNA 2 performed hand hygiene after removing splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) from Resident 22's both arms and both legs.<br><br>Findings:<br><br>a. During a review of Resident 68's Face sheet, the face sheet indicated Resident 68 was admitted on [DATE] and was readmitted on [DATE] with diagnoses including malignant neoplasm of the tongue (a form of cancer in the tongue) and tracheostomy (an opening surgically created through the neck into the trachea [also known as windpipe] to allow air to fill the lungs).<br><br>During a review of the Resident 68's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/13/24, the MDS indicated Resident 68 was able to make independent decisions that were reasonable and consistent.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a observation on 8/19/2024 at 9:34 a.m., Resident 68 was observed with a tracheostomy tube that was scantly filled with bright red secretions and he was looking at the open trash can beside his bed, which contained a tracheostomy extension tube that was soiled with bloody secretions.<br><br>During a concurrent observation and interview on 8/19/2024 at 9:52 a.m., Licensed Vocational Nurse 1 (LVN 1) confirmed the presence of the soiled tracheostomy supplies in the open trash can beside Resident 68's bed. LVN 1 stated the soiled respiratory supplies that were contained inside the open trash can was unacceptable due to risk of exposure to microorganisms.<br><br>During an interview on 8/20/2024 at 4:58 p.m., Respiratory Therapist (RT 1) stated the soiled respiratory supplies should have been bagged and disposed of immediately in the biohazard waste (agent or condition that constitutes a hazard to humans or the environment) container located at a designated area outside the facility.<br><br>During an interview on 8/20/2024 at 4:58 p.m., the Infection Preventionist Nurse (IPN) stated bodily fluids have harmful microorganisms that can transmit infection to the residents, staff, and visitors, thus, soiled tracheostomy supplies should be double bagged and disposed in a biohazard waste container immediately.<br><br>During an interview on 8/202/2024 at 5L15 p.m., the Director of Nursing Services (DON) stated infection control was a collective process and must be implemented by all staff of the facility and one of it was the proper disposal of the soiled respiratory supplies.<br><br>During a review of the facility's Policy and Procedure (P/P) on Medical Waste, handling of revised 9/2010, the P/P indicated the facility must handle the medical wastes in the facility in a safe manner by:<br><br>a. double bagging the items soiled with visible blood, and<br><br>b. disposing/storing the soiled items in the biohazard unit until removal from the premises.<br><br>45269<br><br>b. During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including down syndrome( genetic condition where a person is born with mental and physical challenges during their lifetime), schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and diabetes (a condition in which the body fails to process glucose (sugar) correctly ) .<br><br>During a review of Resident 33's History & Physical (H & P) dated 8/5/2024, H&P indicated Resident 33 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 33's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 8/6/2024, the MDS indicated Resident 33 was dependent on the staff with eating, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of Resident 33's Physician Order Summary Report dated 8/5/2024, the Physician Order indicated Resident 33 was on Enhanced Barrier Precautions due to history of multidrug resistant organism (MRDO, bacteria resistant to many antibiotics).<br><br>During a review of Resident 33's Care Plan, titled Enhanced Barrier Precaution due to colonization (presence of a microorganism on a host without causing a disease) of MDRO initiated 8/5/2024 indicated interventions included providing gloves, gowns, and masks for enhanced barrier precaution.<br><br>During a concurrent observation and interview on 8/19/2024, at 1:17 p.m. in Resident 33's room with CNA 3, CNA3 was wearing a surgical mask without a pair of gloves sitting in a chair feeding Resident 33. Observed a signage of EBP posted in the wall before entering the room. CNA 3 stated Resident 33 was on EBP because of the resident's wound in her bottom. CNA 3 stated Infection Preventionist Nurse (IPN) told them not to wear PPE during feeding a resident but other activities of daily living (ADL, basic skills to carry out tasks of everyday life) PPE will be used.<br><br>During an interview on 8/19/2024, at 2:33 p.m. with IPN admitted she had given the CNA's not to wear a PPE for residents on EBP during feeding because it was not considered a high contact resident care activity. IPN stated the CNA had spent a lot of time feeding Resident 33 and should have worn PPE because it was a close contact activity. IPN stated not wearing the recommended PPE could lead to cross contamination and spread of infection among the staff and residents.