STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056388	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Valley Health Care	2575 E. Eighth St. National City, CA 91950

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure individuals are not inappropriately placed in nursing homes) was completed correctly for one of two residents (42). This failure had the potential to result in Resident 42's mental health needs to be unmet. Findings: Resident 42 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a serious mental illness that affects a person's thoughts, perceptions, emotions, and social interactions), according to the Admission Record. A joint interview and record review was conducted with the Minimum Data Set (MDS; assessment tool) Nurse (MDSN) on 11/21/24 at 8:25 A.M. The MDSN stated that Resident 42 had a diagnosis of schizophrenia on admission, but the PASARR, dated 3/21/24 did not indicate Resident 42 had any serious mental illness. A review of the MDS dated [DATE], indicated Resident 42 had an active diagnosis of schizophrenia. A second PASARR, dated 6/10/24, also did not indicate Resident 42 had any serious mental illness. The MDSN stated the PASARR should have been reviewed and corrected both times because the resident had a diagnosis of schizophrenia. An interview with the MDSN was conducted on 11/21/24 at 11:07 A.M. The MDSN stated that the PASARR should have been reviewed and corrected to make sure Resident 42 received the correct mental health care and services. An interview with the Director of Nursing (DON) was conducted on 11/21/24 at 3:42 P.M. The DON stated the PASARR should have been revised. The DON stated an accurate PASARR was important so Resident 42 could have received appropriate mental health treatment. A review of a directive from the California Department of Health Care Services (HCS) titled Skilled Nursing Facilities' (SNF's) Preadmission Screening and Resident Review (PASARR) Responsibilities, dated 8/30/23, indicated The SNF is required to initiate a Resident Review (RR) .when the Minimum Data Set (MDS) does not match the .screening from the hospital. The SNF must initiate the RR .within 72 hours of .identification of variance between the MDS and .Screening .

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview and record review, the facility failed to provide needed care and services that are resident-centered in accordance with professional standards of practice for one of 18 residents (Resident 82) reviewed with congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). This failure had the potential to contribute to Resident 82's declining health status with worsening CHF complications. Findings: A review of Resident 82's Admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses which included a history of CHF. A record review of Resident 82's Minimum Data Set (MDS: a federally mandated resident assessment tool) dated 10/19/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 0 points out of 15 possible points which indicated Resident 82 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 82's Medical Doctor (MD) orders dated 10/12/24 indicated, Daily weights 3x/wk [three times per week] every day shift Mon (Monday), Wed (Wednesday), Fri (Friday) . A review of Resident 82's History and Physical (H&P) dated 10/14/24 indicated, .CHF with exacerbation (increase in severity): edema present to BUE [bilateral upper extremities]/BLE [bilateral lower extremities] managed on [diuretic-medication that removes excess fluid from the body] and fluid restriction . A record review of Resident 82's CHF care plan interventions dated 10/13/24 indicated, .Observe for edema, weight gain .report abnormal findings to physician .Weights as ordered. A record review of Resident 82's weights indicated that Resident 82 gained five pounds (lbs) within one week that included: - On 10/13/24 Resident 82 weighed 139.8 lbs - On 10/21/24 Resident 82 weighed 144.8 lbs On 11/21/24 at 10:40 A.M., an interview and record review was conducted with Restorative Nurse Assistant (RNA) 1. RNA 1 stated that he checked Resident 82's weight on 10/13/24. RNA 1 stated that only the RNAs weighed the residents, and on 10/21/24, Resident 82's weight was checked by either him or RNA 2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 10:45 A.M., an interview and record review was conducted with RNA 2. RNA 2 stated that the charge nurse was responsible for communicating with the RNA team regarding which residents had weight orders and their frequency to check weights. RNA 2 stated that she did not have a binder or a formal order list, but a cheat sheet that she relied on that was not part of the medical record. RNA 2 stated the cheat sheet