STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555158	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Centro Post-Acute Care	1700 S. Imperial Ave El Centro, CA 92243

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool used to identify resident care needs) was completed accurately for 2 (Resident #60 and Resident #118) of 24 sampled residents reviewed for accurate assessments. Findings included: A facility policy titled, Comprehensive Assessments, Minimum Data Set (MDS), revised March 2022, revealed, 8. Accuracy of MDS Data: d. All sections of the MDS must be completed with information that accurately reflects the resident's status during the assessment reference period. 1. An Admission Record revealed the facility admitted Resident #60 on 01/06/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of schizophrenia. An annual MDS, with an Assessment Reference Date (ARD) of 01/11/2024, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #60 was not considered by the state Level II PASRR (Pre-Admission Screening and Resident Review) process to have a serious mental illness and/or intellectual disability or a related condition. A letter from the State of California- Health and Human Services Agency Department of Health Care Services, dated 01/24/2023, revealed a Level II evaluation was completed for Resident #60 on 01/23/2023. The attached, Preadmission Screening and Resident Review (PASRR) Individualized Determination Report, indicated Resident #60 required specialized services from a nursing facility due to a medical and/or a mental health condition. The MDS Coordinator was interview on 09/11/2024 at 2:46 PM. The MDS Coordinator stated Resident #60's MDS was not accurate, and the answer for the PASRR Level II section was not correct. The Director of Nursing (DON) was interviewed on 09/12/2024 at 12:13 PM. The DON stated she expected the MDS to be accurate. The Executive Director was interviewed on 09/12/2024 at 12:18 PM. The Executive Director stated he expected the MDS to be accurate. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31524 2. An Admission Record revealed the facility admitted Resident #118 on 05/28/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction, type two diabetes mellitus, and chronic kidney disease. Further review revealed Resident #118 discharged to their home on 06/18/2024. An admission MDS, with an Assessment Reference Date (ARD) of 06/04/2024, revealed Resident #118 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Resident #118's Care Plan, cancelled on 06/19/2024, indicated the resident wished to discharge to their home or another facility after completing skilled nursing and rehabilitation services. Interventions directed staff to arrange post skilled nursing facility support as needed with resources such as home health, therapy, nursing services, pharmacy services, and appointment follow-up services. Resident #118's Order Summary Report, contained an order dated 06/13/2024, that indicated the resident's last covered day (LCD) was 06/17/2024, and the resident was to discharge home on 06/18/2024 with home health. Resident #118's nurse Progress Notes, dated 06/18/2024, revealed Resident #118 left the facility with their responsible party. The note revealed that following discharge, the nurse called Resident #118's responsible party who confirmed the resident was safe at home. Resident #118's Skilled Nursing - Notice of Proposed Transfer/Discharge, dated 06/18/2024, revealed Resident #118 discharged home due to improved health and the resident no longer required the services of the facility. A discharge MDS, with an ARD of 06/18/2024, revealed Resident #118 had a planned discharge with no anticipated return. Further review revealed Resident #118 discharged to a short-term hospital, not to their home. During an interview on 09/11/2024 at 2:46 PM, the MDS Coordinator stated it was important to have an accurate MDS to ensure adequate care and services were provided to the residents. The MDS Coordinator further stated Resident #118's discharge MDS was inaccurate due to indicating the resident was discharged to an acute care hospital when the resident went home instead. During an interview on 09/12/2024 at 12:13 PM, the Director of Nursing (DON) stated MDS accuracy was important for billing purposes and expected each resident's MDS to be accurate. During an interview on 09/12/2024 at 12:18 PM, the Executive Director stated he expected a resident's MDS to be accurate because it was important for providing adequate care.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46258 Based on interview, record review, and facility policy review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level 1 was accurate for 3 (Resident #37, #91, and #71) of 5 sampled residents reviewed for PASRR. Findings included: A facility policy titled, Admission Criteria, dated 2001, revealed, 9. All new admissions and readmissions for a Medicaid contracted facility are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASRR) process. 1. An Admission Record revealed the facility admitted Resident #37 on 04/03/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis (onset date 04/03/2023) and anxiety disorder (onset date 04/03/2023). An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2024, revealed Resident #37 had Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of anxiety disorder and psychotic disorder. Resident #37's care plan included an undated focus area that indicated the resident was at risk for a decline in psychosocial well-being due to their overall health condition, signs and symptoms of dementia, signs and symptoms of psychosis, and agitation. The care plan also revealed Resident #37 was known to strike at staff and refuse care. Resident #37's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 04/04/2023, revealed the resident had a diagnosis of anxiety. Further review revealed the resident's diagnosis of psychosis was not listed. During an interview on 09/12/2024 at 12:48 PM, the Admissions Coordinator revealed the PASRRs were completed at the hospital. The Admissions Coordinator stated, after the facility reviewed the PASRR, a new one was always done; if needed, corrections would be made at that time. The Admissions Coordinator stated Resident #37's diagnosis of psychosis should have been on the PASRR, and their current PASRR was not correct. 