<br><br>During a review of facility's policy and procedure (P&P) titled Enhanced Barrier Precautions dated 6/5/2024, the P&P indicated EBP are used as an infection prevention and control intervention to reduce the spread of MDRO to residents. The P&P indicated colonized residents are at risk of developing invasive infections that can be transmitted to other residents.<br><br>c.During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic respiratory failure (develops when the lungs could not get enough oxygen into the blood) , dependence on respirator(breathing machine), personal history of methicillin resistant staphylococcus aureus (MRSA , bacteria that does not get better with the type of antibiotics that usually cure staphylococcal infections), tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck), and gastrostomy( G-Tube, surgical procedure that creates an opening in the abdomen and into the stomach to provide nutritional support or administration of medicine).<br><br>During a review of Resident 3's H&P dated 3/24/2024, the H&P indicated the resident did not have the capacity to make decision and understand.<br><br>During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was dependent on staff with bathing, oral hygiene, bed mobility, transfer, toileting hygiene and dressing.<br><br>During a review of Resident 3's Physician Order Summary Report dated 4/1/2024, indicated an order for Contact Isolation Precautions for Carbapenem Acinetobacter Baumanii (CRAB, multi drug resistant organism that do not respond to common antibiotics) and Carbapenem resistant Pseudomonas aeruginosa (CRE, a group of bacteria that are resistant to one or several antibiotics) in sputum (phlegm).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of Resident 3's Care Plan titled Contact Isolation due to CRE and CRAB in the sputum initiated 4/10/2024, indicated goal of reducing the risk of complications and infection. The Care Plan's interventions included to observe contact isolation precaution and isolate resident as indicated.<br><br>During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic respiratory failure, tracheostomy, gastrostomy diabetes and anoxic brain damage (when brain loses oxygen supply causing serious and permanent cognitive problems and disabilities).<br><br>During a review of Resident 17's H&P dated 10/17/2023, the H & P indicated Resident 17 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 17's MDS dated [DATE], the MDS indicated the resident was dependent on staff with bed mobility, oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 17's Care Plan titled Resident had CRE in the urine and required contact isolation dated 4/10/2024, the Care Plan indicated interventions included observing contact isolation precaution and will isolate or cohort resident as indicated.<br><br>During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including gastrostomy, anoxic brain damage, and epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]).<br><br>During a review of Resident 37's H&P dated 5/23/2024, the H&P indicated Resident 37 did have the capacity to understand and make decisions.<br><br>During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 was dependent on staff with bed mobility, oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 37's Physician Order Summary Report dated 5/24/2024, indicated an order for Contact Isolation for CRE in the sputum (mixture of saliva and mucus coughed up from the lungs).<br><br>During a review of Resident 37's Care Plan titled Resident was on contact isolation for CRE in the sputum. dated 5/24/2024, indicated interventions included to observe contact isolation precaution, and isolate or cohort resident as indicated.<br><br>During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including tracheostomy, gastrostomy, quadriplegia (condition that causes partial or total loss of function in the arms, legs, and torso), and diabetes.<br><br>During a review of Resident 76's H & P dated 8/2/2024, the H & P indicated the resident had the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of Resident 76's MDS dated [DATE], the MDS indicated Resident 76 was dependent on staff with bed mobility, oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene.<br><br>During a review of Resident 76's Physician Order Summary Report dated 8/1/2024, the Order Summary Report indicated an order of Contact Isolation Precautions for CRAB in the sputum.<br><br>During a review of Resident 76's Care Plan titled Resident was on contact isolation for CRAB in the sputum , indicated interventions included to observe contact isolation precaution, and educate family and resident regarding isolation precautions.<br><br>During an observation on 8/19/2024, at 1:46 p.m., observed physician (MD 1) entered Resident 3 and Resident 76 's room without a gown, wearing a pair of gloves and N 95 mask (high filtering respirator). Observed a signage posted on the wall near the door of residents 'room indicating Contact Isolation precautions should be observed before entering.<br><br>During an observation on 8/19/2024, at 2;14 p.m., MD 1 entered Resident 17 and Resident 37's room wearing a pair of gloves and N95 mask worn below the nose and spoke to Resident 17. Observed a signage indicating Contact isolation precaution posted on the wall near the door of Resident 17 and 37's room.