

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2024
NAME OF PROVIDER OR SUPPLIER  Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 S. Record St. Los Angeles, CA 90023	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure effective infection control measures were practiced, by failing to ensure:</p> <ol style="list-style-type: none"> <li>1. Cleaned and uncleaned oxygen concentrators (a medical device that takes air from the environment and filters it into purified oxygen) were not stored in the same storage room (Storage 1).</li> <li>2. The oxygen concentrators were labeled to distinguish the cleaned oxygen concentrators from the uncleaned oxygen concentrators.</li> </ol> <p>These deficient practices had the potential to result in cross contamination and increase the risk of infection to residents receiving supplemental oxygen.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 8/12/2024 at 4 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 pointed out the storage room used to store oxygen concentrators in the facility. LVN 1 stated all cleaned, used, and broken oxygen concentrators were placed in one storage room. The storage room held six oxygen concentrators, with one concentrator covered in plastic. The concentrators were unlabeled and facing in different directions, with some of the concentrators touching the others. LVN 1 stated when the oxygen concentrators were discontinued, the concentrators would be placed in the same storage area as the clean and dirty concentrators. LVN 1 stated once she removed the concentrator from the room a resident, she would bring the uncleaned concentrator to the storage room. LVN 1 stated did not place a label on the concentrator to indicate it was used, but she would attempt to separate the unclean concentrators from the clean ones. LVN 1 admitted the room was too small to separate the clean concentrators from the unclean ones and there was no way to indicate which concentrators were cleaned and which ones were uncleaned. LVN 1 stated someone comes to clean the concentrators and she would grab one from the storage area when she needed one. LVN 1 stated she was not familiar with how the facility maintains and cleans the concentrators.</p> <p>During an interview on 8/12/2024 at 4:16 p.m. with the Director of Maintenance (DOM), the DOM stated housekeeping staff was responsible for cleaning the concentrators in the storage area every Monday. The DOM stated he had nothing in writing regarding this policy, but the housekeeping staff was aware of their responsibility of cleaning the concentrators and placing them in Storage 1.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 8/13/2024 at 8:25 a.m. with Housekeeper 1, Housekeeper 1 went to the storage room where the cleaned concentrators were kept. Housekeeper 1 initially stated that all concentrators stored in Storage 1 were cleaned before they were brought into the storage room. Housekeeper 1 stated when a resident was discharged and no longer used the equipment, the housekeeping staff was responsible for cleaning the room, cleaning all the equipment, and bringing it back to Storage 1. Housekeeper 1 then stated all concentrators in Storage 1 were not clean except for the concentrator that was covered in plastic. Housekeeper 1 proceeded to a small closet (Storage 2) with sliding doors located in another hallway of the facility. Housekeeper 1 stated, This is where the clean concentrators are kept, and the nursing staff should know this. Storage 2 was observed with one oxygen concentrator stored along with other equipment. Housekeeper 1 stated the clean concentrators should not be stored with the uncleaned concentrators in Storage 1 because storing clean and dirty concentrators together could contaminate the cleaned ones.</p> <p>During a concurrent observation and interview on 8/13/2024 at 9 a.m., with LVN 2, LVN 2 stated that she had dual roles as the desk nurse and respiratory therapist. Observed seven oxygen concentrators in Storage 1. Another concentrator had been placed in Storage 1 with a respiratory plastic bag hanging from the concentrator. The respiratory bag had the name of a resident written on the bag. LVN 2 stated that the concentrator had been used by a resident that had been transferred to the hospital the night before. LVN 2 stated Storage 1 was for clean concentrators and the concentrator that was used on the resident should not have been in Storage 1 because it had not been cleaned. LVN 2 removed the plastic bag and stated she would clean the concentrator immediately. LVN 2 stated the resident ' s respiratory bag should have been removed from the concentrator and the concentrator cleaned before storing in Storage 1. LVN 2 stated she did not know where the dirty concentrators were stored. LVN 2 stated whenever a concentrator was needed for a resident, nursing staff would retrieve the concentrator from Storage 1. LVN 2 stated she believed the DOM was responsible for cleaning the concentrators, but she was not sure of the cleaning process. LVN 2 was shown where Storage 2 was located. LVN 2 stated she unaware that Storage 2 contained clean concentrators. LVN 2 stated she had always gotten oxygen concentrators from Storage 1 and was never informed about Storage 2. LVN 2 stated there appeared to be a miscommunication amongst staff as to where the clean concentrators were kept. LVN 2 stated the uncleaned concentrator could have been used on another resident and caused cross contamination. LVN 2 stated, The resident that was transferred to the hospital could have had COVID and that concentrator would have been placed on another resident and passed COVID to that resident.</p> <p>During an interview on 8/13/2024 at 10:05 a.m., with the DOM, the DOM stated Storage 1 was called the dirty utility room. The DOM stated housekeeping staff would take the concentrators from the residents ' room and make sure they were disinfected before placing them in Storage 1. The DOM stated that the nursing staff were responsible for disinfecting the concentrators before placing them on another resident. The DOM stated the facility needed to have another room to separate the dirty equipment from the clean equipment. The DOM stated, If we are going to call Storage 1 the dirty utility room, we can not place clean equipment in that room. The DOM stated that the delivery persons also delivered the clean concentrators to Storage 1. The DOM stated that placing the clean and dirty concentrators was a problem because the facility did not label the concentrators that were clean. The DOM stated that the current process would cause everything in Storage 1 to be contaminated.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/13/2024 at 1:20 p.m. with the Infection Preventionist (IP) Nurse, the IP stated the clean oxygen concentrators were to be stored in Storage 1. The IP stated the concentrators were supposed to be disinfected by housekeeping at the bedside before they were placed in Storage 1. The IP stated uncleaned concentrators should not have been stored in Storage 1. The IP stated that a resident could mistakenly be given an unclean concentrator if they were stored in the same area as the clean concentrators. The IP stated that whatever infection the previous resident had could be passed on to another resident. The IP stated no equipment should leave the room dirty. The IP stated the concentrators should be disinfected, bagged, labeled clean and put away for the next resident.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P), titled Departmental (Respiratory Therapy) - Prevention of Infection, dated November 2011, the P&amp;P indicated the following:</p> <ol style="list-style-type: none"> <li>1. Transport respiratory therapy equipment to designated soiled utility area for decontamination.</li> <li>2. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry.</li> <li>3. Nursing staff should perform a visual inspection of each Oxygen Concentrator daily, checking for dust, dirt, or visible contamination. If any issues are observed, the device should be cleaned immediately.</li> <li>4. Use a clean, damp cloth to wipe down the exterior surfaces of the Oxygen Concentrator.</li> <li>5. Apply an EPA-approved disinfectant to all exterior surfaces following the manufacturer ' s contact time recommendations.</li> <li>6. Oxygen Concentrators should be stored in a clean and designated storage area if not in use.</li> </ol> <p>During a review of the facility ' s P&amp;P, titled Infection Control and Prevention Program, revised October 2018, the P&amp;P indicated, an infection prevention and control program (IPCP) was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The P&amp;P indicated important facets of infection prevention included the following:</p> <ol style="list-style-type: none"> <li>1. Identifying possible infections or potential complications of existing infections.</li> <li>2. Instituting measures to avoid complications or dissemination.</li> <li>3. Educating staff and ensuring that they adhere to proper techniques and procedures.</li> <li>4. Communicating the importance of standard precautions and cough etiquette to visitors and family members.</li> <li>5. Enhancing screening for possible significant pathogens.</li> </ol>		