STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055575	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Haven Subacute and Healthcare Center	12072 Trask Ave. Garden Grove, CA 92843

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident who had not been assessed as safe to self-administer medications did not self-administer an inhaler, failed to follow physician's orders for administration of an inhaler, and failed to follow facility policy for medication administration for 1 (Resident #299) of 4 residents observed during a medication pass. Findings included: A review of an undated facility policy titled Self-Administration of Medications revealed, Each resident will be informed of his/her right to self-administer medications. The Interdisciplinary Team will assess and determine if the practice is safe. Medications to be self-administered are specifically ordered, and monitored by the facility nursing staff. Such orders will be periodically reassessed to assure that they may still be given safely. The policy further revealed the procedure included, 5. The Physician's Orders for such drugs will be clarified to include: MAY KEEP AT BEDSIDE. 6. Residents who self-administer drugs will be periodically re-evaluated based on any changes in the resident's status. 7. Medication errors occurring with the resident who self-administers drugs will not be counted in the facility error rate but should alert the ID team to re-evaluate the resident's ability to safely self-administer the drugs. A review of an undated facility policy titled Metered-Dose (Oral) Inhaler Administration revealed it was the policy of the facility to Administer metered dose inhalers accurately and optimally. The policy further indicated, 4. Administer medications as follows: a. Shake inhaler well and remove cap from mouth piece [sic]; have patient breath out full to expel air from lungs. b. To assure that medication reaches lungs and is no deposited in throat, position inhaler upside down (with mouthpiece on bottom) and attach spacer device if ordered. c. Have patient tilt head back, tilt head back to open airway. d. Place mouthpiece in front of mouth if no spacer is ordered. e. While patient breaths in slowly and deeply (except if using a breath activated inhaler device), depress medication canister with you index finger. f. Instruct patient to hold breath for 5-10 seconds or as long as possible to maintain medication contact with lung tissue. g. When patient begins to breath out slowly, remove finger from canister and mouthpiece from patient's mouth. h. Pause per manufacturer's instructions or 1 to 2 minutes between inhalations of the same medication. Wait at least 5 minutes between inhalations of different medications. 5. If steroid inhaler, have the patient thoroughly rinse mouth with water and spit out after use to minimize risk of oral pharyngeal candidiasis. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an Admission Record indicated Resident #299 was admitted to the facility on [DATE] with diagnoses that included unspecified asthma with (acute) exacerbation, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, and unspecified chronic bronchitis. A review of Resident #299's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/2024 revealed Resident #299 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed the resident required partial/moderate assistance with toileting hygiene, showering/bathing self, lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS revealed the resident required supervision or touching assistance with upper body dressing and required setup or clean-up assistance with eating and oral hygiene. A review of Resident #299's care plan revealed a Focus area initiated on 03/23/2024 that indicated the resident was at risk for respiratory distress related to diagnoses of asthma, COPD, chronic bronchitis, SOB (shortness of breath), and wheezing. Interventions directed staff to administer breathing treatments as ordered: Fluticasone Propionate HFA (hydrofluoroalkane) Inhalation, Aerosol 110MCG/ACT (micrograms per actuation), one puff inhaled orally two times a day for asthma, and gurgle mouth with water after each use. A review of Resident #299's medical record revealed an assessment for medication self-administration had not been completed to ensure the resident's safety in self-administering an inhaler, a physician's order had not been obtained to self-administer the inhaler, nor had the order for the inhaler been clarified with May Keep at Bedside, per the facility's policy. During an observation on 04/10/2024 at 8:22 AM, Licensed Vocational Nurse (LVN) #5 prepared Resident #299's medications to include seven pills and one inhaler. LVN #5 then entered the resident's room and handed the inhaler to Resident #299. Resident #299 self-administered three puffs, one right after the other. LVN #5 did not address the additional puffs, nor did he give Resident #299 instructions to swish and spit out water after the inhaler use. Resident #299 took a