listed residents who had weight orders. RNA 2 reviewed Resident 82's October 2024 record, titled Order Listing Report provided by the Medical Records (MR) department. This record indicated that Resident 82 was on the list for weight orders. RNA 2 stated that Resident 82's weights were not taken/checked 3x/week as ordered by the MD. RNA 2 stated that Resident 82's weight should have been checked as ordered, to help monitor Resident 82's health status. On 11/21/24 at 1:06 P.M., a concurrent interview and record review was conducted with LN 1, in the conference room. LN 1 stated that on 10/12/24 she was the nurse that completed the admission for Resident 82. LN 1 stated that on 10/12/24 the MD ordered for weights to be taken 3x/week and that Resident 82 had edema (swelling) on her upper arms and legs. LN 1 stated that Resident 82 was being treated for CHF with diuretic medications, fluid restrictions, and weight orders. LN 1 stated Resident 82 was not being weighed according to MD orders. LN 1 stated it was important to monitor Resident 82's weight because this could indicate worsening CHF symptoms and that Resident 82 could go into fluid overload (occurs when body has too much fluid) complications. LN 1 stated Resident 82 gained five pounds within a week on 10/21/24 and stated there was no evidence that the MD was notified that day regarding the five-pound weight gain. LN 1 stated it was necessary to follow Resident 82's CHF plan of care and MD orders regarding the weight gain to prevent complications. On 11/21/24 at 3:58 P.M., an interview and record review was conducted with the Director of Nursing (DON), in the conference room. The DON stated his expectation was for the nursing staff to make sure the MD orders to monitor Resident 82's weights 3x/week were followed. The DON stated it was important to notify the MD of the five pound weight gain to prevent any delay in caring for Resident 82's CHF symptoms that may worsen. The DON stated that the facility's CHF policy and procedure was in accordance with the American Heart Association (AHA) recommendations for heart failure, and acknowledged that they did not meet the professional standards of practice for Resident 82's CHF plan of care when they did not notify the MD of the resident's (5 lb) weight gain. According to the American Heart Association titled MANAGING HEART FAILURE SYMPTOMS dated 2024 https://www.heart. org/en/health-topics/heart-failure/warning-signs-of-heart-failure/managing-heart-failure-symptoms .Many people are first alerted to worsening heart failure when they notice a weight gain of more than two or three pounds in a 24-hour period or more than five pounds in a week . A review of the facility's policy and procedure titled HEART FAILURE-CLINICAL PROTOCOL dated, November 2018, indicated .The physician will prescribe treatments for residents with heart failure that are consistent with relevant guidelines and protocols; for example, those of the American Heart Association and American Medical Directors Association (AMDA).

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to ensure low air loss mattresses (LAL - an air flow mattress used to prevent skin breakdown by distributing weight over the mattress to reduce pressure to the skin) were set according to the physician's order, for one of four residents (Resident 47) reviewed for pressure ulcers. This failure had the potential to increase the risk for skin breakdown and pressure ulcers for residents who used LAL mattresses. Findings: A review of Resident 47's Admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses which included a history of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A record review of Resident 47's Minimum Data Set (MDS; assessment tool) dated 10/31/24, indicated that Resident 47 was rarely or never understood, with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. A record review of Resident 47's MDS dated [DATE] indicated Resident 47 was at risk for pressure ulcers/injuries and had one or more unhealed pressure ulcers/injury. Resident 47's MDS also indicated Resident 47 required dependent (.helper does ALL of the effort .) to substantial/maximal assistance (.helper does MORE THAN HALF the effort .) with bed mobility. A record review of Resident 47's care plan dated 10/27/24 indicated, .Resident has a DTPI [deep tissue pressure injury] upon admit (admission) (left heel area) and is at risk for further skin breakdown .Pressure reduction mattress for bed . On 11/19/24 at 8:28 A.M., a concurrent observation and interview was conducted with Resident 47 and Certified Nursing Assistant (CNA) 1, in Resident 47's room. CNA 1 stated that Resident 47 was on a LAL mattress because Resident 47 was at risk