STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Crest Health Care Center	11834 Inglewood Avenue Hawthorne, CA 90250

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to ensure, the undressed, cleaned wounds for the two of 2 residents (Residents 1 and 2), did not touch the bed's mattress after the wound care was done. This deficient practice placed the residents ' wounds at increased risk for wound infection. Findings: a). A review of Resident 1 ' s admission record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of muscle weakness (physical weakness or a lack of energy), type 2 diabetes mellitus (abnormal sugar levels), and acute osteomyelitis, left ankle and foot (bacterial or fungal infection of the bones, leading to inflammation and potential complication). A review of Resident 1 ' s history and physical (H&P) dated 4/12/2024 indicated Resident 1 was awake, not alert, unresponsive, nonverbal. A review of Resident 1 ' s minimum data set ([MDS] a standardized care assessment and care screening tool), dated 1/24/2024, indicated Resident 1 ' s cognitive skills (thought process) was rarely/never understood by others. The MDS indicated Resident 1 required dependent assistance with activities of daily living (ADL) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). A review of Resident 1 ' s physician orders dated 4/12/2024, indicated Resident 1 had an order for Povidone-Iodine (antiseptic used for skin disinfection) external solution, to apply to left (L) plantar below 5th toe, (L) 5th toe, (L) big toe, (L) 2nd toe, (L) lateral foot, topically every day shift for diabetic ulcer for 30 days, cleanse with normal saline (NS, a solution), pat dry, apply treatment and cover with dry dressing, abdominal pads, wrap with kerlix (uncompressed gauze roll). During an observation on 4/19/2024 at 9:50 a.m., in Resident 1 room, Licensed Vocational Nurse 2 (LVN2) applied iodine gauze on the left below, (L) 5th toe, without cleaning the wound with NS as ordered. The LVN2 picked up another iodine gauze and realized that he needed to clean the wound first with NS. The LVN2 stated, I forgot to clean. After the LVN2 cleansed and applied betadine on the (L) 5th toe, the treatment nurse left the foot wound uncovered. The (L) 5th toe touched the mattress. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555719	A. Building B. Wing	04/19/2024

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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 - Few	b). A review of Resident 2 ' s admission record, indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE], with type 2 diabetes mellitus, muscle weakness, and acute osteomyelitis, left ankle and foot. A review of Resident 2 ' s history and physical (H&P) dated 4/1/2024, indicated Resident 2 was awake and alert, responsive, verbal. A review of Resident 2 ' s MDS indicated Resident 2 ' s had intact cognitive skills. The MDS indicated Resident 2 required substantial/maximal assistance with activities of daily living (ADL) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). A review of Resident 2 ' s physician orders dated 4/12/2024, indicated Resident 2 had an order for Povidone-Iodine external solution, to cleanse (L) 2nd toe surgical wound with NS pat dry apply treatment and cover with dry dressing, every shift for 30 days. Another physician order for Resident 2 dated 3/25/2024, indicated to cleanse (L) plantar foot surgical wound with NS, pat dry, loosely pack with iodoform packing strips and cover with dry dressing, abdominal pads wrap with kerlix, every day for 30 days. During an observation on 4/19/2024 at 10:43 a.m., in Resident 2 ' room, the LVN2 removed Resident 2 ' socks. LVN 2 placed socks in the front of Resident 2 ' s left 2nd toe surgical wound. LVN2 cleaned the 2nd toe wound with NS and when to washed hands. LVN2 the 2nd toe wound uncovered and touched the mattress. During an interview on 4/19/2024 at 12:30 p.m., with LVN2, LVN2 stated, it was important to keep the environment clean when providing wound care to prevent infections. LVN2 stated, after the wounds were cleaned, it was not acceptable for the wound to touch the mattress as it can cause infection. LVN2 stated, that he forgot to clean Resident 1 ' s wound first with NS before applying iodine as ordered. LVN2 stated, keeping the wound clean could prevent possible infections and wound complications. During an interview on 4/19/2024 at 3:06 p.m., with Director of Nursing (DON), the DON stated, all wound care should be done in a clean environment to prevent wound infections. The DON stated, usually, the mattress can be padded with a disposable linen so if wounds touch the mattress, it ' s in a clean area. A review of the facility ' s undated policy and procedures (P&P) titled, Treatment Procedure, indicated, the facility will ensure a clean field by lining the table with paper towels or disposable liners or place linen-saver or towel under resident, then proceed with treatment order.