DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555785	A. BUILDING _____ B. WING _____	10/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD CARE CENTER	1880 DAWSON AVENUE SIGNAL HILL, CA 90806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the recertification survey Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 45269 Health Facilities Evaluator Nurse ID: 45891 Health Facilities Evaluator Nurse ID: 45777 Total Census: 50 Total Sampled Residents : 21 Highest scope and severity is F	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 10/21/23

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.

POC accepted 10/30/2023 by 45891, HFEN.
43906,HFEN

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10/20/23

PLAN OF CORRECTIONS

Disclaimer Statement

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies .The plan of corruption is prepared and submitted solely because of requirement under state and federal law.

F-580- Notify of Changes (Injury/Decline/Room etc)
CFR(s):483.10(g)(14)(i)-(iv)(15)

Immediate Action:

Resident # 34 attending Physician was notified on 10/1/23 with order for Hydrocortisone 1% cream for the reported insect bites. There was no additional reports of insect bites observed. No reported side effects from the insect bites including psychosocial concern.

How to identify other residents having the potential to be affected by same deficient practice:

No residents were found affected by the deficient practice. Nursing supervisor and treatment nurse conducted a skin check to identify other resident who may be affected. No similar deficient practice reported.

What measures to be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:

The DON and designee conducted staff re-education and in-service to License Nurses to notify attending Physician when a change of condition is reported. In-service conducted on 10/3/2023.

How the facility plans to monitor its performance to make sure that solutions are sustained.

The medical records will conduct an audit on the reported changes in the communication log to check for SBAR and prompt physician notification. Results of the audits shall be reported in the monthly Quality Assurance Performance Improvement Committee and recommendations monthly for the next 3 months and the quarterly after there after until substantial compliance is achieved.

Compliance Date :

10/3/2023 and ongoing

Person responsible to ensure correction:

Administrator

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F684-Quality of Care
CFR(s): 483.25

Immediate Action:
Resident #205 was provided with a snack – sack on his next hemodialysis schedule and thereafter. There was no report of exhaustion or hunger following hemodialysis.
How to identify other residents having the potential to be affected by the same deficient practice:
No residents were found affected by the deficient practice. The Nursing department will provide a list of residents receiving dialysis with the days and time schedule to the dietary department.
What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:
The DON/designee in-serviced the nursing staff to:

a. Provide a list of dialysis residents to the dietary department. Update the list for new residents and or any changes in dialysis schedule.
b. Nursing shall maintain a calendar list of dialysis resident to include the days and time of dialysis schedule.
c. Nursing staff to ensure that sack lunch is provided prior to departure for dialysis. Residents who declines the sack lunch shall be documented.

In-service conducted on 10/3/23.
How the facility plans to monitor its performance to make sure that solutions are sustained
The DON will report the results of the audits to the Quality Assurance Performance Improvement (QAPI) For review and recommendations monthly for the next 3 months and then quarterly thereafter until substantial compliance is achieved.
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F689-Free of Accident Hazards/Supervision /Devices
CFR(s):483,25(d)(1)(2)

Immediate Action
Resident #11 was assisted with her meals immediately during lunch .There was no episode of coughing or choking observed and reported.
How to identify other residents having the potential to be affected by same deficient practice.
Residents requiring 1:1 assist with meals identified. No similar deficient practice reported.
The DON and the MDS nurse reviewed the residents requiring 1:1 assistance. Staff assignment reflects those residents requiring assistance to maintain appropriate assistance.
Measures and systemic changes to ensure that the deficient practice does not recur :
The DON and DSD completed an in-service to nursing staff to review the staffing assignment which includes the list of residents requiring 1:1 assist with meals. The review of resident care is also included in the shift huddles. The in-service completed on 10/3/2023.
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F755-Pharmacy Services /Procedures/Pharmacy /Records
CFR(s):483.45(a)(b)(1)-(3)

