| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555589 | A. Building<br>B. Wing | 04/14/2024 |

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| Whittier Hospital Medical Ctr D/P Snf | 9080 Colima Road<br>Whittier, CA 90605 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878<br><br>Based on interview and record review the facility failed to ensure two (2) of 4 sampled residents (Residents 15 and 19) had a completed advanced directive acknowledgment form (a form indicating to the resident or responsible party the right to give written directions about future treatment before becoming seriously ill or unable to make healthcare decisions).<br><br>This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions.<br><br>Findings:<br><br>1. A review of Resident 15's Admission Record indicated the resident was readmitted to the facility on [DATE], with diagnoses that included anoxic brain damage (a brain injury caused by lack of oxygen to the brain resulting in brain cells death).<br><br>During a concurrent interview and record review on 4/13/2024 at 12:40 PM, with the Social Services Director (SSD) of Resident 15's medical records, the SSD stated she was unable to find Resident 15's Advance Directive in Resident 15's records. The SSD stated she did not know when Resident 15's responsible party had signed an Advance Directive Decision form because Resident 15 had previously been admitted to the facility.<br><br>2. A review of Resident 19's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included spastic quadriplegic cerebral palsy (a condition that affects both arms and legs and often the torse and face).<br><br>During a concurrent interview and record review on 4/13/2024 at 11:47 AM, with the SSD, the SSD stated she was unable to find Resident 19's Advance Directive Decision form in Resident 19's medical record. The SSD stated upon admission, Resident 19's responsible party had not signed the Advance Directive Decision form and had not had a chance to follow up with the responsible party.<br><br>During an interview on 4/14/2024 at 7 PM with the Director of Nursing (DON), the DON stated it was important to have Resident 15 and Resident 19's Advance Directive on file in the resident's records so that it was easily accessible in case of an emergency.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's Policy and Procedure titled, Advance Directives, revised 10/2021, the P&P indicated, the facility policy supports patient ' s right to self-determination in their healthcare decision through the use of an Advance Directive. Each adult patient or surrogate decision maker, is provided with pertinent information regarding the requirements necessary to execute, and limitations attached to, various Advance Directives. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878<br><br>Based on observation, interview, and record review the facility failed to develop and implement individualized person-centered care plans with measurable objectives, timeframes and interventions for one of two sampled resident's (Resident 15) with urinary catheter (a device that drains urine from the urinary bladder into a collection bag).<br><br>This deficient practice had the potential for Resident 15 not to receive appropriate care, treatment and/or services.<br><br>Findings:<br><br>A review of Resident 15's Face Sheet indicated the resident was readmitted to the facility on [DATE], with diagnoses that included anoxic brain damage (a brain injury caused by lack of oxygen to the brain resulting in brain cells death).<br><br>A review of Resident 15's Minimum Data Set (MDS, a standardized resident assessment and care planning tool) dated 3/10/2024, indicated Resident 15 had diagnoses that included neurogenic bladder (a person lacks bladder control due to brain, spinal cord or nerve problems), and urinary tract infection (UTI, an infection in any part of the urinary tract system).<br><br>A review of Resident 15's Order Information Report, dated 4/12/2024 timed 11:02 AM, indicated may discontinue clean intermittent catheterization (CIC) for now, place indwelling Foley (urinary) catheter continue for one month.<br><br>During a concurrent observation and interview on 4/12/2024, at 1:30 PM, in the presence of Licensed Vocational Nurse (LVN) 2, Resident 15 ' s urinary catheter was observed hanging from the lower left side of Resident 15's bed frame. LVN 2 stated Resident 15 has a history of recurrent UTI's and was currently receiving IV (intravenous) antibiotics.<br><br>During an interview and concurrent record review on 4/14/2024 of Resident 15's medical record with Minimum Data Assistant (MDSA) 1, MDSA 1 stated Resident 15 did not have an individualized plan of care for the urinary catheter. MDSA 1 stated Resident 15 had a short-term care plan for UTI that mentioned the urinary catheter, but it did not include specific interventions, and goals. MDSA 1 stated residents ' care plans should be specific to each resident and include measurable goals, timeframes and interventions.