for pressure ulcers. Resident 47 was in a semi-upright position in bed, wearing her own clothing, and stated she did not have any skin breakdown that she knew of. Resident 47 stated she did not know why she was using a LAL mattress. Resident 47's LAL mattress was set at 250 pounds (lbs). CNA 1 stated that they (the CNAs) did not touch the LAL mattress and that the licensed nurses (LN) were responsible for changing settings and monitoring the LAL mattress. On 11/20/24 at 2:12 P.M., an observation was conducted. Resident 47 was laying in a semi-upright position in bed, watching TV. Resident 47's LAL mattress was set at 250 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:49 P.M., an observation, interview, and record review was conducted with LN 3, at the 2nd floor nursing station. LN 3 stated that Resident 47's weight was checked and recorded on 11/19/24 at 189 lbs. LN 3 went to Resident 47's room to observe the LAL mattress settings. LN 3 stated that the LAL mattress was set at 250 lbs. LN 3 acknowledged that Resident 47's LAL mattress was not set according to Resident 47's weight. LN 3 stated Resident 47's LAL mattress should be readjusted and set correctly for management and prevention of pressure ulcers. LN 3 stated that she did not know how to change the LAL mattress settings and would need to call the maintenance director (MTD) to adjust the settings, since the MTD sets up all LAL mattresses. On 11/21/24 at 9:17 A.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated that on 10/31/24 the MDS nurse coded a DTPI on 10/31/24 on the MDS. The DON stated that Resident 47 had a DTPI on her admission assessment with treatment orders for both heels, and stated the LAL mattress was for the DTPI on Resident 47's heels. The DON stated his expectation was for the LNs to make sure the LAL mattresses were adjusted to the correct weight and comfort level. The DON stated it was important to set the LAL mattresses correctly to prevent pressure ulcer injuries for residents at risk. A review of the manufacturer guidelines for Front Panel diagrams, provided by the facility: [Brand Name] Low Air Loss Mattress manual dated 2017 When the mattress is fully inflated, set the dial in accordance with the patient's size and weight . A review of the facility's policy and procedure titled PREVENTION OF PRESSURE ULCERS dated April 2022, indicated, .Select appropriate support surface based the resident's risk factors, in accordance with current clinical practice .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to ensure dialysis (the process of cleaning the blood through a machine) access site was properly cared for two of two residents reviewed for dialysis (2 and 78). This deficient practice had a potential for Resident 2 and Resident 78's dialysis access to clot. Findings: 1. A review of Resident 2's Admission Record indicated Resident 2 was readmitted to the facility on [DATE], with diagnoses which included end stage renal disease (ESRD - kidney failure) and was dependent on dialysis. A review of Resident 2's History and Physical (H&P) dated 10/21/24, indicated Resident 2 had the capacity to understand and make decisions. A review of Resident 2's minimum data set (MDS - a federally mandated resident assessment tool) dated 10/24/24, indicated Resident 2 had a brief interview for mental status (BIMS - ability to recall) was 14/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). On 11/18/24 at 3:43 P.M., a concurrent observation and interview was conducted in Resident 2's room. Resident 2 was in bed. A meal tray was on the bedside table. Resident 2 had a pressure dressing on the dialysis access of his left upper arm. Resident 2 stated that he had two dialysis accesses, one on his right upper arm and one on his left upper arm. Resident 2 stated the dialysis access on his right upper arm was clotted. Resident 2 stated they are using my left upper arm. Resident 2 stated that he had dialysis, and the facility Licensed Nurses (LNs) removed the pressure dressing on his left dialysis access arm the next day. On 11/19/24 at 8:19 A.M., an observation and interview of Resident 2 was conducted in his room. Resident 2 was sitting up in bed, with a meal tray at the bedside table. Resident 2 had a pressure dressing on his left upper dialysis access arm. Resident 2 stated the pressure dressing was from the dialysis center on 11/18/24. Resident 2 stated They (LNs) will take if off when they want to. On 11/19/24 at 8:40 A.M., a joint observation and interview was conducted with LN 11. LN 11 stated the pressure dressing on Resident 2's dialysis access arm was still on and should have been removed after 4-6 hours to prevent irritation and clotting of Resident 2's dialysis access. A review of Resident 2's physician's order dated 10/21/24 indicated check .site dressing upon return from dialysis. May remove the pressure dressing ([4] enter number of hours) following dialysis and apply non-pressure dressing. The non-pressure dressing may be removed ([4] enter number of hours) .every Monday, Wednesday, and Friday afternoon . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 4:02 P.M., a joint interview and review of Resident 2's clinical record was conducted with LN 12. LN 12 stated the physician order and the care plan for Resident 2's dialysis access was for the LNs to check the dialysis access site and remove the pressure dressings after four hours from dialysis to prevent clotting of the access. On 11/21/24 at 8:19 A.M., a telephone interview was conducted with the outpatient dialysis nurse (ODN). The ODN stated she was familiar with Resident 2. The ODN stated Resident 2 had two access, one on his right upper arm which was clotted, and one on his left upper arm. The ODN stated Resident 2 received dialysis through his left upper arm access. The ODN stated the pressure dressings on Resident 2's left upper arm should be removed not more than four hours after his dialysis to prevent clotting of the access. On 11/21/24 at 1:32 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the LNs to check and remove the pressure dressings on the resident's dialysis access arm four hours after the resident's dialysis to prevent clotting of the access. A review of the facility's policy titled, Hemodialysis - Access and Care of, revised 2/2023, was conducted. The policy did not provide instructions or guidance of the hours related to removal of access dressing. 48263 2. Resident 78 was admitted to the facility on [DATE] with diagnoses which included a history of end stage kidney disease (ESRD-irreversible kidney failure), per the Admission Record. A review of Resident 78's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 10/29/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 12 points out of 15 possible points which indicated Resident 78's mental cognition (pertaining to memory, judgement and reasoning ability) was intact. On 11/19/24 at 8 A.M., an observation and interview was conducted with Resident 78 and LN 1, in Resident 78's room. Resident 78 stated that he was not here yesterday (11/18/24) morning because he went out for dialysis. Resident 78 stated that he returned from dialysis at night around 7 PM, and further stated that they did not change his dialysis dressing that night. Resident 78 stated, They're [LN-Licensed Nurse] supposed to change it within 6 hours after dialysis. On 11/19/24 at 8:07 A.M., an interview was conducted with LN 2, outside of Resident 78's room. LN 2 stated Resident 78 goes to dialysis on Monday, Wednesday and Friday (MWF). LN 2 stated that Resident 78 leaves for dialysis in the morning and returns to the facility at NOC [night] shift. LN 2 was shown a picture of Resident 78's dialysis site, which was not dated. LN 2 stated that Resident 78's dialysis site should be changed within 4-6 hours, and further stated that post-dialysis care included monitoring the dialysis site, dressing changes as ordered, and the observation of the dialysis site should be documented. On 11/19/24 at 11:38 A.M., a review of Resident 78's Daily Skilled Nurse Charting dated 11/18/24 at 2:33 A. M., was conducted. There was no documentation of post-dialysis observations/site care or dressing change. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:19 P.M., a concurrent interview and record review was conducted with LN 3, at the second-floor nursing station. LN 3 stated Resident 78 had dialysis dressing change orders from dialysis, dated 11/19/24, that indicated remove 4 hours after dialysis. LN 3 stated the dressing should have been removed during NOC shift to observe the dialysis site for complications. LN 3 stated there was no documentation on the Daily Skilled Nurse Charting or progress notes regarding post-dialysis care for Resident 78's left upper arm dialysis site. On 11/21/24 at 9:31 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated his expectations was for the LNs to provide post-dialysis care for residents with dialysis, such as Resident 78. The DON stated it was important that Resident 78's dressing was removed as ordered within 4 hours to observe the site for infection and prevent the clogging of the site, excessive bleeding, and reinforced as necessary, to prevent complications. A review of the facility's policy and procedure titled HEMODIALYSIS CATHETERS-ACCESS AND CARE of revised February 2023 indicated, .The nurse should document in the resident's medical record every shift as follows: 1. Location of catheter 2. Condition of dressing .5. Observation post-dialysis.