<br><br>During an interview on 8/19/2024, at 2:16 p.m. with Administrator (ADM), ADM stated MD 1 was the director of subacute care unit (level of care for individuals needing services that are more intensive than those typically receiving skilled nursing care).<br><br>During an interview on 8/21/2024, at 1:07 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated Residents 3, 17, 37 and 76 were on Contact isolation Precautions and the staff should do hand washing, wear a gown, gloves, and mask before entering their rooms. LVN 2 stated staff could not go in there with just a pair of gloves and mask because your arm or clothing could touch the surfaces of the bed, table or equipment or sputum. LVN 2 stated the practice of not wearing correct PPE could cause cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread the infection to other residents or staff members.<br><br>During an interview on 8/19/2024, at 2:24 p.m. with IPN, IPN stated Resident 17, Resident 37, Resident 3, and Resident 76 were on Contact isolation. IPN stated every time a staff member or a physician enter the room of a resident on Contact Isolation, the staff member should wear a gown, gloves, and mask. IPN stated MD 1 should have worn gown, gloves, and mask and not just a pair of gloves because it could spread infection to residents and staff members. IPN stated MD 1 had left the facility and would talk to him about his infection control practices.<br><br>During an interview on 8/22/2024, 1:10 p.m. with the Director of Nursing (DON), DON stated MD 1 should have worn gown, gloves, mask and change PPE in between residents because it could cause spread of infection among residents and staff.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of facility's P&P with MDRO's titled Isolation- Categories of transmission -Based Precautions revised 9/2022, the P&P indicated contact precautions are used for residents infected with MDRO's. The P/P indicated staff and visitors wear gloves and disposable gowns upon entering the room and remove before leaving the room. The P/P indicated staff and visitors should avoid touching potentially contaminated surfaces with clothing after the gown is removed.<br><br>45382<br><br>d. During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (chronic respiratory failure (long term condition that occurs when the lungs cannot get enough oxygen into the blood) and atherosclerotic heart disease (damage or disease in the heart's major vessels).<br><br>During a concurrent observation and interview on 8/21/2024 at 9:38 a.m., in the resident's room, Resident 20 was sitting in a wheelchair. RNA 1 placed a splint onto Resident 20's left leg that extended from the left thigh to the foot and placed a sling (flexible strap used to support and immobilize an injured part of the body) onto Resident 20's left arm. RNA 1 brought Resident 20 to the door entrance in the wheelchair and placed a cloth gait belt around Resident 20's waist. RNA 1 assisted Resident 20 to walk down the hallways intermittently (from time to time) holding onto the gait belt while following behind Resident 20 with a wheelchair. After completing walking exercises, Resident 20 sat in a wheelchair in the hallway. RNA 1 removed Resident 20's gait belt from around the waist, wiped the cloth gait belt with disinfectant wipes, rolled up the gait belt, and put it in RNA 1's pocket. RNA 1 stated the cloth gait belt was made of fabric and used disinfecting wipes disposable wipes to disinfect the cloth gait belt after use with Resident 20. RNA 1 stated it was important to properly clean and disinfect cloth gait belts before and after resident use to prevent the spread of infection.<br><br>During an interview on 8/21/2024 at 1:09 p.m., the Infection Preventionist Nurse (IPN) stated cloth gait belts were made of fabric, a porous (having small spaces or holes through which liquid or air may pass) material. The IPN reviewed the manufacturer instructions for the disinfectant disposable wipes and confirmed the wipes were to be used on hard, non-porous surfaces only for disinfection. The IPN stated cloth gait belts should not be cleaned and disinfected with any type of disposable wipes after resident use because it was not the appropriate cleaning agent to use on porous material. The IPN stated she thought the facility did not have any cloth gait belts in the facility because they were too hard to properly disinfect since the cloth absorbed the disinfectant and was ineffective. The IPN stated the only way to properly clean and disinfect cloth gait belts was to launder them after each resident use. The IPN stated it was important to clean and disinfect shared equipment properly and according to manufacturer's recommendations to maximize infection control, ensure the cleaning was effective, and to prevent the spread of infection.<br><br>During an interview on 8/23/2024 at 1:11 p.m., the Director of Nursing (DON) stated shared resident equipment such as gait belts must be cleaned and disinfected before and after each resident use. The DON stated it was important shared resident equipment was cleaned and disinfected appropriately and according to manufacturer's guidelines to prevent the spread of infection.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055457 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/23/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Intercommunity Healthcare & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 12627 Studebaker Road Norwalk, CA 90650 | |

