

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER St Edna Subacute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1929 N. Fairview Street Santa Ana, CA 92706	

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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683</p> <p>Based on observation, interview, medical record review, and facility document review, the facility failed to follow the infection control practices while cleaning the resident rooms for two of two sampled residents (Residents 1 and 2) and 10 nonsampled residents (Residents 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12.)</p> <p>* Housekeepers 1 and 2 did not use a new cloth while cleaning the individually used equipment between Residents 1, 2, 3, 4, 5, 6, 7, 8, and 9.</p> <p>* Housekeepers 1 and 2 did not wear a gown while cleaning the resident rooms with the EBP signage.</p> <p>* Housekeeper 1 scrubbed the toilet seats for Rooms A and B's shared restroom, and Room C's restroom with a toilet scrub brush for toilet bowl use only.</p> <p>* Housekeeper 1 failed to clean the restroom grab bars for Rooms A and B's shared restroom, and Room C's restroom.</p> <p>These failures had the potential to spread infection to the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's Infection Prevention Manual for Long Term Care revised 5/2024 showed EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms by wearing a gown and gloves during high contact resident care activities, which may include environmental sanitation.</p> <p>1.a. On 7/30/24 at 0919 hours, Housekeeper 1 was observed cleaning Resident Room C. The signage showed three residents (Residents 7, 8, and 9) resided in the room. An EBP sign was observed outside the room's doorway. The following observations were made:</p> <ul style="list-style-type: none"> - Housekeeper 1 did not wear a gown while cleaning inside Room C. - Housekeeper 1 was observed using a damp washcloth with disinfectant and wiped down Residents 7, 8, and 9's tray tables with the same damp washcloth. <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 - Some</p>	<ul style="list-style-type: none"> - Housekeeper 1 got a new damp washcloth and cleaned Residents 7, 8, and 9's call light and call light cord with the same washcloth. - Housekeeper 1 got a new damp washcloth and cleaned Residents 7, 8, and 9's nightstand with the same washcloth. - Housekeeper 1 used a handled toilet bowl brush to scrub the top and bottom of the toilet lid and seat, and then scrubbed the toilet bowl. - Housekeeper 1 was not observed wiping down the handrail next to the toilet. <p>Medical record review for Resident 7 was initiated on 7/30/24. Resident 7 was readmitted to the facility on [DATE].</p> <p>Review of Resident 7's Order Review Report dated 7/30/24, showed a physician's order dated 5/30/24, for EBP.</p> <p>Medical record review for Resident 8 was initiated on 7/30/24. Resident 8 was readmitted to the facility on [DATE].</p> <p>Review of Resident 8's Order Review Report dated 7/30/24, showed a physician's order dated 6/18/24, for EBP.</p> <p>b. On 7/30/24 at 0855 hours, Housekeeper 1 was observed cleaning Resident Room A. The door signage showed three residents (Residents 1, 2, and 3) resided in the room. The following observations were made:</p> <ul style="list-style-type: none"> - Housekeeper 1 was observed using a washcloth soaked with disinfectant and wiped down Residents 1, 2, and 3's tray tables with the same damp cloth. - Housekeeper 1 then got a new washcloth soaked with disinfectant and cleaned Residents 1, 2, and 3's nightstands, and a bookshelf across from Resident 3's bed with the same cloth. - Housekeeper 1 then got a new washcloth soaked with disinfectant and cleaned Residents 1, 2, and 3's call-lights and call-light cords with the same cloth. <p>c. On 7/30/24 at 0905 hours, Housekeeper 1 was observed cleaning Resident Room B. The door signage showed three residents (Residents 3, 4, and 5) resided in the room. The following observations were made:</p> <ul style="list-style-type: none"> - Housekeeper 1 was observed using a washcloth soaked with disinfectant and wiped down Residents 4, 5, and 6's tray tables with the same damp cloth. - Housekeeper 1 then got a new washcloth soaked with disinfectant and cleaned Residents 4, 5, and 6's call-lights and call-light cords with the same cloth. <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>- Housekeeper 1 then got a new washcloth soaked with disinfectant and cleaned Residents 4, 5, and 6's nightstand, and Resident 6's transfer pole (a pole from floor-to-ceiling for resident use) with the same washcloth. Resident 6 was observed grabbing onto the transfer bar after the housekeeper wiped it down.</p> <p>d. On 7/30/24 at 0934 hours, Housekeeper 1 was observed cleaning the shared restroom for Resident Rooms A and B. Housekeeper 1 was observed scrubbing both sides of the toilet seat with the same toilet scrub brush used in Room C. The housekeeper failed to clean the grab bar located next to the toilet.</p> <p>On 7/30/24 at 0940 hours, an interview was conducted with Housekeeper 1, translated by CNA 1. Housekeeper 1 stated they cleaned all the call lights with the same cloth, then got a new cloth for the tray tables, and a new cloth for all the nightstands. The housekeeper stated it was to prevent cross contamination. Housekeeper 1 stated they forgot to clean the grab bar in the restrooms and verified they used a toilet brush to clean the toilet bowls and seats. Housekeeper 1 verified they used the toilet bowl brush to scrub the toilet seats.</p> <p>2. On 7/30/24 at 0951 hours, an observation and concurrent interview was conducted with Housekeeper 2. Housekeeper 2 was observed cleaning Resident Room D. The door signage showed three residents (Residents 10, 11, and 12) resided in the room. An EBP sign was observed outside the room's doorway. The following observations were made:</p> <p>- Housekeeper 2 did not wear a gown while cleaning inside Room D.</p> <p>- Housekeeper 2 was observed using a washcloth soaked with disinfectant and wiped down Resident 10's tray table, nightstand, call-light and call-light cord; then Resident 11's tray table, call-light and call-light cord; and Resident 12's call-light and call-light cord with the same damp cloth.</p> <p>Housekeeper 2 stated they did not need to wear a gown while cleaning the resident rooms with EBP if they were not in contact with the resident. Housekeeper 2 stated they used one wash cloth to clean the tray tables, nightstands, call-lights, and call-light cords for all three residents.</p> <p>Medical record review for Resident 10 was initiated on 7/30/24. Resident 10 was readmitted to the facility on [DATE].</p> <p>Review of Resident 10's Order Review Report dated 7/30/24, showed a physician's order dated 6/18/24, for EBP.</p> <p>Medical record review for Resident 11 was initiated on 7/30/24. Resident 11 was admitted to the facility on [DATE].</p> <p>Review of Resident 11's Order Review Report dated 7/30/24, showed a physician's order dated 5/30/24, for EBP.</p> <p>On 7/30/24 at 1010 hours, an interview was conducted with the Environmental Services Supervisor. The Environmental Services Supervisor stated the housekeeping staff should never use the same cloth to clean between the residents, should always wear a gown when cleaning in a room with EBP, and should only use the toilet bowl scrubber for inside the toilet bowl, not outside of the toilet bowl.</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>On 7/30/24 at 1023 hours, an interview was conducted with the Infection Preventionist. The Infection Preventionist stated the housekeeping staff should always wear a gown when cleaning the resident rooms with EBP since they were in contact with the residents' environment.</p>