Immediate Action:
Resident #2 medication patch was corrected on 9/30/23.
Resident # 32 medication patch was corrected on 9/30/23.
How to identify other residents having the potential to be affected by the same deficient practice
The DON and designee reviewed and audited residents with orders for medication and no similar deficient practice observed and reported.
Measures and systemic changes to ensure that he deficient practice does not recur :
The DON and designee completed an in-service to license nurses to date all medication patch when applied. In-service conducted on 10/3/23. The Nursing supervisor shall conduct a verification of medication patches dates during clinical rounds. Nursing supervisor shall print a copy of medication patch orders prior to clinical rounds. Nursing supervisor shall record the findings in the adherence tool.
How the facility plans to monitor its performance to make sure that solutions are sustained.
The DON will report the results of the verification audit conducted by nursing supervisor to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations monthly x 3 months and then thereafter until compliance is achieved.
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F812-Food Procurement, Store/Prepare/Serve-Sanitary
CFR(s):486.60(i)(1)(2)

Immediate Action:

A. The Chocolate Cream Squares pan was discarded on 9/29/23.
B. The maintenance supervisor checked the water heater and the setting was 160°F. The RD provided dietary staff training on the procedure for dish washing thru the use of dish machine. The dish machine was checked by an outside technician to assure that it was working properly.
C. The AM Cook staff was provided one-on one education regarding gloves usage by the DSS.

How to identify other residents having the potential to be affected by the same deficient practice

A. The DSS checked the temperature of other food items in the walk-in refrigerator and reach in refrigerator and they registered 41°F.

B. The DSS observed the process in washing the breakfast soiled dishes on 9/30 and the dish machine water temperature was 120°F on the wash cycle and 140°F on rinse cycle.

C. The DSS/RD observed the dietary staff on 9/30 on glove usage practices. The staff performed hand washing before donning the gloves and removing the gloves.

Measures and systemic changes to ensure that he deficient practice does not recur :

A. The RD provided training to all dietary staff regarding the food storage temperature in the refrigerator. The DSS will make random spot checks of the food temperature in the refrigerator twice a week for two weeks and then once a week for two weeks. The RD will check the refrigerated food temperature once a week for a month. The dietary staff will maintain the air curtain in placed of the walk-in refrigerator.

B. The dietary staff will notify the DSS or maintenance supervisor when the dish machine water temperature is out of range. The DSS will observe the dietary staff in washing dishes to ensure compliance once a week for a month. The RD will incorporate on the monthly sanitation report the dish machine water temperature and staff practices on dish washing procedure.

C. The RD provided training to all dietary staff in gloves usage procedure on 9/30. The RD will add on the monthly sanitation report in observing the staff practices of gloves usage and handwashing during tray line services. The DSS will random check the staff in a week on the glove usage practices in a month

How the facility plans to monitor its performance to make sure that solutions are sustained.

This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI). The QAPI Committee will monitor the effectiveness of the interventions and modify the

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interventions as necessary, review staff competency in gloves usage, refrigerated food temperature and dish machine water temperature on monthly basis or as needed to ensure compliance.

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F880- Infection Control and Prevention
CFR(s) 483.80(a)(1)(2)(4)(e)(f)

Immediate Action:

a. Staff involved in failing to handle soiled linen in a safe and sanitary way while providing care to resident #1 was re-educated and in-serviced immediately by IPN and DSD on 9/30/23.
b. Laundry aide involved in reusing isolation gown when sorting soiled linen in the dirty linen room was re-educated and in-serviced immediately by IPN and DSD on 10/1/23.

How to identify other residents having the potential to be affected by the same deficient practice:

No residents were found affected by the deficient practice.

a. The IPN and DSD conducted an observation of CNAs providing care. No similar deficient practice observed and reported.
b. The IPN and housekeeping supervisor conducted an observation of laundry staff sorting soiled linen. No deficient practice observed.