<br><br>A review of the facility's policy and procedure titled, Care Plan, Comprehensive with a revision date of January 2018, indicated 1.4 Plan of Care: is updated/reviewed/revised with any change in needs, or care, weekly, quarterly, and with any significant change in condition. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854<br><br>Based on observation, interview, and record review, the facility failed to provide the appropriate care to four of four sampled residents (Resident 4, 9, 11, and 12) who had a gastrostomy tube (G-Tube, a tube placed directly into the stomach through an abdominal wall incision for the administration of food, fluids, and medications) by failing to:<br><br>1. Ensure the tube feeding syringe was labeled with date opened for Resident 4, 9, 11, and 12.<br><br>2. Ensure a new bottle of Peptide-Based Nutrition ( nutritional formula) was used for Resident 4, feeding was used for more than 24 hours.<br><br>These deficient practices placed Resident 4, 9, 11, and 12's G-tube at risk for getting clogged and contaminated which had the potential to cause discomfort and infection.<br><br>Findings:<br><br>1a. A review of Resident 9's Admission record indicated an admission to the facility on [DATE] with a diagnosis of atresia (absence or abnormal narrowing of an opening or passage in the body) of foramina (an opening that allows passage of structures from one region to another) of Magendie and Luschka (the [NAME] cyst (congenital [happening before birth] condition where the cerebellum [an area at the back of the brain that controls movement and balance] does not develop normally).<br><br>A review of Resident 9's Minimum Data Set (MDS, a standardized resident assessment and care planning tool) dated 3/10/2024, indicated Resident 9 had diagnoses that included respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and gastrostomy status (G-tube). The MDS indicated Resident 9 had impaired functional limitation in range of motion for both sides of upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities.<br><br>A review of Resident 9's Order Summary indicated a physician order dated 2/9/2024 for G-tube size: 12 French/ 1.7 centimeter (cm, unit of measure).<br><br>During an observation in Resident 9's room on 4/12/2024 at 1:13 PM, Resident 9's tube feeding syringe was observed in a clear plastic cup with no label of date opened on top of bedside dresser. Observed opened syringe bag with no label of date opened.<br><br>1b. A review of Resident 11's Admission record indicated an admission to the facility on [DATE] with a diagnosis of congenital hypoplasia (rare neurological condition present at birth, characterized by the underdevelopment or incomplete development of the cerebellum).<br><br>A review of Resident 11's MDS dated [DATE], indicated Resident 11 had diagnoses that included chronic respiratory failure with hypoxia and gastrostomy status (G-tube). The MDS indicated Resident 11 had impaired functional limitation in range of motion for both sides of upper and lower extremities.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 11's Order Summary indicated a physician order dated 3/16/2020 for G-tube size: [NAME] 12 French/ 1.0 cm, 5 milliliter (ml, unit of measure) balloon.<br><br>During an observation in Resident 11's room on 4/12/2024 at 1:17 PM, Resident 11's tube feeding syringe was observed in a bag with no label of date opened on top of bedside dresser.<br><br>During a concurrent observation and interview in Resident 9 and 11's room on 4/12/2024 at 1:28 PM, Licensed Vocational Nurse (LVN) 1, confirmed she opened new packages and did not label Resident 9 and 11's tube feeding syringes. LVN 1 stated she would label them right now. LVN 1 stated it was important to label the syringes with the date opened so they would not get mixed with other patients, to make sure it was not in use for too many days, and to avoid cross contamination.<br><br>1c. A review of Resident 12's Admission record indicated an admission to the facility on [DATE] with a diagnosis of disorders of copper metabolism ([NAME] disease, defect makes it hard for the body to properly distribute copper throughout the body).<br><br>A review of Resident 12's MDS dated [DATE], indicated Resident 12 had diagnoses that included epileptic spasms (sudden abnormal movements of the body) and gastrostomy status (G-tube). The MDS indicated Resident 12 had impaired functional limitation in range of motion for both sides of upper extremities.<br><br>A review of Resident 12's Order Summary indicated a physician order dated 7/31/2019 for G-tube size: 16 French silicon.<br><br>During an observation in Resident 1's room on 4/12/2024 at 1:28 PM, Resident 12's tube feeding syringe was observed in a bag with no label of date opened on top of bedside dresser.<br><br>1d. A review of Resident 4's Admission record indicated an admission to the facility on [DATE] with a diagnosis of encephalopathy (brain disease that alters brain function or structure).<br><br>A review of Resident 4's MDS dated [DATE], indicated Resident 4 had diagnoses that included anoxic brain damage (lack of oxygen to the brain which results in death of brain cells) and encounter for gastrostomy status (G-tube). The MDS indicated Resident 4 had impaired functional limitation in range of motion for both sides of upper and lower extremities.