STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555734	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Childrens Hc Org No CA -Pediatric Hospital D/P Snf	3777 South Bascom Avenue Campbell, CA 95008

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice for four of 12 sampled residents (Resident 125, 9, 16, and 19) when: 1. There were no Identification (ID) bracelets for Resident 125 and 9, 2. Licensed nurses documented medication administration completed before administering the medication for Residents 16 and 19. The failures had the potential to compromise residents' health and well-being. Findings: 1.A Review of Resident 125's medical record indicated Resident 125 was admitted on [DATE] with diagnoses including Choanal Atresia (a congenital condition where a baby is born with tissue blocking their nasal airway), acute respiratory failure (a life-threatening condition that occurs when patients' lungs cannot exchange oxygen and carbon dioxide properly), and tracheostomy status (a hole in the neck that helps a patient breathe when their airway is blocked or reduced). During an observation and concurrent interview with Registered Nurse (RN) M on 7/22/24 at 9:12 a.m., RN M provided suction care to Resident 125 and confirmed no ID bracelet for Resident 125 on his arms or legs. RN M stated that every resident should have an ID bracelet. During an observation and concurrent interview with RN N on 7/23/24 at 4:01 p.m., RN N administered medications to Resident 125 and confirmed no ID bracelet on his arms or legs. RN N stated that Resident 125 should have the Identification bracelet. A Review of Resident 9's medical record indicated Resident 9 was admitted on [DATE]. During an observation and concurrent interview with RN G on 7/23/24 at 4:12 p.m., RN G entered Resident 9's room to administer medication and confirmed no ID bracelet on Resident 9's arms or legs. She stated that every resident should have an Identification bracelet. (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 7/26/24 at 1:50 p.m., The DON stated that every resident should have an ID bracelet for identification to prevent medical errors. A review of the facility's undated police and procure (P&P) Patient Identification indicated, . if the ID bracelet is removed or lost, the nurse should obtain a new ID bracelet and assure replacement . the ID bracelet or photo ID shall be used for identification of residents during medication administration, treatment, lab draws, and other treatments . 2. During a medication pass observation in the hallway with RN O on 7/23/24 at 11:29 a.m., RN O prepared two medications: Midodrine (a medication for low blood pressure) 5mg(one-thousandth of a gram) 1 tablet and Docusate Sodium (a stool softener used to treat occasional constipation) 1 ml (one thousandth of a liter) for Resident 16. RN O documented that those two medications were administered before she brought them to Resident 16's room. RN O confirmed the above observation and stated that she should have documented it after administering medications. During a medication pass observation in the hallway on 7/22/24 at 8:39 a.m., Licensed Vocational Nurse (LVN) P prepared the three medications for Resident 19: Chlorothiazide Suspension (used to treat fluid retention and hypertension)1.5ml, vitamin D (a group of fat-soluble secosteroids responsible for increasing intestinal absorption of calcium, magnesium, and phosphate, and for many other biological effects) oral liquid 1ml and Bactrim zinc ointment (used to prevent minor skin infections caused by small cuts, scrapes) 500 units. LVN P documented those three medications were administered before she brought the medication to Resident 19's room. She confirmed the above observation and stated that she should have documented it after administering the medications. During an interview with the Director of Nursing (DON) on 7/26/24 at 1:45 p.m., the DON stated the nurse should document administered medication after administering medications to keep the document accurate and prevent medication error.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on interview and record review, the facility failed to ensure one of 12 sampled residents (Residents 16) was free from unnecessary psychotropic (drug that affects brain activities associated with mental processes and behavior) medications when there was no documentation indicating the facility obtained informed consent before the medication start date. This failure had the potential to result in unnecessary use of medications. Findings: A review of Resident 16's face sheet indicated Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's physician order summary indicated: a. Diazepam (a Schedule IV controlled drug under the Convention on Psychotropic Substances and used to treat a range of conditions, including anxiety, seizures, alcohol