STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555804	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza El Cajon, CA 92020

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to treat two of seven residents reviewed for resident rights, in a dignified manner when staff stood over while feeding the residents (Resident 63 and Resident 67). In addition a resident (Resident 65) was served food in a Styrofoam (foam-like) food container. This deficient practice had the potential for residents' self-esteem and self-worth to be devalued and as a result Resident 65 had a difficult time with self feeding requiring feeding assistance from the nursing staff. Findings: 1. Resident 63 was readmitted to the facility on [DATE] with diagnoses including unspecified Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) and dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's Admission Record. During an observation on 9/10/24 at 8:41 A.M., a staff member was observed sitting next to Resident 63's bed assisting Resident 63 with feeding. Resident 63's eyes were closed but Resident 63 was chewing the food and opened his eyes when greeted. A review of Resident 63's care plans were conducted. Resident 63's care plan for activities of daily living (ADL-basic tasks of everyday life) initiated on 12/17/21 indicated, .ADL Self Care Performance Deficit r/t [related to]assistance required in ADLs . Resident 63's nutritional care plan initiated on 12/17/21 indicated, . Interventions .1:1 [one on one] Feeding assistance for all meals .Date initiated: 9/11/24 . During a joint observation and interview on 9/10/24 at 12:29 P.M., Resident 63 was observed sitting up in bed having lunch. A staff member was observed feeding Resident 63 standing next to Resident 63. Licensed nurse (LN) 11 observed the staff member standing and stated he expected certified nurse assistants (CNA) to sit while feeding residents. LN 11 stated if he was the resident, he would feel intimidated if someone was standing to feed him. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated staff should assist in the appropriate height based on the resident's need to maintain dignity. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER: Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 654 S. Anza El Cajon, CA 92020	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure (P&P) titled, Resident Rights was conducted. The P&P indicated, .The Resident has the right: 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality . 2. Resident 67 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's Admission Record. During an observation on 9/10/24 at 9:41 A.M., Resident 67 was in bed and did not respond when greeted, but with good eye contact. A review of Resident 67's care plans were conducted. Resident 67's undated care plan for ADLs indicated, . has ADL Self Care Performance Deficit r/t [related to] assistance with ADLS .EATING: Requires total assistance to eat . The undated nutritional care plan indicated, .Interventions .1:1[one on one] feed . Resident 67 was observed during mealtime on 9/10/24 at 12:23 P.M. Resident 67 was in bed in a sitting position with a staff member feeding Resident 67. The staff member was standing at bedside while feeding Resident 67. A joint observation on 9/10/23 at 12:29 P.M. was conducted with licensed nurse (LN) 11. LN 11 observed Resident 67 being fed while a staff member was standing. LN 11 stated he expected certified nurse assistants (CNA) to sit while feeding residents. LN 11 stated if he was the resident, he would feel intimidated if someone was standing to feed him. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated staff should assist in the appropriate height based on the resident's need to maintain dignity. A review of the facility's undated policy and procedure (P&P) titled, Resident Rights was conducted. The P&P indicated, .The Resident has the right: 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality . 48263 3. A review of Resident 65's Admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses which included a history of traumatic brain injury (an injury to the brain caused by a trauma to the head) and anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress). A record review of Resident 65's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 9/5/24, indicated a Brief Interview for Mental Status (BIM- developed by reviewing the resident's status during the prior seven day period) score of 6 points out of 15 possible points which indicated Resident 65 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 9:08 A.M., an observation and interview was conducted with Resident 65, in Resident 65's room. Resident 65 was in bed in an upright position wearing a hospital gown and stated, I'm hungry for more food. Resident 65 pressed the call light and told CNA 1 that he wanted to get changed and asked for a breakfast tray. CNA 1 returned with a Styrofoam food container that included a fried egg with scattered ketchup on top of the eggs. Resident 65 grabbed his adaptive fork(eating utensil/specialized tool designed to help individuals with physical disabilities, motor impairments, and cognitive issues) with his right hand. His right hand was shaking as he tried to lift his fork high enough to grab on to the eggs, due to the edges of the Styrofoam container that caused a barrier to lift the fork and grab the eggs. Resident 65 stated they [the facility] don't usually serve my meals like this in a container box. Resident 65 stated he preferred to eat the food that was served to him, on a regular food tray in order for him to eat independently. Resident 65 stated he was having a hard time feeding himself, and then used the call light to call CNA 1. On 9/10/24 at 9:17 A.M., an observation and interview was conducted with Resident 65 and CNA 1, in Resident 65's room. Resident 65 told CNA 1 that he needed help to eat because he was having a hard time scooping the food with his fork. CNA 1 stated that Resident 1 goes to the dining room during lunch for restorative nursing assistant (RNA) dining, but usually had no problem feeding himself during breakfast. CNA 1 stated that when they ask the kitchen staff for an extra meal for a resident, they serve the meals in Styrofoam containers. CNA 1 stated that Resident 65 had a breakfast tray prior, as to why the extra meals were in Styrofoam food containers because it was convenient for staff. On 9/11/24 at 12:45 A.M., an observation and interview was conducted with the Dietary Supervisor (DS). The DS stated that they have a list of residents who preferred using plastic utensils or other dishware such as Styrofoam, to honor preferences. On 9/11/24, a document provided by the DS was reviewed. The document titled Residents that Prefer and or Recommended to use Plastic Utensils or Dishware . did not include Resident 65 on the list. On 9/12/24 at 3:22 P.M., an interview was conducted with CNA 5. CNA 5 stated sometimes they'll [kitchen staff] put food in a Styrofoam container and stated, maybe it's easier to give. CNA 5 stated she has not seen a preference list that lists residents for dishware use. On 9/12/24 at 3:27 P.M., an interview was conducted with LN 3. LN 3 stated it was only appropriate to serve a meal in a Styrofoam container if it was a preference for a resident because it was a resident's right to choose an alternate dishware. LN 3 stated there were only a few residents that preferred different dishware and Resident 65 was not one of them. LN 3 stated this would be a dignity concern for Resident 65 because this was not his preference to be served in a Styrofoam container and should be treated with respect to promote his independence and well-being. On 9/12/24 at 8:26 A.M., an interview and record review was conducted with LN 2. LN 2 stated Resident 65 was able to feed himself for breakfast and dinner but goes to RNA dining during lunch only. LN 2 stated Resident 65's meals should not be served in a Styrofoam container because he required adaptive eating utensils (built up fork and scoop dish) to promote self-performance with eating. LN 2 stated Resident 65 should be treated with dignity. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza El Cajon, CA 92020

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/24 at 1:13 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 65 should be treated according to his choices and preferences should be honored in a dignified manner. The DON stated that the kitchen staff should be preparing meals on dishware that was appropriate for Resident 65 and not served on a Styrofoam container to promote independence and dignity. A review of the facility's policy and procedure titled RESIDENT RIGHTS undated, indicated . 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality .

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NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environments for five of 22 sampled residents (Resident 33, Resident 80, Resident 9, Resident 14 and Resident 54) when: 1. Resident 33's sliding door was stuck in a position that was unable to open and close fully causing safety concerns along with a damaged closet door and an ineffective overhead bed lighting to cause safety and emotional distress for Resident 33. 2. Resident 80's telephone wall jack was detached and hanging from the wall causing the telephone line to dangle with concerns for pests and safety concerns to cause accidents. 3. Resident 9, Resident 14 and Resident 54's rooms were not comfortable. These failures have caused and/or had the potential to place residents, staff, and visitors at risk for harm due to safety concerns and emotional distress. Findings: 1. A review of Resident 33's Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses which included a history of spastic paraplegia (group of rare inherited disorders that cause weakness and stiffness in the leg muscles). A review of Resident 33's admission Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 8/2/24, indicated that Resident 33 understood or understood others, and had no cognitive (mental process involved in knowing, learning, and understanding things) deficits. On 9/10/24 at 10:04 A.M., an interview was conducted with Resident 33, in Resident 33's room. Resident 33 stated he had notified the maintenance director directly over a month ago that his sliding door was busted since his current admission to the facility. Resident 33 stated he was frustrated and upset because there were times that it was hot outside, and the heat comes in making the temperature uncomfortable for him. Resident 33 also stated that he wanted a lock on his nightstand table to store some belongings and that he notified the maintenance director about this as well. Resident 33 stated because of the lack of storage space and the convenience for staff some items were stored on top of his overhead bed light (baseball cap, urinal, soft case, and sunglasses). Resident 33 also stated that his closet door by the entry had a doorknob sized hole and that his overhead bed light had a broken secondary light that was not working and stated it was important for him that it worked to be comfortable to adjust if he needed more light for reading or relaxing. Resident 33 stated he felt anxious about his safety with the sliding door not opening or closing all the way and stated in an emergency with his built (over 150 lbs) and him relying on his wheelchair that he would not be able to fit through the sliding door opening and exit from the facility. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 33's MDS Prior functioning: Everyday Activities (Section GG 0100B) indicated, Resident 33 was not independent with ambulation (walking) and required partial assistance from another person to complete any activities. On 9/12/24 at 10:22 A.M., an observation and interview was conducted with the Director of Maintenance (DOM), in Resident 33's room. Resident 33's room closet door had a doorknob sized hole, the sliding door opening was the size of a standard printer paper (8x11) landscape width and the overhead bed light turned off. The DOM stated that he found out about the door yesterday and that he was going to fix it and stated he knew about the sliding door about a month ago. The DOM stated that he had already contacted an outside contractor to fix it and would bring the receipt or contact document to show as proof that he had contacted an outside contractor. The DOM stated he did not have a date for when the outside contractor would come out to get the sliding door fixed and stated he will get a lock for Resident 33's nightstand table. The DOM tested the sliding door and was unsuccessful with trying to shut the sliding door to fully close or open. The DOM tested Resident 33's overhead bed light with the secondary light not working. On 9/12/24 at 10:26 A.M. an interview was conducted with the DOM and Resident 33, in Resident 33's room. Resident 33 expressed his frustration with the DOM and stated I've told you more than once about that sliding door and the closet. You come in and you say nothing to me. Resident 33 also stated to the DOM I was not notified of what you would do about it (pointing at sliding door). The DOM stated Resident 33's secondary light should be in working condition due to visibility and safety and stated that the sliding door needed to be fixed right away because Resident 33 cannot escape and it's a health and fire hazard along with possible pests that can get inside the room. The DOM stated he conducts monthly room inspections and documents them on his computer in his office. On 9/12/24 at 10:30 P.M., a concurrent interview and record review was conducted with the DOM, in the DOM office. The DOM stated that residents at the facility can call him directly for any maintenance problems or submit work tickets electronically. The DOM showed a computer screen of work tickets and stated room inspections would be documented here. The DOM was unable to pull a record within the last 3 months of room inspections. On 9/12/24 at 2:54 P.M., an interview was conducted with CNA 6. CNA 6 stated she does not document maintenance concerns and instead personally reaches out to maintenance department to let them know of any broken furniture, fixtures or equipment that needed to be fixed. On 9/12/24 at 3:00 P.M., an interview was conducted with the Activities Director (AD). The AD stated if there were maintenance concerns with anything that needed to be repaired or was broken that she would notify the maintenance department and let them know. The AD also stated that both stations have maintenance logs that staff can also use to let the maintenance department know. On 9/12/24 at 3:12 P.M., an interview was conducted with LN 4, at the Northside nursing station. LN 4 stated she reports to the maintenance department via a group chat line and if she was unable to report it through the group chat, she would notify the administrator directly. LN 4 stated she does not document maintenance concerns in the maintenance log. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 654 S. Anza El Cajon, CA 92020	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 3:50 P.M., an interview was conducted with the DOM, in the conference room. The DOM brought a copy of an email he sent to a contractor company to fix Resident 33's sliding door. The email was sent on Thursday, September 12, 2024 [sic] 3:40 P.M. to the contractor company. The email stated Hello, Please [sic] see below for your payment for today's transaction. The appointment for your sliding glass door inspection is scheduled for Tuesday 09/17/24 . The DOM admitted that he did not contact an outside contractor for the sliding door as from previous interview and stated I just contacted them today. On 9/13/24 at 1:37 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was unacceptable that Resident 33's sliding doors were unable to completely open and shut. The DON stated that it was a fire hazard and a safety concern and stated we don't want things from the outside (animals, people, debris, heat, rain) coming in that can enter Resident 33's room. The DON's expectations was for the maintenance team to also fix Resident 33's broken items such as the closet door, overhead bed light to prevent safety hazards and a lock on Resident 33's nightstand tables as requested and to be as homelike as possible that is comfortable for the Resident 33. A review of the facility's policy and procedure titled SAFE AND HOMELIKE ENVIORNMENT undated, indicated .3. Housekeeping and maintenance service will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .5. The Facility will provide sufficient individual closet space in each resident room .7. The facility will maintain comfortable and safe temperature levels .9. The facility will ensure the equipment's are maintained per manufacture's guideline and as needed . The policy did not indicate the frequency for routine room inspections to promote safe and homelike environments. 2. A review of Resident 80's Admission Record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses which included a history of anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress). A review of Resident 80's admission Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 7/7/24, indicated that Resident 80 understood or understood others, and had no cognitive (mental process involved in knowing, learning, and understanding things) deficits. On 9/10/24 at 10:22 A.M., an observation and interview was conducted with Resident 80, in Resident 80's room. The wall behind Resident 80's headboard centered to left side of the room above the floor had a landline telephone socket with exposed wires dangling off the wall with a hand fist sized opening on the top of the telephone socket. Resident 80 stated she felt uncomfortable and stated I think there's bugs that come out of there. It's not a good site at all. Resident 80 stated the phone outlet had been dangling off the wall for about a week and a half and stated she felt uneasy that it would cause accidents such as falls from someone tripping over the phone cords with her visitors or staff. On 9/11/24 at 3:51 P.M., an observation and interview was conducted with Resident 80, in Resident 80's room. Resident 80 stated that the phone outlet was still not fixed and that it had been broken 3 times since her admission to the facility. Resident 80 stated she had called maintenance to fix the outlet, but they still did not fix it correctly. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 654 S. Anza El Cajon, CA 92020	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:30 P.M., a concurrent interview and record review was conducted with the Director of Maintenance (DOM), in the DOM office. The DOM stated that residents at the facility can call him directly for any maintenance problems or submit work tickets electronically. The DOM showed a computer screen of work tickets and stated room inspections would be documented here. The DOM was unable to pull a record within the last 3 months of room inspections. On 9/12/24 at 10:37 AM an observation and interview was conducted with the DOM, in Resident 80's room. The DOM stated Resident 80's telephone socket should not be dangling of the wall. The DOM stated the wires exposed was not a fire hazard but stated that it was safety hazard for falls, and insects that can come out from the opening of the telephone socket. The DOM attempted to screw back the telephone socket but was unsuccessful and remained dangling off the wall. The DOM stated the wall may need to be replaced. On 9/12/24 at 10:41 A.M., an interview was conducted with Resident 80, in Resident 80's room. Resident 80 stated I have told Maintenance about it but it's hard to get them to come. Resident 80 stated the telephone socket was still dangling off the wall. On 9/12/24 at 2:54 P.M., an interview was conducted with CNA 6. CNA 6 stated she does not document maintenance concerns and instead personally reaches out to maintenance department to let them know of any broken furniture, fixtures or equipment that needed to be fixed. On 9/12/24 at 3:00 P.M., an interview was conducted with the Activities Director (AD). The AD stated if there were maintenance concerns with anything that needed to be repaired or was broken that she would notify the maintenance department and let them know. The AD also stated that both stations have maintenance logs that staff can also use to let the maintenance department know. On 9/12/24 at 3:12 P.M., an interview was conducted with LN 4, at the North side nursing station. LN 4 stated she reports to the maintenance department via a group chat line and if she was unable to report it through the group chat, she would notify the administrator directly. LN 4 stated she does not document maintenance concerns in the maintenance log. On 09/13/24 at 1:44 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 80's room should promote safety and a homelike environment that is comfortable for her. The DON stated her expectations was for the phone outlet to not be dangling off the wall and if the wall needs to be repaired to repair it since attempts to fix the outlet were unsuccessful. The DON stated Resident 80 should be as comfortable with her surroundings to prevent any uneasiness she feels with pests coming out of the socket and to prevent fall hazards. A review of the facility's policy and procedure titled SAFE AND HOMELIKE ENVIORNMENT undated, indicated .3. Housekeeping and maintenance service will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .9. The facility will ensure the equipment's are maintained per manufacture's guideline and as needed . The policy did not indicate the frequency for routine room inspections to promote safe and homelike environments. 47956 3. On 09/10/2024 at 1:25 P.M., an observation was conducted of Resident 9's room. Resident 9's telephone jack located on the wall behind the head of the bed was observed to dangling from the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/2024 at 1:40 P.M., an observation was conducted of Resident 54's room. Resident 54's wall at the head of the bed was observed to have multiple areas of repaired drywall. On 9/10/2024 at 2:45 P.M., an observation was conducted of Resident 14's room. Resident 14's wall was observed to have a green-grey discoloration approximately twenty-four inches in length and fifteen inches in height at its highest point. On 9/15/2024 at 9:20 A.M., an observation was conducted Resident 14's room. Resident 14's wall was observed to have been covered by a Fiberglass Reinforced Panel (FRP). On 09/15/2024 at 9:25 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated That is a wall protector, it is affixed to the wall. It is common when there are heavy scrapes. It does not really match the wall, but it is only temporary. If it was my house, I would fix the wall instead of putting that up. On 9/15/2024 at 9:30 A.M., an interview was conducted with the Director of Maintenance (DOM). The DOM stated It is an FRP panel, to prevent scratches. It is only temporary until we can clean, paint, and re-protect the area and have the area tested . I wouldn't use an FRP at home. On 9/15/2024 at 9:33 A.M. an interview was conducted with the Administrator (ADM). The ADM stated We are aware, we have an older facility. It is a capital expenditure. We have bids out. Repairs are for walls and handrails. A review of Facility Policy and Procedure, titled Safe and Homelike Environment undated, indicated .the facility will provide a safe, clean, comfortable and homelike environment

