

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Southern Inyo Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 501 E Locust Lone Pine, CA 93545	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on interview and record review, the facility failed to ensure nursing staff were certified and kept current in cardiopulmonary resuscitation (first aid technique to help a person who has stopped breathing) for five (5) of 18 Certified Nurse Aide (CNA) (CNA 1, 2, 3, 4, and 5) when the facility was unable to provide documented evidence of current CPR certification.</p> <p>This failure had the potential to negatively affect residents' care due to unqualified or incompetent staff during emergencies at the facility.</p> <p>Findings:</p> <p>During a concurrent interview and record review on [DATE], at 11:10 AM, with the Assistant Director of Nursing (ADON) 1, and the Director of Staff Development (DSD) 1, CNA 1's file, undated, was reviewed. There was no CPR's certification on file. The ADON 1 and DSD 1 explained that when CNA 1 was hired on [DATE], the facility failed to check if the CNA 1 had a CPR card. The DSD 1 further stated that for the last six months, he has not kept track of the staff CPR certification status.</p> <p>During an interview on [DATE], at 1:58 PM, with the DSD 1, the DSD 1 stated that there are three other CNAs (CNA 2, 3, and 4) that did not have CPR cards, and one CNA (CNA 5) CPR card has expired in [DATE]. The DSD 1 stated he has forgotten to check the employee's CPR status.</p> <p>A review of the nursing staff CPR certificate list indicated that four CNAs (CNA 1, 2, 3, and 4) did not have CPR cards.</p> <p>A review of the CNA 5 CPR card issued on [DATE], indicated that the CPR card expired in [DATE].</p> <p>During an interview on [DATE], at 2:59 PM, with the Director of Human Resources (DHR 1), the DHR 1 stated it was completely an oversight; it was an assumption that the CNAs had to have a CPR card before they received their CNA certification. The DHR further stated, It was their fault for not verifying.</p> <p>A review of the facility's policy and procedure (P&P) titled, C.P.R. Certification-Required dated [DATE], indicated, .1. All certified and licensed staff shall hold current cardiopulmonary resuscitation certification through the American Red Cross, the American Heart Association, or another accrediting or certifying agency. 2. C.P.R. certifications shall be kept current at all times .</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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>47110</p> <p>Based on observation, interview, and record review, the facility failed to ensure a Registered Nurse (RN) was available onsite at least eight (8) hours a day, seven (7) days a week for all admitted residents from April 1, 2024, through July 11, 2024 when the facility did not have RN onsite for 17 days and had fewer RN hours than eight (8) hours requirement for three (3) days.</p> <p>This failure had a potential to negatively affect residents care from an oversight of RN which may increase risk of avoidable resident safety events such as medication errors or delayed in comprehensive assessment that could jeopardize residents' health, safety, and lead to actual harm.</p> <p>Findings:</p> <p>During an observation on July 11, 2024, from 8:00 AM, through 10:00 AM, there was no RN working in the unit.</p> <p>During an interview on July 11, 2024, at 11:10 AM, with the Assistant Director of Nursing (ADON) 1, the ADON 1 stated that besides the Director of Nursing (DON) 1 as an RN, they have two other RNs (RN 1, RN 2). The ADON 1 claimed that there was no RN scheduled for today, and the facility was aware of the policy that requires eight (8) hours of RN on duty seven (7) days a week.</p> <p>During an interview on July 11, 2024, at 2:59 PM, with the Director of Human Resources (DHR) 1, the DHR 1 stated that the facility was unable to find RN to cover for DON 1 today.</p> <p>During a concurrent interview and record review on July 12, 2024, at 9:15 AM, with the ADON 1, the DON 1's timecard, dated April 9, 2024, April 17, 2024, and July 11, 2024, were reviewed. The ADON 1 clarified that the reason the DON 1's timecard showed hours on April 9 and April 17 was because DON 1 was working for the hospital on those days. She went on to say that although the DON 1's timecard showed hours on July 11, the DON 1 was not physically present at the facility.</p> <p>A continuous concurrent interview and record review on July 12, 2024, at 9:15 AM, with the ADON 1, RN staffing schedule and timecard, dated April 2024, were reviewed. The ADON 1 confirmed that for the month of April 2024, there were no RN hours on April 1, April 2, April 4, April 9, April 17, and April 29. On April 3, RN hours were 4.5 hours short.