Measures and systemic changes to ensure that the deficient practice does not recur:

a. DON, IPN and DSD conducted a re-education and in-service to CNAs and license staff to observe infection control practices while providing care such and review of safe handling of soiled linen while providing care on 9/30/23, 10/4/23 and 10/5/23.
b. IPN, DSD and housekeeping supervisor conducted a re-education and in-services to laundry staff to observe infection control practices while sorting dirty linen in the dirty linen room on 10/1/23 and 10/4/23.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The DON or IPN will report the results of the adherence monitoring to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations monthly x 3 months and then quarterly thereafter until substantial compliance is achieved.

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Administrator

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the physician regarding insect bites for one of two residents (Resident 34). This deficient practice had the potential to result in lack of necessary care and treatment and place Resident 34 at risk for psychosocial harm. Findings:	F 580		

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F 580	Continued From page 2 During a review of Resident 34's Admission Record (AR), the AR indicated resident was admitted to the facility on 11/3/2022 with diagnoses that included multiple sclerosis (chronic condition that affects your brain and spinal cord) osteoarthritis(condition caused by wearing down the cartilage that covers the ends of bones) and morbid obesity(when a person weighs 100 pounds over the recommended weight). During a review of Resident 34's Minimum Data Set([MDS]standardized screening tool) dated 8/3, 2023, the MDS indicated resident had an intact cognition (thought process) and required one-person physical assist with bed mobility, toilet use and personal hygiene. During a concurrent observation and interview with Resident 34 on 9/29/2023, at 10:09 a.m., observed raised, inflamed red areas on resident's right arm. Resident 34 stated she had mosquito bites on her arm and the bites were itchy. Resident 34 stated she had to cover herself with a blanket always even it was hot in the room at times to prevent getting bitten by mosquito bites. During an interview on 9/30/2023, at 4:01 p.m. with Licensed Vocational Nurse 1(LVN1), LVN1 stated the resident was complaining of itchy mosquito bites on the right arm and he applied hydrocortisone cream (topical medicine used to treat a variety of skin conditions like insect bites) on the affected areas. LVN 1 stated hydrocortisone cream was not ordered by a physician, and he did not notify the physician or document a change of condition (deviation from normal condition). LVN 1 stated he should have notified the physician about Resident 34's	F 580		

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F 580	Continued From page 3 mosquito bites so the resident would be able to receive the right treatment and document a change of condition regarding the mosquito bites so other staff members would know what to monitor on the resident. During a review of Resident 34's Physician Orders indicated no order for hydrocortisone cream to be applied on insect bites. During an interview on 10/1/2023, at 4:19 p.m. with Director of Nursing (DON), DON stated the licensed nurse should have notified the physician about the insect bites and document a change of condition. He stated notifying the physician would help the resident get the right treatment and medicine. During a review of facility's policy and procedure (P/P) titled "Change in a Resident's Condition or Status" revised 9/2021, the P/P indicated the Nurse Supervisor or Charge Nurse will notify the resident's attending physician when there is a significant change in the resident's physical, emotional or mental condition. The P/P indicated Nurse Supervisor or Charge Nurse will record in a resident's medical record information related to changes in the resident's medical condition.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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F 684	Continued From page 4	F 684		

practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to follow physician orders and provide a snack-sack (food items) for one of two sampled residents (Resident 205) who was scheduled to receive hemodialysis (HD, the removing of waste, salt and extra water to prevent build up in the body for residents who have loss of kidney function) treatment on Tuesday, Thursday and Saturday.

This deficient practice had the potential to cause Resident 205 to experience hunger and exhaustion after hemodialysis treatment.

Findings:

During a review of Resident 205's admission record (face sheet), the face sheet indicated resident 205 was admitted to the facility 9/26/2023 with diagnosis of unspecified protein-calorie malnutrition and dependence on renal dialysis.

During a review of Resident 205's history and physical (H&P) report dated 9/28/2023, the H&P indicated Resident 205 had the capacity to understand and make decisions.
During a review of Resident 205's Order Summary Report (OSR), the OSR indicated an order was placed 9/26/2023 for "send snack-sack during dialysis days (Tuesday, Thursday, and Saturday)".