withdrawal syndrome, muscle spasms, insomnia, and restless legs syndrome) Injectable Solution 50mg (one-thousandth of a gram)/10 ml(unit of capacity): Use 0.2 ml intravenously (a way of giving a drug or other substance through a needle or tube inserted into a vein) every 2 hours as needed for dysautonomia (a nervous system disorder that disrupts autonomic body processes) and /or agitation for 90 days from 6/24/2024 to 9/22/2024. b. Diazepam solution 5 mg/ml give 0.4ml via J-Tube (a jejunostomy tube is a soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine) every 6 hours as needed for dysautonomia and/or agitation for 90 days from 6/23/2024 to 9/21/2024. A review of Resident 16's medical records, lacked documented evidence to indicate the facility obtained informed consents to use Diazepam from Resident 16's parents or the responsible party before 6/23/2024. During a concurrent interview and record review with the Director of Nursing (DON) on 7/26/2024 at 11:57 a. m., the DON reviewed Resident 16's medical record and confirmed there was no no documentation to indicate the facility obtained informed consent before the medication start date of 6/23/2024 for the two Diazepam physician orders. A review of the facility's policy and procure (P&P) Psychotropic Medication, Revised: 6/12, indicated, . It is the policy of Children's Recovery Center to obtain informed consent on all patients receiving psychotropic medications. Informed consent must be obtained before an order can be carried through .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38573 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen when: 1. Two dietary aides (DA) did not cover their hair completely with hairnets; 2. Temperature logs of a free-standing side-counter refrigerator and freezer had missing temperatures entries; 3. An undercounter refrigerator temperature log for clients' use had missing temperatures entries; 4. A daily dishwasher temperature log had missing temperatures entries, and a chlorine water strip check log had missing results, and 5. One opened bottle of ranch dressing inside the undercounter refrigerator lacked an open date. These failures had the potential to cause food-borne illness for the residents. Findings: 1. During an initial kitchen tour on 7/22/24 at 8:23 a.m., Dietary Aide D (DA D), prepared bottled formula for the patients in the food preparation area while her hair on the right side and back was not completely covered with a hairnet. During a concurrent observation and interview with DA D on 7/22/24 at 8:25 a.m., she confirmed the above observation and stated she should fix her hairnet and make sure that her hair was fully covered by the hairnet while preparing the bottled formula. During a follow up kitchen observation with the director of nursing (DON) on 7/24/2410:07 a.m., DA E prepared the bottled formula in the food preparation area while her hair on the right side and back was not completely covered with a hairnet. The DON confirmed the above observation and stated all of the hair should have been covered by the hairnet while preparing the bottled formula to prevent cross contamination and keep the hair from contacting the bottled formula, clean equipment, and utensils. During a concurrent observation and interview on 7/24/24 at 10:08 a.m., DA E acknowledged the above observation and stated the hairnet was too small for the staff to wear. Review of the facility's policy and procedure Manual 7-19, Personal Hygiene Training, dated 2013, indicated, all dietary employees will be trained on personal hygiene . Keep hair neat and clean, wear a hair restraint when around exposed foods, in the kitchen or food service areas including dining areas. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During record review of temperature logs on 7/24/24 at 10:17 a.m., the free-standing side-counter refrigerator's temperature log and a freezer's temperature log were missing entries for several months from the end of 2023 to the middle of 2024. During a concurrent interview and record review with the DON on 7/24/24 at 10:22 a.m., The DON confirmed the refrigerator and freezer had unrecorded dates on them. The DON stated kitchen staff should have checked and recorded the temperatures daily. 3. During a concurrent interview and record on 7/24/24 at 11:04 a.m., the DON reviewed the undercounter refrigerator temperature log for clients' use and confirmed there were missing entries from the end of December through early January. The DON stated that the kitchen staff should have checked and recorded the temperatures daily. Review of facility's Freezer, Refrigerator and Pantry Temperature log Form, indicated, . temperature for refrigerator should be at 36-46 degrees Fahrenheit, Freezer should be negative 20 to 0 degrees Fahrenheit . Alert change if temperatures are out of acceptable range. 