

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Alden Terrace Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 1240 S Hoover St Los Angeles, CA 90006	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive care plan (CP: a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) that met resident's identified individual needs for one of four sampled residents (Resident 1). By failing to implement Resident 1's CP for scabies (a parasitic infestation caused by tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash).</p> <p>This deficient practice had the potential to result negative impact on residents' health, safety, spread infection, and negatively impact the quality of care and services received.</p> <p>Cross reference: F880</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH - is a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream) and disturbance (conditions that disrupt a person's thinking, feeling, and general daily functioning).</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 5/12/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were severely impaired and the resident required maximal assistance from staff for activities of daily living (ADL- shower/bathing, lower body dressing and putting on/taking off footwear). The MDS indicated Resident 1 required supervision with repositioning such as sit to stand, toilet transfer, and walking.</p> <p>A review of Resident 1's Order Audit Report order dated 6/3/2024, created on 6/4/2024 at 10:36 a.m. (late entry) indicated, Resident 1's physician ordered to isolate the resident from roommates when Elimate (medication used to treat scabies) was applied.</p> <p>A review of Resident 1's Care Plan for scabies dated 6/3/2024 indicated an approach of contact isolation precautions (applies to any person with signs of an illness easily transmitted by direct patient contact or by indirect contact with items in the patient's environment) for 1 day for prophylaxis (an attempt to prevent disease) treatment.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Change of Condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) dated 5/30/2024, indicated Resident 1 was noted with scattered rashes on the torso.</p> <p>During an interview with Certified Nursing Assistant 1 (CNA1) on 6/4/2024 at 10:51 a.m., CNA1 stated Resident 1 was showered in the morning (6/4/2024) and had multiple rashes on the torso and extremities. CNA1 stated Resident 1 was not on contact precautions (steps healthcare visitors and staff need to follow before going into a resident's room. It is intended to prevent transmission of infectious agents and includes use of personal protective equipment such as gloves and a gown before resident contact) and CNA1 did not wear any personal protective equipment (PPE: gowns, gloves, masks, goggles) when giving resident 1 a shower. CNA1 stated Resident 1 had two roommates.</p> <p>During a concurrent observation of Resident 1 and interview on 6/4/2023 at 11:03 a.m., Resident 1 was observed with reddish/pink raised bumps on the skin of both upper legs and knees and all around the torso and back. Resident 1's room did not have any contact precaution signage posted and no PPE cart observed outside the room. Resident 1 was observed scratching both knees and stated, it itches. Resident 1's palms of both hands and fingers were observed with dry, crusted, and scaly skin. Resident 1 appeared uncomfortable due to constant scratching.</p> <p>During an interview on 6/4/2024 at 12:59 p.m., CNA4 stated, Resident 1 was scratching and had rashes all over the torso and legs. CNA4 stated, the Treatment Nurse 4 (TXN4) and another nurse applied a cream on Resident 1's body after the resident was showered the night before (6/3/2024). CNA4 stated Resident 1 was placed in a room with two roommates throughout the night and CNA4 did not see a PPE cart or isolation signage for isolation after the cream was applied.</p> <p>During an interview with Infection Preventionist Nurse (IPN) on 6/4/2024 at 10:17 a.m., the IPN stated Resident 1 was first observed with scattered skin rashes on 5/30/2024 and was started on hydrocortisone cream (medication used to treat a variety of skin conditions such as insect bites, poison oak/ivy, eczema, dermatitis, allergies, rash, and itching). The IPN stated Resident 1 went out on pass on 6/3/2024 and went to an appointment at a General Acute Care Hospital 1 (GACH1) where Resident 1 was ordered to be given Elimite treatment for scabies. The IPN stated the facility applied the Elimite cream on Resident 1 on the night of 6/3/2024. The IPN confirmed by stating Resident 1 was not put on contact isolation during the prophylaxis (attempt to prevent) treatment of scabies because based on facility policy isolation precautions were not necessary for prophylactic treatment. When asked if Resident 1 showed signs and symptoms of scabies, the IPN stated, yes.</p> <p>During a concurrent follow-up interview with the IPN and review of Resident 1's CP and Order Audit Report on 6/4/2024 at 1:55 p.m., the IPN stated Resident 1's order report indicated the resident was to be isolated from roommates when the Elimite was applied. The IPN stated the resident's care plan indicated Resident 1 was to be put on contact isolation. The IPN confirmed by stating Resident 1 was not isolated during the treatment of Elimite and was not put on contact isolation according to the CP. The IPN did not have a log/list of which facility staff were asked to monitor themselves in case they develop any rashes and shows s/sx of scabies. The IPN stated Resident 1 should have been placed on contact precautions as indicated in the CP. The IPN stated the facility staff should have been more vigilant and the IPN should have kept a log to monitor staff who were exposed to Resident 1.