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to include the appropriate indication (reason) and monitor the target behaviors for two of five residents (16 and 134) when: 1. Resident 16 did not have appropriate indications for the use of an antipsychotic medication (a medication used to treat symptoms of psychosis such as hallucinations and delusions). 2. Resident 134 did not have appropriate indication for anti-anxiety (medication used for worry and fear) medications and appropriate target behavior for the use of anti- anxiety medications. These failures had the potential for unnecessary psychotropic (mind-altering medications) medication use and a decline for resident's psychological and mental well-being. Findings: 1. Resident 16 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that would affect a person's daily life) and anxiety disorder (a mental health condition that involved persistent and uncontrollable feelings of fear and worry), according to the Admission Record. A joint interview and record review was conducted with the minimum data set (MDS; an assessment tool) nurse (MDSN) and Licensed Nurse (LN) 20 on 11/21/24 at 9:04 A.M. The MDSN stated that Resident 16 had an active physician's order (November 2024) for quetiapine (Seroquel, an antipsychotic medication), ordered on 10/13/24, to be given for dementia. The MDSN stated there was a physician's order, dated 10/13/24, indicating quetiapine was to be given because Resident 16 had sudden mood changes with agitation. The MDSN stated that dementia was not a psychotic diagnosis. A review of hospital discharge paperwork dated 9/27/24 was conducted with LN 20. LN 20 stated quetiapine was not listed as a discharge medication. The MDSN and LN 20 stated they did not know why Resident 16 was taking quetiapine. A review of Resident 16's medication administration records (MAR) dated October and November 2024, was conducted on 11/21/24. The MAR indicated Resident 16 did not have any sudden mood changes with agitation in the month of October 2024. The MAR dated November 2024 indicated Resident 16 had one occurrence of sudden mood changes with agitation in which she was easily redirected. A telephone interview with Resident 16's responsible party (RP 21) was conducted on 11/21/24 at 10:12 A. M. RP 21 stated he was not aware that Resident 16 was taking quetiapine/seroquel. An interview with LN 20 was conducted on 11/21/24 at 12:21 P.M. LN 20 stated that dementia was not a psychotic diagnosis. LN 20 stated anxiety medications could be given if Resident 16 had agitation. LN 20 stated Resident 16 did not do much of anything and needed family to try and convince her to participate in activities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) was conducted on 11/21/24 at 3:48 P.M. The DON stated quetiapine was an antipsychotic medication. The DON stated agitation was not a psychotic behavior. The DON stated agitation was not an adequate indication for the use of quetiapine. The DON acknowledged that the indication should have been questioned/clarified, but was not. A review of the facility's policy titled Antipsychotic Medication Use, revised 7/2022, indicated .5. Residents who are admitted .the interdisciplinary team will .re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks .9. Diagnoses alone do not warrant the use of antipsychotic medication . 40610 2. Resident 134 was readmitted to the facility on [DATE], with diagnoses which included aphasia (a language disorder that makes it difficult to understand, speak, read, or write) after a stroke, per the Admission Record. A review of Resident 134's History and Physical (H&P) dated 11/13/24, indicated Resident 134 had no capacity to understand and make decisions. On 11/18/24 at 8:41 A.M., an observation was conducted in Resident 134's room. Resident 134 was sitting up in bed. A staff member was at the beside, feeding her. Resident 134 did not respond when her name was called. On 11/19/24 at 8:26 A.M., an observation of Resident 134 was conducted in her room. Resident did not respond to questions or to greetings. On 11/20/24 at 2:06 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated Resident 134 was non-verbal and just looks at the person. CNA 11 stated Resident 134 could not say a word or formulate a sentence. CNA 11 stated there was no behavioral monitoring for Resident 134 because she was a nice resident. On 11/20/24 at 3:44 P.M., a joint interview and review of Resident 134's clinical record was conducted with Licensed Nurse (LN) 11. LN 11 stated that Resident 134 was non-verbal, alert to self, followed eye contact, and was not able to verbalize her feelings. On 