4. During a concurrent interview and record on 7/24/24 at 11:07 a.m., the DON reviewed the daily dishwasher temperature log and chlorine test log. Temperature entries were missing on 3/21/24, 5/15/24, 6/10/24, 6/12/24 and 6/14/24. Chlorine test results were missing from 4/15/24 through 4/18/24, 4/21/24 through 4/23/24, 4/25/24 through 4/30/24, 5/1/24, 5/2/24, 5/5/24 through 5/9/24, 5/12/24 through 5/14/24, 5/26/24 through 5/31/24, 6/1/24, 6/3/24 through 6/9/24, 6/15/24 through 6/21/24, 6/24/24 through 6/30/24 and 7/4/24 through 7/14/24. The DON stated kitchen staff should and check record the dishwasher temperature and chlorine water test strip results daily. Review of facility's Daily Dishwasher Temperature, chlorine log Form, indicated, . dishwasher, Water temperature should be 120 degrees Fahrenheit or greater and Chlorine Acceptable >50 ppm. 5. During an observation in the kitchen on 7/24/24 at 1:52p.m., one opened bottle of ranch dressing inside the undercounter refrigerator lacked an open date. During a concurrent observation and interview with Dietary supervisor C (DS C) on 7/24/24 at 1:53 p.m., she acknowledged the above observation and stated that ranch dressing should have been labeled with a date for when it was opened. Review of facility's policy and procedure titled Refrigerated Storage, revised 9/18, indicated, Foods held in refrigerator or other storage areas shall be stored appropriately, clearly labeled, and dated.

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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** 38573 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for three of 12 sampled residents (Residents 14, 19 and 1) when: 1. A white plastic garbage can by the bathroom inside Resident #14's room was overflowing with used yellow disposable gowns and gloves, 2. Licensed Nurses did not change gloves bewtween tasks, nor did they perform hand hygiene during glove changes, 3. Three medications were not kept clean in two medication carts. These failures could result in the spread of infection and cross-contamination for residents in the facility. Findings: 1.During an observation inside Resident #14's room on 7/23/24 at 1:45 p.m., There was one white plastic garbage can by the bathroom overflowing with used yellow disposable gowns and gloves. During a concurrent observation and interview on 7/23/24 at 1:46 p.m., with registered nurse A (RN A), RN A confirmed the above observation and stated the garbage can should not be overflowing with used gowns and gloves. During an interview on 7/26/24 at 10:05 a.m., with infection preventionist (IP), she stated that the housekeeper is the one collecting the garbage inside the resident rooms every shift, and as needed. She stated garbage cans should not be overflowing with used gowns and gloves due to the infection control issues it could pose. During an interview on 7/26/24 at 10:13 a.m., with director of nursing (DON), she stated that it was the facility staff's responsibility to ensure the garbage cans were not overflowing, and the staff need to notify housekeeping for collection to do so. DON further stated that garbage cans should not be overflowing to prevent the spread of infectious microorganism. Review of facility's policy and procedure dated 1/2018, titled Infection Prevention and Control indicated, Disposal of PPE . Trash disposal bins to be positioned inside of the . Designated room for staff to discard PPE after removal and prior to exiting the room . Housekeeping is to empty trash bins at least once during day shift and as needed thereafter. 46001 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. A review of Resident 19's medical record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including bronchopulmonary dysplasia (a lung condition that affects premature babies with breathing problems and oxygen needs) originating in the perinatal period (the time frame surrounding childbirth, including pregnancy, labor, delivery, and postpartum), chronic respiratory failure (a life-threatening condition that occurs when patients' lungs cannot exchange oxygen and carbon dioxide properly), and gastrostomy status (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression). A review of Resident 19's physician order indicated Resident 19 would receive the following medications in the morning: a). Chlorothiazide Suspension (used to treat fluid retention and hypertension) 250mg (one-thousandth of a gram)/5ml (one-thousandth of a liter) given via G-tube (A gastrostomy tube, often called a G tube, is a surgically placed device used to provide direct access to patient's stomach for supplemental feeding, hydration or medicine) every 12 hours for severe bronchopulmonary dysplasia, b). Vitamin D (a group of fat-soluble secosteroids responsible for increasing intestinal absorption of calcium, magnesium, and