

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER The Gardens Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17650 Devonshire Street Northridge, CA 91325	
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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plan (contains relevant information about a resident ' s health conditions, goals of treatment, specific actions that must be performed, and a plan for evaluation) with measurable objectives and interventions for two of five sampled residents (Resident 1 and Resident 2) by failing to: a. Indicate the frequency of Resident 1 ' s neuro-checks after the resident ' s unwitnessed fall. b. Address Resident 2 ' s urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) care. These deficient practices placed Resident 1 and Resident 2 at risk for not receiving the necessary services and assistance that can result in infection and injury. Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 6/10/2024 with diagnoses including Parkinson ' s disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and essential tremors (a condition that affects the nervous system, causing involuntary and rhythmic shaking or trembling). During a review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 6/13/2024, the MDS indicated the resident ' s cognitive (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions) skills was moderately impaired. The MDS indicated Resident 1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on chair or bed to chair transfer and the toilet transfer was not attempted due to medical condition or safety concerns. The MDS indicated Resident 1 required maximal assistance on ability to wheel once seated on a wheelchair at least 50 feet and make two turns. The Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder section of the MDS indicated Resident 1 had an indwelling urinary catheter. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/20/2024 at 4:28 p.m. and concurrent record review with Licensed Vocational Nurse 2 (LVN 2) on Resident 1 ' s Care Plan on falls, initiated on 7/7/2024, the Care Plan indicated Resident 1 had an unwitnessed fall. The Care Plan interventions indicated neuro checks (a physical examination to identify signs of disorders affecting the brain, spinal cord, and nerves [nervous system]). The neuro check frequency was not indicated and specified. LVN 2 stated Resident 1 ' s neuro check frequency should be specified in the Care Plan. LVN 2 stated Resident 1 ' s Care Plan on falls was not complete. During an interview on 9/23/2024 at 2:45 p.m. with the Director of Nursing (DON), the DON stated resident care plan should be individualized and complete. During a review of the facility ' s policy and procedure titled, Comprehensive Person-Centered Care Plans, dated 1/15/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs is developed and implemented for each resident. The policy indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy further indicated the comprehensive, person-centered care plan will describe services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses including fusion of spine (a surgery to connect two or more bones in any part of the spine) in the lumbar region, muscle weakness, and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 2 ' s Physician Orders, dated 8/31/2024, the Physician Orders indicated Foley catheter (one of many types of urinary catheters) care, 16 French (sized by a universal system that measures the diameter of the tube, larger sizes will be a higher number and smaller sizes will be a lower number) connected to drainage bag every day shift (7 a.m. to 3 p.m. shift) for catheter care. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated the resident ' s cognitive skills was moderately impaired. The Bowel and Bladder section of the MDS indicated Resident 2 had an indwelling urinary catheter. During a review of Resident 2 ' s Care Plan on indwelling catheter, initiated on 9/1/2024, indicated the resident ' s Care Plan had an unspecified catheter and an unspecified surgery. The Care Plan interventions did not specify the date the urinary catheter was last changed, the frequency, size, and type of urinary catheter. The Care Plan interventions did not have a completed statement. During an interview on 9/19/2024 at 2:16 p.m. and a concurrent record review of Resident 2 ' s Care Plans, reviewed with LVN 1, indicated Resident 2 ' s Care Plan did not indicate the urinary catheter drainage bag change and the surgical wound treatment. LVN 1 stated Resident 2 ' s care plan was not specific and not individualized. During an interview on 9/23/2024 at 2:45 p.m. with the Director of Nursing (DON), the DON stated resident care plan should be individualized and complete. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure titled, Comprehensive Person-Centered Care Plans, dated 1/15/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs is developed and implemented for each resident. The policy indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy further indicated the comprehensive, person-centered care plan will describe services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46445 Based on observation, interview, and record review, the facility failed to ensure that a resident with indwelling urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) received proper care and services that included to anchor (secure) the urinary catheter tubing to the resident ' s thigh for one of five sampled residents (Resident 2). This deficient practice had the potential to result in urinary catheter dislodgement (forcefully pulled out of a secure position) causing urethral (the tube through which urine leaves the body) tearing that may result in pain, bleeding, and infection. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses including fusion of spine (a surgery to connect two or more bones in any part of the spine) in the lumbar region, muscle weakness, and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 2 ' s Physician Orders, dated 8/31/2024, the Physician Orders indicated Foley catheter (one of many types of urinary catheters) care, 16 French (sized by a universal system that measures the diameter of the tube, larger sizes will be a higher number and smaller sizes will be a lower number) connected to drainage bag every day shift (7 a.m. to 3 p.m. shift) for catheter care. During a review of Resident 2 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 9/3/2024, the MDS indicated the resident ' s cognitive (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions) skills was moderately impaired. The Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder section of the MDS indicated Resident 2 had an indwelling urinary catheter. During a review of Resident 2 ' s Care Plan on indwelling urinary catheter, initiated on 9/11/2024, the Care Plan indicated the resident was a high risk for developing complications including urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra]). The Care Plan interventions included to prevent tension on meatus (opening from the inside to the outside) from the urinary catheter and to secure the urinary catheter to the thigh with a leg strap as needed. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 9/19/2024 at 9:40 a.m., Resident 2 was observed lying on bed facing the right side with the urinary catheter inside one of the two statlock (a device used to minimize catheter movement and accidental removal) holes attached on the resident ' s left thigh. Resident 2 ' s urinary catheter drainage bag was hanging on the left side of the bed with the urinary catheter tugging over the resident ' s left hip. Registered Nurse 1 (RN 1) assisted Resident 2 on the resident ' s back after providing surgical wound treatment. Resident 2 ' s urinary catheter was observed to be able to move through the statlock hole. RN 1 was unable to secure Resident 2 ' s urinary catheter on the statlock. RN 1 stated proper placement of the urinary catheter was not part of the treatment. RN 1 stated he was tasked only to change the urinary catheter drainage bag. During an observation and concurrent interview on 9/19/2024 at 10:12 a.m., Resident 2 ' s unsecured urinary catheter was observed with the Director of Nursing (DON). The DON stated that Resident 2 ' s urinary catheter ' s Y junction should be in the statlock with each urinary catheter port in its designated hole to secure and stabilize the urinary catheter. The DON stated unsecured urinary catheter could get dislodged, cause trauma, and infection to the resident. During a review of the facility ' s policy and procedure titled, Urinary Catheter Care, dated 1/15/2024, indicated the purpose is to prevent catheter-associated UTI. The Changing Catheters section of the policy and procedure indicated to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46445 Based on observation, interview, and record review, the facility failed to ensure medical records were complete and accurately documented for one of five sampled residents (Resident 2) by failing to: a. Ensure Resident 2 ' s physician ' s order for surgical wound treatment was documented in the resident ' s clinical record before the surgical wound treatment was performed. b. Ensure Resident 2 ' s physician ' s order to change the resident ' s indwelling urinary catheter (a flexible plastic tube inserted into the bladder [a hallow organ that stores urine] to provide continuous urinary drainage) drainage bag was documented in the resident ' s clinical record before the drainage bag was changed. c. Ensure surgical wound treatments and urinary catheter drainage bag changes provided to Resident 2 were documented in the resident ' s Treatment Administration Record (TAR). These deficient practices resulted in inaccurate information on Resident 2 ' s clinical record and had the potential for delayed and inaccurate medical interventions for Resident 2. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses including fusion of spine (a surgery to connect two or more bones in any part of the spine) in the lumbar region, muscle weakness, and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 2 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 9/3/2024, the MDS indicated the resident ' s cognitive (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions) skills was moderately impaired. The Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder section of the MDS indicated Resident 2 had an indwelling catheter. The Skin Condition section of the MDS indicated Resident 2 had a surgical wound. During an interview on 9/19/2024 at 9:40 a.m. and concurrent record review of Resident 2 ' s Physician Orders were reviewed with Registered Nurse 1 (RN 1), the Physician Orders indicated there was no surgical wound treatment order in the resident ' s clinical record. RN 1 was unable to provide a physician order that indicated the treatment for Resident 2 ' s surgical wound. RN 1 proceeded to perform the wound treatment on Resident 2 ' s surgical wound. During an observation and concurrent interview on 9/19/2024 at 9:56 a.m., Resident 2 ' s urinary catheter drainage bag was observed to be dated 9/12/2024 in red ink. Resident 2 stated facility staff changed the surgical wound dressing (a type of bandage that covers a wound by sticking to the surrounding skin using a tape or glue) every day. Resident 2 stated the facility staff changed the urinary catheter drainage bag several times since Resident 2 was admitted to the facility. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/19/2024 at 9:58 a.m., RN 1 was observed changing Resident 2 ' s urinary catheter drainage bag, dated 9/19/2024, in red ink. During an interview on 9/19/2024 at 1:27 p.m. and concurrent record review, Resident 2 ' s Physician Orders were reviewed with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated there were no Physician Orders for the Dakin ' s solution (a strong topical antiseptic used to clean infected wounds, ulcers, and burns) and betadine (an antiseptic agent used for the treatment and prevention of infection) treatment provided to Resident 2. LVN stated Dakin ' s solution and betadine were considered as medications and should have a physician ' s order to administer to a resident. During a follow up interview on 9/19/2024 at 2:16 p.m. and concurrent record review, Resident 2 ' s clinical records were reviewed with LVN 1. Resident 2 ' s Progress Notes, dated 9/13/2024, indicated continue with current treatment orders and cleaned surgical wound with normal saline (NS, a mixture of water and salt that has many different uses for the health), pat dry, cover with medihoney (a medical-grade honey intended for wound care), and dry dressing. LVN 1 stated Resident 2 ' s Physician Orders did not indicate an order for the surgical wound treatment. LVN 1 stated the Physician Orders, dated 9/19/2024 at 11:06 a.m., indicated to change Resident 2 ' s urinary catheter drainage bag and tubing. During a review of Resident 2 ' s TAR, dated 9/1/2024 to 9/30/2024, indicated there were no surgical wound treatments and urinary catheter drainage bag changes provided to Resident 2 from 9/1/2024 to 9/18/2024. During an interview on 9/19/2024 at 2:53 p.m., RN 1 stated he called the Attending Physician 1 (MD 1) on 9/19/2024 within the first hour of his shift (7 a.m. to 3 p.m. shift) and received an order to apply betadine on Resident 2 ' s surgical wound and to change the resident ' s urinary catheter drainage bag and tubing. RN 1 stated he informed the Director of Nursing (DON) on 9/19/2024 at 8:30 a.m. to enter MD 1 ' s telephone order in Resident 2 ' s clinical records. During an interview on 9/19/2024 at 3:41 p.m. and concurrent record review, Resident 2 ' s Physician Orders were reviewed with the DON. The Physician Orders indicated the treatment for Resident 2 ' s surgical wound was entered in the resident ' s clinical records on 9/19/2024 at 3:16 p.m., more than seven hours after MD 1 gave the telephone order to RN 1. The Physician Orders indicated the order to change Resident 2 ' s urinary catheter drainage bag and tubing as entered in the resident ' s clinical records on 9/19/2024 at 11:06 a.m., more that three hours after MD 1 gave the telephone order. The DON stated the licensed nurse that got the physician ' s order should enter the order in Resident 2 ' s clinical records. The DON stated that orders not entered timely had the potential to be missed. During a review of the facility ' s policy and procedure titled, Medication and Treatment Orders, dated 1/15/2024, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy indicated verbal orders must be recorded immediately in the resident ' s chart by the person receiving the order and must include prescriber ' s last name, credentials, the date and the time of the order. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure titled, Charting and Documentation, dated 1/15/2024, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record. The policy indicated the following information is to be documented in the resident medical record . b. medications administered c. treatments or services performed. The policy indicated documentation in the medical record will be objective, complete, and accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46445 Based on observation, interview and record review, the facility failed to follow infection control procedures for one of five sampled residents (Resident 2) by failing to ensure Registered Nurse 1 (RN 1) changed gloves after touching unclean surfaces while performing wound treatments and changing an indwelling urinary catheter (a flexible plastic tube inserted into the bladder that helps provide continuous urinary drainage) drainage bag. Resident 2 was on enhanced barrier precaution (EBP - an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities). This deficient practice placed Resident 2 at risk for exposure and contracting infections. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 8/30/2024 with diagnoses including fusion of spine (a surgery to connect two or more bones in any part of the spine) in the lumbar region, muscle weakness, and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 2 ' s Physician Orders, dated 8/31/2024, the Physician Orders indicated Foley catheter (one of many types of urinary catheters) care, 16 French (sized by a universal system that measures the diameter of the tube, larger sizes will be a higher number and smaller sizes will be a lower number) connected to drainage bag every day shift (7 a.m. to 3 p.m. shift) for catheter care. During a review of Resident 2 ' s Physician Orders, dated 9/2/2024, the Physician Orders indicated the resident was on enhanced barrier precautions. During a review of Resident 2 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 9/3/2024, the MDS indicated the resident ' s cognitive (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions) skills was moderately impaired. The Bowel (a long tube in the body which digested food passes from the stomach to the anus) and Bladder section of the MDS indicated Resident 2 had an indwelling urinary catheter. During a review of Resident 2 ' s Care Plan on indwelling urinary catheter, initiated on 9/11/2024, the Care Plan indicated the resident was a high risk for developing complications including urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra]). The Care Plan interventions included to implement EBP. A review of the facility-provided list of residents on EBP, dated 9/18/2024, indicated Resident 2 was on EBP because the resident had a urinary catheter and a lower back surgical incision. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 9/19/2024 at 9:40 a.m., RN 1 was observed wearing a disposable gown and gloves inside Resident 2 ' s room. RN 1 stated he will change Resident 2 ' s surgical wound dressing (a type of bandage that covers a wound by sticking to the surrounding skin using a tape or glue) and urinary catheter drainage bag. RN 1 removed Resident 2 ' s surgical wound dressing and threw it in the trash bin. RN 1 applied Dakin ' s solution (a strong topical antiseptic used to clean infected wounds, ulcers, and burns) and betadine (an antiseptic agent used for the treatment and prevention of infection) on Resident 2 ' s surgical wound and covered with dry dressing. RN 1 did not change gloves throughout the wound treatment. RN 1 touched Resident 2 ' s urinary catheter and the drainage bag wearing the same gloves used on the wound treatment. RN 1 was observed maneuvering the urinary catheter in the securement device and was going to disconnect the urinary catheter from the drainage bag. RN 1 was asked to stop. RN 1 changed his gloves. During an observation and concurrent interview on 9/19/2024 at 9:58 a.m., RN 1 was observed inside Resident 2 ' s room changing the urinary catheter drainage bag wearing a disposable gown and gloves. RN 1 stated he was going to change Resident 2 ' s urinary catheter drainage bag. RN 1 did not have a clean working area on Resident 2 ' s bed and observed RN 1 place the alcohol pad packets on Resident 2 ' s bed. RN 1 disconnected Resident 2 ' s urinary catheter from the drainage bag and held the urinary catheter with his left hand and the drainage bag with his right hand. RN 1 placed the drainage bag in the basin under Resident 2 ' s bed and touched the basin with his right gloved hand. RN 1 held the new drainage bag port cover and removed it using his right thumb and second finger. RN 1 picked up the alcohol swab from Resident 2 ' s bed, opened the package and used the alcohol pad to clean the port of the urinary catheter and another alcohol pad from the resident ' s bed for the drainage bag. RN 1 connected the urinary catheter to the drainage bag. During a follow up interview on 9/19/2024 at 10:18 a.m. with RN 1, RN 1 stated he should had changed his gloves after removing Resident 2 ' s soiled wound dressing and before starting a new treatment. RN 1 stated he should had placed a clean working area to prevent potential infection to the resident. During an interview on 9/19/2024 at 4:33 p.m. with the DON, the DON stated gloves should be changed after every treatment and after soiled surfaces were touched. The DON stated not changing gloves had the potential to cause infection. The DON stated the facility failed to ensure the infection prevention and control policies and procedures were followed. During a review of the facility ' s policy and procedure titled, Infection Prevention and Control Program, dated 1/15/2024, indicated an 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 review of the facility ' s policy and procedure titled, Personal Protective Equipment - Using Gloves, dated 1/15/2024, indicated gloves were used when touching excretions, secretions, blood, and body fluids, or non-intact skin. During a review of the facility ' s policy and procedure titled, Wound Care, dated 1/15/2024, indicated the purpose to provide guidelines for the care of wounds to promote healing. The Steps in the Procedure section of the policy indicated to . 4. put on gloves, loosen tape, and remove dressing; 5. Pull glove over dressing and discard into appropriate receptacle then wash and dry hands thoroughly; 6. Put on gloves.		