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interviews, and record review, the facility failed to complete a comprehensive assessment within 14 calendar days after admission for one of three residents (Resident 94) reviewed for dialysis. This deficient practice had the potential to delay the care planning process that would have been identified by Resident 94's care area assessments (CAA) to meet Resident 94's individualized care needs. Findings: A review of Resident 94's Admission Record indicated Resident 94 was admitted to the facility on [DATE] with diagnoses which included a history of end stage renal disease (the last stage of long-term (chronic) kidney disease when the kidneys are no longer able to carry out their daily functions). A record review of Resident 94's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 8/28/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 14 points out of 15 possible points which indicated Resident 94 had an intact cognition. A record review of Resident 94's MDS dated [DATE], indicated Resident 94 was coded for dialysis (Section O0100 J1) while a resident at the facility within the last 14 days. On 9/13/24 at 8:44 A.M., a concurrent interview and record review was conducted with the MDS Coordinator (MDSC), in the MDS office. The MDSC stated Resident 94 was admitted on [DATE] with an assessment reference date (ARD) of 8/28/24. The MDSC stated that she completed the MDS and the CAA on 9/5/24 and stated it was completed late. The MDSC stated both the MDS and CAA needed to be completed within 14 days of admission. The MDSC stated it was important that the MDS was completed timely because this triggers the CAA to develop a comprehensive person-centered plan of care for Resident 94's current health status such as dialysis and may cause financial penalties for reimbursement. On 9/13/24 at 1:32 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was important that the MDSC complete the MDS and the CAA in a timely manner for Resident 94 to develop a comprehensive care plan that reflects Resident 94's health status and to prevent health care delays needed to appropriately care for Resident 94. A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2023, (Page 4-3) 4.3 What Are the Care Area Assessments (CAAs)? .By statute, the RAI must be completed within 14 days of admission . (Page 5-2) 5.2 Timeliness Criteria .For the Admission assessment, the MDS Completion Date must be no later than 13 days after the Entry [admission] Date .For the Admission assessment, the Care Area Assessment (CAA) Completion Date must be no later more than 13 days after the Entry Date .

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	555804	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza El Cajon, CA 92020

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interviews, and record review, the facility failed to accurately code the Minimum Data Set (MDS: a nursing assessment tool) for one of two residents (Resident 45) reviewed for dementia care. As a result, the facility sent Resident 45's MDS to the federal database with inaccurate picture of the Resident 45's current health status. Findings: A review of Resident 45's Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses which included a history of bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). A record review of Resident 45's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 9/3/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 45 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/12/24 at 1:33 P.M., an interview and record review was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated she was unable to find a diagnosis of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) written by a physician or anywhere in Resident 45's current and past medical record within the last 14 days of the assessment reference dated (ARD: Date of MDS) 9/3/24. The MDSC stated she was following the previous coding from the previous MDS assessments to code the dementia diagnosis. The MDSC stated only active diagnosis within the last seven days should be coded on the MDS. The MDSC stated she did not code Resident 45's MDS accurately for dementia. The MDSC stated it was important to accurately code the MDS because the MDS had to reflect Resident 45's current health status which drives the plan of care that is triggered to appropriately meet Resident 45's individual needs and would cause misinformation to treat Resident 45 for dementia care. The MDSC further stated that information from the MDS gets sent to State and Federal databases and that she needed to modify Resident 45's MDS. On 9/13/24 at 1:32 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated it was important that the MDSC accurately codes Resident 45's MDS because the MDS triggers the plan of care for Resident 45. The DON stated if Resident 45 does not have a diagnosis of dementia then this would cause inaccurate care for dementia and cause confusion with reporting giving an inaccurate picture of Resident 45's health status. The DON stated her expectations was for the MDSC to code accurately according to the Resident Assessment Instrument (RAI: MDS manual) and to modify the MDS and re-submit to the Federal databases. A review of Centers for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2023, (Page I-5) Section I4800: Non-Alzheimer's Dementia .Active Diagnosis in the last 7 days-check all that apply