<br><br>A review of Resident 4's Order Summary indicated the following physician orders:<br><br>On 12/21/2016 to hang new bottle of Pediasure Peptide as needed.<br><br>On 1/22/2017 for G-tube [NAME] 12 French/ 2.0 cm change every 3 months and as needed for dislodge or plugging as needed.<br><br>On 2/22/2024 for Pediasure Peptide 1.0 calorie (cal, unit of measure), give 190 ml per hour for 30 minutes to give 95 ml every 4 hours with 190 ml of water every 4 hours.<br><br>During an observation in Resident 4's room on 4/12/2024 at 1:31 PM, Resident 12's tube feeding syringe was observed in a bag with no label of date opened on top of bedside dresser.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. At 1:33 PM, observed Resident 4's Pediasure Peptide bottle dated 4/10/2024 timed at 7:30 PM.<br><br>During a concurrent observation and interview in Resident 12 and 4's room on 4/12/2024 at 1:47 PM, LVN 2 stated she would label Resident 12 and 4's tube feeding syringes to indicate it was opened today. LVN 2 stated the purpose of labeling the syringes was for infection control. At 1:50 PM, LVN 2 stated Resident 4's feeding was decreased, but the Pediasure Peptide bottle should be changed every 24 hours to prevent infection or growth of bacteria.<br><br>During an interview with the Director of Nursing on 4/14/2024 at 4:45 PM, the DON stated all equipment used for g-tube including the syringe should be labeled with the date opened. The DON stated the staff must dispose of the syringe and bottle feeding at 24 hours to minimize bacteria growth.<br><br>A review of the facility's policy and procedure titled Tube Feedings, dated 5/31/2007 indicated the maximum hanging time for closed system (bottle) was 24 hours. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878<br><br>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 13):<br><br>1. Resident 13's aerosol, oxygen system(a medical device is used to convert the medication into fine aerosol particles which can be inhaled or propelled directly into the airway and lungs) was dated with the date it was changed, in accordance with the facility ' s policy and procedure on Respiratory Equipment Handling.<br><br>2. Resident 1's tracheostomy mask (a soft plastic mask that fits over the trachea opening) was stored in a plastic bag when not in use, for infection control.<br><br>This deficient practice placed the Resident 13's respiratory equipment at risk for contamination and Resident 13 at risk for infection.<br><br>Findings:<br><br>A review of Resident 13's Admission Record indicated an admission to the facility on [DATE], with a diagnosis of Di [NAME] ' s syndrome (a chromosomal disorder that results in poor development of several body systems).<br><br>A review of Resident 13's Minimum Data Set (MDS, a standardized resident assessment and care planning tool) dated 2/11/2023, indicated Resident 13 had diagnoses that included seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures.), asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe).<br><br>A review of Resident 13's Order Summary Report, dated 4/1/2024, indicated the resident's Tracheostomy size/brand/type was Bivona Neo 4.0 cuffless.<br><br>During a concurrent observation and interview on 4/12/2024, at 1:45 PM, in the presence of Licensed Vocational Nurse (LVN) 2, Resident 13 ' s tracheostomy mask was observed in between the crib rails and touching space between the resident's mattress and crib rails. LVN 2 stated when the tracheostomy mask was not in use, it should be placed inside a storage bag next to Resident 13's bed with the resident ' s name and date labeled. LVN 2 stated this if for infection control to prevent any contamination of Resident 13's tracheostomy mask.<br><br>During a concurrent observation and interview on 4/12/2024, at 1:55 PM, in the presence of Respiratory Therapist (RT) 1, Resident 13 ' s aerosol, oxygen system was not labeled. RT 1stated Resident 13 ' s aerosol oxygen system did not have a date to indicate when it was last replaced. RT 1 stated the systems are changed every week on Tuesdays and are dated when changed to indicate that it was changed on the designated date.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/13/2024, at 12:50 PM, with Respiratory Therapist Lead (RTL) 1, RTL 1 stated there is no policy stating trach mask should be stored in plastic bag when not in use but it is facility practice to for staff to store when not in use , RTL 1 further stated should be dated to verify that they were changed according to facility policy and prevent Resident ' s from contracting an infection.<br><br>During an interview on 4/14/2024, at 4:38 PM, with the facility ' s Director of Nurses, the DON stated it is the facility ' s practice for the resident ' s tracheostomy mask to be placed inside the bag when not in used for infection control.<br><br>A review of the facility's policy and procedure titled, Respiratory Equipment Handling with a revision date of 9/2018, indicated Aerosol, oxygen systems are to be changed on Tuesdays. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854<br><br>Based on interview and record review, the facility failed to ensure the Attending Physician (AP) reviewed the drug regimen thoroughly and documented in the resident's medical record if the identified irregularities and recommendation of the pharmacyst were accepted, rejected and a rationale was documented if the Pharmacist recommendations in the Medication Regimen Review (MRR)were accepted or rejected for four of four sampled residents (Resident 3, 5, 9, and 10).<br><br>This deficient practice had the potential for the residents to receive excessive or insufficent dosage of medications that the could harm the residents and/or not receive the right medication to treat the resident's underlying medical condition due to the missed opportunity to act upon the reported irregularities.<br><br>Findings:<br><br>1. A review of Resident 9's Admission record indicated an admission to the facility on [DATE] with a diagnosis of atresia (absence or abnormal narrowing of an opening or passage in the body) of foramina (an opening that allows passage of structures from one region to another) of Magendie and Luschka (the [NAME] cyst a congenital [happening before birth] condition where the cerebellum [an area at the back of the brain that controls movement and balance] does not develop normally).<br><br>A review of Resident 9's Minimum Data Set (MDS, a standardized resident assessment and care planning tool) dated 3/10/2024, indicated Resident 9 had diagnoses that included respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and gastrostomy status (G-tube). The MDS indicated Resident 9 had impaired functional limitation in range of motion for both sides of upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities.<br><br>A review of Medication Regimen Review (MRR) for Resident 9, dated 3/6/2024 indicated to: (1) increase dose of Levocarnitine (medication used to prevent and treat condition in patients with kidney disease) and (2) inform physician of potassium level (a chemical that is critical to the function of nerve and muscle cells including the heart, normal levels 3.6 to 5.2 millimoles (mmol, unit of measure) per liter (L, unit of measure) of 3.2 on 3/4/2024. The MRR dated 3/28/2024 indicated, the Attending Physician signed the document, but provided no rationale if Pharmacist recommendations were accepted or rejected.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Medication Regimen Review (MRR)for Resident 9, dated 4/4/2024 indicated to: (1) increase Pepcid dose to 15 milligrams (mg, unit of measure) twice a day, (2) to change to Amikacin Inhalation cycle (a medication used to treat infection) for a few months, then alternate with tobra (monitoring adequacy of serum concentration during tobramycin [antibiotic commonly used in the management and treatmetn of various systemic and ocular (eye) infections] therapy) to prevent resistance (not treating the disease causing organism with current medication therapy) and (3) check for edema while using hydrochlorothiazide (medication that removed excess fluid in the body). The MRR dated, 4/8/2024 indicated the Attending Physician signed the document, but provided no rationale if Pharmacist recommendations were accepted or rejected.<br><br>2. A review of Resident 5's Admission record indicated an admission to the facility on [DATE] with a diagnosis of anoxic brain damage (when the brain gets no oxygen, which results in the death of brain cells).<br><br>A review of Resident 5's MDS dated [DATE], indicated Resident 5 had diagnoses that included chronic respiratory failure with hypoxia and dependence on respirator (ventilator) status. The MDS indicated Resident 5 had impaired functional limitation in range of motion for both sides of upper and lower extremities.<br><br>A review of Resident 5's MRR dated 3/6/2024 indicated to: (1) increase dose of milk of magnesia (medication used for a short time to treat occasional constipation [problem with passing stool]) or add another constipation drug and (2) to supplement with Vitamin D (supplement for building and maintaining healthy bones). The MRR, dated 3/11/2024, indicated the Attending Physician signed the document, but provided no rationale if Pharmacist recommendations were accepted or rejected.<br><br>During a concurrent interview and record review of Resident 3, 5, 9, and 10's MRR with the DON on 4/14/2024 at 4:55 PM, the DON stated the charge nurses of the unit, and clinical managers and herself, reviews the MRR for compliance. The DON stated she will call the physician to ask for clarification regarding the pharmacist recommendaton and follow up with physician's order. The DON stated it was important for the MRR to be completed to ensure the staff does not make any medication errors like overdosing ( to much medication) or underdosing (not enough medication) the resident.<br><br>42878<br><br>3. A review of Resident 3's Admission Record indicated an admission to the facility on [DATE], with diagnosis that included spastic quadriplegic (a permanent neuromuscular disorder causing limitations on all four limbs following a lesion on the developing brain) cerebral palsy (a disorder caused by abnormal brain development affecting a person's ability to move and maintain balance and posture).<br><br>A review of Resident 3's Minimum Data Set (MDS, a standardized resident assessment and care planning tool), dated 11/22/2023, indicated the resident had diagnoses that included non-traumatic brain disfunction, gastroesophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) The MDS indicated Resident 3 had impaired functional limitation in range of motion for both sides of upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities.<br><br>(continued on next page) |

