

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

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Imperial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 100 East 2nd Street Imperial, CA 92251	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 39449 Based on interview and record review, the facility failed to ensure 2 of 2 sampled residents (8, 24) had end of life wishes or a POLST (physician orders for life sustaining treatment) completely signed by the RP(responsible party) and physician respectively in their record. As a result there was a potential to not have their life end of life wishes honored. Findings: 1. On 4/17/24 at 9 A.M., an interview and record review was conducted with the DON. The DON stated Resident 8's POLST was the physician order for life sustaining treatment. The DON stated Resident 8's POLST was a legal document, which meant a major decision for sustaining life for Resident 8. The DON stated Resident 8's POLST should be reviewed, agreed upon by both parties, and signed to include the title or relationship to Resident 8. The DON further stated, Resident 8 's POLST was not valid without the signature. A review of Resident 8's medical record indicated Resident 8 was on a public conservatorship from 1/17/24 to 1/17/25. A review of Resident 8's POLST (Physician Orders for Life-Sustaining Treatment) indicated it was signed by the physician on 5/14/19. The section for Patient or Legally Recognized Decisionmaker had a box for Signature (required) and Relationship (write self if patient) which was left blank and was not completed. 2. On 4/18/24 at 11:23 A.M, an interview and record review were conducted with the DON. The DON stated Resident 24's POLST should have been signed by the physician because POLST was an order and needed a physician signature. A review of Resident 24's POLST (Physician Orders for Life-Sustaining Treatment) indicated the section for Signature of Physician/Nurse Practitioner/Physician Assistant (Physician/NP/PA) had the physician's name but there was no signature and date. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555919	Facility ID: 555919 If continuation sheet Page 1 of 13

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility policy entitled Palliative/End-of-Life Care-Clinical Protocol, revised date March 2018 indicated, 1. Upon admission, the attending physician will help identify the prognosis for each resident .2. The physician and staff will identify individuals who desire or are likely candidates for palliative car .3. The physician will review the resident's decision-making capacity and support the resident's participation in the care plan to the extent possible .		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to complete a significant change in status assessment (SCSA) in minimum data set (MDS, an assessment tool) for one of 12 sampled residents (Resident 5). This was when Resident 5 had developed stage III pressure ulcer (full thickness tissue injury, open wound that goes deeper into the tissue beneath) of her coccyx (tailbone). This failure had the potential to result in Resident 5 to be unable to achieve or maintain optimal status of health, function, and quality of life. Findings: Resident 5 was admitted to the facility on [DATE], with diagnoses which included dementia (the loss of cognitive function like thinking, remembering, and reasoning to such an extent that interferes with a person's daily life and activities), per the facility's Admission Record. A review of Resident 5's MDS dated [DATE], indicated her cognition (mental, thought processes) and brief interview for mental status (BIMS, cognition level) score was three, which indicated the resident's cognition was severely impaired. The MDS for skin conditions indicated Resident 5 had no skin conditions but was prone to developing skin damage. A review of Resident 5's physician's order dated 3/18/24, indicated there was an antibiotic (anti-infective) ointment order for Resident 5's pressure ulcer stage III of her tailbone which was completed on 4/9/24. A review of the facility's matrix (is used to identify pertinent care categories like pressure ulcer) dated 4/15/24 did not indicate Resident 5 had stage III pressure ulcer of her tailbone. A review of Resident 5's MDS for significant change in status assessment was conducted. There was no SCSA MDS for Resident 5's stage III pressure ulcer of the coccyx. During an observation and interview of Resident 5 in her room on 4/15/24 at 11:28 A.M., Resident 5 laid in bed, with her eyes closed and yelled out when her name was called. Resident 5 did not respond to questions. During an interview with Certified Nursing Assistant (CNA) 1 on 4/16/24 at 3:02 P.M., CNA 1 stated Resident 5 was alert, yelled out when she did not want to get up in bed. CNA 1 stated Resident 5 required assistance from her bed to her wheelchair but was able to wheel herself to the hallway. CNA 1 stated Resident 5 had strong hands but had no mobility on her legs. CNA 1 stated Resident 5 had a wound on her tailbone, and the Licensed Nurses (LNs) put some ointment and that the wound had gotten better. During a concurrent observation of Resident 5 and LN 2 performing wound treatment on Resident 5 on 4/18/24 at 9:17 A.M., LN 2 cleansed Resident 5's tailbone with normal saline (solution) and put some cream on Resident 5's pressure ulcer. (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LN 2 on 4/18/24 at 9:18 A.M., LN 2 stated Resident 5's pressure ulcer had improved from a size of 2 centimeter (cm) by 2 cm to a scrape like and clean edges wound. During a joint review of Resident 5's clinical record and an interview