</p> <p>A continuous concurrent interview and record review on July 12, 2024, at 9:15 AM, with the ADON 1, RN staffing schedule and timecard, dated May 2024, were reviewed. The ADON 1 confirmed that for the month of May 2024, there were no RN hours on May 16, May 20, May 21, May 22, May 23, and May 27. On May 6, RN hours were 6 hours short, and on May 7, RN hours were 3.75 hours short.</p> <p>A continuous concurrent interview and record review on July 12, 2024, at 9:15 AM, with the ADON 1, RN staffing schedule and timecard, dated June 2024, were reviewed. The ADON 1 confirmed that for the month of June 2024, there were no RN hours on June 18, June 19, and June 27.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A continuous concurrent interview and record review on July 12, 2024, at 9:15 AM, with the ADON 1, RN staffing schedule and timecard, dated July 1, 2024, through July 11, 2024, were reviewed. The ADON 1 confirmed that for the month of July 2024, there were no RN hours on July 4 and July 11.</p> <p>A review of the facility's policy and procedure (P&P) titled, RN/Director of Nursing Coverage, dated July 9, 2020, indicated, . 4. A registered nurse will be present 7 days a week for at least 8 consecutive hours a day .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38869</p> <p>Based on observation, interview, and record review, the facility failed to protect residents from food contamination for a universe of 29 residents when one kitchen staff was not wearing a hair net during food preparation.</p> <p>This failure had the potential to contaminate food, equipment, and utensils.</p> <p>Findings:</p> <p>During a concurrent observation and interview on July 8, 2024, at 02:08 PM, in the kitchen, Kitchen Aide (KA) 1 was not wearing a hair net while preparing food. When pointing out the absence of a hair net on, she then walked to the kitchen entrance and put on a hair net. KA 1 stated she should have put a hair net on, and the facility have said many times that staff are to wear hair net while in the kitchen.</p> <p>During an interview on July 12, 2024, at 11:07 AM, with the Dietary Services Supervisor (DSS) 1, the DSS stated staff should wear the hair net due to potential contamination of food, equipment, or utensils.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Hair nets & personal permitted in FNSD (Food and Nutrition Services Department), dated September 2023, the P&P indicated, All Food and Nutrition staff are required to wear hairnets or caps or other suitable coverings to confine hair when required to prevent the contamination of food, equipment, or utensils.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe operating equipment for one (1) of 29 residents (Resident 27) when Resident 27's bedrail had sharp edges on it.</p> <p>This failure resulted in Resident 27 sustaining an abrasion on her right elbow from the sharp edges which may cause an infection and putting Resident 27's health in jeopardy.</p> <p>Findings:</p> <p>A review of resident 27's Admission Record (which contains demographic and medical information), indicated, Resident 27 was admitted to the facility on [DATE], with diagnoses that included elevated white blood cell count, abnormality of albumin (a protein in your blood plasma), insomnia (difficulty falling asleep, staying asleep, or both), and weakness.</p> <p>During a concurrent observation and interview on July 8, 2024, at 4:14 PM, Resident 27's right elbow was observed in wound dressing. Resident 27 stated, she got a cut from a sharp edge of her bedrail. Upon closer inspection, the right-side bedrail's far end was found to have sharp edges.</p> <p>During an interview on July 9, 2024, at 10:18 AM, with the License Vocational Nurse (LVN) 1, LVN 1 stated that Resident 27 reported a cut on her right elbow coming from a sharp edge on the bedrail. LVN 1 further stated she cleaned the wound and put dressing on it. LVN 1 denied reporting the incident to the facility's management. LVN 1 confirmed, Resident 27's bedrail had a sharp edge.</p> <p>During an interview on July 10, at 8:35 AM, with the Director of Nursing (DON) 1, the DON 1 stated she was unaware of the sharp edge on resident 27's bedrail. The DON 1 further explained that one of her staff members reported that Resident 27 sustained an abrasion but did not chart how the wound occurred. The DON 1 stated that she has not followed up on the bedrail yet.</p> <p>During an interview on July 12, 2024, at 09:06 AM, with the Environmental Services Manager (EVSM) 1 filling in for the Director Facilities, the EVSM 1 stated he was unaware of any sharp edges on Resident 27's bedrail and that there was no report on the subject.</p> <p>A review of the facility's policy and procedure (P&P) titled, Safe Environment, dated July 20, 2022, indicated, . 2. The facility will maintain all essential mechanical, electrical and patient care equipment in safe operating condition .</p>		