phosphate, and for many other biological effects) oral liquid 10mcg/ml give1ml via a G-tube in the morning for a supplement, c). Bactrim zinc ointment (used to prevent minor skin infections caused by small cuts or scrapes) 500 units of left dorsal foot topically. During a medication pass observation in Resident 19's room on 7/22/24 at 8:11 a.m., after administering the medications via G-tube, Licensed Vocational Nurse (LVN) P did not change gloves and used her fingers to apply Bactrim Zinc ointment topically to the cut on Resident 19's left dorsal foot. During an interview with LVN P on 7/22/24 at 8:39 a.m., LVN P confirmed the above observation that she did not change gloves before using her finger to apply Bactrim zinc ointment to Resident 19's cut on the left dorsal foot. LVN P stated that she should have used a new pair of gloves to apply the ointment to prevent infection. During an interview with the Director of Nursing (DON) on 7/26/24 at 1:45 p.m., the DON stated that the nurse should have changed gloves to apply Bactrim Zinc ointment topically to Resident 19's cuts on the left dorsal foot to prevent infection. 2b. A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (damage to the brain due to a lack of oxygen supply) and gastrostomy status. During a medication pass observation in Resident 1's room on 7/25/24 at 12:35 p.m., LVN Q administered three medications via G-Tube and changed to a new pair of gloves to administer the eye drops. She did not wash or sanitize her hands between the glove changes. During an interview with LVN Q on 7/25/24 at 1:00 p.m., LVN Q confirmed that she did not sanitize her hands between the glove change and that she should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 7/26/24 at 1:55 p.m., the DON stated that nurses should wash or sanitize their hands after removing gloves and wearing a new pair of gloves. A review of the facility's undated policy and procedure (P&P) gloves indicated, . [gloves] removed and hand hygiene performed after completing procedure that involves direct patient contact . 3. During a medication cart inspection with Registered Nurse (RN) O on 7/23/24 at 10:38 a.m., a bottlecap of an iron supplement had brownish stains in Medication Cart 1. RN O confirmed the above observation and stated the cap should be cleaned. During a medication cart inspection with LVN I on 7/23/24 at 10:50 a.m., a box of Anti-Diarrheal 24 caplets had a brown stain, and a bottle of Children's All-day Allergy had some solid white substance on the cap in Medication Cart 2. LVN I confirmed the above observation and stated that the box and the bottle cap should be cleaned. During an interview with the Director of Nursing (DON) on 7/26/24 at 1:55 p.m., the DON stated the nurses should have kept all the medications in the medication carts clean to prevent infection.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49345 Based on observation, interview, and record review the facility failed to maintain a safe environment for one resident (Residents 9) out of 12 sampled residents, when the front vent cover of an air-conditioning unit was loosely ajar. This failure had the potential to cause injury to staff and residents. Findings: During a concurrent observation and interview on 7/22/24 at 10:02 a.m., Resident 9 stood adjacent to the end of the bed and front of a working air-conditioning unit. The air-conditioning unit's front vent cover was loosely ajar. There were traces of old tape residue on the outer surface of both sides of the airconditioning unit and its vent cover. Gray duct tape (strong cloth-backed waterproof adhesive tape) was stuck to the length of the right side of the panel with grayish strips of medical paper tape (medical paper tape is whitish in color when it is new and is designed to attach bandages, gauze, and other dressings to a patient's skin around wounds) atop the duct tape. Strips of grayish paper tape was also used to tether the front vent cover at its upper left corner to the air-conditioning unit. The inner fins of the airconditioning unit were exposed where the vent cover was loosely ajar. Certified Nurse Aide (CNA) K confirmed this observation of the airconditioning unit's condition. CNA K stated the front cover was usually taped, but got loose. During an interview on 7/23/24 at 1:56 p.m. with Maintenance Supervisor (MS), MS stated the parts of the air-conditioning unit were brittle and replacement parts for it were not requested. MS also stated the only repair was to put a tape on it. MS confirmed the airconditioning unit's vent cover that was loosely ajar could be a potential accident hazard for the residents. A review of facility's undated policy and procedure (P&P) titled Accidents and Incidents, indicated, It is the policy of this facility to ensure that the patient environment remains free of accident hazards as is possible .