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| Whittier Hospital Medical Ctr D/P Snf | 9080 Colima Road<br>Whittier, CA 90605 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 3's Order Summary, dated 4/1/2024, indicated an order for Motrin (brand name for Ibuprofen) 400 milligrams (a unit of measurement) every 6 hours as needed via G-Tube (a surgically placed device used to give direct access to stomach for supplemental feeding,) for temperatures higher than 102 Fahrenheit.<br><br>A review of Resident 3's Medication Regimen Review (MRR) dated 2/6/2024 indicated the following information:<br><br>Increase dose of ibuprofen from 350 milligrams (mg,unit of measure) to ibuprofen 400 mg. The MRR dated 2/12/2024, indicated the Attending Physician signed the document, but provided no rationale if Pharmacist recommendations were accepted or rejected.<br><br>4. A review of Resident 10's Admission Record indicated an admission to the facility on [DATE] with a diagnosis of acute (sudden) and chronic (something that continues over an extended version of time) respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).<br><br>A review of Resident 10 ' s MDS dated [DATE], indicated Resident 10 had diagnoses that included gastroesophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), seizure (a sudden, uncontrolled burst of electrical activity in the brain) disorder.<br><br>A review of Resident 10's Order summary report dated 4/01/2024, indicated an order for Tylenol 200 milligrams every 4 hours as needed via G-Tube for temperatures over 101 Fahrenheit.<br><br>A review of Resident 10's Order summary report dated 4/01/2024, indicated an order for Tylenol 200 milligrams every 4 hours as needed via G-Tube for mild pain.<br><br>A review of Medication Regimen Review (MRR) dated 3/6/2024 indicated the following:<br><br>Increase dose of Tylenol current dose 200 milligrams change to 250 milligrams. The MRR dated 3/11/2024, indicated the Attending Physician signed the document, but provided no rationale if Pharmacist recommendations were accepted or rejected.<br><br>A review of the facility's policy and procedure titled Pharmacy Drug Audits, dated 8/3/2021 indicated the physician and/or nurse practitioner will review the pharmacist recommendation and either accept the recommendation, or reject the recommendation. The policy indicated the physician will accept the pharmacist recommendation by checking the appropriate box on the form and create a new medication order. The policy indicated the physician will check the appropriate location on the form and document the clinical reason for rejecting the recommendation. |

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|---|---|---|---|
| | 555589 | A. Building<br>B. Wing | 04/14/2024 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>42878<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage, labeling of food, and preparation practices in the kitchen, in accordance with the facility's policy and procedures on Cleaning Schedule Use and Cleaning of Equipment.<br><br>1. One opened unlabeled plastic container with a single ice cream cone was found in the freezer.<br><br>2. Food particles found inside the freezer floor.<br><br>3. A bundle of wilted black colored cilantro (leafy vegetable) and molded jicama (fruit) were found in the refrigerator.<br><br>4. Open, unlabeled and undated personal beverage cup found in the kitchen food prep area.<br><br>These deficient practices had the potential to put residents at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins).<br><br>Findings:<br><br>During the initial observation of the facility's kitchen freezer on 4/12/2024 at 11:52 AM, one opened unlabeled plastic container with a single ice cream cone was found in the freezer shelve, and pieces of unknown food particles was observed inside the freezer floor.<br><br>During a concurrent interview on 4/12/2024 at 11:52 AM, with the Dietary Supervisor (DS), the DS stated all food should be labeled especially when it was first opened. The DS stated it was important to lawith the use by and open date. The DS stated the freezer floor should be cleaned on a daily basis especially when food falls on the floor to prevent cross contamination.