During a review of Resident 205's Nutritional Assessment (NA) dated 9/30/2023, the NA

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F 684	Continued From page 5	F 684		

indicated in the section for registered dietician (RD) assessment, the nourishments (snacks, nutritional supplements) Resident 205 was supposed to receive was a snack-sack during dialysis days.

During an observation on 9/30/2023 at 8:33 a.m., Resident 205 was seen leaving to his HD treatment with the transportation company via wheelchair. Resident 205 did not have a snack-sack with him when he left the facility for his HD treatment.

During an interview on 9/30/2023 at 2:51 p.m., Licensed Vocational Nurse (LVN 3) stated she was not aware if the kitchen provided snack-sacks to HD patients and Resident 205 was not sent with a snack-sack when he left for HD treatment that morning.

During an interview on 9/30/2023 at 2:56 p.m., Resident 205 was laying in his bed post HD and stated he was very "sleepy". Resident 205 stated he was not provided a snack-sack when he left for his HD treatment and he gets hungry and weak after his treatment, so "it would be nice if he was provided a snack-sack to take during treatment." Resident 205 stated he wanted food after his treatment, so his brother visited him and brought him a bean and cheese burrito.

During an interview on 9/30/2023 at 3:02 p.m., the Dietary Service Supervisor (DSS) stated she was unsure if Resident 205 was sent to HD treatment with a snack-sack. The DSS stated HD residents are sent with a snack-sack to their HD treatments because they are there for long periods of time and might get hungry.

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F 684	Continued From page 6 During an interview on 9/30/2023 at 3:42 p.m., Registered Dietician (RD 1) stated the importance of HD residents being provided with a snack-sack during HD treatment was, they wait a long-time during HD treatment, so the facility needs to make sure they are provided with snacks if the resident becomes hungry. RD 1 verified a physician's order was placed for Resident 205 on 9/26/2023 to "send snack-sack during dialysis days." RD 1 stated the kitchen staff arrived at the facility around 5:30 a.m. and if a snack-sack was not provided by kitchen staff the night prior, the nursing staff could call the kitchen and request a snack-sack prior to the resident leaving for their HD treatment. During an interview on 10/1/2023 at 3:38 p.m., with the Director of Nursing (DON) stated all physicians' orders needed to be carried out and the importance of following physician's orders was the resident receiving proper care. The DON stated the importance of providing a snack-sack to HD residents was, after a resident receives HD their health condition lowers and they become tired, so the snack helps to regain some energy lost during HD treatment. During a review of the facility's policy and procedure (P/P) titled "Meal Service: Packed/ Boxed Meals" dated 2018, the P/P indicated there was times when a resident needed to leave the facility for an appointment and needed to have a meal sent with them. The P/P indicated the nursing department was to notify the kitchen department preferably 24 hours in advance, of the resident's need for a packed/ boxed meal.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 7 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure to assist Resident 11 that was on one to one supervision (1:1 a nurse who is assigned solely to one Resident) during lunch time for one of one sample resident. This deficient practice had the potential to put Resident 11 at risk for choking or aspiration (have severe difficulty in breathing because of a constricted or obstructed throat or a lack of air). Findings : During a review of Resident 11's admission record (face sheet) , the face sheet indicated Resident 11 was originally admitted to the facility on 3/22/2021 and re-admitted on 2/3/ 2023 with diagnosis that included a history of Alzheimer's Disease (a progressive disease that destroys memory and other important memory functions) , Hemiplegia , unspecified affecting the left dominant side (paralysis), and dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or throat). During a review of Resident's 11 history and physical (H&P) reported date 3/17/2023, the H&P	F 689		