with the Director of Staff Development (DSD) on 4/17/24 at 8:54 A.M., the DSD stated Resident 5's pressure ulcer had been treated with antibiotic ointment and the open area had closed. The DSD stated Resident 5's pressure ulcer stage III was identified on 3/16/24 and was not coded in MDS. The DSD stated the LNs who identified the change in Resident 5's skin condition should have triggered a situational alert to trigger the MDS tool. The DSD stated it was important to code Resident 5's changed in skin condition in MDS to communicate with the nursing staff what was the status of the resident and was a part of the resident's medical history. The DSD stated a comprehensive assessment was conducted to aid in developing a care plan for the residents. During an interview with the Director of Nursing (DON) on 4/18/24 at 10:43 A.M., the DON stated Resident 5's pressure ulcer was recent. The DON stated Resident 5's pressure ulcer was not coded in the MDS tool. The DON stated the LNs should be coding the resident's MDS as mandated. A review of the facility's policy titled, Comprehensive Assessment, revised October 2023 was conducted. The policy indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plan .7. Significant Change in Status Assessment (SCSA) - the SCSA is a comprehensive assessment for a resident that must be completed when the IDT (Interdisciplinary Team - group of healthcare professionals with various areas of expertise who work together toward the goals of the residents) has determined that a resident meets the significant change guidelines for either major improvement .8. A significant change is a major decline or improvement in a resident's status .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record reviews, the facility failed to develop a person-centered care plan for a resident (5) at risk for pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin), and for a resident (19) involved in a resident-to-resident altercation for two of 12 sampled residents reviewed for care plans. These failures had the potential of Resident 5 and Resident 19 to not receive the care and services needed to preserve optimal health status and prevent further decline. Findings: 1. Resident 5 was admitted to the facility on [DATE], with diagnoses which included dementia (the loss of cognitive function like thinking, remembering, and reasoning to such an extent that interferes with a person's daily life and activities), per the facility's Admission Record. A review of Resident 5's MDS dated [DATE], indicated her cognition (mental, thought processes) and brief interview for mental status (BIMS, cognition level) score was three, which indicated the resident's cognition was severely impaired. The MDS for skin conditions indicated Resident 5 had no skin conditions but was prone to developing skin damage. A review of Resident 5's physician's order dated 3/18/24, indicated there was an antibiotic (anti-infective) ointment order for Resident 5's pressure ulcer of her tailbone which was completed on 4/9/24. During an observation and interview of Resident 5 in her room on 4/15/24 at 11:28 A.M., Resident 5 laid in bed, with her eyes closed and yelled out when her name was called. Resident 5 did not respond to questions. During a joint review of Resident 5's clinical record and an interview with the Director of Staff Development (DSD) on 4/17/24 at 8:54 A.M., the DSD stated Resident 5's pressure ulcer was identified on 3/16/24. The DSD stated the LNs who identified the change in Resident 5's skin condition should have triggered a situational alert to trigger the system for the LNs to develop a care plan. The DSD stated a care plan should have been developed because it directed what kind of care was provided to the resident. During an interview with the Director of Nursing (DON) on 4/18/24 at 10:43 A.M., the DON stated Resident 5's pressure ulcer was recent. The DON stated a care plan should have been developed related to Resident 5's pressure ulcer because it was a way of implementing the treatment of care and a way of measuring if the targeted treatment goal was achieved. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Goals and Objectives, Care Plans revised April 2009 was conducted. The policy indicated, .Care plan goals and objectives are defined as the desired outcome for a specific problem .4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved . 2. Resident 19 was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), per the facility's Admission Record. A review of Resident 19's history and physical dated 9/25/23 indicated Resident 19 was alert and oriented. During an interview with Resident 19 in the hallway on 4/15/24 at 4:10 P.M., Resident 19 stated her roommate hit her in the left side of her face while she was sleeping in her bed. Resident 19 stated, Now they are moving me to another room. I don't know why I am transferred. During an interview with Certified Nursing Assistant (CNA) 2 on 4/16/24 at 11:49 A.M., CNA 2 stated Resident 19 had an altercation with another resident on 4/15/24. CNA 2 stated there was no behavioral monitoring on Resident 19. During an interview with the Social Worker (SW) on 4/17/24 at 4:01 P.M., the SW stated Resident 19 had an altercation with her roommate. The SW stated she did not develop a care plan for Resident 19 after the altercation. The SW stated there was no care plan in Resident 19's clinical record. The SW stated a care plan should have been developed to know the plan for the residents' care like monitoring them after an altercation. During an interview with the Director of Nursing (DON) on 4/18/24 at 10:43 A.M., the DON stated a care plan should have been developed after an altercation between Resident 19 and her roommate because a care plan was a way of monitoring the care of the resident and to monitor them to prevent further incidents. A review of the facility's policy titled, Goals and Objectives, Care Plans revised April 2009 was conducted. The policy indicated, Care plan shall incorporate goals and objectives that lead to the highest obtainable level of independence .3. Care plan goals and objectives are derived from information .in the resident's . assessment and: a. are resident oriented; b. are behaviorally stated, c. are measurable .