STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview and record review, the facility failed to implement the facility ' s policy and procedure titled Clean Dressing Change to prevent infection during wound care of the pressure ulcer (a skin injury resulting from prolonged unrelieve pressure in the body). Licensed Vocational Nurse (LVN 1) failed to change gloves and wash hands after touching a soiled wound dressing during wound care for one of three sample residents (Resident 2) who had Stage 4 pressure ulcer (skin injury that involves full-thickness tissue loss that exposes bone, tendon, or muscle). This deficient practice had the potential for Resident 2 to develop severe wound infection, pain and could lead to delayed healing process and a decline in the resident ' s wellbeing. Findings: During a review of the admission record indicated Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included diabetes (a disease in which your blood glucose, or blood sugar, levels are too high) hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), sepsis (a severe blood infection), and ESBL (Extended Spectrum Beta Lactamase- an enzyme that makes some bacteria resistant to many antibiotics) Resistance. During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/5/2024, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired. The MDS indicated Resident 2 was dependent (resident does none of the effort to complete the activity) on facility staff for eating, toileting, showers, lower body dressing. The MDS further indicated Resident 2 was dependent with care (helper does all the activity) with turning and mobility. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/16/2024, at 10:40 AM, in Resident ' s 2 room, the Treatment Nurse (TN1) was observed providing wound treatment to Resident 1 with ulcer on the left heel. During the wound care, TN 1 put on a pair of clean gloves to remove a soiled dressing (stained with blood and brownish drainage) from the resident's left heel and placed the soiled dressing into a disposal bag without changing the soiled gloves and did not wash hands. Then TN 1 opened a clean normal saline (salt solution) bottle to wet a 4x4 gauze (sterile or clean pads used to clean wound). Then TN 1 picked the wet 4x4 gauze up wearing the soiled gloves, which touched the soiled dressing, and cleaned the ulcer of the left ankle without changing the gloves or washing hands. After cleaning the wound, TN 1 proceeded treating the wound ulcer on the left heel and applied clean dressing without changing gloves and washing hands. TN 1 proceeded to perform the wound care treatment as ordered to Resident 2's right mid back with stage 4 wound (full thickness tissue loss with exposed bone, tendon, or muscle) without changing gloves and washing hands. During an interview on 10/16/2024 at 11AM, TN 1 stated she should have removed the gloves, which touched the soiled dressing, and should have washed her hands before she proceeded with the treatment on the left heel. TN 1 stated she should have change gloves and wash hands before proceeding with wound care on Resident 2 ' s stage 4 pressure ulcer. During an interview on 10/16/2024 at 11:20 AM with infection Prevention Nurse (IPN), stated during wound care treatment, each wound needs to be treated individually by washing hands and applying clean gloves when gloves are soiled, then remove the old dressing, after removing gloves, wash hands, and put on new gloves before cleaning the wound. The IPN stated after removing the gloves, perform hand hygiene, apply clean gloves, and apply clean dressing. IPN stated, hand hygiene was essential to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Clean Dressing Change, revised 12/19/2022, indicated: 1. Wash hands and put on clean gloves; place a barrier cloth or pad next to the resident under the wound to protect the bed linen and other body sites. 2. Loosen the tape and remove the existing dressing; if needed to minimize skin stripping or pain moisten with prescribed cleansing solution or use adhesive remover to remove tape. 3. Remove gloves, by pulling inside out over the dressing; discard into appropriate receptacle; Wash hands and put on clean gloves. 4. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound). 5. Pat dry with gauze. Measure wound using disposable measuring guide. Wash hands and put on clean gloves. 6. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant. Secure dressing.