<br><br>During the initial observation of the kitchen refrigerator and concurrent interview on 4/12/2024 at 11:58 AM with the DS, a bundle of wilted black colored cilantro was observed on the shelf and one jicama was observed with mold around it in a food tray. The DS stated spoiled food should be taken out every day. The DS stated dietary staff should be checking refrigerators two times a day to ensure the quality of the food remained pristine and any spoiled items should be removed from the refrigerator to prevent contamination to the rest of the produce.<br><br>During the initial observation of the kitchen on 4/12/2024 at 12:05 PM, an opened personal beverage cup containing an unknown red liquid was observed on the food prep table at the food prep area.<br><br>During a concurrent interview with the DS on 4/12/2024 at 12:06 PM, the DS stated dietray staff should not have opened personal beverage containers in the kitchen especially during lunch prep time. The DS stated having an opened personal beverage cup could lead to food contamination.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy and procedure titled, Cleaning Schedule Use and Cleaning of Equipment, with a revision date of March 2021, indicated 13. Floors will be swept daily and/or when visibly soiled. 15. Refrigerators are wiped and foods stored are checked daily for freshness. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854<br><br>Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary environment to help prevent the spread and transmission of infections to residents, staff members, visitors in accordance with the facility's policy and procedure on infection control by failing to:<br><br>1. Ensure Housekeeper (HK) 1 wore surgical facemask to cover her nose and wore an N95 respirator (filtering facepiece respirator mask) when entering Patient care areas.<br><br>2. Ensure HK 1, doffed dirty gloves, performed hand hygiene, and donned personal protective equipment (PPE) prior to entering Resident 9, 11, and 14's room who were on contact isolation precautions (procedures to reduce risk of spread of infections through direct or indirect contact) and Resident 18's room who was on droplet isolation precautions (diseases spread by small particles in the air).<br><br>3. To ensure Certified nursing assistant (CNA 1) doffed dirty PPE, perform hand hygine while exiting Resident 13's room and donned new PPE prior to re entering Resident 13's room<br><br>4. Ensure CNA 1 wore N95 respirator when sitting across Resident 13 while feeding lunch.<br><br>These deficient practices had the potential risk of the contamination and spread infection to the residents, staff, and visitors in the facility.<br><br>Findings:<br><br>A review of Resident 18's Admission Record indicated a previous admission to the facility on [DATE] with diagnoses including hypoxic ischemic encephalopathy (type of brain injury that occurs when the brain experiences a decrease in oxygen or blood flow, can occur before birth, during labor and delivery or after birth), bilateral osteoarthritis (degenerative joint disease that affects both knees, causing pain, stiffness, swelling, and decreased mobility) resulting from hip dysplasia (occurs when the hip joint has not developed properly and the socket is too shallow) and dependence on respirator (ventilator) status.<br><br>A review of Resident 18's MDS (Minimum Date Set, a tool for implementing standardized assessment and for facilitating care management in nursing home) dated 3/10/2024, indicated Resident 18 had impaired functional limitation in range of motion for both sides of lower (hip, knee, ankle, foot) extremities.<br><br>During an observation in Resident 18's room on 4/12/2024 at 1:05 PM, a droplet precaution signage was observed prior to entering the room. The signage indicated to perform hand hygiene and don an isolation gown, N95 respirator, goggles or faceshield and gloves prior to entering the room. HK 1 was observed entering Resident 18 ' s room and did not wear proper PPE. HK 1 was observed wearing a surgical face mask that did not cover her nose and did not change gloves. HK 1 emptied the trash bin close to the door entrance and touched her surgical face mask with dirty gloves to pull it up. HK 1 proceeded into the middle of the room to empty the second trash bin. HK 1 did not doff/change gloves or perform hand hygiene during the entire observation.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 9's Admission Record indicated an admission to the facility on [DATE], with diagnoses including atresia (absence or abnormal narrowing of an opening or passage in the body) of foramina (an opening that allows passage of structures from one region to another) of Magendie and Luschka (the [NAME] cyst (congenital [happening before birth] condition where the cerebellum [an area at the back of the brain that controls movement and balance] does not develop normally), respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and gastrostomy status (G-tube- stomach tube use to feed and provide nutrient to the resident).<br><br>A review of Resident 9's MDS dated [DATE], indicated Resident 9 had impaired functional limitation in range of motion for both sides of upper (shoulder, elbow, wrist, hand) and lower extremities.