

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER French Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs of two of 12 sampled residents (Residents 9 and 12).</p> <p>* Resident 12 was observed lying in bed without his call light in reach.</p> <p>* Resident 9 was observed lying in bed callingout repeatedly for water and without his call light in reach.</p> <p>These failures had the potential for their care needs to go unmet.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 12/19/2022,showed the staff will ensure the call light is within reach of the resident and secured as needed.</p> <p>a. Medical record review for Resident 12 was initiated on 5/14/23. Resident 12 was admitted to the facility on [DATE].</p> <p>Review of Resident 12's H&P examination dated 5/16/23, showed Resident 12 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 12's MDS dated [DATE], showed Resident 12 had severe cognitive impairment.</p> <p>Review of Resident 12's Fall Risk assessment dated [DATE], showed Resident 12 was at a high risk for falls.</p> <p>Review of Resident 12's plan of care showed a care plan problem dated 7/20/23, addressing Resident 12's risk for falls. The interventions included to place the call light within reach and answer the call light promptly.</p> <p>On 5/8/24 at 1522 hours, Resident 12 was observed lying in bed. Resident 12's call button was observed underneath his pillow. When Resident 12 was asked if he could find and reach his call light button, Resident 12 shook his head left and right, indicating no.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/8/24 at 1530 hours, an interview and concurrent observation was conducted with LVN 3. A picture of a star was observed by Resident 12's name label on the outside of his room. LVN 3 stated Resident 12 had a star by his name because he was at a high risk for falls. LVN 3 stated when a resident was a fall risk, the staff had to ensure the call light was within reach. LVN 3 asked Resident 12 how he would call the nurse and Resident 12 picked up the bed control. LVN 3 found the call light button underneath Resident 12's pillow. LVN 3 verified the call light button was not within Resident 12's reach.</p> <p>b. Medical record review for Resident 9 was initiated on 5/14/23. Resident 9 was admitted to the facility on [DATE].</p> <p>Review of Resident 9's H&P examination dated 5/11/23, showed Resident 9 had no capacity to understand and make medical decisions.</p> <p>On 5/13/24 at 0842 hours, Resident 9 was observed lying in bed and calling out for water. There was no light observed outside the door to indicate the call light button had been pressed. There was no water pitcher observed on Resident 9's bedside table.</p> <p>On 5/13/24 at 0843 hours, Resident 9 was observed calling out for water again. There was no light observed outside the door to indicate the call light button had been pressed.</p> <p>On 5/13/24 at 0848 hours, Resident 9 was observed lying in bed with his eyes closed. A call light button was not visible within Resident 9's reach.</p> <p>On 5/13/24 at 0900 hours, Resident 9 was observed calling out for water. There was no light observed outside the door to indicate the call light had been pressed.</p> <p>On 5/13/24 at 0904 hours, an interview and concurrent observation was conducted with CNA 6. CNA 6 was observed reaching around to the side of the bed and pulled out the call light button, which was hooked to the top of the bed and hanging off to the side. CNA 6 verified the call light button was not within Resident 9's reach.</p> <p>On 5/14/24 at 1009 hours, an interview was conducted with the DON. The DON stated the call lights should be in reach at all times for the resident safety.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for two of 12 sampled residents (Residents 1 and 10).</p> <p>* The facility failed to ensure Resident 1 did not exceed the maximum hours for her therapeutic leave as ordered by the physician. In addition, the facility failed to notify the physician that Resident 1 was staying out longer than ordered during her therapeutic leave.</p> <p>* The facility failed to ensure Resident 1 was assessed upon leaving and/or returning to the facility and the Release for Temporary Absence sign-in and sign-out sheets were completed each time Resident 1 left and returned from her therapeutic leave.</p> <p>* The facility failed to ensure Resident 10 was assessed upon leaving and returning to the facility from his therapeutic leave. In addition, the facility failed to ensure the Release for Temporary sign-in and sign-out sheet was completed when Resident 10 left the facility.