mouthful of water, swished it around in their mouth, and swallowed it instead of spitting it out. A review of Resident #299's Medication Administration Record (MAR) for the timeframe from 04/01/2024 to 04/30/2024 revealed a transcription of an order dated 03/22/2024 for Fluticasone Propionate HFA inhalation Aerosol 110MCG/ACT, one puff inhale orally two times a day for asthma; gurgle mouth with water after each use. The MAR revealed the medication was signed as given by LVN #5 for the 9:00 AM dose on 04/10/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 4:37 PM with the Director of Nursing (DON) and LVN #5, LVN #5 stated he thought Resident #299 would be able to administer the inhaler themself due to their cognition. LVN #5 further stated he did not even think to hold the inhaler for the resident and had no idea they would give themself three puffs instead of one. He stated he also gave the resident two cups, one cup that was empty and one full of water, so the resident could swish and spit into the empty cup, but they swallowed the water instead. LVN #5 stated he did not think of Resident #299 doing their own inhaler as self-administration. The DON stated she had spoken with Resident #299, and the resident had admitted to taking three puffs of the inhaler earlier. The DON stated the resident said they would swish and swallow the water after using the inhaler at home all the time. The DON further stated Resident #299 did not wish to self-administer their medications and wished for the nursing staff to bring the medications to them when they were due. The DON stated her expectation was for nurses to not sign for medications or treatments they had not administered themselves. A review of an Incident/Event Intake Form dated 04/10/2024 revealed Resident #299 had received extra doses of their inhaler, self-administering three puffs instead of one puff. The form further revealed that during a staff interview, LVN #5 stated, I handed the inhaler and [he/she] administered it to [him/herself]. During an interview on 04/10/2024 at 4:35 PM, the Administrator stated she expected the nurses to follow the physician's orders. She further stated they were to get physician's orders for and assess any resident who wished to give their own medication. The Administrator stated the nurse should have administered the inhaler; it would have prevented the resident from administering three puffs instead of one.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45849 Based on observation, interviews, and facility policy review, the facility failed to ensure staff used appropriate hand hygiene and glove use when they handled ready-to-eat food. This failure affected 59 residents who received meals from the kitchen, out of the 95 residents who currently reside in the facility. Findings included: A review of the facility policy titled, Glove Use Policy, dated 2020, revealed, The appropriate use of gloves is essential in preventing food borne illness. Wearing disposable gloves is one of the acceptable ways that any food, ready-to-eat food, or otherwise, may be prepared and served. Gloved hands are considered a food contact surface that can get contaminated or soiled. During an observation on 04/09/2024 at 12:13 PM, the surveyor noted Cook #1 did not wash his hands or change his gloves after he was noted to scratch the side of their face with a gloved hand, then continued to pick up meat and cilantro with the same gloved hand. In an interview on 04/09/2024 at 2:08 PM, Cook #1 stated he wore gloves for sanitation. Cook #2 stated if he touched something else and then touched food, the gloves he wore would be dirty and could be contaminated. Cook #1 stated he never touched anything other food when he wore gloves. In an interview on 04/09/2024 at 2:24 PM, the Dietary Manager (DM) stated the staff had been in-serviced on wearing gloves and handling food. The DM stated if staff wore gloves to handle food, they should change their gloves any time they changed tasks. In an interview on 04/09/2024 at 2:30 PM, the Registered Dietitian (RD) stated her expectation was that if staff served food, they would use gloves for one task. The RD stated staff should not touch anything else but the one task. The RD stated she expected staff to not touch their hair, face, or other items, with their gloves. In an interview on 04/10/2024 at 8:52 AM, the Administrator stated when staff used gloves to serve food, they should not touch anything else. In an interview on 04/10/2024 at 2:34 PM, the Director of Nursing stated staff were taught to wash their hands prior to putting on gloves and if they touched anything else they needed to wash their hands and change their gloves.