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NAME OF PROVIDER OR SUPPLIER: Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 654 S. Anza, El Cajon, CA 92020	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure three of seven residents reviewed for activities of daily living (ADL- self- care activities such as grooming, bathing, and toileting), who were unable to carry out their ADLs, received assistance with nail care (cleaning, trimming and/or filing of nails) and grooming. (Resident 7, 63 and 67) This deficient practice had the potential for the residents' personal well-being to be affected. Findings: 1. Resident 7 was readmitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain, stroke) affecting right side of the body according to the facility's Admission Record. During an observation on 9/11/24 at 8:38 A.M., Resident 7 was observed sitting up in bed, eating, using a fork with Resident 7's left hand. Resident 7's right hand was contracted (shortening of muscles and tendons, often leading to permanent deformity, and stiffening of joints) holding a hand roll (cushion to keep the hand open). Resident 7's fingernails on both hands were observed to be long, jagged and with faded nail polish. Resident 7 made grunting sounds to communicate and nodded when asked if she wanted her fingernails trimmed. An interview was conducted on 9/11/24 at 11:03 A.M. with certified nurse assistant (CNA) 13. CNA 13 stated only the licensed nurse or treatment nurse can trim residents' fingernails. During an interview on 9/11/24 at 3:34 P.M. with CNA 12, CNA 12 stated CNAs were allowed to trim fingernails which was scheduled during grooming days on Sundays. A joint observation and interview on 9/11/24 at 11:35 A.M. was conducted with licensed nurse (LN) 12. LN 12 observed Resident 7's fingernails and stated the fingernails were long and jagged. LN 12 stated it was the CNA's responsibility to trim fingernails. During an interview on 9/13/24 at 9:52 A.M. with the Director of Staff Development (DSD-person responsible for training staff), the DSD stated she expected CNAs to provide nail care and grooming for residents on shower days for the resident's personal well-being. The DSD stated if fingernails were not trimmed, the resident may be at risk for infection and scratching of skin. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated she expected residents to be clean and well groomed. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Care and Hygiene, dated 2/2024 was conducted. The P&P indicated, .It is the policy of this facility to promote cleanliness, sanitation, hygiene, and assist in necessary Activities of Daily Living as appropriate and necessary to promote well-being and independence . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 63 was readmitted to the facility on [DATE] with diagnoses including unspecified Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) and dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's Admission Record. During a joint observation and interview on 9/13/24 at 9:17 A.M., Resident 63 was sitting up in bed with an opened milk carton at bedside. Resident was observed to be unshaven. Resident 63 was asked if he would like to be shaved and stated yes, but nobody has helped him with shaving. CNA 14 was in the hallway across Resident 63's room and entered the room. CNA 14 stated Resident 63 needed to be shaved. CNA 14 stated residents were supposed to be shaved on shower days. CNA 14 further stated it was important to make residents feel good about their appearance. During an interview on 9/13/24 at 9:52 A.M. with the Director of Staff Development (DSD-person responsible for training staff), the DSD stated she expected CNAs to provide nail care and grooming for residents on shower days for the resident's personal well-being. The DSD stated if fingernails were not trimmed, the resident may be at risk for infection and scratching of skin. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated she expected residents to be clean and well groomed. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Care and Hygiene, dated 2/2024 was conducted. The P&P indicated, .It is the policy of this facility to promote cleanliness, sanitation, hygiene, and assist in necessary Activities of Daily Living as appropriate and necessary to promote well-being and independence . 3. Resident 67 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a condition characterized by loss of memory, language, problem solving and other thinking abilities) according to the facility's Admission Record. During an observation on 9/11/24 at 7:57 A.M., Resident 67 was sitting up in bed having breakfast. Resident 67's fingernails were long and when asked if she wanted them trimmed, Resident 67 nodded. A joint observation and interview on 9/11/24 at 11:20 A.M. was conducted with licensed nurse (LN) 12. LN 12 observed Resident 67's fingernails and stated the fingernails were long. LN 12 stated it was the CNA's responsibility to trim fingernails. During an interview on 9/13/24 at 9:52 A.M. with the Director of Staff Development (DSD-person responsible for training staff), the DSD stated she expected CNAs to provide nail care and grooming for residents on shower days for the resident's personal well-being. The DSD stated if fingernails were not trimmed, the resident may be at risk for infection and scratching of skin. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated she expected residents to be clean and well groomed. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Care and Hygiene, dated 2/2024 was conducted. The P&P indicated, .It is the policy of this facility to promote cleanliness, sanitation, hygiene, and assist in necessary Activities of Daily Living as appropriate and necessary to promote well-being and independence .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observations, interviews, and record review, the facility left medications unattended at the bedside for one of eight residents (Resident 80) reviewed for medication storage. These failures had the potential for medication misuse, divergence (another person taking medications or medications used wrongfully), and/or severe allergic complications. Findings: A review of Resident 80's Admission Record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses which included a history of hemiplegia (one sided muscle weakness) and hemiparesis (inability to move one side of the body) following cerebral infarction affecting left dominant side (a brain attack known as a stroke that stops blood flow to the brain causing left sided weakness and movement to the body). A review of Resident 80's admission Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 7/7/24, indicated that Resident 80 understood or understood others, and had no cognitive (mental process involved in knowing, learning, and understanding things) deficits. On 9/10/24 at 10:22 A.M., an observation and interview was conducted with Resident 80, in Resident 80's room. Two eye medications were left unsecured and unattended on top of Resident 80's bedside table. An antifungal powder was also left unsecured and unattended on top of Resident 80's left nightstand table. Resident 80 stated she was unaware that her antifungal (medication to treat fungal and yeast infection on skin) powder was near the top of her left nightstand table. On 9/11/24 at 3:51 P.M., and observation and interview was conducted with Resident 80, in Resident 80's room. Resident 80's eye drops (two) were left unattended and unsecured on top of Resident 80's bedside table. Resident 80 stated the nurses leave her eye drop medications so that she could self-administer the medications. On 9/12/24 at 4:45 P.M., a record review was conducted on Resident 80's medication orders for the medications left at Resident 80's room. Resident 80's medication record indicated an order that included: miconazole nitrate powder Apply to peri area twice a day every day and evening shift for rash Ocusoft Lid Scrub Plus External Pad (Eyelid Cleanser) apply to both eyelids topically one time a day for Blepharitis (inflammation of the eyelids) Ok to self-administer if able Rephresh Tears Opthalmic [eye] Solution 0.5% (Carboxymethylcellulose Sodium (Opth)) [sic] instill 1 drop in both eyes two times a day for dry eyes May leave at bedside for self administration (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/24 at 9:15 A.M., an interview and record review was conducted with LN 2, at the Northside Nursing station. LN 2 stated to leave medications at the bedside an medical doctor (MD) order would need to be obtained. LN 2 stated that prior to getting an MD order to leave medications at the bedside that safety evaluations should be conducted with any residents to self-administer medications to include a return demonstration. LN 2 stated he was unable to find any nursing assessments and/or evaluations for Resident 80 that demonstrates her ability to safely administer her own medications. LN 2 stated it should also be care planned and was unable to find a care plan that indicated a list of self-administration for the two eyedrops. LN 2 stated it was important that Resident 80 was evaluated for safety with self-administration of medications because she could injure herself if not done correctly. LN 2 stated that all medications should be stored in a secure container that is locked such as in a medication cart and if ok to leave at bedside in a Ziploc (plastic bags with a seal) and stored in a secure locked container such as Resident 80's nightstand table that is locked. LN 2 stated it is unsafe to leave any medications unattended because of the potential for the medication to be used on somebody else like Resident 80's roommate that can cause severe allergic reactions from misuse. On 9/13/24 at 1:46 P.M., an interview was conducted with the DON. The DON stated Resident 80's medications should be stored appropriately in a safe and secured container that is locked and not left unattended regardless if an order stated ok to leave at bedside. The DON stated safety evaluations to include return demonstration is needed to determine if medications are still appropriate for self-administration. The DON stated self-medication evaluations should be continuous on a quarterly basis because resident status can change overtime. The DON stated her expectations were for the nursing staff to do medication safety evaluations prior to obtaining orders to keep medications at the bedside and should be stored securely that in a locked container and not left out in the open to avoid medication misuse. The DON further stated her expectations were for the nurses to be at the resident's bedside and watch the residents self-administer their own medications to monitor for any medication side effects and allergic reactions. A review of the facility's policy and procedure titled MEDICATION ADMINISTRATION AND STORAGE undated, indicated .4. Drugs and/or biologicals should not be left unsecured/unattended. Drug deliveries should be stored immediately after delivery and should not be left unattended .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview and record review, the facility failed to ensure food served was in a palatable, flavorful manner that maintained the nutritional value of the menu items served when: 1. Food complaints were not being addressed appropriately. 2. The recipe was not followed during the preparation for a meat recipe. Cross-reference (F812) This failure had the potential to decrease residents' meal intake and contribute to weight loss. The facility census was 110. Findings: 1. A document review was conducted on 9/10/24 at 9:57 A.M., of the facilities policy titled Meal Service indicated 1. Meal times . Lunch at 11:00-12:30 P.M . An interview was conducted on 9/10/24 at 11:28 A.M., with the licensed nurse (LN) 1. LN 1 stated Due to coronavirus (COVID: a highly contagious respiratory virus caused by the SARS-COV-2 virus) outbreak only the front dining room was being used but mainly for residents that were on restorative nursing assistant (RNA) dining. A dining observation was conducted on 9/10/24 at 11:47 A.M., in the dining room. The lunch trays arrived in the dining room. An interview was conducted on 9/10/24 at 11:50 A.M., in the dining room, with the registered dietician (RD). The RD stated tray line was getting it (resident trays) [sic] ready as to why the meal trays were late. During dining observations and interviews on 9/10/24 and 9/11/24, confidential interviews and observations were conducted with facility residents. Resident food concerns addressed included: - 9/10/24 confidential Resident stated, I don't eat the meals because I want Mexican food and the food taste terrible, so I don't eat it. The staff don't ask me if I want something else and if I call the kitchen they hang up on me. - 9/10/24 confidential Resident stated, The food is cold, I don't like the taste and it looks bad . - 9/10/24 confidential Resident stated, The food is tasteless. - 9/10/24 confidential Resident stated Pizza was like play dough and the burger looked like a poop emoji. Cheese potato made him sick. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/10/24 confidential Resident stated .portions were too small . turkey burger was not something I would ever eat again. -9/10/24 confidential Resident stated . food can be dry. And not aware that they can get an alternative meal. - 9/10/24 confidential Resident stated Not appetizing, not seasoned, not identifiable. - 9/10/24 confidential Resident stated .food portions especially lunch were too large . preferred sandwiches. -9/10/24 confidential Resident stated chicken is dry . - 9/10/24 confidential Resident stated, Chicken is dry, and was unsure it was cooked at thickest part. Unsure of what yellow orange puree was, not going to eat it, broccoli was mushy. - 9/11/24 confidential Resident stated, the meat was awful. I put it in a napkin and threw it away. - 9/11/24 confidential Resident stated, food did not taste good. - 9/11/24 confidential Resident stated, food was institutionalized. - 9/11/24 confidential Resident stated, eggs daily, no variety. - 9/11/24 confidential Resident stated, no variety of food and drinks. Review of the facility's Resident Council meeting minutes dated July 11, 2024, and August 8, 2024, the following dietary concerns were identified: - July 11, 2024 Resident Council meeting minutes indicated, .Went over staffing concerns [Administrator Name] acknowledged and assured them they will get staffing in order . - August 8, 2024 Resident Council meeting minutes indicated, . Resident expressed food preference concerns [Administrator Name] acknowledged and assured the residents he is working with dietary . During an interview on 9/12/24 at 8:32 A.M., with the resident council president (Resident 77). Resident 77 stated there was always concerns about food and often menus were not given. Resident 77 stated people [facility residents] don't like it [food trays] there's no flavor. Resident 77 stated that they always get chicken and fish, it's often cooked the same way without variety and that alternative meals were available but need to order two hours ahead and lacked cultural food alternatives. A review of Resident 77's admission Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 9/4/24, indicated that Resident 77 understood or understood others, and had no cognitive (mental process involved in knowing, learning, and understanding things) deficits. Review of the facility's menu dated 9/11/24 lunch menu indicated the regular diet was served apple glazed meatballs, brown rice Florentine, carrots with parsley, wheat roll and mousse dessert. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 12:45 PM, a test tray observation and interview with the Dietary Supervisor (DS) was conducted, at the end of the hall outside of room [ROOM NUMBER] after the last tray was provided. The pureed and the regular texture diet with apple glazed meatball tasted very sour, and the meat was a little undercooked and red in the center. The brown rice was sticky and lacked flavor. The DS stated the pureed was mixed with sauce according to the recipe to bring to a pureed consistency to taste according to the menu served. On 9/13/24 at 10:30 A.M., an interview with the Registered Dietitian (RD) and the DS was conducted. The RD stated she addressed food complaints with four questions (to address food concerns) but did not use a tracking system to identify issues. The RD stated she documented in the facility's medical record, titled, Nutrition and Evaluation RDN [registered dietician nutritional] review-V2 under preference to indicate dislikes on admission and quarterly. The RD stated complications from food complaints included weight loss and malnutrition. Further, the DS stated that if residents disliked their meals, then they won't enjoy their food and behaviors can change. The facility was not able to provide a policy and procedure that addressed test trays. A review of the facility policy titled MENU PLANNING, dated 2023, the policy indicated .8. Menus are planned to consider A. The religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups. 2. On 9/11/24 a recipe review was conducted with the facility menu titled Apple Glazed Meatballs. The recipe included the following ingredients: - Large Pasteurized (heat treated to kill harmful bacteria) eggs - Milk - Bread crumbs - Ground Turkey - Garlic, chopped (*May substitute with 1/8 tsp garlic powder per 1 clove garlic) On 9/11/24 at 8:30 AM, an observation and interview was conducted with the dietary cook (DC), in the kitchen. The DC was preparing the recipe titled Apple Glazed Meatballs. The DC stated she was preparing the ground turkey according to the serving size of 120 to serve to the 110 residents in the facility. The cook stated that the temperature from when she removed the ground turkey from the refrigerator was at 40 F (Fahrenheit), and moved the ground meat from the holding container to the large capacity industrial mixer. The DC added black pepper, salt, garlic powder, milk, and breadcrumbs to the ground turkey, then mixed the ingredients together in the large capacity industrial mixer. The DC stated she was going to the kitchen refrigerator for the eggs that she needed for the recipe. The DC returned to the food preparation table with 29 unpasteurized (not heat treated to kill harmful bacteria) eggs. The DC stated she needed 12 eggs to add to the turkey meatball recipe, and cracked the unpasteurized eggs into a measuring cup. The DC re-read the recipe which stated, Large Pasteurized eggs. The DC stated she needed 15 large, pasteurized eggs and stated, these eggs are not pasteurized. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 8:54 A.M., an observation and interview was conducted with the Registered Dietician (RD) and the DC. The RD stated that the facility only purchased pasteurized eggs. The RD inspected the eggs and stated the eggs are blank and did not have a stamped P. The DC shook her head and stated no she grabbed the wrong eggs (unpasteurized eggs) and stated pasteurized eggs have a stamped letter P. The DC stated it was important to use the pasteurized eggs because the recipe stated to use pasteurized eggs for the meat recipe and that she was serving food for all the residents, and not just for one resident. The RD stated it was important to use pasteurized eggs because the bacteria was treated. The RD then told the DC it was ok to use the unpasteurized eggs, and moved/positioned the egg crate closer to the DC and stated, continue with the meatball recipe. On 9/11/24 at 12:35 P.M., an observation and interview during test tray was conducted with the Dietary Supervisor (DS), outside of room [ROOM NUMBER]. The DS stated it was important for recipes to be followed according to the menu so that all the residents were aware of what was being served and to preserve the nutritive value and taste. The facility policy and procedure titled FOOD PREPARATION dated 2023 indicated, 2. Recipes are specific as to the portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza El Cajon, CA 92020