</p> <p>These failures posed the risk of the residents not receiving the necessary care and services to meet their needs and negatively affect the residents' health and well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Therapeutic Leave revised 12/19/22, showed the residents have the right to leave the facility for non-medical visits. The facility will abide by the rules for the amount of leave time allowable as per Federal Medicare, State Medicaid, and insurance carrier's guidelines. The P&P also showed the facility will document in the medial record any education given to the resident or the resident's representative prior to the leave. Additionally, the P&P showed if the resident did not return from the therapeutic leave as expected the facility would attempt to contact the resident or resident representative and document it in the medical record.</p> <p>Review of the facility's P&P titled Comprehensive Care Plan revised 12/19/22, showed the facility must develop and implement a comprehensive person-centered care plan that includes measurable objectives. The P&P also showed the care plan should be updated and revised by the IDT after each quarterly MDS assessment.</p> <p>a. On 5/8/24 at 1240,1400, and 1431 hours, Resident 1 was not observed in her room.</p> <p>Medical record review for Resident 1 was initiated on 5/9/24. Resident 1 was admitted to the facility on [DATE].</p> <p>Review of Resident 1's H&P examination dated 3/118/24, showed Resident 1 had the capacity to understand and make medical decisions. Resident 1 had bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration) and anxiety disorder (mental illness characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's MDS dated [DATE], showed Resident 1 was cognitively intact. The MDS also showed Resident 1 was wheelchair bound.</p> <p>Review of Resident 1's Order Summary Report showed a physician's order dated 3/1/23, allowing Resident 1 to leave the facility for therapeutic purposes, for a maximum of four hours.</p> <p>Review of Resident 1's plan of care showed a care plan problem dated 3/7/23, addressing Resident 1's noncompliance with the therapeutic leave time frame of four hours. The plan of care failed to show how the resident would be monitored when she left and returned to the facility. The plan of care also failed to include what measures would be implemented to ensure if Resident 1 returned to the facility within the four-hours timeframe and when Resident 1 did not return to the facility within the allowed timeframe.</p> <p>Review of Resident 1's nursing progress notes dated 3/1 to 5/13/24, failed to show the nurses were consistently documenting the assessments when Resident 1 left and/or returned to the facility from her therapeutic leave. In addition, Resident 1's nursing progress notes failed to show the physician was informed when Resident 1 was out of the facility more than the four hours ordered for her therapeutic leave.</p> <p>Review of Resident 1's Interdisciplinary Care Conference dated 4/17/24, failed to show the IDT had addressed Resident 1's noncompliance with her therapeutic leave order.</p> <p>Review of the facility's Out on Pass binder from August 2023 to May 2024 showed each resident had their own Release for Temporary Absence sign-in/sign out form that included a section for the departure date and time, return date and time, destination, responsible party signature, and witness signature. The Out on Pass binder showed instructions for the nursing staff to ensure the resident was filling out all portions of the out on pass form, i.e., date and time when leaving and returning. In addition, the instructions showed it was the charge nurse's responsibility to make sure all the sections of the forms were completed by the resident/responsible party. Review of Resident 1's Release for Temporary Absence sign-in/sign-out forms from August 2023 to January 2024 showed multiple incomplete illegible entries which were not signed by any of the staff members. Further review of Resident 1's Release for Temporary Absence sign-in/sign out forms failed to show entries for February to May 2024.</p> <p>On 5/13/24 at 1425 hours, an interview was conducted with LVN 8. LVN 8 stated Resident 1 left the facility every day after her 1200 hours medications were administered. LVN 8 stated Resident 1 did not return to the facility within the four-hours timeframe. LVN 8 stated Resident 1 went to the library, restaurants, and stores to shop. LVN 8 stated Resident 1 did not check in with the staff when she returned to the facility.