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 28193 Based on observation, interviews, record review, and facility policy review, the facility failed to licensed staff only documented medications they administered during medication administration for 1 (Resident #299) of 4 residents observed for medication administration. Findings included: A review of an undated facility policy titled Oral Medication Administration revealed 6. The medication nurse is responsible for noting any changes on the Medication Administration Record (MAR). Per the policy, 31. Return to the Medication Cart and document medication administration with initials in appropriate spaces on the MAR. During medication administration observation on 04/10/2024 at 8:22 AM, Licensed Vocational Nurse (LVN) #5 was noted to administer medication to Resident #299 to include cholecalciferol 125 micrograms. However, a review of Resident #299's Medication Administration Record, for 04/01/2024 to 04/30/2023, revealed LVN #9's initials on the MAR to indicate she administered the medication to the resident. On 04/10/2024 at 4:37 PM, the Director of Nursing (DON) brought LVN #5 and LVN #9 into the conference room where the surveyor was and stated LVN #5 administered the medication to the resident during medication administration and LVN #9 signed the MAR that indicated she had administered the medication to the resident as LVN #5 forgot to document the administration of the medication The DON stated her expectation was for the nurse to sign out the medication(s) at the time they were administered during medication administration and only sign to indicate the medications(s) they administered. LVN #5 acknowledged he administered the medication but forgot to the sign the medication out on the MAR. LVN #9 confirmed she did not administer the medication. Per LVN #9, when she realized LVN #5 forgot to sign (initial) the MAR, she did it. LVN #9 stated it was not okay for another nurse to sign for a medication they did not administer. During an interview on 04/10/2024 at 4:35 PM, the Administrator stated she expected the nurses to sign medications out as they gave them and not to sign for medications they did not give.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 28193 Based on observations, interviews, and facility document and policy review, the facility failed to ensure staff properly cleaned glucometers according to a manufacturer's labeled specifications for use as a disinfectant to help prevent the spread of bloodborne pathogens during use, for 2 of 13 glucometers observed in use during medication pass. Findings included: A review of a facility infection control policy titled Cleaning and Disinfecting Glucose Monitoring Devices, revised in June 2022, revealed, It is the policy of the facility to disinfect equipment used to reduce the potential for disease transmission. The policy revealed, The Director of Nursing (DON) and/or its designee shall be responsible for implementation and enforcement of this policy. The policy revealed, If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. The policy further revealed, Refer to manufacturer's guidance of blood glucose meters to determine what products, meeting the criteria specified by the FDA [Food and Drug Administration], are compatible with their meter prior to using any EPA [Environmental Protection Agency]-registered disinfectant for disinfection purposes. On 04/10/2024 at 11:35 AM, Licensed Vocational Nurse (LVN) #4 was observed performing a blood glucose test. Upon returning to the cart, LVN #4 sanitized her hands, removed a disinfectant wipe from a container in the cart, wiped the front and back of the glucometer, and placed it on a barrier tray to dry, throwing away the disinfectant wipe. She stated she cleaned the glucometer between each resident's use and preferred to use bleach wipes. However, the container in the cart was Sani-Cloth AF3 [a germicidal disposable wipe] wipes, which she placed on top of the cart to view. She then walked across the hallway, opened a personal protective equipment (PPE) bin, pulled out a bleach wipe and re-disinfected the glucometer, wiping it down, back and front and placed it on the barrier tray again to dry, and threw the bleach wipe in the trash. Further observation of the Sani-Cloth AF3 container and the Clorox Bleach wipes container revealed a large, red 3 printed on the label of both containers. LVN #4 stated the red 3 meant to wipe the glucometer with either disinfectant wipe and allow the glucometer to air dry for three minutes before using it again. On 04/10/2024 at 11:56 AM, upon approaching LVN #5's medication cart, a glucometer with an already used test strip still in it was observed on top of the cart. LVN #5 emerged from a resident's room, put on gloves, removed the used test strip, and placed it in the trash. He then placed the glucometer, without disinfecting it, into a drawer on the cart, locked the cart, and stated he would be back, as he had to go and get the next resident for a blood glucose level check before lunch. Upon returning to the cart, LVN #5 pulled a container of Sani-Cloth AF3 disinfectant wipes out of the cart, along with the glucometer. He obtained a barrier tray, wiped the glucometer off with a disinfectant wipe, and placed it on the tray to dry. He then threw away the disinfectant wipe and