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 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

48263

Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices in dietary services were maintained for food storage according to standards of practice when:

1. One ice machine, and two three-compartment sinks did not have a proper air gap system to adequately prevent backflow of contaminated foods.

2. One facility prep sink was covered with white stained deposits, rust, and discolored raised pebble sized rock-like substance permanently embedded on the surface was being used.

3. The facility mixer for preparing food did not have a splash guard to prevent contaminating floor and kitchen equipment surfaces during use.

4. The facility did not safely prepare a meat recipe by using unpasteurized eggs.

Cross Reference (F804)

These failures had the potential to cause widespread food borne illness among all 110 residents who received food from the kitchen.

Findings:

1. On 9/10/24 at 8:00 A.M., an observation and interview was conducted with the Dietary Supervisor (DS), in the kitchen. The ice machine was piped directly through a food production sink pipe underneath the food prep sink station with an air gap system that was connected to a black PVC (polyvinyl chloride: synthetic plastic material) drain and two narrow white PVC pipes that was pushed down into the sink floor drain. The DS stated that there was no air gap in between the ice machine drain and the sink floor drain. The DS stated the importance of an air gap was to prevent backflow contamination.

On 9/10/24 at 9:10 A.M., an observation and interview was conducted with the DS and the Director of Maintenance (DOM) in the kitchen. The three-component dishwashing station #1 (by the low-temp dishwashing machine) was connected to a black PVC pipe that was pushed down towards the floor drain with no air gap. The DOM measured the pipe drain for the three-component dishwashing station #1 at four inches inside the floor drain. The DOM stated it's important for the water to drain and the backflow [sic] and it can go up to the sink and you don't want it to back up to contaminate the kitchen.

Per the 2022 Federal FDA food code, section 5-202.13 titled BACKFLOW PREVENTION, AIR, .An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, Or nonfood EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).

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NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 9/10/24 at 8:00 A.M., an observation and interview was conducted with the Dietary Supervisor (DS), in the kitchen. The prep sink posted a sign that stated NO THAWING MEATS IN THIS SINK. SLOW DRAIN, WILL FLOOD. An interview was conducted with the Dietary Supervisor (DS) and stated that the sink was used to prep (prepare) vegetables. The prep sink was observed with discoloration throughout the prep area to the right, with white-stained deposits, with pencil eraser-sized scattered rust surrounding the circular middle surface, along with a burnt-like, raised pebble-sized, rock-like substance that had with a dark grayish bubble discoloration, permanently embedded on the surface. On 9/11/24 at 8:30 A.M., an interview was conducted with the dietary cook (DC), in the kitchen. The DC stated that they [dietary staff] currently used the prep sink to prepare vegetables and other non-meat products. On 9/13/24 at 8:57 A.M., an observation and interview was conducted with the DS and Dietary Aide (DA) 1. The prep sink had a silver serving container with individual packets of sugar, along with a red bucket placed on top of the prep sink. The prep sink was still observed with the same discoloration, white calcium deposits, rust and raised burnt-like, pebble-sized discoloration on the prep surface area. DA 1 stated he left the red sanitation bucket on top of the prep sink with a wet rag hanging off the edge of the bucket to clean the surface. DA 1 tested the sanitation bucket's disinfectant concentration with his bare hands, with a reading of 100 PPM (parts per million). DA 1 stated it should be between 200-400 PPM. The DS stated that DA 1 should have used/wore gloves prior to testing, to protect DA 1's hands from the chemicals in the disinfectant before testing. The DS stated the prep sink did not look clean and sanitary to be used for prepping foods, and that the red sanitation bucket and sugar container should not be placed on top of the prep sink. On 9/13/24 at 10:59 A.M., an interview was conducted with the DS, in the conference room. The DS stated the prep sink was not cleaned from the previous observation and that using the prep sink could have caused food-borne illnesses and chemical contamination with foods being served to the residents. The DS stated that the PPM reading decreased within two hours to validate a possible reason for the 100 PPM reading, and acknowledged if the red sanitation bucket was on the prep sink area for two hours, that this was a safety concern for all residents and staff, for food and chemical contamination. The facility policy and procedure titled FOOD PREPARATION dated 2023 indicated, .10. Do not use cleaning products or sanitizer in the food preparation or food storage areas in any way that could result in contamination of exposed food items. This includes spraying or pouring cleaning products near food items during preparation or cooking . 3. On 9/11/24 at 9:12 A.M., an interview and observation was conducted with the dietary cook (DC), in the kitchen. The DC was preparing a recipe for turkey meatballs and placed the ground turkey in a large capacity industrial mixer. The DC stated the mixer was known to splash food all over the floor and kitchen equipment during food preparation and that staff needed to stay away from the mixer to avoid being splashed with food. The DC stated there was no splash guard for the mixer and the only way to avoid being splashed was to stay away from the mixer. During the mixing process, the ground turkey components splashed on the kitchen floor, and the food preparation area across the stove at about an arm to two arms width apart within the circumference (the approximate circular surrounding of an area) of the mixer. (continued on next page)