2. An Admission Record revealed the facility admitted Resident #91 on 05/05/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #91 had Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had a diagnosis of bipolar disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #91's care plan included an undated focus area that indicated Resident #91 was at risk for a decline in psychosocial well-being due to their overall health condition, signs and symptoms of bipolar disorder, signs and symptoms of depression and agitation, and hitting. Resident #91's hospital records revealed the resident was admitted to the hospital on 04/25/2023. Further review revealed under Patient Active Problem List the resident had a diagnosis of bipolar disorder with depression. Resident #91's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 05/04/2023, revealed the resident did not have any serious mental illness. During an interview on 09/12/2024 at 12:48 PM, the Admissions Coordinator revealed the PASRRs were completed at the hospital. The Admissions Coordinator stated after the facility reviewed the PASRR a new one was always done; if needed, corrections would be made at that time. The Admissions Coordinator stated Resident #91's diagnosis of bipolar disorder should have been on the PASRR, and their current PASRR was not correct. 3. An Admission Record revealed the facility admitted Resident #71 on 03/12/2022. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder (onset 03/12/2022), major depressive disorder (onset 03/12/2022), and anxiety disorder (onset 03/12/2022). An annual [NAME] Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2024, revealed Resident #71 had Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had active diagnoses of anxiety disorder, depression, and bipolar disorder. Resident #71's care plan included an undated focus area that indicated the resident was at risk for altered mood and behavior as evidenced by loss of interest in daily activities, mood swings, sudden changes in emotion, yelling, and throwing fluids possibly due to a diagnosis of bipolar disorder. Interventions directed staff to report any changes in the resident's mood patterns or signs or symptoms of depression or anxiety to the physician. An additional undated focus area indicated that Resident #71 was at risk for a decline in psychosocial well-being due to their overall health condition related to bipolar disorder, schizophrenia, and anxiety. Interventions indicated that social services staff would assist the resident as applicable. Resident #71's History & Physical, dated 03/25/2022, revealed Resident #71 was taking medication for the treatment of anxiety and bipolar disorder. Resident #71's History and Physical Examination, dated 04/06/2022, revealed Resident #71 had diagnoses of schizophrenia and bipolar disorder. Resident #71's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 06/28/2023, revealed Section III- Serious Mental Illness Screen, question #10 was answered Yes and reflected the resident's diagnosis of anxiety, but did not reflect bipolar disorder or schizophrenia. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/12/2024 at 1:00 PM, the MDS Coordinator stated she was notified of new diagnoses many ways but ultimately if a new PASRR needed to be completed, a notification was sent to her to update the PASRR. She stated that Resident #71 should have had a new PASRR completed to reflect their diagnoses. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) revealed she was unfamiliar with the PASRR process but expected them to be accurate. During an interview on 09/12/2024 at 1:58 PM, the Executive Director revealed he expected the regulation to be followed.

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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. 35314 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a physician's order for treatment of a diabetic ulcer was obtained for 1 (Resident #43) of 2 residents reviewed for skin conditions. Findings included: A facility policy titled, Wound Treatment Management, dated 2001, revealed, 1. Initial Assessment and Documentation a. Wound assessment: Upon identification of a wound, a licensed nurse (RN [Registered Nurse] or LVN [Licensed Vocational Nurse]) will: Conduct an initial wound assessment including location, size, depth, appearance, drainage, any signs of infection. Document the wound's characteristics in the resident's medical record and update the care plan. Notify the attending physician to obtain wound treatment orders. b. Physician orders: The attending physician will provide written orders for wound care, specifying the type of treatment (e.g. [exempli gratia, for example], cleansing solution, dressing type, frequency of dressing changes, etc. [et cetera; and so forth]). Ensure the orders are clear and concise, and document them in the resident's medical record. An Admission Record indicated the facility originally admitted Resident #43 on 06/13/2024 and readmitted the resident on 09/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and scar conditions and fibrosis of the skin. