STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555134	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Miguel Covenant Village	325 Kempton St. Spring Valley, CA 91977

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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 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** 38512 Based on observation, interview and record review, the facility failed to ensure residents skin was assessed on admission and reevaluated for two of two residents reviewed for skin conditions when: 1. Resident 15 had leg discoloration and, 2. Resident 71 had a right neck dressing. These failures resulted in a delay of assessment and or treatment for Residents 15 and 71. Findings: 1. Resident 15 was admitted to the facility on [DATE] with diagnoses to include dementia (a loss of memory and other thinking abilities caused by brain damage), per the Face Sheet. On 6/17/24 at 2:33 P.M., Resident 15 was observed asleep on her bed, with her legs crossed at the ankles. Approximately six inches of her skin was exposed between the top of her shoe and the bottom of her pants leg. The visible skin was discolored in a mottled pattern of reddish to purple tones. On 6/17/24 at 3:40 P.M., an interview was conducted with Resident 15. Resident 15 was sitting in a chair in the hallway outside of her room. Resident 15 stated she did not have any pain, and she was not able to explain the discoloration of her skin. On 6/19/24 at 9:01 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated she was assigned to Resident 15 often and was familiar with her care. CNA 2 stated she had noticed the discolored skin about a week ago, and she had reported the concern to the nurse. CNA 2 stated she believed the discoloration had been present for more than a week, but not the entire time Resident 15 had resided at the facility. On 6/19/24 at 10 A.M., an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated she did not recall CNA 2 telling her about the skin discoloration for Resident 15 a week ago. LN 2 stated she was aware Resident 15 had some edema (swelling) of her legs, which was worsening. LN 2 stated the nurses conducted a weekly nursing assessment which included any skin conditions. Per LN 2, she did not recall any documentation regarding the discoloration of Resident 15's legs. On 6/19/24, a record review was conducted. (continued on next page)

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	Resident 15's Brief Interview for Mental Status (BIMS) score on 4/2/24 was three, indicating severely impaired cognition. Per the Nursing Admission Evaluation, dated 1/6/22 (Resident 15's admitted), Resident 15's skin was normal in color, with no rash and no wound. There were no comments added under the skin assessment section of the evaluation. A Nursing Note, dated 1/6/22, indicated Resident 15 had scattered bruising to both arms and both legs. A Weekly Nursing Summary, dated 5/9/24, indicated Resident 15 had no skin problems or lesions, and no change to her skin color or skin temperature. A Nurses Progress Note, dated 6/6/24, indicated Resident 15 had edema on both legs, with a red area on the inner right foot. The LN documented photos were taken and physician was notified. No photos or physician communication were identified. A Weekly Nursing Summary, dated 6/13/24, indicated Resident 15 had no skin problems or lesions, and no change to her skin color or skin temperature. The Nursing Summary did not include the edema of both legs or the red area on the right foot. On 6/19/24 at 3:22 P.M., an interview was conducted with LN 2. LN 2 stated she had assessed the discoloration on Resident 15's legs. LN 2 stated the discoloration was from the ankle to the mid calf. LN 2 stated the skin condition should have been assessed weekly on the Nursing Summary, but since it was not documented, it had not been done. Per LN 2, Resident 15 could have venous insufficiency (blood flow problem) or an infection, which could result in further problems. On 6/20/24 at 2 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the skin discoloration may have been present on admission, but it was not documented. Per the DON, the admission assessment would have been Resident 15's baseline (beginning) skin condition, and then the nurses should have assessed for any changes. The DON stated, We don't have the baseline, so we don't know if she has a circulation issue, or other concern. We can't treat what we haven't identified . Per a facility policy, revised February 2014 and titled Resident Examination and Assessment, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status .Review the resident's admission assessment .to assess for any special situations regarding the residents care .Physical Exam .8. Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes .Documentation: the following information should be recorded in the resident's medical record: .All assessment data obtained during the procedure .Reporting .Notify the physician of any abnormalities such as .wounds or rashes on the resident's skin . 40610 2. Resident 71 was admitted to the facility on [DATE] with diagnoses which included sepsis (blood infection), per the Face Sheet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24, a record review was conducted. Resident 71's History and Physical (H&P), dated 5/30/24, indicated Resident 71 had the mental capacity to make medical decisions. During an observation and an interview with Resident 71 on 6/17/24 at 9:57 A.M., Resident 71 was in bed with a dressing in his right neck. The dressing was approximately half peeled off, with a brown stain. Resident 71 stated the staff had not touched the site nor checked what it was since he was admitted to the facility. During an observation and an interview with Resident 71 in his room on 6/18/24 at 2:15 P.M., Resident 71 still had the half peeled off dressing in his right neck. Resident 71 stated the staff had not checked his neck and he had not had a dressing change. During a concurrent review of Resident 71's clinical record and an interview with LN 11 on 6/18/24 at 2:52 P. M., LN 11 stated they had not touched the dressing in Resident 71's right neck. LN 11 stated there was no hospital notes and progress notes related to the dressing in Resident 71's neck. LN 11 stated the admitting nurse was responsible to do the body assessment and if the resident came with a dressing, there should be a follow up assessment and treatment if needed. During a concurrent review of Resident 71's clinical record and an interview with LN 12 on 6/19/24 at 3:37 P. M., LN 12 stated he did not know what the dressing was in Resident 71's neck. LN 12 stated the dressing was not mentioned in Resident 71's hospital record, but nurses should have assessed the site. LN 12 stated there was no assessment of Resident 71's neck related to the dressing. LN 12 stated there was no excuse as to why the assessment was missed. During an interview with the DON on 6/20/24 at 2:40 P.M., the DON stated the LNs were expected to assess the resident's skin upon admission, to follow up, and to get an order from the resident's attending physician for any skin issues to prevent possible infection. Per the facility's policy titled Resident Examination and Assessment, revised February 2014, .The purpose of this procedure is to examine and assess the resident for any abnormalities .Physical Exam .8. Skin: a. intactness .

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to ensure non-pharmacological interventions (NPI, an approach to healthcare that did not involve medications, such as relaxation or repositioning) were implemented for one of three residents reviewed for behaviors (Resident 19). This failure had the potential to place Resident 19 at risk for overuse of medication. Findings: Resident 19 was admitted to the facility on [DATE] with diagnoses to include unspecified mood disorder (a mental condition which adversely affects emotional state, such as depression), per the Face Sheet. On 6/17/24 at 2:52 P.M., a concurrent observation of Resident 19 and an interview with Certified Nursing Assistant (CNA) 1 was conducted. Resident 19 was in bed, yelling out unintelligible sounds. CNA 1 was at the bedside, attempting to remove Resident 19's hands from inside his brief. CNA 1 changed Resident 19's clothes, while repeatedly removing his hands from his brief. Resident 19 then placed his right thumb in his mouth. CNA 1 stated this was Resident 19's usual behavior, and he always wanted something in his mouth. On 6/18/24 at 2 P.M., an observation of Resident 19 was conducted. Resident 19 was in bed, sleeping. On 6/18/24 at 2:05 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 19 had continued to be agitated the previous night and all morning, anxious and yelling out. LN 1 stated she had given Ativan (a medication for anxiety) at about 12:30 P.M. to calm down the resident. LN 1 stated the medication was effective, and Resident 19 was now asleep. LN 1 stated she did not know if the CNA had attempted to feed Resident 19, or reposition him, or any other NPI. On 6/19/24, a record review was conducted. A physician's order, dated 6/6/24, indicated Resident 19 was to receive Ativan as needed every four hours. The order specified the indication for Ativan was anxiety as evidenced by yelling or restlessness. Ativan was administered on 6/17/24 at 3:01 A.M., 8:13 A.M., 1:22 P.M., 5:35 P.M., and 9:48 P.M. Ativan was administered on 6/18/24 at 4:55 A.M., 12:24 P.M., 4:44 P.M., and 9:38 P.M. No NPI's were documented prior to Ativan administration. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 8:24 A.M., a concurrent observation of Resident 19 and and an interview with CNA 1 was conducted. CNA 1 was seated at the bedside, feeding Resident 19 breakfast. Resident 19 did not respond to questions. CNA 1 stated Resident 19 was calm, and was eating well. CNA 1 stated eating was the only thing that calmed Resident 19 down, that the CNAs did not attempt to hold his hand since he usually put his hands in his brief, or in his mouth. CNA 1 stated she did not think Resident 19 liked the television on, or enjoyed going to activities. On 6/19/24 at 9:26 A.M an observation of Resident 19 was conducted. Resident 19 was in bed, with his eyes closed. Resident 19 had a portion of a cloth bed sheet in his mouth, and was vigorously chewing and sucking on the cloth. Resident 19 occasionally yelled out unintelligible noises. No staff were present in the room. On 6/19/24 at 9:45 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 19 always wanted something in his mouth, and wanted to be fed constantly. The ADON stated Ativan was given when Resident 19 yelled continuously, and staff had not identified any other interventions or NPIs that were effective to prevent the behavior. On 6/20/24 at 11:22 A.M., a concurrent interview and record review was conducted with LN 2. LN 2 stated she was assigned to Resident 19, and was familiar with his care. LN 2 stated NPIs such as repositioning, or reducing stimulus in the room, should be attempted before giving a medication. LN 2 reviewed the Medication Administration Record (MAR), and was unable to locate NPIs attempted before Ativan was given. LN 2 stated, The NPI should be specific. I know he likes the lights turned off in his room, but that is not indicated here. The NPI is not individualized for him. On 6/20/24 at 2:40 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 19's medications had been adjusted several times. The DON stated NPIs should be attempted before a medication was given, and the NPI should be specific and individualized to meet the needs of the resident. Per the DON, NPIs were not a part of the Ativan order, but should have been. Per a facility policy, revised July 2022 and titled Psychotropic Medication Use, .Non-pharmacological approaches are used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38512 Based on observation, interview and record review, the facility failed to ensure food production and storage were implemented in a manner that lessened the risk for foodborne illness when: 1. The ice machine lid did not close tightly, 2. Leftover food temperatures were not documented on a cool-down log, 3. Refrigerator and freezer temperature logs, thermometer calibration logs, and sanitation logs were incomplete, and 4. Temperatures were not taken for all foods on the trayline prior to meal service. These failures had the potential to cause foodborne illness to a population of 71 residents who received food from the kitchen. Findings: On 6/17/24 at 8:23 A.M., a tour of the kitchen, document review and interview was conducted with the Registered Dietitian (RD). 1. An ice machine was located near a doorway. The lid covering the ice was closed, but did not securely touch the bin, leaving approximately a half-inch gap. The RD stated the ice machine lid should securely close, leaving no gap. The RD stated if the lid did not close tightly, there was a risk of cross-contamination from debris or bacteria, and the ice may lose temperature and melt. 2. A reach-in refrigerator contained two large, deep metal pans. One pan contained macaroni and cheese, labeled with a production date of 6/15/24, discard on 6/17/24. The second pan contained rice, labeled with a production date of 6/16/24, discard on 6/21/24. The RD stated she was unable to find a log of temperatures taken as the foods had been cooled. The RD stated the macaroni and cheese and rice should not have been refrigerated without cooling them down properly, with temperatures taken throughout the cool-down process. 