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	555804	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza El Cajon, CA 92020

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/13/24 at 10:59 A.M., an interview was conducted with the Registered Dietician (RD) and the Dietary Supervisor (DS), in the conference room. The DS stated using a splash guard for the mixer should be used to prevent food from splashing and contaminating the kitchen floor, and surfaces from food contaminants. The DS stated problems with the mixer could result in cross contamination from contaminated surfaces. The RD stated she did not think it was a problem for the mixer to splash on the kitchen surfaces and stated, as long as they clean the mess. The facility policy and procedure titled FOOD PREPARATION dated 2023 indicated, .8. Consider all raw product as contaminated. Handle it with methods designed to reduce existing contamination or to prevent cross-contamination to other products . 4. On 9/11/24 at 8:30 A.M., an observation and interview was conducted with the dietary cook (DC), in the kitchen. The DC was preparing the recipe titled Apple Glazed Meatballs. The DC stated she was preparing the ground turkey according to the serving size of 120 to serve to the 110 residents in the facility. The cook stated that the temperature from when she removed the ground turkey from the refrigerator was at 40 F (Fahrenheit), and moved the ground meat from the holding container to the large capacity industrial mixer. The DC added black pepper, salt, and breadcrumbs to the ground turkey, then mixed the ingredients together in the large capacity industrial mixer. The DC stated she was going to the kitchen refrigerator for eggs that she needed for the recipe. The DC returned to the food preparation table with 29 unpasteurized (not heat-treated to kill harmful bacteria) eggs. The DC stated she needed 12 eggs to add to the turkey meatball recipe and cracked the unpasteurized eggs into a measuring cup. The DC re-read the recipe which stated, Large Pasteurized (heat-treated to kill harmful bacteria) eggs. The DC stated she needed 15 large, pasteurized eggs and stated, these eggs are not pasteurized. On 9/11/24 at 8:54 A.M., an observation and interview was conducted with the Registered Dietician (RD) and the DC. The RD stated that they [the facility] only purchased pasteurized eggs. The RD inspected the eggs and stated the eggs are blank and did not have a stamped P. The DC shook her head and stated no she grabbed the wrong eggs (unpasteurized eggs) and stated pasteurized eggs have a stamped letter P. The DC stated it was important to use the pasteurized eggs because the recipe stated to use pasteurized eggs for the meat recipe and that she was serving food for all the residents and not just for one resident. The RD stated it was important to use pasteurized eggs because the bacteria was treated. The RD then told the DC it was ok to use the unpasteurized eggs and moved/positioned the egg crate closer to the DC and stated, continue with the meatball recipe. On 9/11/24 at 8:58 A.M., an observation and interview was conducted with the DC. The DC proceeded to retrieve pasteurized eggs from the kitchen refrigerator. The DC stated that complications of using unpasteurized eggs with the meat recipe included food-borne illnesses, since the facility residents can easily become sick due to their health status. Per the 2022 Federal FDA (Food Drug Administration) Food Code, section 3-801.11 (B) titled SPECIAL REQUIREMENTS FOR HIGHLY SUSCEPTIBLE POPULATIONS: Pasteurized Foods, Prohibited Re-service, and Prohibited food, Pasteurized eggs or egg products shall be substituted for raw eggs in the preparation of . (2) ., recipes in which more than one egg is broken and the eggs are combined . (F) Subparagraph (B) (2) of this section does not apply if: (1) the raw eggs are combined immediately before cooking for one CONSUMER's serving at a single meal . and served immediately, such as an omelet, souffle, or scrambled eggs; (2) the raw EGGS are combined as an ingredient immediately before baking and the EGGS are thoroughly cooked to a READY-TO-EAT form, such as a cake, muffin, or bread . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure titled FOOD PREPARATION dated 2023 indicated, .4. Poorly prepared food will not be served-such food is to . either be improved, prepared again, or replaced with an appropriate substitution .

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43518 Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility), trends identified by surveyors during the recertification survey concerning grooming/hygiene and the cleaning of bi-level positive airway pressure/continuous positive airway pressure machines (BIPAP/CPAP- a type of noninvasive ventilation that helps you breathe). This failure had the potential for the facility to overlook trends in resident care that might have affected residents' dignity and/or health. Cross Reference: F677, F880 Findings: On 9/13/24 at 2:15 P.M., a concurrent interview with the Administrator (ADM) and the Director of Nursing (DON) and a review of QAPI program was conducted. The ADM stated that the main areas that the QAPI team monitored were Falls, Abuse, Staffing and Retention, and Infection Control. In addition, the ADM stated some new areas that QAPI were addressing were Food Preferences and Room Renovations. During the recertification survey, deficient trends in basic grooming (nail care and beard care) and cleaning of CPAP and BIPAP machines were identified by surveyors. The ADM stated that neither of these trends had been identified by the QAA Committee and/or included in the QAPI plan. On 9/13/24 at 3 P.M., an interview with the ADM was conducted. The ADM stated that the expectation was for the QAA Committee to have identified the trends that were identified by the surveyors. In addition, the ADM stated the deficient trends should have been included in the QAPI plan. The ADM stated the importance of the QAA Committee identifying deficient trends and including them in the QAPI plan was to promote the highest standard of care for their residents. On 9/13/24 at 3:05 P.M., an interview with the DON was conducted. The DON stated that the expectation was that the QAA Committee should have identified the trends identified by the surveyors. In addition, the DON stated the deficient trends should have been included in the QAPI plan. The DON stated the importance of QAA Committee identifying trends was to maintain resident dignity (for grooming) and to minimize the risk of infection (CPAP and BIPAP cleaning), and to promote the highest standard of care for their residents. A review of the undated facility policy titled Quality Assurance and Performance Improvement indicated 1. Quality Assessment and Assurance Committee (QAA) .d. Committee functions include .identifying and prioritizing PIP's [Performance Improvement Plan (PIP) is a document that helps employees improve their job performance], implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented being sustained .3. Identification of, and prioritizing of, PIPs through .f. Prioritizing through identification of high-risk, high volume, or problem prone issues .