</p> <p>On 5/13/24 at 1445 hours, an interview and concurrent facility document review was conducted with Unit Manager 1. Unit Manager 1 verified the above findings. Unit Manager 1 stated the residents were supposed to sign in and out in the Out on Pass binder and the nurses were supposed to write a brief resident assessment in the progress notes when the resident left and returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/24 at 1009 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON verified there were no nursing progress notes indicating the physician was informed of how long Resident 1 was staying out or where she was going during her therapeutic leave. The DON stated the therapeutic leave required a physician's order and it was the facility's expectation to notify the physician if the orders were not being followed.</p> <p>b. Medical record review for Resident 10 was initiated on 5/14/24. Resident 10 was admitted to the facility on [DATE].</p> <p>Review of Resident 10's H&P examination dated 3/9/24, showed Resident 10 had the capacity to understand and make medical decisions.</p> <p>Review of Residents 10's Order Summary Report showed a physician's order dated 3/1/24, allowing Resident 10 to go out on pass with his family member/responsible party for therapeutic purposes.</p> <p>On 5/14/24 at 0900 hours, an interview and concurrent facility document review was conducted with Unit Manager 3. Review of Resident 10's Release for Temporary Absence sign-in and sign-out forms showed Resident 10's family member signed the resident back in on 5/4/24 at 1739 hours and 5/13/24 at 1715 hours. However, under the departure hour column, it showed 132 B, instead of the time Resident 10 left the facility. Review of Resident 10's nursing progress notes did not show any notes regarding Resident 10's condition when he left the facility or when he returned. Unit Manager 3 verified the above findings. Unit Manager 3 stated she was not sure what time Resident 10 left for his therapeutic leave on 5/13/24. Unit Manager 3 stated the nurses were supposed to write a progress note when a resident leaves and when the resident returns to the facility.</p> <p>On 5/14/24 1130 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator verified the above findings. The Administrator stated the staff should follow the instructions inside the Out on Pass binder. The Administrator stated there should be a nurse's note in the progress notes before a resident leaves and upon their return to the facility. The Administrator stated the sign-in and sign-out sheets for the therapeutic leave should be completed and witnessed by a staff member.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment were followed for three of 12 sampled residents (Resident 5, 6, and 7).</p> <p>* The facility failed to ensure the ESP was practiced related to the PICC line for Resident 6 and GT for Residents 5, and 7. This failure had the potential to result in the spread of infection to the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Enhanced Barrier Precautions revised 4/22/24, showed it was the facility's policy to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The P&P also showed enhanced barrier precautions/enhanced standard precautions were indicated for residents with chronic wounds and/or indwelling medical devices such as central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy tubes, and ventilator tubes, even if the resident was not known to be infected or colonized with a MDRO (Multidrug-resistant organisms- organisms that that are resistant to multiple antibiotics or antifungals).</p> <p>a. Medical record review for Resident 5 was initiated on 5/13/24. Resident 5 was admitted to the facility on [DATE].</p> <p>Review of Resident 5's H&P examination dated 2/20/24, showed Resident 5 had dysphagia (difficulty swallowing) and on GT feeding.</p> <p>Review of Residents 5's MDS dated [DATE], showed Resident 5's cognitive skills were severely impaired.</p> <p>Review of Residents 5's Order Summary Report showed a physician's order dated 3/29/24, for ESP due to the long-term use of an indwelling medical device.</p> <p>On 5/8/24 at 1522 hours, Resident 5 was observed to have a red dot beside his name outside of the room, and the enteral tube feeding was infusing. Observation of Resident 5's room showed no evidence of ESP sign or PPE availability outside the door.</p> <p>On 5/8/24 at 1530 hours, an interview and concurrent observation was conducted with LVN 3. When LVN 3 was asked what the red dot beside Resident 5's name indicated, LVN 3 stated the red dot was new. LVN 3 stated she was not sure what the red dot meant but she thought it meant the resident had a GT. When asked if a resident with a GT should be on enhanced standard precautions, LVN 3 stated she was not sure.