3. Refrigerator and freezer temperature logs, thermometer calibration logs, and daily cleaning schedules were posted and reviewed. a) Per the Refrigerator and freezer log, Check all freezer and coolers twice a day (am & pm) . The refrigerator and freezer temperature log was missing documentation for 6/14/24, P.M. shift, 6/15/24 P.M. shift, and all day 6/16/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Per the Thermometer Calibration Log, Check calibration of thermometers daily . The thermometer calibration log was missing documentation for 6/16/24. c) Per the Daily Cleaning Schedule, Please initial when job is completed . The Daily Cleaning Schedule had four of 21 assignments initialed as completed for the week of 6/7/24, and three of 21 assignments initialed as completed for the week of 6/14/24. Per the RD, all temperatures and thermometer calibrations should be documented daily as specified on the log. The RD stated taking temperatures and calibrating thermometers was important to ensure the food was safe to serve. On 6/19/24 at 11:25 A.M., an interview was conducted with the Dietary Operations Manager (DOM). The DOM stated he was responsible for overseeing food production for the facility. The DOM stated food safety was very important to prevent foodborne illness. Per the DOM, staff had not completed the temperature logs, thermometer calibration logs, or the daily cleaning schedule, which could lead to unsafe food temperatures and sanitation. 4. On 6/19/24 at 12 P.M., an observation of trayline and document review was conducted with the DOM in the dining room. Two temperature logs were being used: one for hot foods, and one for cold foods. The hot food temperature log had 12 hand-written foods listed on it, with temperatures documented. The DOM counted 22 hot items being served. 10 hot foods were being served without temperatures taken. The cold food temperature log had two items hand-written on it, with temperatures documented. The DOM counted 12 cold food items being served. 10 cold foods were being served without temperatures taken. On 6/19/24 at 12:30 P.M., an interview was conducted with the DOM. The DOM stated it was important to document all food temperatures prior to meal service in order to prevent foodborne illness, and they had not done this. On 6/20/24 at 3:35 P.M., an interview was conducted with the administrator (ADM). The ADM stated she was ultimately responsible for overall facility compliance with the regulations. Per a facility policy, dated January 2016 and titled Sanitation & Infection Control, Cleaning Schedules, Cleaning schedules are used to maintain high levels of sanitation .This sample form .is to be used as a record, with the responsible person initialing the item after cleaning has occurred . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per a facility policy, dated January 2016 and titled Meal Service, Taste & Temperature Control/Food Holding, .food is maintained at proper temperatures during service to .ensure that food safety principles are maintained to prevent foodborne illness .Prior to the start of each meal period, there is an evaluation of . temperature of food .Cold foods must be held at 40 degrees or below .food temperatures should be taken just prior to service to ensure that holding temperatures of 135 degrees are maintained .At the end of service, any hot leftover foods must be discarded or cooled properly based on cooling guidelines .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observations, interview and record review, the facility failed to ensure safe infection control practices when: 1. A urinary catheter (a tube inserted into the bladder to aide in urine flow) bag was lying on the floor for two of two residents reviewed for urinary catheter care (Resident 41 and Resident 43), and, 2. The Licensed Nurse (LN) 11 did not perform hand hygiene in between glove changed during wound treatment for a sampled resident (Resident 22). These failures had the potential for cross contamination (spread of germs and bacteria) and infection. Findings: 1a. Resident 41 was admitted to the facility on [DATE] with a urinary catheter, per the Face Sheet. During an observation on 6/17/24 at 9:42 A.M., in Resident 41's room, Resident 41 was in bed with a urinary catheter visible next to the bed. Resident 41's catheter bag was on the floor. During an observation on 6/18/24 at 1:51 P.M., in Resident 41's room, Resident 41 was in bed with a urinary catheter and the catheter bag was on the floor. During a joint observation of Resident 41 and an interview with Certified Nursing Assistant (CNA) 11 on 6/18/24 at 1:53 P.M., CNA 11 stated Resident 41's urinary catheter bag was on the floor and should have always been elevated or off the floor for infection control purposes. During