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observations, interviews, record reviews the facility failed to provide a safe, sanitary (clean), and comfortable environment to help prevent highly contagious infections when: 1. Facility did not store respiratory equipment properly for Resident 261. 2. Licensed Nurses (LN) did not have interventions in place to clean Resident 33's continuous positive airway pressure (CPAP) mask according to professional standards of practice. 3. Three certified nursing assistants (CNA) did not practice infection control protocols with hand hygiene and/or the use of protective personal equipment (PPE: clothing or equipment that protects people from injury or infection in the workplace) for residents (Resident 45, Resident 95, and Resident 108) on transmission-based precautions. a) Resident 45 with droplet precautions for corona virus (COVID-19: A highly contagious respiratory infection caused by the SARS-2 virus). b) Resident 95 with droplet precautions for corona virus (COVID-19: A highly contagious respiratory infection caused by the SARS-2 virus). c) Resident 108 with contact precautions for clostridioides difficile (CDiff: a germ [bacterium] that causes diarrhea and colitis [an inflammation of the colon] and can be life-threatening) 4. No hand hygiene was observed during a dining observation in the dining room. This deficient practice had the potential to cause a wide-spread infection outbreak to all residents, staff, and visitors in the facility. Findings: 1. Resident 261 was readmitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (a problem in which breathing pauses during sleep due to blocked airways) according to the facility's Admission Record. The MDS (a clinical assessment tool) dated 8/20/24 for Resident 261 listed a cognitive (thinking, reasoning, or remembering) score of 15, indicating cognition was intact. During an observation and interview on 9/10/24 at 9:58 A.M., Resident 261 was lying in bed. A bilevel positive airway pressure (BIPAP-machine as breathing support and administered through a face mask or nasal mask) machine was observed on top of Resident 261's bedside drawer. The BIPAP machine was observed without water inside the machine and the tubing was touching the floor. The tubing did not have a mask. Resident 261 stated that she used the BIPAP occasionally. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another observation on 9/11/24 at 8:06 A.M., Resident 261 was lying in bed with her eyes closed. Resident 261 did not have the BIPAP mask on her. The BIPAP tubing was hanging on the bedside table with no mask and the tubing was touching the floor. A joint observation and interview was conducted with licensed nurse (LN) 11 on 9/11/24 at 8:10 A.M. LN 11 entered Resident 261's room and stated Resident 261 had a continuous positive airway pressure (CPAP- a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) machine. LN 11 observed the machine's tubing hung over the bedside table and touching the floor. Upon further observation of the machine's tubing, LN 11 was not able to find the mask for the tubing. LN 11 stated the CPAP tubing and mask should always be stored in a plastic bag for infection control. A review of physician's orders for Resident 261 titled, Order Summary Report .Active Orders As of: 9/13/24 . indicated, .BIPAP .Apply at Bed Time and Remove in AM upon Awakening . The physician's order did not indicate proper storage of the BIPAP mask. During an interview on 9/13/24 at 2:04 P.M. with the Director of Nurses (DON), the DON stated Resident 261's BIPAP tubing was an infection control issue, and the mask should be stored in a plastic bag. A review of the facility's undated policy and procedure (P&P) titled, CPAP/BiPAP Monitoring and Management, was reviewed. The P&P did not provide guidance to staff regarding proper storage of BIPAP mask for infection control. 48263 2. A review of Resident 33's Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses which included a history of obstructive sleep apnea (OSA: a disorder in which a person frequently stops breathing during sleep). A review of Resident 33's admission Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 8/2/24, indicated that Resident 33 understood or understood others, and had no cognitive (mental process involved in knowing, learning, and understanding things) deficits. On 9/10/24 at 10:08 A.M., an observation and interview was conducted with Resident 33, in Resident 33's room. Resident 33's CPAP machine and CPAP accessories (masks, headgear, and tubing) was placed on top of his right nightstand. The CPAP accessories were not bagged (stored in a bag) or secured. Resident 33 stated the nursing staff would leave his CPAP machine and CPAP accessories on top of the nightstand table for easy access. On 9/11/24 at 12:38 P.M., an observation and interview was conducted with Resident 33, in Resident 33's room. Resident 33's CPAP machine and CPAP accessories were still placed on top of his right nightstand table. Resident 33 stated he did not remember the last time that LNs performed any cleaning for his CPAP machine and CPAP accessories. Lastly, Resident 33 stated they did not clean it [CPAP machine and CPAP accessories] yesterday or today. On 9/11/24 a review of Resident 33's electronic health record (EHR) was conducted. There were no physician's orders for CPAP cleaning. There were no care plans for CPAP maintenance. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 654 S. Anza, El Cajon, CA 92020	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/24 at 9:37 A.M., a concurrent interview and record review was conducted with LN 2, at the Northside nursing station. LN 2 stated he did not know when Resident 33's CPAP machine and CPAP accessories needed to be cleaned. LN 2 stated Resident 33 only had one CPAP order since he was admitted to the facility on [DATE] that indicated, Apply Oxygen 2LPM [liters per minute] with CPAP at bedtime for OSA. LN 2 stated they (LNs) just initiated new physician's orders for cleaning and CPAP settings for Resident 33's CPAP maintenance as of 9/12/24. LN 2 stated he was unable to find records in Resident 33's EHR since his admitted [DATE], regarding CPAP cleaning and use. LN 2 stated it was important to clean Resident 33's CPAP machine and CPAP accessories daily to prevent respiratory infections. On 9/13/24 at 12:47 P.M., an interview was conducted with the Infection Prevention Nurse (IPN). The IPN stated she did not know CPAP machines needed to be cleaned. The IPN stated it was important to clean Resident 33's CPAP because there's air that goes in their lungs with the use of a CPAP, and complications that included breathing and respiratory infections, if not cleaned. On 9/13/24 at 1:37 P.M., the DON stated she was aware that there were no orders to maintain and clean Resident 33's CPAP device as of 9/12/24. The DON stated her expectation was for the LNs to make sure that orders were in place for Resident 33's CPAP use, so that LNs know they have to clean the CPAP device. The DON stated complications including harmful microbes (bacteria, virus, and fungi that can cause illness and death) can grow in CPAP machines and CPAP accessories if not maintained in a sanitary way. [Brand Name] Auto set CPAP Elite Manual dated 2021 .Clean the device and its components according to the schedules shown in this guide, to maintain the quality of the device and to prevent the growth of germs that can adversely affect your health . [Brand Name] Full Face Mask User Guide dated 7/2020 .Regularly clean your mask and its components to maintain the quality of your mask and to prevent the growth of germs that can adversely affect your health . 3a. A review of Resident 45's Admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses which included a history of chronic obstructive pulmonary disease (COPD-prevents airflow to the lungs, causing breathing problems). A record review of Resident 45's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 9/3/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 10 points out of 15 possible points which indicated Resident 45 had moderate cognitive (pertaining to memory, judgement and reasoning ability) deficits. (continued on next page)

