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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 Ventura Blvd Studio City, CA 91604

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46445

Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program regarding influenza (a contagious respiratory illness caused by influenza viruses) for two of seven sampled residents (Resident 3 and Resident 5) by failing to:

1. Ensure Licensed Vocational Nurse 1's (LVN 1) personal protective equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) was worn properly before touching Resident 3. LVN 1's disposable gloves were worn under the disposable isolation gown. LVN 1's N95 mask (respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) top elastic strap was on the neck and created a break in the seal of the N95 mask.

2. Ensure LVN 1 performed hand hygiene (hand washing with soap and water and use of alcohol-based hand sanitizer) and change gloves after touching unclean surfaces while taking care of Resident 3.

3. Ensure Activity Assistant Coordinator (AAC) performed hand hygiene after providing care to Resident 5.

4. Ensure used cleaning cloths were not placed on the clean kitchen countertop that had the clean kitchen utensils used for resident dining.

5. Ensure Housekeeper 2's (HKP 2) N95 mask was worn properly. The N95 mask was folded inward and was not covering HKP 2's mouth and chin.

6. Ensure the Assistant Maintenance Supervisor (AMS) wore N95 mask before entering the facility.

These deficient practices placed the residents at risk for exposure and contracting infections.

Findings:

During a record review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 3/14/2022 with diagnoses including Alzheimer's disease (a progressive disease with specific brain abnormalities marked by memory loss and progressive inability to function normally at even the simplest tasks), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition).

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER: Imperial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 11441 Ventura Blvd Studio City, CA 91604	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2024, the MDS indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills were severely impaired. During a record review of Resident 3's Care Plan on risk for infection, initiated on 1/7/2025, the Care Plan indicated the resident had a high risk for infection secondary to possible exposure to influenza. The Care Plan Intervention indicated perform hand hygiene and gloves while performing high contact activities. During an observation and concurrent interview on 1/7/2025 at 9:32 a.m. with LVN 1, LVN 1's N95 mask top elastic strap was observed below the earlobe with an open area around the nose and mouth. LVN 1 stated the N95 mask top elastic strap should be around the head above the earlobe with a seal around the face. LVN 1's disposable gloves were worn under the disposable isolation gown that did not create a seal on LVN 1's wrist. LVN 1 adjusted her N95 mask with her gloved hands and continued to prepare Resident 3's medications. LVN 1 went inside Resident 3's room and assisted Resident 3 with the resident's medications. LVN 1 touched Resident 3 and the resident's bed. LVN 1 touched her hair with her gloved hands. LVN 1 did not change her gloves and did not perform hand hygiene before providing care to Resident 3. LVN 1 stated her disposable gloves should be changed after fixing her N95 mask and before preparing Resident 3's medications. LVN 1 stated her disposable gloves should be worn above her disposable isolation gown to create a seal on her arms. LVN 1 stated she should remove her PPEs and washed her hands before touching her hair or face. LVN 1 stated the actions she took had the potential to spread infection to other residents. During an interview on 1/7/2025 at 2:47 p.m., the Director of Nursing (DON) stated LVN 1 should have donned (put on) the PPEs properly and changed the PPEs after touching unclean items. The DON stated LVN 1's actions had the potential to spread infection to other residents. The DON stated the facility failed to follow infection prevention and control protocols. During a record review of the facility's policy and procedure (PnP) titled, Infection Prevention and Control Program, last reviewed on 7/2024, the PnP indicated the infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a record review of the facility's PnP titled, Personal Protective Equipment - Using Gloves, last reviewed on 7/2024, the PnP Objectives indicated to prevent the spread on infection and to prevent hands from potentially infectious material. The PnP indicated if gowning procedure were used, put gloves on after putting on the gown so that the cuff of the gloves can be pulled over the sleeve of the gown. During a record review of the facility's PnP titled, PPE Use, last reviewed on 7/2024, the PnP indicated the facemask should fit securely over the nose and mouth. The PnP indicated put the gloves on last ensuring that the cuffs of the gloves cover the wrists and go over the gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's PnP titled, Handwashing / Hand Hygiene, last reviewed on 7/2024, the PnP indicated all personnel shall follow the handwashing and hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The PnP indicated to use an alcohol-based hand rub . or soap and water for the following situations . b. before and after direct contact with residents, c. before preparing and handling medications . i. after contact with a resident's intact skin . l. after contact with objects in the immediate vicinity of the resident . n. before and after entering isolation precaution settings. During a record review of the facility-provided document titled, Sequence for Donning PPE, the facility-provided document indicated to secure elastic bands of the mask or respirator at the middle of the head and neck, fit flexible band to nose bridge, fit snug to face and below the chin, and fit-check the respirator. During a record review of Resident 5's Admission Record, the Admission Record indicated the facility admitted the resident on 10/13/2023 with diagnoses including metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), dementia, and essential hypertension. During a record review of Resident 5's MDS, dated [DATE], the MDS indicated the resident's cognitive skills were severely impaired. During a record review of Resident 5's Care Plan on risk for infection, initiated on 1/7/2025, the Care Plan indicated the resident had a high risk for infection secondary to possible exposure to influenza. The Care Plan Intervention indicated perform hand hygiene and gloves while performing high contact activities. During an observation and concurrent interview on 1/7/2025 at 10:46 a.m. with Activity Assistant Coordinator (AAC)., AAC was observed standing in the hallway, touching Resident 5's shoulder and back. AAC walked towards nurse station 1 and touched the residents' chairs lined in the hallway. AAC proceeded to walk down the hallway and passed by residents at the station 1 hallway. AAC was not observed performing hand hygiene during the observation. AAC stated handwashing or use of hand sanitizer should be done after close contact or after touching a resident. AAC stated if hand hygiene was not done, it had the potential to spread infection or virus from the resident or surfaces to other residents. During an interview on 1/7/2025 at 2:47 p.m., the DON stated hand hygiene and proper use of PPEs were the infection prevention and control measures the facility should follow. The DON stated the dirty cleaning supplies should not be in the same area as the clean kitchen items. The DON stated facility staff and visitors should wear a N95 properly and before entering the facility. The DON stated not following the facility's PnP on infection prevention and control had the potential to spread the infection and virus to residents and staff. The DON stated the facility failed to follow the PnP on infection prevention and control. During a record review of the facility's policy and procedure (PnP) titled, Infection Prevention and Control Program, last reviewed on 7/2024, the PnP indicated the infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)

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