STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
French Park Care Center	600 E Washington Avenue Santa Ana, CA 92701

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 0813 Level of Harm - Potential for minimal harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 49324 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the safe and sanitary handling of the residents' foods brought in from the outside, as per the facility's P&P and standards of practice. * Two bottles of drinks and muffins were found near the window and air conditioner. This failure had the potential to expose the residents to food contamination. Findings: According to the 2017 USDA FDA Food Code, section 3-501.17 (B), .food .shall be clearly marked, at the time the original container is opened .and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed .or discarded . Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors, revised 9/2023showed all food items that are brought in by family or visitor must be approved per Nursing to ensure that it is labeled with content and dated. The facility may refrigerate labeled and dated. On 4/19/24 at 0951 hours, an observation was conducted in Room A. There were two bottled drinks found on the floor near the window and air conditioner. One bottle had a label showing it needed to be refrigerated. Additionally, there were muffins found below the window on top of the air conditioner. On 4/19/24 at 1048 hours, an interview as conducted with CNA 8. CNA 8 stated the two bottled drinks should not be on the floor, and the muffins should not be placed on top of the air conditioner. All food items should have been stored properly, labeled, and dated.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, and facility P&P review, the facility failed to maintain the complete and accurate medical record for one of eight sampled residents (Resident 1). * The facility failed to ensure the completion of Resident 1's ADL- Bed Mobility Intervention/Task. This failure had the potential for the resident care needs not being met as the medical information was incomplete and inaccurate. Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/2022 showed documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Medical record review for Resident 1 was initiated on 4/3/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Care Plan with an initiation date of 8/3/23, showed Resident 1 had an ADL self-care performance deficit related to impaired function and limited mobility. Review of Resident 1's ADL- Bed Mobility Intervention/Task Documentation Survey Report for February and March 2024 showed missing documentation for the night shifts on 2/7, 2/8, 2/11, 2/14, 2/15, 2/16, 2/18, 2/19, 3/1, 3/14, 3/19, 3/20, and 3/26/24; and the morning shifts on 3/2 and 3/22/24. On 4/5/24 at 1348 hours, an interview was conducted with Medical Records Director. The Medical Records Director verified the above missing documentation. The Medical Records Director stated the CNAs assigned should have not missed their documentation. On 4/5/24 at 1457 hours, an interview was conducted with DSD. The DSD acknowledged all the missing documentation from the mentioned dates.

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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 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** 49324 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were maintained. * The staff failed to perform hand hygiene during care provided to two of two sampled residents (Residents 1 and 3). * The facility failed to ensure proper handling, storing, processing, and transporting of the linens to prevent the spread of infection. * CNA 5 failed to perform hand hygiene when leaving an Enhanced Precaution room and touched clean linen with their soiled gloves. These failures had the potential to result in the spread of infection to the residents. Findings: 1. Review of the facility's P&P titled Hand Hygiene Policy revised 12/2024 showed all staff will perform proper hand hygiene procedures to prevent spread of infection to other personnel, residents and visitors, the use of gloves does not replace hand hygiene, if a task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene is indicated and will be performed under the conditions: hands are visibly dirty, after handling contaminated objects, before applying and removing personal protective equipment, including gloves, before preparing and handling medications, before and after handling clean or soiled dressings, before performing resident procedures, after handling items potentially contaminated with blood, body fluids, secretions or excretions, when, during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions (e. g., elimination) a. On 3/27/24 at 1111 hours, a wound care treatment observation was conducted for Resident 1 with Treatment Nurse 1. Treatment Nurse 1 was observed sanitizing hands before entering the room and put on a gown and double gloves. Treatment Nurse 1 was observed removing the dirty dressing from Resident 1's wound and wiped the wound. Treatment Nurse 1 did not remove the gloves and perform hand hygiene after removing the old dressing and prior to clean Resident 1's wound. After cleaning the wound site, Treatment Nurse 1 removed the first layer of gloves and did not perform hand hygiene. Treatment Nurse 1 proceed to wear new set of gloves and continued with wound care. When finished, Treatment Nurse 1 removed her gloves, picked up the treatment tray and proceeded to place it in the cart. On 4/4/24 at 1025 hours, Treatment Nurse 1 acknowledged she did not perform proper hand hygiene during the wound care treatment for Resident 1. Treatment Nurse 1 further verified she should have not worn double gloves during wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 4/2/24 at 1008 hours, a wound care observation for Resident 3 was conducted with Treatment Nurse 2 and CNA 3. CNA 3 was observed cleaning Resident 3 before wound care treatment. CNA 3 removed her dirty gloves, washed her hands, and wore new two pairs of gloves on each hand. CNA 3 cleaned Resident 3, then touched the clean linen without performing hand hygiene. CNA 3 again cleaned Resident 3 and placed the soiled linen in the soiled bin. CNA 3 took out a clean underpad and placed it under Resident 3. CNA 3 repositioned the resident to the left side and found Resident 3 to be soiled again. CNA 3 went to perform hand hygiene and wore new gloves. CNA 3 proceeded to clean Resident 3 again and went to get Saniwipes (disinfectant wipes) to clean the mattress. CNA 3 did not perform hand hygiene, continued to place another clean pad under Resident 3, and repositioned towards the left side of the wall. On 4/2/24 at 1315 hours, an interview was conducted with CNA 3. CNA 3 acknowledged not performing proper hand hygiene and further stated she should not have worn double gloves. CNA 3 stated she should have washed hands in between the change of gloves to prevent spread of infection. On 4/4/24 at 0903 hours, an interview was conducted with Treatment Nurse 2. Treatment Nurse 2 stated CNA 3 should have not worn double gloves and should always observe proper hand hygiene. 2. Review of the facility's P&P titled Soiled Linen and Trash Containers revised 12/2022 showed all mobile containers shall be actively attended when not in the soiled utility rooms. These containers shall not be stored in the corridors at any time. On 4/2/24 from 1410 hours to 1446 hours, an unattended mobile soiled linen bin with the lid not closing due to overflow was located beside the medication room along the hallway of Station 1. On 4/2/24 at 1448 hours, an interview was conducted with LVN 4 and CNA 4. LVN 4 stated the mobile overflowing soiled linen bin should not be left unattended for long time and bin should be closed due to infection control. CNA 4 stated the soiled linen bin should not be overflowing and should have been brought to the Laundry. 3. Review of the facility's P&P titled Enhanced Barrier Precautions last revised on 2/2024 showed staff receive training on enhanced barrier precautions are expected to comply with all designated precautions. It further stated position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. On 4/2/24 at 0917 hours, CNA 5 was observed wearing gloves and gown and running out from room [ROOM NUMBER] to grab a bed sheet from a clean linen cart two doors down the hallway. room [ROOM NUMBER] was noted with signage of Enhanced Precaution at the door. On 4/2/24 at 0922 hours, an interview was conducted with CNA 5. CNA 5 stated she should have removed gloves and gown and performed hand hygiene prior to leaving the resident's room. CNA 5 stated the clean linen cart should not be accessed with soiled gloves. On 4/2/24 at 1015 hours, an interview conducted with the RN Supervisor. The RN Supervisor acknowledged the above findings.