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/15/2024, revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS also revealed Resident #43 had a diabetic foot ulcer. According to the MDS, skin/ulcer treatment included a turning/repositioning program, nutrition or hydration intervention to manage skin problems, and application of dressings to the feet. Resident #43's care plan included an undated focus area that indicated Resident #43 had a diabetic ulcer to the left dorsum hallux (big toe) and was at risk for worsening of the ulcer and amputation due to the disease process. Interventions directed staff to notify the physician as indicated. Resident #43's Progress Notes, dated 09/02/2024, revealed the resident was admitted to the hospital. Further review revealed Progress Notes dated 09/04/2024 indicated the resident was admitted back to the facility. Resident #43's hospital History and Physical dated 09/02/2024, revealed the resident had chronic infection of the left big toe. Resident #43's Skilled Nursing-Admission Initial Eval [Evaluation] dated 09/04/2024, revealed Registered Nurse (RN) #10 documented the resident had a diabetic wound to the left toe. According to the evaluation, the physician was notified of the resident's admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43's Wound Evaluation note dated 09/05/2024, completed by RN #6, who was the treatment nurse, revealed the resident had a diabetic ulcer. The note revealed the ulcer was located on the left foot 1st digit (hallux) and was 1.1 centimeters (cm) in length and 1.09 cm in width. The note revealed the wound bed had eschar (black, dead tissue), evidence of infection that included redness/inflammation, and the surrounding tissue was calloused. The note revealed treatment included povidone iodine, mechanical debridement, and dry gauze. According to the note, additional care included a heel suspension/protection device, a moisture barrier, and moisture control. The note revealed the physician was notified of the treatment and ulcer. Per the note, the ulcer was a Chronic stalled wound that was painted with iodine and left open to air. The note revealed there were no open areas or drainage, and foam heel protectors were applied bilaterally. Resident #43's Order Summary Report, with an order date range of 09/04/2024 to 09/30/2024, revealed no active order for treatment to the resident's toe. Resident #43's September 2024 Treatment Administration Record [TAR], revealed staff documented that the left hallux was painted with iodine every day shift from 09/01/2024 through 09/03/2024. The TAR revealed the treatment was discontinued on 09/03/2024. Per the TAR, there was no documented evidence a treatment was provided to the left hallux from 09/04/2024, when the resident was readmitted to the facility, through 09/09/2024. An observation on 09/09/2024 at 12:02 PM of Resident #43 revealed the resident's left foot big toe had a black, crusty discoloration. During a concurrent interview, Resident #43 stated the facility staff had not provided treatment to the toe since re-admission from the hospital. An interview on 09/11/2024 at 8:58 AM with RN #6, revealed it was the responsibility of the admitting nurse to complete an assessment and document any skin issues. RN #6 stated the admitting nurse must also contact the physician and obtain physician orders for treatment. RN #6 revealed she completed the skin assessment and treatment for Resident #43 on 09/05/2024; however, she was not aware there was not an order for care. RN #6 stated all the previous orders were discontinued on 09/03/2024 after the resident was discharged to the hospital. RN #6 stated when the resident returned, the wound care order was not resumed. RN #6 stated she failed to ensure an order was active for care for Resident #43's toe. RN #6 reviewed Resident #43's medical chart and was unable to locate any evidence wound care had been completed on 09/07/2024, 09/08/2024, or 09/09/2024 (Friday through Sunday). RN #6 stated Licensed Vocational Nurse (LVN) #7 was responsible for completing wound/skin care treatment over the weekend. During a follow-up interview on 09/11/2024 at 9:45 AM, RN #6 stated she had not notified the physician, and failed to get an order for skin care for Resident #43. She stated it was an error on her part for failing to obtain an order. During an interview on 09/11/2024 at 9:26 AM, LVN #7 stated staff must receive skin care orders when a resident is admitted . LVN #7 stated he had not completed skin care for Resident #43 since the resident was readmitted because there was no order. An interview with LVN #8 on 09/11/2024 at 10:28 AM, revealed he was the assigned nurse for Resident #43 for the weekend and had not completed wound/skin care for Resident #43. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 7:57 AM, Nurse Practitioner (NP) #9 stated when a resident was admitted to the facility, a nurse notified him. He stated that he was aware Resident #43 had discharged and returned to the facility from the hospital. He stated there was a lapse in the resident's treatment of the left big toe; however, the few days the treatment lapsed would not have made a significant difference on the wound. NP #9 stated regardless of the healing, there should not have been any lapse in the resident's treatment. An interview with the Director of Nursing (DON) on 09/12/2024 at 1:07 PM, revealed the staff should have reviewed and resumed the order for Resident #43's skin/wound care treatment. During an interview with the Executive Director on 09/12/2024 at 1:23 PM, he stated he expected the staff to provide quality care. He stated staff should get physician orders and follow the orders.