11/21/24 at 10:18 A.M., a joint interview and review of Resident 134's clinical record was conducted with the Minimum Data Set (MDS; assessment tool) Nurse (MDSN). The MDSN stated Resident 134 had no diagnosis of anxiety from the acute hospital records. The MDSN stated the facility record indicated Resident 134 was placed on lorazepam (anti-anxiety medication) for anxiety. The MDSN stated the LNs should have clarified the indication for lorazepam to prevent unnecessary medication and to prevent confusion among staff members. The MDSN stated the target behavior to be monitored of Resident 134 for taking the lorazepam was verbalizing anxiety. The MDSN stated Resident 134 was non-verbal. On 11/21/24 at 1:32 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the LNs to clarify the indication of the psychotropic medication, resident's correct diagnosis, and the target behavior to prevent the use of unnecessary medication. The DON stated it was also important to know if the medication was appropriate for the resident's behavior and ensure its effectiveness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056388	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradise Valley Health Care	2575 E. Eighth St. National City, CA 91950

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** 40610 Based on observation, interview, and record review the facility failed to ensure infection control procedures were followed when a Licensed Nurse (LN) 14 did not perform hand hygiene (the practice of cleaning hands to remove germs, dirt, or other harmful substances) consistently after removing her gloves while providing wound care to one of four residents (Resident 43), reviewed for pressure ulcer (sore). This failure had the potential for cross contamination, spread of infection, and Resident 43's decline in health. Findings: Resident 43 was readmitted to the facility on [DATE], with diagnoses which included immunodeficiency (when the body's immune system is reduced or absent) and an infection on her right knee, per the Admission Records. A review of the facility's matrix (used to identify pertinent care categories), indicated that Resident 43 had an unstageable (a type of bed sore that occurs due to prolonged pressure on a specific area of the skin) pressure sore on her right heel. On 11/21/24 at 9:48 A.M., an observation of Licensed Nurse (LN) 14 providing wound care to Resident 43 was conducted. LN 14 prepared supplies for Resident 43's wound care and placed them on a tray. LN 14 put on a pair of gloves, removed the old dressing from Resident 43's right knee, took off her gloves, put on a new pair of gloves, treated Resident 43's knee with betadine (antiseptic solution), and placed a bandage on Resident 43's right knee with a gauze on top of the wound. LN 14 wrapped Resident 43's right knee wound with a rolled gauze. LN 14 then moved to Resident 43' right heel pressure sore. LN 14 put on a new pair of gloves and removed the old dressing from Resident 43's right heel pressure sore. LN 14 removed her gloves, applied betadine to Resident 43's right heel pressure sore, wiped it dry with dry dressings, and placed a bandage on Resident 43's right heel pressure sore. LN 14 removed her gloves, put on a new pair of gloves, wrapped Resident 43's right leg with an elastic wrap and placed an immobilizer (used to correct or help certain injuries heal) on Resident 43's right leg. LN 14 did not perform hand hygiene in between tasks. On 11/21/24 at 10:12 A.M., an interview with LN 14 was conducted. LN 14 stated Resident 43 had an infection on her right knee after a surgery. LN 14 stated Resident 43 developed a pressure sore on her right heel. LN 14 stated she did not perform hand hygiene after removing her gloves. LN 14 stated she usually brings a little spray and forgot it today. LN 14 stated, it was important to perform hand hygiene before putting on new gloves to prevent infection because anything can get into the gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056388	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 1:32 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the staff to sanitize their hands every time they removed their gloves to prevent cross contamination because there might be some bacteria on their hands and this may cause infection to the residents. A review of the facility's policy titled, Wound Care revised October 2010, indicated .5. Pull gloves over dressing and discard .Wash and dry .hands thoroughly . A review of the facility's policy titled, Infection Prevention and Control Program, revised October 2018, indicated, .11. Prevention of Infection .a .(2) educating staff and ensuring that they adhere to proper techniques and procedures .