

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 North Park Avenue Pomona, CA 91768	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and/or diseases in the healthcare setting) were followed in accordance with the facility's policies and procedures (P&amp;P) titled, Hand Hygiene (procedures that included the use of alcohol-based hand rubs (containing 60%-95% alcohol) and hand washing with soap and water), and Management of COVID-19 (infections airborne disease caused by SARS-CoV-2 virus) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure six of 12 sampled staff (Certified Nurse Assistant [CNA] 2, CNA, 3, CNA 4, CNA 5, and CNA 6, and Treatment/Licensed Vocational Nurse [LVN] 6 wore appropriate PPE when entering residents' room and when providing care for residents on TBP (Transmission Based Precautions) for COVID-19.</li> <li>2. Ensure four of nine sampled residents (Residents 5, 6, 7, and 8) who tested positive for COVID-19 wore a mask when outside Resident 5, 6, 7, and 8's room.</li> <li>3. Ensure CNA 5, CNA 6, and LVN 6 performed hand hygiene before and after providing care to Residents 5, 6, 7, and 8, and before and after entering Resident 9's room.</li> </ol> <p>As a result of these failures, infectious agents were transmitted and spread from staff to residents that resulted in widespread infection in the facility.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included Huntington's disease (causes the nerve cells in the brain to decay over time that affects a person's movements, thinking ability, and mental health) and oral-pharyngeal dysphagia (difficulty or discomfort in swallowing)</p> <p>a).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 11/3/2024, the MDS indicated Resident 4 had severely impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 4 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with eating, oral hygiene, upper body dressing, personal hygiene, rolling left to right (in bed), sitting to lying, lying to sitting on side of bed, sitting to standing and chair/bed-to-chair transfers.</p> <p>During an observation on 11/27/2024 at 12:30 pm, outside of Resident 4's room in the hallway, CNA 3 and CNA 4 were observed inside of Resident 4's room. CNA 3 and CNA 4 were observed at Resident 4's bedside, touching Resident 4 and Resident 4's bedding. CNA 3 and CNA 4 were observed in the room with Resident 4 not wearing a face shield. There is a novel respiratory precautions sign (indicated to clean hands-on room entry, wear a gown on room entry, wear a N-95 mask and face shield, wear gloves on room entry, and clean hands when exiting) on the wall next to the room door. Another sign on the wall next to the door indicated Resident 4 was on quarantine (state, period, or place of isolation in which residents that may have been exposed to infectious disease are placed). There was an isolation cart outside the room in the hallway by the door that contained gowns. There were gloves and ABHR on top of the cart.</p> <p>During an interview on 11/27/2024 at 12:38 pm, with CNA 3, CNA 3 stated CNA 3 was not wearing a face shield because there were no face shields in the isolation cart. CNA 3 stated CNA 3 was supposed to wear a face shield because the isolation sign on the wall next to Resident 4's door indicated to do so. CNA 3 stated Resident 4 had been exposed to COVID-19. CNA 3 stated CNA 3 was supposed to wear all PPE indicated on the novel respiratory precautions sign to keep CNA 3 safe.</p> <p>During an interview on 11/27/2024 at 12:45 pm, with CNA 4, CNA 4 stated CNA 4 was not wearing a face shield because there were no face shields in the isolation cart. CNA 4 stated the sign on the wall next to Resident 4's door indicated CNA 4 was supposed to wear a face shield when inside Resident 4's room. CNA 4 stated CNA 4 should wear a face shield to protect CNA 4 from infection and was supposed to wear whatever PPE the isolation precaution sign indicated to wear.</p> <p>b). During a review of Resident 2's AR, the AR indicated Resident 2 was initially admitted to the facility on [DATE] and again on 9/24/2024, with diagnoses that included immunodeficiency (condition in which the immune system is unable to fight infection or other disease) due to conditions classified elsewhere and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/27/2024 at 1:53 pm, with CNA 6, CNA 6 stated CNA 6 was providing care to Resident 5 without wearing gloves, gown, and face shield. CNA 6 stated CNA 6 did not perform hand hygiene before or after caring for Resident 5. CNA 6 stated CNA 6 knew Resident 5 had COVID-19. CNA 6 stated CNA 6 thought PPE and hand hygiene for COVID-19 positive residents were only required when providing patient care such as brief changes and feeding assistance. CNA 6 stated CNA 6 did not know what novel respiratory precautions meant.</p> <p>During an interview on 11/27/2024 at 3:23 pm, with IPN 1 and IPN 2, IPN 1 stated IPN 1 did monitoring of staff and was reeducating, and ensuring staff followed infection-control protocols. IPN 1 stated the IPNs replenished the isolation carts, but that it was central supply's responsibility to replenish them. IPN 1 stated if staff noticed PPE was missing from the isolation cart, then they are expected to pull the needed PPE from another cart and inform central supply, the IPNs, or Registered Nurse (RN) supervisors so the carts could be restocked. IPN 1 stated it was not acceptable for staff to not wear required PPE because it was missing from the isolation carts. IPN 1 stated hand hygiene needed to be performed with ABHR (Alcohol Based Hand Rub) for 20 seconds until dry, or soap and water 20 seconds before entering rooms, upon exiting, and in between caring for residents. IPN 1 stated staff were required to wear the appropriate PPE when indicated to minimize the spread of infection. IPN 1 stated if staff were not, they could spread infection to other residents and staff who were not infected. IPN 1 stated residents could get sick requiring hospitalization or even die if infected residents were immunocompromised.</p> <p>During an interview on 11/27/2024 with the Director of Nursing (DON), the DON stated staff were supposed to wear the appropriate PPE when indicated to prevent the spread of infection and for the safety of all residents and staff. The DON stated if staff were not following the appropriate isolation precautions and wearing the appropriate PPE, outbreaks like the facility's current COVID-19 outbreak could happen. The DON stated staff were supposed to follow novel respiratory precautions or droplet precautions for suspected or confirmed COVID-19 residents. The DON stated hand hygiene was important because it was the best practice in infection control. The DON stated staff should perform hand hygiene before and after patient care, in-between patients, after the restroom, after eating, and before donning and after doffing (removing) PPE. The DON stated if staff were not following the hand hygiene protocol it would increase the risk of spreading infection throughout the facility. The DON stated if more residents get infected with COVID-19, they could end up with respiratory distress or other effects from the virus, become sicker, require hospitalization, or even die, which was why infection prevention and control was so important.</p> <p>During a review of the facility's P&amp;P titled, Hand Hygiene, revised 9/1/2020, the P&amp;P indicated the facility considered hand hygiene as the primary means to prevent the spread of infections. The P&amp;P indicated hand hygiene meant to clean the hands by washing with soap and water or ABHR including gel or foam. The P&amp;P indicated staff were to follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, volunteers, and visitors. The P&amp;P indicated hand hygiene was required before eating, after using the bathroom, after contact with blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, wound drainage, and soiled dressing, before and after food preparation, before assisting a resident with dining if direct contact with food was anticipated or occurred, before donning and after doffing PPE, and immediately upon entering and exiting a resident room.</p> <p>(continued on next page)</p>		

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