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	555158	A. Building B. Wing	09/12/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40141 Based on interview, record review, and facility policy review, the facility failed to ensure physician ordered medications were available for 2 (Resident #75 and Resident #171) of 6 residents reviewed for pharmacy services. Findings included: 1. A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber order, including any required time frame. An Admission Record indicated the facility admitted Resident #75 on 08/06/2024. According to the Admission Record, the resident had a medical history that included diagnoses of gastro-esophageal reflux disease (GERD) and an acute peptic ulcer. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/12/2024, revealed Resident #75 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #75's Order Summary Report, dated 09/12/2024, contained an order, dated 08/06/2024, for pantoprazole sodium 40 milligrams (mg) by mouth daily for GERD. Resident #75's Medication Administration Record [MAR], for the timeframe from 09/01/2024 through 09/11/2024, revealed staff documented that Resident #75's pantoprazole sodium was not available for administration from 09/03/2024 through 09/08/2024. During an interview on 09/09/2024 at 10:03 AM, Resident #75 stated they were not getting their stomach medications. During a follow-up interview on 09/11/2024 at 1:38 PM, Resident #75 stated they still had not received their stomach medication. Resident #75 stated they were not sure what the name of the medication was but knew it was for their peptic ulcer. Resident #75 stated they had not received the medication since they had been at the facility. During a telephone interview on 09/11/2024 at 2:28 PM, the Consultant Pharmacist stated a 14-day supply of Resident #75's pantoprazole sodium had been dispensed on 08/06/2024 and 09/07/2024. During an interview on 09/12/2024 at 11:40 AM, Licensed Vocational Nurse (LVN) #4 stated if a medication was not available after checking the medication cart, then the process was to go to the medication dispensing machine to see if it was available there. LVN #4 stated if the medication was not in the medication dispensing machine, staff should call the pharmacy. During an interview on 09/12/2024 at 1:00 PM, the Assistant Director of Nursing (ADON) stated Resident #75's medication for GERD had been destroyed. The ADON stated he did not know why the medication was destroyed, but staff were looking into it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) stated, if medication was not available on the medication cart, staff were required to check the medication dispensing system and the emergency kit for the medication, and, if there, it should be given. The DON stated she expected physician-ordered medications to be available for administration. The DON stated Resident #75 should have received the pantoprazole. 2. An Admission Record indicated the facility admitted Resident #171 on 09/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of osteomyelitis and diabetes. Resident #171's Order Summary Report, dated 09/11/2024, contained an order, dated 09/05/2024, for ketotifen fumarate ophthalmic solution 0.035% one drop in both eyes every morning and at bedtime for itchiness. An observation of medication pass on 09/10/2024 at 9:34 AM, with Licensed Vocational Nurse (LVN) #2 revealed she prepared Resident #171's medications. LVN #2 did not administer ketotifen fumarate ophthalmic solution to the resident. During an interview on 09/10/2024 at 11:56 AM, Resident #171 stated they did not receive their eye drops that morning because they had to be ordered. During an interview on 09/10/2024 at 2:11 PM, LVN #2 stated Resident #171's eye drops were not administered because they were not available. LVN #2 said the eye drops had not been administered since the resident admitted to the facility because they were either on back order or the insurance did not cover them. Resident #171's Medication Administration Record [MAR], for the timeframe from 09/01/2024 to 09/10/2024, revealed Resident #171's ketotifen fumarate had not been available for administration from 09/06/2024 through 09/09/2024. During a telephone interview on 09/11/2024 at 2:28 PM, the Consultant Pharmacist indicated the ketotifen fumarate for Resident #171 could have been an over-the-counter medication. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) stated, if medication was not available on the medication cart, staff were required to check the medication dispensing system and the emergency kit for the medication, and, if there, it should be given. The DON stated she expected physician-ordered medications to be available for administration. The DON stated Resident #171 should have received their eye drops. During an interview on 09/12/2024 at 1:58 PM, the Executive Director indicated he expected medications to be available and, if they were not, a way needed to be found to make the medications available.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40141 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure pharmacy recommendations were followed up on timely for 1 (Resident #82) of 6 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Pharmacy Medication Regimen Review, revised in 10/2018, specified, The consultant pharmacist documents in a separate written report any found irregularities. The policy indicated, e. Otherwise, if an irregularity does not require urgent action, attending physician is to be contacted by nursing using the provided recommendation forms. The policy also indicated, The physician may choose to decline the pharmacist's suggestion either directly on the recommendation form, through a telephone order with a licensed nurse, or within the resident's chart (such as in a progress note); but a response must be noted within 30 days with rationale documented in the resident's medical record. An Admission Record indicated the facility admitted Resident #82 on 03/09/2022. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2024, revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the resident received an antianxiety medication during the assessment period. Resident #82's Order Summary Report, dated 09/12/2024, contained an order dated 05/30/2024 for lorazepam 0.5 milligrams (mg) one tablet by mouth every six hours as needed for anxiety/restlessness. The order did not indicate an end date. A Note to Attending Physician/Prescriber for Resident #82 from the Consultant Pharmacist, dated 06/28/2024, specified, This resident has PRN [pro re nata, as needed] Lorazepam 0.5 mg PO [by mouth] Q6H [every six hours] for anxiety. PRN psychotropic medications are limited to 14 days. The Note to Attending Physician/Prescriber also indicated, Please add a length of therapy. Further review revealed the physician had not signed the document. Another Note to Attending Physician/Prescriber for Resident #82 from the Consultant Pharmacist, dated 07/26/2024, specified, This resident has PRN Lorazepam 0.5 mg PO Q6H for anxiety. PRN psychotropic medications are limited to 14 days. The Note to Attending Physician/Prescriber also indicated, Please add a length of therapy. Further review revealed the physician had not signed the document. Resident #82's September 2024 Medication Administration Record [MAR] contained a transcription of an order for lorazepam 0.5 mg one tablet by mouth every six hours as needed with a start date of 05/30/2024. Documentation indicated the medication had been administered to the resident seven times during the month. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555158	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Centro Post-Acute Care	1700 S. Imperial Ave El Centro, CA 92243

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 09/11/2024 at 2:28 PM, the Consultant Pharmacist stated she reviewed each resident's chart monthly. The Consultant Pharmacist stated on the June and July reviews she had noted there was no stop date for Resident #82's PRN psychotropic medication and advised the facility it needed a stop date. The Consultant Pharmacist said it had not yet been done. During an interview on 09/12/2024 at 1:00 PM, the Assistant Director of Nursing (ADON) stated he and the Director of Nursing (DON) were both responsible for the completion of the pharmacy recommendations. The ADON stated if there was something the physician needed to review then the recommendation would be sent to him via facsimile. The ADON stated he did not know why Resident #82's pharmacy recommendations for June and July were not addressed. During an interview on 09/12/2024 at 1:25 PM, the DON stated PRN psychotropic medications needed to have a 14-day stop date. The DON said she did not understand her role in the pharmacy recommendations, and she had been placing them in the nurse practitioner's box. During an interview on 09/12/2024 at 1:58 PM, the Executive Director stated he did not know why the pharmacy recommendations for June and July were not followed. The Executive Director said it was facility practice to address the recommendations.

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	555158	A. Building B. Wing	09/12/2024

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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. 40141 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure an as-needed (PRN, pro re nata) order for psychotropic medication specified the duration of use for 1 (Resident #82) of 6 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Psychotropic Medication Use, dated 07/2022, specified, a. PRN orders for psychotropic medications are limited to 14 days. An Admission Record indicated the facility admitted Resident #82 on 03/09/2022. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2024, revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the resident received an antianxiety medication during the assessment period. Resident #82's Order Summary Report, dated 09/12/2024, contained an order dated 05/30/2024 for lorazepam 0.5 milligrams (mg) one tablet by mouth every six hours as needed for anxiety/restlessness. The order did not indicate an end date. A Note to Attending Physician/Prescriber for Resident #82 from the Consultant Pharmacist, dated 06/28/2024, specified, This resident has PRN Lorazepam 0.5 mg PO [by mouth] Q6H [every six hours] for anxiety. PRN psychotropic medications are limited to 14 days. The Note to Attending Physician/Prescriber also indicated, Please add a length of therapy. Further review revealed the physician had not signed the document. Another Note to Attending Physician/Prescriber for Resident #82 from the Consultant Pharmacist, dated 07/26/2024, specified, This resident has PRN Lorazepam 0.5 mg PO Q6H for anxiety. PRN psychotropic medications are limited to 14 days. The Note to Attending Physician/Prescriber also indicated, Please add a length of therapy. Further review revealed the physician had not signed the document. During a telephone interview on 09/11/2024 at 2:28 PM, the Consultant Pharmacist stated she reviewed each resident's chart monthly. The Consultant Pharmacist stated PRN psychotropic medications required a 14-day stop date. The Consultant Pharmacist said Resident #82's lorazepam did not have a 14-day stop date. During an interview on 09/12/2024 at 11:40 AM, Licensed Vocational Nurse (LVN) #4 stated Resident #82 was administered PRN lorazepam when they got anxious and agitated. LVN #4 said the lorazepam should have a 14-day stop date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555158	A. Building B. Wing	09/12/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 1:00 PM, the Assistant Director of Nursing (ADON) stated PRN psychotropic medications required a 14-day stop date. The ADON stated Resident #82's PRN lorazepam should have had a 14-day stop date and was unsure why it did not. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) stated PRN psychotropic medications needed a 14-day stop date. The DON said she expected for the 14-day stop date to be on the physician order. During an interview on 09/12/2024 at 1:58 PM, the Executive Director stated he expected for the regulation to be followed.