</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 - Few</p>	<p>On 5/8/24 at 1545 hours, an interview and concurrent observation was conducted with Unit Manager 1. Unit Manager 1 verified the above findings. Unit Manager 1 stated a red dot by a resident's name indicated the resident needed to be on ESP. Unit Manager 1 stated any resident on ESP should have an ESP sign outside their door indicating which infection control measures were required and to serve as a reminder to the staff. Unit Manager 1 stated any resident with an indwelling medical device such as a GT, or urinary catheter needed to be on ESP. Unit Manager 1 stated when the staff were performing high contact care for a resident on ESP, such as changing an incontinence brief, the staff were required to wear a gown and gloves.</p> <p>b. Medical record review for Resident 6 was initiated on 4/25/24. Resident 6 was admitted to the facility on [DATE].</p> <p>Review of Resident 6's H&P examination dated 4/25/24, showed Resident 6 had the capacity to understand and make medical decisions. Resident 6 had a diagnosis of a spinal cord abscess (swelling and collection of pus in or around the spinal cord).</p> <p>Review of Resident 6's plan of care showed a care plan problem dated 4/26/24, addressing Resident 6's need for ESP due to the long-term use of the PICC line.</p> <p>On 5/9/25 at 1245 hours, Resident 6 was observed with a PICC line. Observation of Resident 6's room showed no evidence of ESP sign or PPE availability outside the door.</p> <p>On 5/9/24 at 1325 hours, an interview was conducted with the IP. The IP stated ESP came into effect on 4/1/24, making it mandatory for residents with indwelling medical devices and chronic wounds to be on ESP. The IP stated the staff caring for residents on ESP should put on a gown and gloves when providing high contact care. The IP stated residents on ESP should have an ESP sign outside their door so the staff were aware. The IP stated the resident who required ESP should have a red dot by his/her name outside the door so the staff would know which resident the ESP guidelines applied to. The IP stated a PPE cart should be located by the door so the gowns could be readily accessible.</p> <p>On 5/9/24 at 1355 hours, a follow-up interview and concurrent observation was conducted with the IP. The IP verified the above findings. The IP stated Resident 6 had a PICC line and was at a higher risk of infection. The IP stated there should be an ESP sign outside Resident 6's room and a PPE cart close by.</p> <p>c. Medical record review for Resident 7 was initiated on 5/14/24. Resident 7 was admitted to the facility on [DATE].</p> <p>Review of Resident 7's H&P examination dated 4/28/24, showed Resident 7 had dysphagia and on GT feeding.</p> <p>Review of Resident 7's MDS dated [DATE], showed Resident 7 was assessed to have a BIMS score of 8 which meant the resident had moderate cognitive impairment.</p> <p>Review of Resident 7's Order Summary Report showed a physician's order dated 5/9/24, for ESP due to the long-term use of the GT.</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 - Few</p>	<p>On 5/9/24 at 1420 hours, Family Member 1 was observed walking outside of Resident 7's room and requesting for a staff assistance for Resident 7. Family Member 1 was observed telling the staff the tube feeding pump was alarming for Resident 7. An ESP sign was not observed outside Residents 7's room. A red dot was not observed by Resident 7's name outside of the room.</p> <p>On 5/9/24 at 1434 hours, an interview and concurrent observation was conducted with the IP. CNA 9 and LVN 6 were observed entering Resident 7's room. CNA 9 and LVN 6 were observed performing hand hygiene and putting on gloves but not a gown. CNA 9 then walked to Resident 7's bedside and closed the curtain around Resident 7's bed. LVN 6 was observed walking out of Resident 7's room and stated she was inside the room to check on Resident 7's tube feeding because the pump was alarming. LVN 6 stated CNA 9 was inside the room to change Resident 7's incontinence brief. The IP verified CNA 9 and LVN 6 entered Resident 7's room without donning on a gown. The IP stated CNA 9 should have been wearing a gown. The IP stated there should have been an ESP sign outside the door, so the staff were aware Resident 7 was on ESP. The IP stated since there were two residents in the same room, Resident 7 should have had a red dot by her name to indicate she was the resident who required the ESP. The IP stated there should be PPE supplies outside the room.</p> <p>On 5/9/24 at 1439 hours an interview was conducted with CNA 9. CNA 9 stated if there was an ESP sign outside the door for Resident 7, she would have worn a gown.</p>