<br><br>A review of Resident 11's Admission record indicated an admission to the facility on [DATE] with a diagnosis of congenital hypoplasia (rare neurological condition present at birth, characterized by the underdevelopment or incomplete development of the cerebellum), indicated Resident 11 had diagnoses that included chronic respiratory failure with hypoxia and gastrostomy status (G-tube).<br><br>A review of Resident 11's MDS dated [DATE], indicated Resident 11 had no impairment for functional limitation in range of motion for both sides of upper and lower extremities.<br><br>A review of Resident 14's History and Physical Assessment indicated a readmission to the facility on [DATE] with a diagnosis that included chronic respiratory failure, tracheostomy (surgical airway management procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck) dependent and gastrostomy dependent.<br><br>A review of Resident 14's MDS dated [DATE], indicated Resident 14 had impaired functional limitation in range of motion for both sides of upper and lower extremities.<br><br>During an observation in Resident 9, 11, and 14's room on 4/12/2024 at 1:08 PM, a contact precaution signage was observed prior to entering room. The signage indicated everyone must clean their hands, including before entering and when leaving the room, to put on gloves and gown before room entry and discard gloves and gown before room exit. HK 1 was observed entering Resident 9, 11, and 14's room wearing the same used gloves and did not don new gloves and an isolation gown or perform hand hygiene. HK 1 proceeded to change trash bags of the 2 trash bins inside the room. HK 1 did not doff gloves or perform hand hygiene during the entire observation. HK 1 could not state why she did not wash her hands or don the proper PPE.<br><br>During a concurrent and interview of HK 1 with Registered Nurse (RN) 1 on 4/12/2024 at 1:10 PM, RN 1 stated she would make sure HK 1 receives one to one in-service regarding infection control. RN 1 stated HK 1 should have worn PPE when emptying out the trash bins because it was dirty and because of infection control.<br><br>42878<br><br>3. A review of Resident 13 ' s Admission record indicated an admission to the facility on [DATE], with a diagnosis of Di [NAME] ' s syndrome (a chromosomal or form of genetic disorder that results in poor development of several body systems).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 13 ' s MDS dated [DATE], indicated Resident 13 had diagnoses that included seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures.), asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe).<br><br>During an observation on 4/12/2024 at 12:30 PM, the facility ' s unit entrance signage was observed indicating N95 mask must be worn in all patient care areas.<br><br>During an observation of Resident 13 ' s room on 4/12/2024 at 12:59 PM, a contact precaution signage was observed prior to entering the resident ' s room. The signage indicated everyone must clean their hands, including before entering and when leaving the room, to put on gloves and gown before room entry and discard gloves and gown before room exit.<br><br>During an observation on 4/12/2024 at 1 PM, Certified Nursing Assistant (CNA) 1 was observed exiting from Resident 13 ' s room, wearing a yellow disposable gown and gloves. CNA 1 was observed attempting to open a supply room door and then reentered Resident 13 ' s room without changing the disposable gown, gloves or performing hand hygiene.<br><br>During a concurrent interview with CNA 1, CNA 1 stated she forgot to doff (to take off) the dirty PPE (personal protective equipment) before exiting Resident 13 ' s room and don (to put on) a new PPE before reentering Resident 13 ' s room. CNA 1 stated she should always change PPE to prevent cross contaminating different areas and exposing the resident to infection.<br><br>During an observation on 4/12/2024 at 1:10 PM, CNA 1 was observed sitting across Resident 13. CNA 1 was observed feeding Resident 13 while wearing a surgical mask.<br><br>During a concurrent observation and interview on 4/12/2024 at 1:11 PM, with CNA 1, CNA 1 stated she forgot to change mask when she entered the facility. CNA 1 stated it was important to wear an N95 mask when providing direct patient care to protect the residents who are vulnerable from diseases that can be transmitted to them from the staff or any other people.<br><br>During an interview on 4/14/2024 at 4:45 PM, with the Director of Nursing (DON), the DON stated the facility did not have a policy indicating an N95 mask was required to be worn in the facility, but it was a facility practice to require staff to wear N95 mask in patient care areas as indicated in signage posted at the entrance to facility/unit.<br><br>A review of the facility's policy and procedure titled Infection Prevention and Control Plan, dated 2023 indicated the purpose of the infection prevention and control plan is to identify infections, opportunities for disease transmission, implementation of prevention and control interventions and educations to reduce the incidences of infection and provide a safe environment for the resident's families, and staff on Pediatric Subacute. |