

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Imperial Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11926 LA Mirada Blvd LA Mirada, CA 90638	

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 - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility did not ensure doors remained closed to residents' rooms that tested positive for COVID-19 (highly contagious respiratory disease) for five of five sampled residents (Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10).</p> <p>This deficient practice had the potential to expose all residents, staff, and visitors to COVID-19.</p> <p>Findings:</p> <p>a. During a review of Resident 6's Admission Record, dated 4/2/2024, the admission record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included COVID-19, muscle weakness, acute kidney failure (the sudden and rapid loss of kidney's ability to filter waste and balance fluid in blood), type 2 diabetes mellitus (when your sugar is too high in the blood), hypertension (high blood pressure), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [a sudden, uncontrolled burst of electrical activity in the brain]).</p> <p>During a review of Resident 6's History and Physical (H&P), dated 2/20/2024, the H&P indicated that Resident 6 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 2/14/2024, the MDS indicated Resident 6 was cognitively intact (the ability to think, remember, and reason) for daily decision making. The MDS indicated Resident 6 required some assistance with personal hygiene and self-care.</p> <p>During a review of Resident 6's COVID-19 Point of Care Test Result Report Form, dated 3/29/2024, the COVID-19 test result report indicated Resident 6 had a positive test result for COVID -19.</p> <p>b. During a review of Resident 7's Admission Record dated 4/2/2024, the admission record indicated Resident 7 was admitted on [DATE] with the following diagnosis which included contact with a suspected exposure to COVID-19, hydrocephalus (the accumulation of too much fluid in the brain and spinal cord), muscle weakness, seizures, and acute respiratory failure (inability to maintain adequate oxygen) with hypoxia (low oxygen in the tissue).</p> <p>During a review of Resident 7's H&P, dated, 3/6/2024, the H&P indicated that Resident 7 did not have the capacity to understand and make decisions.</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 - Many</p>	<p>The IPN stated that residents with a positive COVID-19 status were not cohorting (grouping residents together based on their risk of infection or whether they have tested positive for COVID-19 during an outbreak) but were to isolate (in place in their current rooms. The IPN stated that this was done because the facility was full and changing rooms to move COVID-19 positive residents to other rooms could have potentially cause cross contamination and exposed more residents to COVID-19. The IPN stated that she was waiting on further recommendations from the public health outbreak nurse (OBN). The IPN stated that residents that are isolating in place should have a filtration system in the room along with curtains drawn to separate and cause a barrier between each resident in the COVID-19 positive rooms. The IPN stated that doors should be kept closed at all times to prevent airborne particles from emitting into the hallways. The IPN stated that the doors should not have been open. The IPN also stated that there are residents in the hallway and not all residents wear masks. The IPN stated that residents are notified that there is a COVID-19 outbreak and the residents were encouraged to wear masks while in the hallways and public area, but resident have a choice not to wear the masks. The IPN stated that the staff should have made sure that the doors were closed to all COVID-19 positive residents and residents that were exposed to COVID 19. The IPN stated that there was an in-service regarding COVID-19 on 3/28/2024 during the all-staff meeting, so the staff should know to close the doors of COVID-19 residents' rooms.</p> <p>The IPN stated that there was no designated staff to care for COVID-19 residents only. The IPN stated that staff are told to do the positive resident firsts and do the negative resident last so that they do not cross contaminate. The IPN stated that staff will also change N95 masks when leaving COVID-19 positive rooms and put on a fresh one.</p> <p>The IPN stated that nurses that work in the front are not rotated. The IPN stated that certified nursing assistants (CNAs) were seeing both positive and negative residents. The IPN stated that if the facility gets more than seven COVID-19 positive residents, she would then assign one nurse to the COVID-19 area.