assembled the remainder of the needed supplies. LVN #5 grabbed a pair of gloves and the tray of supplies and went in to perform the blood glucose test. Upon returning to the cart, LVN #5 placed the glucometer back into the cart without disinfecting it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a previous interview with LVN #5 on 04/10/2024 at 8:49 AM, during the morning med pass, he stated he used bleach wipes to disinfect the glucometer at the end of the medication pass, and the nurses did not clean the glucometer in between residents. He stated, however, he would want to check the rules on that before giving a final answer. A review of both LVN #4 and LVN #5's Nursing Comprehensive Clinical Competency Review Skills Checklist revealed both nurses met the requirements for blood glucose monitoring and use of the equipment and demonstrated knowledge of the glucometers requirements for cleaning and disinfecting it after each use. Further interviews with the nursing staff regarding the disinfecting process for glucometers and the meaning of the red 3 on the label of the containers revealed the following: On 04/10/2024 at 12:07 PM, during an interview with LVN #6, she stated she would clean a glucometer between each resident with a bleach wipe. She stated the red 3 on the side of both disinfectant wipes meant to wipe the glucometer and let it air dry for three minutes before using it again on the next resident. On 04/10/2024 at 12:09 PM, during an interview with LVN #7, he stated he would clean the glucometer before using it and in between every resident with the gray-topped cleaner (Sani-Cloth AF3). He stated the red 3 on the container meant to wipe the glucometer and let it dry for three minutes before using it on the next resident. On 04/10/2024 at 12:10 PM, during an interview with LVN #8, he stated he would clean the glucometer before the initial use and after each resident. He stated he would use the disinfectant wipes (Sani-Cloth AF3) and the red 3 meant to wipe down the machine with the wipe and let it air dry for three minutes before using it on the next resident. During an interview on 04/10/2024 at 12:14 PM, the Infection Previntionist (IP) stated she would disinfect the glucometer before use and after each resident. She stated she would use the gray top disinfectant wipes (Sani-Cloth AF3) and the red 3 on the container meant to wipe the glucometer with the wipe and let it air dry for three minutes. A review of the Assure Platinum Blood Glucose Meter manufacturer's guide revealed Cleaning and Disinfecting Guidelines Option 1: Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. To use a wipe, remove from container and follow product label instructions to disinfect the meter. A review of the Sani-Cloth AF3 label revealed the product disinfected in three minutes. The label's indication for use revealed, To Disinfect and Deodorize: Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for three (3) minutes. Let air dry. A review of the Clorox Bleach disinfectant wipes label revealed, To clean and disinfect and deodorize hard, nonporous surfaces: wipe surface to be disinfected. Use enough wipes for treated area to remain visibly wet for the contact time listed. / Let air dry. On the side of the container a chart was observed with varying contact times ranging from 30 seconds up to three minutes, depending on the type of bacteria/virus needed addressed with the wipe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2024 at 3:22 PM, the Director of Nursing (DON) stated the glucometers should be cleaned before use and after use on each resident. She stated staff could use either the bleach wipes or the disinfectant wipes (Sani-Cloth AF3), and the red 3 on the label meant to clean the glucometers and then let them air dry for three minutes between uses. After reviewing the directions for the Sani-Cloth AF3, the DON became aware that it was to be a three-minute wet-dwell time and then air-dry. The DON had a container of bleach wipes in her office and read the directions for disinfection, which included saturating the surface of the glucometer and keeping it wet for 30 seconds up to three minutes based on what type of bacteria/virus it was being used to kill. The DON stated she felt the staff were confusing the instructions for the two disinfectants and stated she, herself, was unaware of the specific directions on the disinfectant wipes (Sani-Cloth AF3) and thought the staff was disinfecting the glucometers correctly. She stated her expectation of the staff was for them to use the disinfectant products per the manufacturer's instructions when cleaning the glucometers, and she would in-service the staff on the differences between the use of the two products. During an interview on 04/10/2024 at 3:27 PM, the Administrator stated she understood the error and her expectation was that staff clean the glucometers before use, in between use on residents, and before it was put in the cart, and for staff to follow the instructions on the container.