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	555158	A. Building B. Wing	09/12/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40141 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate less than 5 percent (%). The facility had 2 medication errors out of 28 opportunities, affecting 2 (Resident #3 and Resident #171) of 6 residents reviewed during the medication administration task, resulting in a medication error rate of 7.14%. Findings included: A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 1. An Admission Record indicated the facility admitted Resident #3 on 06/28/2024. According to the Admission Record, the resident had a medical history that included diagnoses of protein-calorie malnutrition and osteoarthritis. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/30/2024, revealed Resident #3 had modified independence with cognitive skills for daily decision making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated the resident had active diagnoses that included malnutrition and anemia. Resident #3's Order Summary Report, with active orders as of 09/11/2024, revealed an order dated 06/28/2024 for vitamin D3 1000 units one capsule by mouth one time a day for supplement. An observation of medication pass on 09/10/2024 at 8:27 AM, with Licensed Vocational Nurse (LVN) #1, revealed she prepared Resident #3's medications, including vitamin D3 2000 units one tablet and administered the vitamin D3 2000-unit tablet to the resident. During an interview on 09/10/2024 at 11:59 AM, LVN #1 retrieved a bottle of vitamin D3 from the medication cart and stated it was the vitamin D3 that was administered to Resident #3. LVN #1 confirmed Resident #3's physician order was for vitamin D3 1000 units but stated vitamin D3 2000 units was the only vitamin D3 that was available. LVN #1 stated she should contact the physician to notify them that the vitamin D3 1000-unit dose was not available. 2. An Admission Record indicated the facility admitted Resident #171 on 09/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of osteomyelitis and type 2 diabetes mellitus. Resident #171's Order Summary Report, dated 09/11/2024, contained an order dated 09/05/2024 for ketotifen fumarate ophthalmic solution 0.035% one drop in both eyes every morning and at bedtime for itchiness. An observation of medication pass on 09/10/2024 at 9:34 AM, with LVN #2 revealed she prepared Resident #171's medications. LVN #2 did not administer ketotifen fumarate ophthalmic solution to the resident. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/2024 at 11:56 AM, Resident #171 stated they did not receive their eye drops that morning because they had to be ordered. During an interview on 09/10/2024 at 2:11 PM, LVN #2 stated Resident #171's eye drops were not administered because they were not available. LVN #2 said the eye drops had not been administered since the resident admitted to the facility because they were either on back order or the insurance did not cover them. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) stated her expectation was for the medication error rate to be below the required rate. During an interview on 09/12/2024 at 1:58 PM, the Executive Director stated his expectation was for medications to be available and for staff to follow the regulations.

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	555158	A. Building B. Wing	09/12/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40141 Based on interview, record review, and facility policy review, the facility failed to ensure a significant medication error did not occur for 1 (Resident #93) of 6 residents reviewed for unnecessary medications. Specifically, facility staff failed to follow a physician's order to hold losartan potassium and metoprolol tartrate (medications used to treat high blood pressure) when the resident's systolic blood pressure (SBP, the top number in a blood pressure reading) was less than 120 millimeters of mercury (mmHg). Findings included: A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy also indicated, 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. An Admission Record indicated the facility admitted Resident #93 on 06/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral ischemia (diminished blood flow to the brain) and atrial fibrillation (irregular heartbeat). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/12/2024, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had active diagnoses of atrial fibrillation or other dysrhythmias and cerebral ischemia. Resident #93's Order Summary Report, dated 09/12/2024, contained an order dated 06/10/2024 for losartan potassium (antihypertensive) 25 milligrams (mg) one tablet by mouth two times a day, with instructions to hold if the resident's SBP was less than 120 mmHg. Resident #93's Order Summary Report, dated 09/12/2024, also contained an order dated 07/28/2024 for metoprolol tartrate (antihypertensive) 25 mg one tablet by mouth two times a day, with instructions to hold if the resident's SBP was less than 120 mmHg or their heart rate (HR) was less than 60 beats per minute. Resident #93's Medication Administration Record [MAR], for the timeframe from 09/01/2024 through 09/11/2024, revealed staff documented that they administered losartan potassium 25 mg to the resident when the resident's SBP was less than 120 mmHg on 09/01/2024 at 6:00 PM, 09/03/2024 at 6:00 PM, 09/06/2024 at 6:00 PM, 09/07/2024 at 9:00 AM, 09/08/2024 at 6:00 PM, and 09/09/2024 at 9:00 AM. Resident #93's MAR for the timeframe from 09/01/2024 through 09/11/2024, revealed staff documented that they administered metoprolol tartrate 25 mg when the resident's SBP was less than 120 mmHg on 09/01/2024 at 6:00 PM, 09/06/2024 at 6:00 PM, 09/07/2024 at 9:00 AM, 09/08/2024 at 6:00 PM, and 09/09/2024 at 9:00 AM. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 11:40 AM, Licensed Vocational Nurse (LVN) #4 stated if there was a parameter included in the order, she would check the resident's blood pressure, then either administer the medication or hold it, based on the parameters. LVN #4 reviewed Resident #93's September MAR for 09/08/2024 and stated she had administered the resident's blood pressure medications but should not have. During an interview on 09/12/2024 at 1:00 PM, the Assistant Director of Nursing (ADON) stated if a resident's blood pressure was not within the ordered parameters, then the medication should be held. The ADON reviewed the MAR for Resident #93 for the timeframe from 09/01/2024 through 09/11/2024 and stated the blood pressure parameters were not followed. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) reviewed Resident #93's MAR and said staff should have followed the parameters. The DON stated her expectation was for the blood pressure parameters to be followed. During an interview on 09/12/2024 at 1:58 PM, the Executive Director stated he expected staff to follow the physician ordered parameters.