</p> <p>The IPN stated that there were currently three staff members that tested positive for COVID-19 (CNA 4, CNA 5, and the Activities Director (AD). The IPN stated that CNA 4 tested positive for COVID-19 on 3/31/2029 and her last day at work was 3/29/2024. The IPN stated that on CNA 4's last workday, CNA 4 worked the 3 p. m. to 11 p.m. shift and was assigned to care for COVID-19 positive residents, Resident 5, Resident 10, Resident 11, Resident 12, and Resident 14 and Resident 9 who was exposed to Five of which tested positive to COVID-19 and one exposed. The IPN stated that staff CNA 5 and AD both tested positive on the morning of 4/1/2024 when they arrived to work and were both sent home the same day. IPN stated that staff can return to work after 5 days if they have a negative COVID-19 test and asymptomatic (have no symptoms).</p> <p>During an observation on 4/1/2024 at 6:05 p.m., at Station 1, with the Physical Therapy Assistant (PTA) and the Occupational Therapy Assistant (OTA), in Resident 11's room, observed both the PTA and the OTA providing therapy for Resident 11 with the door open for approximately 15 minutes. Observed Licensed Vocational Nurse (LVN) 2 standing outside of the room tending to a resident in a wheelchair who refused to put her mask over her nose and mouth. The resident rolled down the hallway with the mask on her chin. The PTA and OTA came out of Resident 11's room but did not close the door when they both left the room.</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 - Many</p>	<p>During a concurrent observation and interview on 4/1/2024 at 6:30 p.m., with the PTA and OTA, at Station 1, outside of Resident 11's room, PTA and OTA was asked if the door to Resident 11's room should remain open if the residents in the room are COVID-19 positive. PTA stated that he was about to close the door to Resident 11's room and stated that he is aware that it is unsafe to keep the doors open when residents are COVID-19 positive. The PTA stated that COVID-19 could possibly spread further. The OTA also acknowledged that the door should have been closed while they were providing therapy and the door should have been closed as soon as they both left the room and of the resident.</p> <p>During an interview on 4/1/2024 at 6:35 p.m., with LVN 2, LVN 2 stated that she was just recently trained on the COVID protocol and that the doors were not to be kept open when a resident was COVID-19 positive. LVN 2 stated, If the infection (COVID-19) is in the air, it can come out of the room and infect other residents. LVN 2 stated that the goal is to contain COVID-19 and not spread it further. LVN 2 stated that the resident that was in the hallway across from Resident 11's room with not mask could have been exposed to COVID-19 because the doors were open.</p> <p>During an interview on 4/1/2024 at 6:50 p.m., with CNA 3, CNA 3 stated that when a resident becomes COVID-19 positive, it was her responsibility as a CNA to ensure the doors were closed. CNA 3 stated that some residents would open the door and get agitated if the doors were closed. CNA 3 stated that if this happens, the CNA staff should report it to the charge nurse so that they can intervene. CNA 3 stated that leaving the doors open could spread COVID-19 to other residents.</p> <p>During an interview on 4/1/2024 at 7:00 p.m., with the Administrator (ADM), the ADM stated that the doors should be closed on rooms with COVID-19 positive residents.</p> <p>During a telephone interview on 4/2/2024 at 2:02 p.m., with the Outbreak Nurse (OBN), the OBN stated that she spoke with the IPN on 4/1/2024 to inform her of the COVID-19 recommendations. The OBN stated that she was there in January 2024 for another COVID-19 outbreak in the facility. The OBN stated that she did not think that the facility was following some of the recommendations provided. The OBN stated that she gave the same recommendation for this COVID-19 outbreak as she did for the outbreak in January 2024. The OBN stated that the doors should be closed to the COVID-19 positive residents and there should be dedicated CNAs to work only with COVID-19 positive residents or the CNAs and staff would be at a higher risk of cross contamination.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, COVID-19, Prevention and Control, revised 9/29 2023, the P&P indicated Residents suspected or confirmed COVID-19 infection will be placed on transmission-based precautions (contact and droplet precautions). The P&P also indicated, Dedicated, consistent staffing teams who directly interact with residents that are COVID-19 positive.</p>		