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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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of the facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 9/2022, the P&P indicated resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration<br><br>(OSHA) Bloodborne Pathogens Standard. The P/P further indicated reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions.<br><br>e. During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and traumatic brain injury (damage to the brain from an external force that can cause temporary or permanent changes in brain function).<br><br>During a review of Resident 60's Physician Order Summary Report, indicated a physician's order for Resident 60 to be placed on EBP due to tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea) and enteral feeding (tube placed directly into the stomach for long-term feeding).<br><br>During an observation on 8/21/2024 at 10:53 a.m., RNA 1 entered Resident 60's room and was not wearing an isolation gown. Upon entering the room, Resident 60 requested RNA 1 put ointment on her lips. RNA walked over to Resident 60 and put an ointment onto Resident 60's lips. Once finished, RNA 1 assisted Resident 60 with exercises to the left arm and left leg and placed splints onto Resident 60's both hands, left elbow, and left knee.<br><br>During an interview on 8/21/2024 at 11:15 a.m., RNA 1 stated he did not wear an isolation gown while providing RNA services to Resident 60. RNA 1 stated he should have worn an isolation gown during the RNA session because he provided direct patient care to Resident 60 who was on EBP precautions. RNA 1 stated it was important to follow infection control protocols to protect the residents, himself, and staff from infection.<br><br>During an interview on 8/21/2024 at 1:09 p.m., the Infection Preventionist Nurse (IPN) stated the purpose of EBP was to reduce the transmission of Multi-Drug Resistant Organisms (MRDO, bacteria resistant to many antibiotics). The IPN stated all staff providing direct resident care which included RNA exercises to residents on EBP precautions must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection and reduce the transmission of MRDO.<br><br>During an interview on 8/23/2024 at 1:11 p.m., the Director of Nursing (DON) stated it was important all staff followed the proper infection control protocols to prevent the spread of infection.<br><br>During a review of the facility's P&P titled, Enhanced [NAME] Precautions, dated 6/5/2024, the P&P indicated EBP precautions were used as an infection prevention and control intervention to reduce the spread of MRDO to residents. The P&P indicated EBP precautions required the use of gowns and gloves during high contact resident care activities.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | f. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including functional quadriplegia (complete inability to move due to severe physical disability or medical condition) and epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]).<br><br>During a concurrent observation and interview on 8/20/2024 at 3:43 p.m., Resident 22 was lying in bed with splints to both hands, the left elbow, and both feet. RNA 2 entered Resident 22's room, put on gloves, lifted Resident 22's both arms to remove the hand splints and left elbow splint, and lifted Resident 22's both legs to remove both foot splints. RNA 2 removed her gloves, exited Resident 22's room, walked down the hall, pulled out a cell phone from her pocket, began texting, walked to the nursing station, and did not perform hand hygiene. RNA 2 stated she did not perform hand hygiene after removing Resident 22's splints because she got distracted. RNA 2 stated she should have performed hand hygiene after removing Resident 22's splints to prevent the spread of infection.<br><br>During an interview on 8/21/2024 at 1:09 p.m., the Infection Preventionist Nurse (IPN) stated hand hygiene must be performed before and after any type of patient care or procedure which included removal of a resident's splints since it involved direct contact with the resident. The IPN stated it was important to follow the proper hand hygiene and infection control protocols to prevent the spread of infection.<br><br>During an interview on 8/23/2024 at 1:11 p.m., the Director of Nursing (DON) stated it was important all staff followed the proper infection control protocols to prevent the spread of infection.<br><br>During a review of the facility's undated P&P titled, Handwashing, the P&P indicated handwashing must be performed before and after direct care of individual patients. |