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40610 Based on observation, interview and record review, the facility failed to ensure safe and sanitary measures were met in the kitchen during dietary operations according to standards of practice when: 1. Food items were not properly labeled with the expiration or use by date, 2. Oven exhaust fan and the air vent were not kept cleaned; and, 3. Kitchen staff did not calibrate the food thermometer correctly. These findings had the potential to expose the facility's residents to unsafe and unsanitary food practices that could lead to widespread forborne illnesses. Findings: 1. On 4/15/24 at 9:54 A.M., an observation in the kitchen was conducted. The refrigerator labeled as refrigerator # (number sign) 1, contained the following food items: - a plastic bag of cilantro with preparation (prep) date on 4/10/24, no use by date. - a plastic bag of cut cabbage leaves with brownish core and leaves, and carrots with prep date on 4/9/24, no use by date. - a plastic bag of grated parmesan cheese with date opened on 3/21/24, no use by date. - a plastic bag of tortilla with opened date on 4/9/24, no use by date. - a plastic bag of Monterey cheese with opened date on 4/10/24, no use by date. - a bag of bagel with opened date on 3/26/24, no use by date. - a bag of cocoa with prep date on 11/28/23, no use by date. - On 4/15/24 at 9:59 A.M., an observation in the dry food storage room was conducted. There was a rack that contained dry foods in plastic bins. The plastic bins contained the following dry foods with no use by date or expiration date: - Gelatino - prep date 10/31/23, no expiration date. - Marshmallow - prep date 10/24/23, no expiration date. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/24 at 10:56 A.M., a joint observation of the kitchen and an interview with the cook (Ck) and interpreted by the Facility Manager (FM) was conducted. Per the Ck, the policy was for the kitchen staff to indicate the use by date or the expiration date of the opened food items. Per the Ck, once the kitchen staff indicated the opened or the prep date of the food items, the kitchen staff knew when to discard them though there was no use by date or expiration date. Per the Ck, the policy was for the kitchen staff to write the expiration date of the food items that were not in their original boxes like the gelatin and the marshmallows. Per the Ck, some food items like the cheese should be discarded after seven days and with the bread and the bagel, the Ck stated the kitchen staff based it on the look of the bread and did not use them if it did not look or smell good. On 4/17/24 at 9:47 A.M., an interview with the Certified Dietary Manager (CDM) was conducted. The CDM stated the policy was for the kitchen staff to properly label the food items when they were opened and when was the expiration date or the use by date. On 4/18/24 at 10:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectations was for the kitchen staff to label all food including fresh foods at the time of opening and indicate the expiration or used by date to prevent foodborne illness for the residents. A review of the facility's policy titled Food Service Policy dated 12/10/2010 was conducted. The policy indicated, .It is the policy of this facility to provide a means for the safe storage of refrigerated items that have been opened and may not be in their original container . 2. On 4/17/24 at 10:22 A.M., an observation and an interview with the Certified Dietary Manager (CDM) was conducted. There was dust and lint in the oven exhaust fan and in the air vent. The CDM stated the expectation was for the staff to maintain the cleanliness of the exhaust fan and the air vent in the kitchen for infection control because it could cause food related illness. On 4/18/24 at 10:43 A.M., an interview with the DON was conducted. The DON stated the oven exhaust fan and the air vent in the kitchen should be maintained clean to ensure there was no dust particles and microbes that goes into the residents' food that could potentially cause harm to the residents when ingested. A review of the facility's undated policy titled, Sanitation and Maintenance was conducted. The policy indicated, Policy: All kitchen and food storage areas will be maintained and sanitized according to state and federal regulations in order to assure sanitary conditions for food preparation and service .The Food Service Supervisors (FSS) is responsible for monitoring and maintaining department sanitation . 3. On 4/17/24 at 10:43 A.M., an observation of the Ck calibrating the food thermometer and an interview with the Ck and the CDM was conducted. The Ck placed some ice into a cup and added some water. The Ck immersed the food thermometer into the cup and let the thermometer rest with the tip of the thermometer touching the base of the cup. The CDM stated the tip should not be touching the base of the cup to get an accurate reading to ensure the temperature of the food was safe for the residents. On 4/18/24 at 10:43 A.M., an interview with the DON was conducted. The DON stated the kitchen staff should know how to calibrate the food thermometer to keep the food safe at a temperature that it should prevent foodborne illness. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, Calibrating Your Bi-Metal Stemmed Thermometer dated 12/10/2010 was conducted. The policy indicated, .The best method for calibrating the accuracy of this type of thermometer is the ice point procedure. 1. Fill an insulated container such as Styrofoam cup or thermos with crushed ice and water. The consistency of the solution must be a slurry to be at 32 degrees Fahrenheit (F). 2 When the slurry has stabilized .immerse the thermometer into the contents. Make sure the stem of the thermometer is away from the bottom and sides of the container .		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 39449 Based on interview and record review, the facility failed to electronically submit staffing information based on payroll data on a quarterly schedule to Centers for Medicare & Medicaid Services (CMS) for one of four fiscal quarters (1st quarter of 2023 [10/01/23 to 12/31/23]). This failure resulted in lack of reporting of facility's direct care staffing as required by CMS. Findings: During a concurrent interview on 4/15/24 at 10:40 A.M. and 4/17/24 at 9:47 A.M. with the Director of Nursing (DON) and Facility Manager (FM), the Payroll -Based Journal Staffing Data Report (PBJ) for 1st quarter of 2023 (10/1/23 to 12/31/23) was reviewed. The DON and FM verified by stating the report indicated the 1st quarter was triggered because the facility did not submit the direct care staffing information data. The DON stated they did not submit PBJ because the facility residents were all with Medicaid insurance and this PBJ was only applicable for residents with Medicare insurance. FM stated we had not set up for PBJ submission because it was for Medicare and our facility had residents with Medicaid insurance. FM stated it was important to report the actual hours to make sure the facility was properly staffed for resident care. A review of the facility's [NAME] Report for Quarter 1 2024 October 1 to December 31, 2023 indicated the following Metric was Failed to Submit Data for the Quarter which resulted as triggered which by definition meant no data submitted for Quarter. A review of the CMS Electronic Staffing Data Submission Payroll-Based Journal; Long-Term Care Facility Policy Manual, version 2.6 , date June 2022 indicated .1.2 Submission Timeliness and Accuracy .Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate .Submissions must be received by the end of the 45th calendar day 911:59 pm Eastern Time) after the last day in each fiscal quarter in order to be considered timely.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39449 Based on interview and record review, the facility failed to follow infection control practices when the facility did not do water testing for germs. This failure had the potential to spread germs and placed residents at risk for infections. Findings: On 4/17/24 at 11:40 A.M., an observation and interview was conducted with the DON and Maintenance Personnel (MP) during a facility tour. MP stated there was no water testing done to check water level for germs and elements including Legionella (germs in water). The DON stated there was no illnesses noted with residents in the facility related to water-borne infections. There was no documented evidence provided by the facility to ensure water was being tested .		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation and review of the Analysis of Client Accommodations, the facility failed to ensure one resident room accommodated no more than four residents. One of nine resident rooms (room [ROOM NUMBER]) accommodated six residents. Findings: During the recertification survey 4/15/24 through 4/18/24, room [ROOM NUMBER] was observed to accommodate six residents. There were no observed quality of care or quality of life concerns that negatively impacted the residents residing in that room. Continuance of a waiver allowing the six-bed room was therefore recommended.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 40610 An observation of resident rooms was conducted from 4/15/24 through 4/18/24 during the annual recertification survey. The following resident rooms contained less than 80 square feet for each resident: <table><thead><tr><th>Room number</th><th>Number of Residents</th><th>Room Size</th></tr></thead><tbody><tr><td>1 3 216</td><td>(allowing 72 square feet per resident)</td><td></td></tr><tr><td>2 3 222</td><td>(allowing 74 square feet per resident)</td><td></td></tr><tr><td>3 3 216</td><td>(allowing 72 square feet per resident)</td><td></td></tr><tr><td>6 3 210</td><td>(allowing 70 square feet per resident)</td><td></td></tr><tr><td>7 3 221</td><td>(allowing 73.66 square feet per resident)</td><td></td></tr><tr><td>8 4 283</td><td>(allowing 70.75 square feet per resident)</td><td></td></tr></tbody></table> There were no observed quality of care or quality of life concerns that negatively impacted the residents residing in those rooms. Continuance of a waiver allowing the six rooms that contained less than 80 square feet per resident was therefore recommended.			Room number	Number of Residents	Room Size	1 3 216	(allowing 72 square feet per resident)		2 3 222	(allowing 74 square feet per resident)		3 3 216	(allowing 72 square feet per resident)		6 3 210	(allowing 70 square feet per resident)		7 3 221	(allowing 73.66 square feet per resident)		8 4 283	(allowing 70.75 square feet per resident)	
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