an interview with LN 11 on 6/18/24 at 2:48 P.M., LN 11 stated Resident 41's catheter bag should not have touched the floor. LN 11 stated the germs and bacteria might transfer from the floor to the bladder which could cause infection. During an interview with LN 12 on 6/19/24 at 3:35 P.M., LN 12 stated Resident 41's catheter bag should be off the floor to prevent infection. LN 12 stated if the bag came in contact with the floor due to the bedframe being low, staff should have a barrier such as a basin but they had not done that. During an interview with the Infection Prevention Nurse (IPN) on 6/20/24 at 2:23 P.M., the IPN stated urinary catheter bag should have been off the floor. The IPN stated it was important for urinary catheter bags not to touch the floor to prevent cross contamination. During an interview with the Director of Nursing (DON) on 6/20/24 at 2:40 P.M., the DON stated the urinary catheter bag should have not touched the floor in order to prevent an infection to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility's policy titled Catheter Care, Urinary, revised August 2022, .Infection Control: 2.b. Be sure the catheter tubing and drainage bag are kept off the floor . 1b. Resident 43 was readmitted to the facility on [DATE] with diagnoses which included history of urinary tract infections (UTI) and with a urinary catheter, per the Face Sheet. During an observation on 6/17/24 at 2:49 P.M., in Resident 43's room, Resident 43 was in bed with a urinary catheter visible next to the bed. Resident 43's catheter bag was on the floor. During an interview with CNA 11 on 6/19/24 at 10:28 A.M., CNA 11 stated Resident 43's urinary catheter bag should have been off the floor for infection control purposes. During a concurrent review of Resident 43's clinical record and an interview with LN 12 on 6/19/24 at 3:14 P. M., LN 12 stated Resident 43 had a previous UTI. LN 12 stated Resident 43 's catheter bag should be off the floor to prevent recurrence of infection. During an interview with the Infection Prevention Nurse (IPN) on 6/20/24 at 2:23 P.M., the IPN stated urinary catheter bag should have been off the floor. The IPN stated it was important for urinary catheter bags not to touch the floor to prevent cross contamination. During an interview with the DON on 6/20/24 at 2:40 P.M., the DON stated the urinary catheter bag should have not touched the floor in order to prevent an infection to the resident. Per the facility's policy titled Catheter Care, Urinary, revised August 2022, .Infection Control: 2.b. Be sure the catheter tubing and drainage bag are kept off the floor . 2. Resident 22 was admitted to the facility on [DATE] with diagnoses which included cellulitis (bacterial skin infection) of the right leg, per the Face Sheet. During an observation and an interview on 6/14/24 at 12:18 P.M., in Resident 22's room, Resident 22 was in bed, with an intravenous (IV) antibiotics (anti-infective) medication connected to Resident 22. Resident 22 stated he was getting the IV medication for the leg infection. An observation of LN 11 performing a dressing change to Resident 22's right leg was conducted on 6/19/24 at 2:53 P.M. With gloved hands, LN 11 removed Resident 22's old wound dressing. LN 11 did not perform hand hygiene or change gloves after removing the old dressing. LN 11 then cleansed the wound while still wearing the first pair of gloves. After cleansing the wound, LN 11 removed her gloves and put on a new pair of gloves without performing hand hygiene. During an interview with LN 11 on 6/19/24 at 3:04 P.M., LN 11 stated she had forgotten to perform hand hygiene between glove changes, and should have changed her gloves after removing the old dressing. LN 11 stated it was important for infection control. During an interview with the IPN on 6/20/24 at 2:23 P.M., the IPN stated glove use was not a substitute for hand hygiene. Hand hygiene was the most effective infection control. The IPN stated the staff should be performing hand hygiene after glove removal and after removing an old dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 6/20/24 at 2:40 P.M., the DON stated staff should have performed hand hygiene between glove use and after contacting a soiled dressing as part of standard infection precautions. Per the facility's policy titled Handwashing/ Hand Hygiene, revised August 2019, Policy Statement, This facility considers hand hygiene the primary means to prevent the spread of infection .7. Use an alcohol-based hand rub .for the following situations .k. After handling used dressings .m. After removing gloves .