STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Balboa Care Center	16955 Vanowen Street Van Nuys, CA 91406

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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39550

Based on interview and record review, the facility failed to implement the facility's infection control policy by failing to:

1. Ensure two of two visitors were offered Coronavirus disease-2019 [COVID-19, a highly contagious viral infection that can trigger respiratory tract infection]) testing upon entering the facility.

2. Ensure a resident was placed on contact isolation (used when a resident has an infectious disease that may be spread by touching either the resident or other objects the resident has handled) per physician's order for one of four sampled residents (Resident 4).

These deficient practices had the potential to place residents, staff members, and visitors at risk of spreading infections.

Findings:

a. During an interview on 12/12/2024 at 9:45 a.m., with Family Member 1 (FM 1) in the facility's lobby, FM 1 stated that she was not offered a COVID-19 test when she walked in the facility today (12/12/2024).

During an interview on 12/12/2024 at 10:02 a.m., with Receptionist 1 (Rec 1), Rec 1 stated that when a visitor enters the facility, Rec 1 instructs visitors to check their temperature and Rec 1 offers visitors to wear a mask. Rec 1 stated that she does not offer visitors a COVID-19 test upon entering the facility.

During an interview on 12/12/2024 at 10:16 a.m., with the Infection Preventionist (IP), the IP stated that the facility does not offer COVID-19 testing to visitors upon entry to the facility. The IP stated that as long as visitors are feeling well and are not experiencing any COVID-19 or flu like symptoms, the facility does not offer COVID-19 testing. The IP stated if the visitor presents to the facility with COVID-19 or flu like symptoms upon entry, the facility offers COVID-19 testing.

During an interview on 12/12/2024 at 11:15 a.m., with Caregiver 1 (CG 1), CG 1 stated that she was not offered a COVID-19 test when she entered the facility on 12/12/2024.

(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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/12/2024 at 11:26 a.m., with the IP, reviewed the facility's policy titled, Masking Policy, with a review date of 11/19/2024. The IP stated that based on the facility's policy, the facility should be offering COVID-19 testing to visitors upon entry to the facility. When asked why this is not being done, the IP did not answer. During an interview on 12/12/2024 at 11:26 a.m., with the Director of Nursing (DON), the DON stated that the facility does not offer COVID-19 testing to visitors upon entry to the facility because the facility does not have to. The DON stated that the facility does not have to offer COVID-19 testing because the facility does not have a COVID-19 outbreak (more cases of disease in time or place than expected). The DON further stated that the facility does not have the resources to offer a COVID-19 test to every visitor that comes through the facility door. During a follow-up interview on 12/13/2024 at 2:00 p.m., with the DON, the DON stated that when visitors will ask for a COVID-19 test, the facility will then offer the COVID-19 test. The DON stated if visitors don't ask, the facility will not offer COVID-19 testing. The DON stated the facility does not offer COVID-19 testing because it is not necessary. The DON stated the facility should offer COVID-19 testing when the facility is in an outbreak, however, the facility is not in an outbreak. During a review of the facility's policy and procedure titled, Masking Policy, reviewed 11/19/2024, the policy indicated although masking regardless of vaccination status may continue to be required by the facility or, if warranted based on local respiratory virus transmission. The following requirement is still in place: Before entry, all visitors must be offered self-testing with a COVID-19 antigen test and a well-fitting, high-quality mask with good filtration to wear during their visits. This is regardless of vaccination status. If a visitor tests positive for COVID-19, whether symptomatic (showing symptoms) or not, they should not be allowed to visit until after they recover. b. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 12/11/2024 with diagnoses that included abnormalities of gait (manner of walking or moving on foot) and mobility, need for assistance with personal care, and thrombocytopenia (low number of platelets [small cell fragments in our blood that form clots and stop or prevent bleeding] in the blood). During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 12/9/2024 with diagnoses that included sepsis (a life-threatening complication of an infection) and bacteremia (the presence of bacteria in the blood). During a review of Resident 4's physician's order dated 12/9/2024 at 6:32 p.m., the physician order indicated transmission-based precautions (steps taken to prevent spread of infection to others): contact isolation: Escherichia coli (E-coli - a type of bacteria commonly found in the intestines of humans and animals, but some types can make people sick)/bacteremia blood until 12/12/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lake Balboa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16955 Vanowen Street Van Nuys, CA 91406	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/13/2024 at 9:15 a.m., with the IP, reviewed Resident 4's Admission Record and Resident 4's physician orders. The IP stated Resident 4 was readmitted to the facility on [DATE]. The IP stated that she received an order for Resident 4 to be placed on contact isolation for E. coli/bacteremia on 12/9/2024. The IP continued to state that Resident 4 was not placed in a private/isolation room upon Resident 4's readmission. The IP stated that during the time of Resident 4's readmission, the facility was expecting a new admission (Resident 2) to be assigned to the private/isolation room. When asked if the new admission (Resident 2) required to be in a private/isolation room, the IP stated that the new admission (Resident 2) did not require isolation. During an interview on 12/13/2024 at 11:46 a.m., with the Admission Coordinator (AC), the AC stated that the facility was aware that Resident 4 would be readmitted back to the facility on [DATE], however was not aware that Resident 4 required a private/isolation room upon readmission. The AC stated that the facility was expecting a new admission, Resident 2, that was assigned and family expected to be in the private/isolation room. However, the new admission, Resident 2, did not arrive on 12/9/2024 as planned. Resident 2 was admitted to the facility on [DATE]. During a concurrent interview and record review on 12/13/2024 at 12:30 p.m., with the IP, reviewed the facility's census (daily list indicating resident names with corresponding room numbers) dated 12/8/2024 (census for 12/9/2024), 12/9/2024 (census for 12/10/2024), and 12/10/2024 (census for 12/11/2024). The IP stated that there was a private/isolation room available on 12/9/2024, 12/10/2024, and 12/11/2024. The IP reviewed Resident 2's Admission Record and stated that Resident 2 was admitted to the facility on [DATE] and was assigned to the private/isolation room. The IP reviewed Resident 4's Admission Record and stated that Resident 4 was admitted on [DATE] and placed in a room with roommates with curtains to be drawn. The IP stated that Resident 4 should have been placed in a private/isolation room because the facility had an available room. When asked why Resident 4 was not placed in an isolation room, the IP did not answer. During a concurrent interview and record review on 12/13/2024 at 1:06 p.m., with the DON, reviewed Resident 4's physician orders. The DON stated that Resident 4 had an order for contact isolation dated 12/9/2024. The DON stated that there was a private/isolation room available upon Resident 4's readmission on 12/9/2024. The DON stated that Resident 4 required a private/isolation room because the facility received an order from the physician for contact isolation. The DON continued to state that the DON decided not to place Resident 4 in a private/isolation room because the infection was not in Resident 4's urine, or sputum (mucus and other matter brought up from the lungs by coughing), but the infection was in the blood and Resident 4 had no active bleeding. The DON stated Resident 4 did not have a true infection and did not require isolation precautions, despite the physician's order. The DON further stated that the IP had a proactive approach and the IP discussed and received an order for contact isolation. The DON stated Resident 4 should have just been placed on enhanced barrier precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions, reviewed 11/19/2024, the policy indicated it is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions .Contact Precautions are used with a known infection that is spread by direct or indirect and the resident or the resident's environment .Room Placement: iii. When private rooms are not available, some residents may be cohorted (a group of people with a shared characteristic) or per an alternative risk-based approach.