</p> <p>During an interview with the Director of Nursing (DON) on 6/4/2024 at 2:35 p.m., the DON confirmed by stating Resident 1's CP was not implemented.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedures (P&P) titled The Resident Care Plan reviewed on 5/21/2024, indicated The resident care plan shall be implemented for each resident on admission and developed throughout the assessment process. It is the responsibility of the Director of Nursing to ensure that each professional involved in the care of the resident is aware of the written plan of care, including its location, the current problems of the resident, and the goals or objectives of the plan.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on observation, interviews, and record review the facility failed provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of diseases for 2 sampled Residents (Resident1 and 2) in accordance with professional standards of practice by:</p> <ol style="list-style-type: none"> 1. Failing to place Resident in isolation on 5/30/2024 when the resident was suspected of having scabies (a parasitic infestation caused by tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash) and showed signs and symptoms (S/Sx). 2. Failing to ensure staff wore appropriate Personal Protective Equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, PPE may include respirators, gloves, overalls, boots, disposable gowns, and goggles) when providing care to residents with potential scabies exposure. 3. Failing to ensure nurses and other healthcare workers (HCW) were trained to recognize and report signs and symptoms compatible with scabies infestation according to the facility's policy and procedure (P&P) titled, Scabies Outbreak Control Plan reviewed on 5/21/2024. <p>These deficient practices had the potential to spread infection to the residents, visitors, and the community.</p> <p>Cross Reference F656</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH - is a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream) and disturbance (conditions that disrupt a person's thinking, feeling, and general daily functioning).</p> <p>During a review of the Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 5/12/2024, indicated Resident 1's cognitive skill (mental action or process of acquiring knowledge and understanding) for daily decision-making were severely impaired and the resident required maximal assistance from staff for activities of daily living (ADL- shower/bathing, lower body dressing and putting on/taking off footwear). The MDS indicated Resident 1 required supervision with repositioning such as sit to stand, toilet transfer, and walking.</p> <p>4/2024 at 10:36 a.m. (late entry) indicated, Resident 1's physician ordered to isolate the resident from roommates when Elimate (medication used to treat scabies) was applied.</p> <p>A review of Resident 1's Care Plan for scabies dated 6/3/2024 indicated an approach of contact isolation precautions (applies to any person with signs of an illness easily transmitted by direct patient contact or by indirect contact with items in the patient's environment) for 1 day for prophylaxis (an attempt to prevent disease) treatment.</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 a concurrent follow-up interview with the IPN and review of Resident 1's CP and Order Audit Report on 6/4/2024 at 1:55 p.m., the IPN stated Resident 1's order report indicated the resident was to be isolated from roommates when the Elimite was applied. The IPN stated the resident's care plan indicated Resident 1 was to be put on contact isolation. The IPN confirmed by stating Resident 1 was not isolated during the treatment of Elimite and was not put on contact isolation according to the CP. The IPN did not have a log/list of which facility staff were asked to monitor themselves in case they develop any rashes and shows s/sx of scabies. The IPN stated Resident 1 should have been placed on contact precautions as indicated in the CP. The IPN stated the facility staff should have been more vigilant and the IPN should have kept a log to monitor staff who were exposed to Resident 1.</p> <p>During an interview with the Director of Nursing (DON) on 6/4/2024 at 2:35 p.m., the DON confirmed by stating Resident 1's CP was not implemented.</p> <p>A review of the facility's policy and procedures (P&P) titled Scabies - Prevention and Control reviewed on 5/21/2024, indicated As soon as a case of scabies is confirmed or suspected, the following precautions should be implemented . place symptomatic resident on contact isolation precautions. Restrict resident to his/her room for the duration of the first treatment period, usually eight to twelve hours. Education will be provided to staff as soon as possible after identification of scabies and for residents/ family members and visitors regarding the control, prophylaxis, and prevention of the spread of scabies as soon as possible. The same P&P also indicated that, nurses and other HCW will be trained to recognize and report any patient, themselves or other HCW with S/Sx compatible with scabies infestation.</p> <p>A review of the facility's P&P titled Infection Control reviewed on 5/21/2024, indicated gowns and gloves are to be worn when providing care or working with environmental surfaces.</p>		