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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 - Some	On 9/10/24 at 10:52 A.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 3, outside of Resident 45's room. Posted outside of Resident 45's room was a red and white sign in all capital letters which indicated, Droplet and contact precaution hand hygiene, gown, N95 (a mask that filters airborne particles to prevent and guard against respiratory infections such as COVID), eye protection, and gloves before entering the room and a PPE drawer outside of Resident 45's room. CNA 3 was seen walking into Resident 45's room without performing hand hygiene and putting on PPE up until Resident 45's bathroom by the back sliding door of the room, then exited the room. CNA 3 stated he went into Resident 45's room because he did not know where she was, and to help assist Resident 45's roommate (Resident 95) who was in the bathroom calling out to him. CNA 3 stated he did not perform hand hygiene before entering Resident 45's room or put on PPE. CNA 3 stated I know it's a droplet precaution because they have COVID. CNA 3 stated regardless of the time spent in the room, if it was a droplet precaution room, he had to perform hand hygiene and wear PPE's before entering, to prevent any COVID outbreak. On 9/10/24 at 10:56 A.M., an observation and interview was conducted with LN 1, outside of Resident 45's room. LN 1 stated she saw CNA 3 and CNA 4 enter Resident 45's room without performing hand hygiene and wearing PPE prior to entry. LN 1 stated it was important for all staff to read the signage prior to entering Resident 45's room and abide by the droplet precautions to prevent the spread of COVID infections. On 9/13/24 at 12:54 P.M., an interview and record review was conducted with the Infection Prevention Nurse (IPN). The IPN stated Resident 45's COVID status was confirmed on 9/2/24 and tested positive for the virus. The IPN stated that CNA 4 should have performed hand hygiene and wore PPE prior to entering (Resident 45's room) because Resident 45's room was a droplet precaution room, and regardless of performing direct or indirect care, anyone who entered a droplet or contact precautions room needed to gown up (put a gown on). On 9/13/24 at 1:21 P.M., an interview was conducted with the DON. The DON stated her expectations was for all staff to perform hand hygiene before and after, wear PPEs before entry of any resident room identified as contact or droplet precautions, regardless if they were performing resident care or not. The DON stated the potential for not adhering to infection control protocols could lead to the spread of infection to other residents, staff, and visitors in the facility. A review of the facility's policy and procedure titled IPCP [infection prevention and control program] and Transmission-Based Precautions undated, indicated . 4. Droplet Precautions .c. Use personal protective equipment (PPE) appropriately . A review of Centers for Disease Control and prevention (CDC, a federal agency) Transmission-Based Precautions: Droplet Precautions Everyone must: Clean their hands before entering, and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry . chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cdc.gov/infection-control/media/pdfs/droplet-precautions-sign-P.pdf 3b. A review of Resident 95's Admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses which included a history of cerebral infarction (blood flow to the brain is blocked, leading to symptoms such as speech difficulty, headache, motor weakness, and in severe cases, death). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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	A record review of Resident 95's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 8/12/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 15 points out of 15 possible points which indicated Resident 95 had an no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 9/10/24 at 10:55 A.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 4, outside of Resident 95's room. Posted outside of Resident 95's room was a red and white sign in all capital letters which indicated, Droplet and contact precaution hand hygiene, gown, N95 (a mask that filters airborne particles that guard against respiratory infections such as COVID), eye protection, and gloves before entering the room and a PPE drawer outside of Resident 95's room. CNA 4 was walking down the hallway pushing a snack cart towards Resident 95's room. Resident 95 was unmasked sitting on her wheelchair in her room when CNA 4 entered the room. CNA 4 did not perform hand hygiene and wear PPE prior to entering Resident 95's room. CNA 4 stated he went inside Resident 95's room to ask if Resident 95 wanted a snack. CNA 4 stated he did not perform hand hygiene or wore PPEs because he was not doing resident care. CNA 4 stated the droplet sign outside of Resident 95's door meant that Resident 95 or her roommate (Resident 45) had COVID. CNA 4 stated the purpose for performing hand hygiene and wearing PPEs was to prevent the spread of infection for himself, and other people in the facility. On 9/10/24 at 10:56 A.M., an observation and interview was conducted with LN 1, outside of Resident 95's room. LN 1 stated she saw CNA 3 and CNA 4 enter Resident 95's room without performing hand hygiene and wearing PPE prior to entry. LN 1 stated it was important for all staff to read the signage prior to entering Resident 95's room and abide by the droplet precautions to prevent the spread of COVID infections. On 9/13/24 at 12:54 P.M., an interview and record review was conducted with the Infection Prevention Nurse (IPN). The IPN stated that CNA 4 should have performed hand hygiene and wore PPE prior to entering (Resident 95 and 45's room) because the room was identified as a droplet precaution room. The IPN furter stated that even if the CNA did not touch anything or provide direct resident care, anyone who entered a droplet or contact precautions room needed to gown up. On 9/13/24 at 1:21 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was for all staff to perform hand hygiene before and after, wear PPEs before entry of any resident room identified as contact or droplet precautions, regardless if they were performing resident care or not. The DON stated the potential for not adhering to infection control protocols could lead to the spread of infection to other residents, staff, and visitors in the facility. A review of the facility's policy and procedure titled IPCP [infection prevention and control program] and Transmission-Based Precautions undated, indicated . 4. Droplet Precautions .c. Use personal protective equipment (PPE) appropriately . A review of Centers for Disease Control and prevention (CDC, a federal agency) Transmission-Based Precautions: Droplet Precautions Everyone must: Clean their hands before entering, and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry . chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cdc. gov/infection-control/media/pdfs/droplet-precautions-sign-P.pdf (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 654 S. Anza El Cajon, CA 92020	

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3c. A review of Resident 168's Admission Record indicated Resident 168 was admitted to the facility on [DATE] with diagnoses which included a history of sepsis (a serious condition in which the body responds improperly to an infection).

A record review of Resident 168's Minimum Data Set (MDS- a nursing assessment tool that is used to develop a plan of care) dated 9/4/24, indicated a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven day period) score of 8 points out of 15 possible points which indicated Resident 168 had an no cognitive (pertaining to memory, judgement and reasoning ability) deficits.

On 9/12/24 at 8:18 A.M., an observation and interview was conducted with LN 2, outside of Resident 168'2 room. Posted outside of Resident 168's room was a yellow sign that indicated, CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands . put on gloves . put on gown . and a PPE drawer outside of Resident 45's room. LN2 stated Resident 168 had clostridioides difficile (CDiff: a very contagious bacterial infection that causes symptoms such as frequent watery diarrhea, abdominal cramping, and nausea that can be life-threatening).

On 9/12/24 a record review was conducted on Resident 168's electronic health record (EHR). Resident 168 had a care plan dated, 9/11/24 that indicated, Has Clostridium Difficile r/t [related to] chronic diarrhea, hx [history] of antibiotic Cefpodoxime for UTI last dose 9/6/24 . CONTACT ISOLATION: Wear gowns and masks [PPE] when changing contaminated linens. Place soiled linens in bags marked biohazard .

On 9/12/24 at 8:21 A.M., an observation and interview was conducted with CNA 7, outside of Resident 168's room. CNA 7 was in Resident 168's room, and was not wearing PPE while changing Resident 168's linens. Afterwards, CNA 7 walked outside of Resident 168's room and placed the dirty linens in an unmarked clear plastic bag. CNA 7 stated I went in the room thinking it was an orange sign for enhanced barrier precautions [EBP: PPE's used only during direct resident care] but it wasn't. CNA 7 stated he should have PPE prior to entry regardless if he was doing direct patient care or not because Resident 168 had CDiff. CNA 7 stated it was important to gown up to prevent the spread of infection because CDiff was contagious.

On 9/12/24 at 8:23 A.M., an interview was conducted with LN 2, outside of Resident 168's room. LN 2 stated CNA 7 was supposed to perform hand hygiene before entering Resident 168's room and washed hands with soap and water upon exit, because alcohol-based hand rubs (ABHR) does not kill the CDiff bacteria. LN 2 stated CNA 7 was supposed to wear a gown and mask before entry regardless of performing resident care or not, to prevent the spread of infection.

On 9/13/24 at 12:57 P.M., an interview was conducted with the Infection Prevention Nurse (IPN). The IPN stated whenever I give my in-services, the second you see a contact or droplet sign you have to have PPEs. The IPN stated that all staff should be washing their hands before and after entering a contact precautions room, especially for Resident 168 because he had CDiff. The IPN stated her expectations were for the nursing staff to also bleach objects (clean objects with bleach) if they used them and to remove their PPEs prior to exiting Resident 168's room or anyone with contact precautions. The IPN stated not following infection control protocols can cause infection outbreaks in the facility.

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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 - Some	On 9/13/24 at 1:21 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was for all staff to perform hand hygiene before and after, wear PPEs before entry of any resident room identified as contact or droplet precautions, regardless if they were performing resident care or not. The DON stated the potential for not adhering to infection control protocols could lead to the spread of infection to other residents, staff, and visitors in the facility. A review of the facility's policy and procedure titled IPCP [infection prevention and control program] and Transmission-Based Precautions undated, indicated . 2. Contact Precautions .b. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment . 4. On 9/10/24 at 11:28 A.M., a dining observation and interview was conducted with LN 1, in the front dining room. There were a total of eight residents and three staff members. LN 1 stated they had two dining rooms, but only one dining room was being used because of the corona virus (COVID-19: a highly contagious respiratory illness that is caused by the Sars-2 virus) outbreak in the facility. On 9/10/24 at 11:50 A.M., an observation and interview was conducted with the Registered Dietician (RD), in the front dining room. The RD stated meal tray delivery was late and the usual schedule was 11 A.M., for food trays to arrive. The dining room reached eight residents waiting for their meal tray, which finally arrived. The nursing staff distributed the meal trays to the residents, but did not perform hand hygiene for the residents. On 9/10/24 at 12:50 P.M., an observation was conducted in the front dining room. The last resident left the dining room without hand hygiene performed on any residents, prior to leaving the dining room. On 9/11/24 at 12:14 P.M., an observation and interview was conducted with LN 1, in the front dining room. LN 1 stated they did not perform hand hygiene (on 9/10 and 9/11) prior to residents receiving their meal trays. LN 1 stated that residents in the dining room should have had antibacterial hand wipes once trays were delivered, and after residents were finished with their meals before leaving the dining room. LN 1 stated it was important that hand hygiene was performed when trays were delivered to make sure resident's hands were clean, because she was unsure if hand hygiene was performed prior to entering the dining room. LN 1 stated it was important that hand hygiene was performed right after resident's were finished with their meal trays, before leaving the dining room, to make sure the residents were clean and comfortable and to prevent the spread of germs. On 9/13/24 at 1:21 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was important for residents eating in the dining room to perform hand hygiene before and after residents received their meal trays. The DON stated she expected staff to provide hand hygiene wipes prior to the resident's meals and after they finished their meals, to prevent the spread of infection. A review of the facility's policy and procedure titled IPCP [infection prevention and control program] and Transmission-Based Precautions undated, indicated . 1. Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status .b. Hand hygiene .