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	555158	A. Building B. Wing	09/12/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 31524 Based on observation, interview, and facility policy review, the facility failed to dispose of garbage and refuse properly, affecting 1 of 2 trash dumpsters and 2 of 2 recycle dumpsters. Specifically, a trash dumpster was missing a lid and the recycle dumpsters were full to the point of being unable to be covered. The deficiency had the potential to affect all residents residing in the facility. Findings included: A facility policy titled, Waste Management, dated 2001, indicated, The facility will maintain the outside dumpster area in a manner that minimizes health hazards, pest infestations, and environmental contamination, ensuring all waste is properly disposed of in accordance with local, state, and federal guidelines. The policy indicated, 1. Dumpster Maintenance: included a. Dumpsters must be kept closed at all times to prevent the attraction of pests and to contain odors. An observation on 09/09/2024 at 8:52 AM revealed two trash dumpsters at the end of the parking lot. The dumpsters were designed to have two lids each. One trash dumpster was completely missing one of its two lids, exposing the contents of the dumpster to open air. Further observation revealed two recycle dumpsters containing cardboard boxes stacked up above the walls of the dumpsters and their lids were open exposing the dumpster contents to open air. During an interview on 09/09/2024 at 8:54 AM, the Certified Dietary Manager (CDM) stated she did not know why the trash dumpster's lid was missing or why the two recycle dumpsters were open and stated that she planned to ask the Director of Maintenance. The CDM further stated the facility would have to call the dumpster company to replace the missing lid. An observation on 09/10/2024 at 8:05 AM revealed two recycle dumpsters containing cardboard boxes stacked up above the walls of the dumpsters, making the lids unable to fully close, exposing the dumpster contents to open air. Further observation revealed the dumpster with the missing lid was no longer present at the end of the parking lot. During an interview on 09/10/2024 at 9:20 AM, the Director of Maintenance stated he called the dumpster company the previous day to replace the lid on the dumpster. Per the Director of Maintenance, maintenance staff moved the dumpster away from the end of the parking lot and put a sign on it for staff to not use until the lid was replaced. During an interview on 09/11/2024 at 9:15 AM, Maintenance Assistant #13 stated he did not know how long the lid to the dumpster had been missing and they pushed that dumpster into a covered garage so staff would not use it. Maintenance Assistant #13 further stated the lid to the dumpster's needed to be shut to prevent the spread of infection and to keep people out of the dumpsters. During an interview on 09/11/2024 at 9:30 AM, the Director of Maintenance stated the lid to the dumpster broke over the weekend and the dumpster company was to replace it that day. The Director of Maintenance further stated the dumpsters should be kept closed to prevent the spread of infection and to reduce odors. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/12/2024 at 12:13 PM, the Director of Nursing (DON) stated she did not know there was a regulation related to the dumpsters but expected trash to be enclosed in the dumpsters with a closed lid. During an interview on 09/12/2024 at 12:18 PM, the Executive Director stated he expected the maintenance department to maintain the dumpster area and stated that the dumpsters should be clean and covered.

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	555158	A. Building B. Wing	09/12/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, record review, and facility policy review, the facility failed to have a physician's order for hospice services for 1 (Resident #221) of 2 residents reviewed for hospice services. Findings included: A facility policy titled, Hospice Program, revised 07/2017, revealed, 12. Our facility has designated [Name] (Name) RN [registered nurse] DON [Director of Nursing] (Title) to coordinate care provided to the resident by our facility staff and the hospice staff. The policy also indicated, He or she is responsible for the following: d. Obtaining the following information from the hospice: (7.) Hospice physician and attending physician (if any) orders specific to each resident. An Admission Record revealed the facility admitted Resident #221 on 09/06/2024. According to the Admission Record, Resident #221 had a medical history that included diagnoses of adult failure to thrive and Alzheimer's disease. Resident #221's Skilled Nursing-Admission Initial Eval [Evaluation], dated 09/06/2024, revealed New Admission under Hospice [Name] Care. The record revealed, Evaluation done with Hospice Nurse at side. Pending Hospice Medication Orders. Resident #221's undated care plan included a focus area that indicated the resident had a terminal prognosis or end stage condition with less than six months to live and required hospice services. Interventions directed staff to provide maximum comfort for Resident #221. Resident #221's Order Summary Report, with active orders as of 09/10/2024, revealed no order for hospice care. During an interview on 09/10/2024 at 2:44 PM, Hospice Aide #11 stated she was the hospice aide for Resident #221 and thought the resident had recently been admitted to hospice. During an interview on 09/10/2024 at 2:49 PM, Licensed Vocational Nurse (LVN) #12 revealed Resident #221 was admitted to the nursing facility for hospice care. LVN #12 reviewed Resident #221's physician's orders and stated there was no order for the resident's hospice care. During an interview on 09/10/2024 at 2:56 PM, LVN #2 stated there was no order for Resident #221 to receive hospice services. During an interview on 09/12/2024 at 10:23 AM, RN #10 revealed, when a resident arrived at the facility for hospice services, the nurse must enter the order. RN #10 stated she was not aware Resident #221 did not have a hospice order. (continued on next page)

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	555158	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/2024 at 1:00 PM, the DON stated when residents were admitted to the facility for hospice services, she expected the nursing staff to obtain and document the order in the medical records. The DON stated residents receiving hospice must have an order from the physician. During an interview on 09/12/2024 at 1:26 PM, the Executive Director revealed he expected the staff to obtain an order from the physician for hospice care.

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	555158	A. Building B. Wing	09/12/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46258 Based on observation, interview, record review, facility policy review, and Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure staff were fit tested for a respirator required for respiratory protection when working with Coronavirus Disease 2019 (COVID-19) positive residents, which had the potential to affect all residents that resided in the facility, and failed to use proper hand hygiene during catheter care for 1 (Resident #221) of 1 resident observed for catheter care. Findings included: 1. A facility policy titled, Personal Protective Equipment - Contingency and Crisis Use of N-95 Respirators (COVID-19 Outbreak), revised 09/2021, specified, When N95 filtering facepiece respirators (FFR) are available and there is not an anticipated shortage, the facility operates under conventional capacity measures, including: a. using airborne isolation rooms for aerosol-generating procedures performed on residents with suspected or confirmed SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] infection. A facility policy titled, Coronavirus Disease (COVID-19) - Using Personal Protective Equipment, revised 09/2022, specified, 4. When caring for a resident with suspected or confirmed SARs-CoV-2 infection: b. Respirator: (1) An N95 respirator (or equivalent or higher-level respirator) is donned before entry into the resident room or care area. CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 03/18/2024, indicated, HCP [healthcare providers] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protections. During an interview on 09/11/2024 at 1:15 PM, the Infection Preventionist (IP) stated they were not doing any N95 fit testing. The IP stated she did not know N95 fit testing was required until August (2024). The IP stated they were using KN95 masks. During an interview on 09/11/2024 at 3:03 PM, the Director of Nursing (DON) stated the facility was not doing any N95 fit testing. During an interview on 09/12/2024 at 1:42 PM, the Executive Director stated the facility was not completing N95 fit testing. The Executive Director stated he expected his clinical team to know if they were required to complete N95 fit testing. 40141 2. An Admission Record indicated the facility admitted Resident #221 on 09/06/2024. According to the Admission Record, the resident had medical history that included a diagnosis of urinary tract infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555158	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Centro Post-Acute Care	1700 S. Imperial Ave El Centro, CA 92243

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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 - Many	Resident #221's care plan included an undated focus area that indicated the resident required an indwelling urinary catheter and was at risk for urinary tract infection. Interventions directed staff to provide catheter care and perineal care every shift and as needed. During an observation of indwelling catheter care on 09/11/2024 at 1:45 PM, Certified Nurse Assistant (CNA) #5 performed hand hygiene and donned gloves. CNA #5 provided catheter care for Resident #221, and then, without changing gloves, turned the resident onto their side and started cleansing bowel movement from the resident's buttocks. CNA #5 placed the soiled wipes into the soiled brief, rolled the soiled brief, and removed it. Without changing gloves, CNA #5 obtained and applied a clean brief. CNA #5 then touched the resident's shirt, the package of wipes, the sheet to cover the resident, and used the bed controller to reposition the bed before she removed her gloves. During an interview on 09/11/2024 at 1:55 PM, CNA #5 stated catheter care was provided by going from clean to dirty tasks. CNA #5 stated the resident had been soiled with bowel movement. CNA #5 stated she should have changed her gloves between dirty and clean tasks. CNA #5 confirmed she did not change gloves. CNA #5 stated gloves needed to be changed to stop the spread of infection. During an interview on 09/12/2024 at 9:27 AM, CNA #3 stated gloves should be changed before clean items were obtained because the gloves could soil and contaminate other items. During an interview on 09/12/2024 at 12:09 PM, the Infection Preventionist (IP) stated gloves should be changed when staff needed to touch something else during the provision of care or when contaminated. The IP was informed of CNA #5 not changing gloves after providing incontinence care for Resident #221, and then touching the resident's clean brief. The IP stated the CNA should have changed gloves before touching the clean brief. During an interview on 09/12/2024 at 1:25 PM, the Director of Nursing (DON) stated the CNA should have changed her gloves before touching the resident's clean brief. The DON stated she expected staff to follow infection control practices and change gloves to prevent infections. During an interview on 09/12/2024 at 1:58 PM, the Executive Director stated it was the facility's practice to follow the regulations, especially hand washing and changing gloves, to mitigate the risk for infection control.