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F 689	Continued From page 8 indicated Resident 11 does not have the capacity to understand and make decisions. During a review of Resident 11's Order Summary Report I (OSR) , the OSR indicated Resident 11's diet dated 4/30/2023 was a Fortified diet pureed (a way to change the texture of solid food so that it is smooth with no lumps and has a texture like pudding)texture, thin consistency 1:1 assist with meals no straws family may bring in outside food that patient is comfortable eating. A review of t Resident 11's the Speech Therapy (ST) SLP Evaluation and Plan of Treatment dated 4/10/2023 , indicated Resident 11 's oral motor structure and function was impaired and cognitive communicative skills impaired. Resident 11's overall swallowing abilities indicates she needs minimal close supervision with staff. A review of the Interdisciplinary Team (IDT) Care Conference on 8/24/2023 for Resident 2 , indicates Resident 11 is at risk for aspiration (the accidental ingestion of food or solid into the trachea (windpipe) and lungs. During an observation on 9/28/2023 at 12:57 p.m. in Resident 11's room 26 A, Resident 11 was in bed in an upright position feeding herself there was no available staff around . At 1:15 p.m. Certified Nurse Assistant (CNA 3) step inside the room and left the room. During an interview on 9/28/2023 at 3:25 p.m. with CNA 2, CNA 2 stated the sign above Resident 11's head was for aspiration precaution . CNA 2 stated Resident 2 was a one-to-one assist which means CNA 2 must always stay and assist	F 689		

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F 689	Continued From page 9 Resident 11 at all times during meals CNA 2 stated Resident 11 can choke while eating. During a record review of the care plan(CP) titled " Alteration in nutritional status" initiated 3/22/2021, the CP indicated !:1 feeding assistance.During an interview on 9/28/2023 at 3:30 p.m. with the Licensed Vocational Nurse, (LVN 3) stated Resident 11 needs supervision with her meals due to aspiration precautions. LVN3 stated Resident 11 can eat on her own, LVN 3 she stated we promote independence for the Resident's . LVN 3 Stated Resident 11 must be supervised with meals and is on aspiration precautions which means there must be a CNA/LVN present at the bedside at all times assisting with feeding Resident 11. During an interview on 10/1/2023 at 1:30 p.m. with the Director of Nursing (DON), the DON stated Resident 11 is on aspiration precaution and careplan indicated 1:.1 assistance ,which means Resident 11 is at risk for choking if not properly supervised. The Don stated when a Resident is on aspiration precaution the head of the bed needs to be up 90 degrees and a nurse needs to be at that Resident 11's bedside to keep them safe . During a review of the facility's policies and procedure (P&P) titled," Dysphagia - Clinical Protocol", revised 9/2021 the P&P, indicated, monitoring, and preventing aspiration staff .Provide supervision and assistance as needed during mealtime based on assessment, to ensure resident is sitting in upright position and not rushing resident during mealtime.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 10 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff follows the policies and procedure (P& PP) for the application of medication patches for two out of	F 755		

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F 755	Continued From page 11 two sampled residents (Resident 2 and Resident 32), by not putting the Licensed Vocational Nurse(LVN) initial and dating the medication patches. This deficient practice had the potential for Resident 2 and Resident 32 to have the medication patch on for the incorrect time ordered by the physician. Findings: A. During a review of Resident 32's admission record (face sheet), the face sheet indicated Resident 32 was admitted to the facility on 3/9/2021 with diagnosis of muscle weakness and unspecified osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), unspecified site. During a review of Resident 32's history and physical (H&P) report dated 12/30/2022, the H&P indicated resident 32 had the ability to understand and make decisions. During a review of Resident 32's Order Summary Report (OSR), the OSR indicated an order for Lidoderm patch (lidocaine, topical [used on outside of body] pain medication) 5%- apply to left neck topically one time a day for muscle spasms, dispose by folding in half and discard in sharps container, remove per schedule (apply at 9 a.m., remove at 9 p.m.) was ordered on 7/26/2023. During a medication pass observation on 9/30/2023 at 8:12 a.m., Licensed Vocational Nurse (LVN 4) applied the lidocaine 5% patch to the left side of Resident 32's neck. The lidocaine patch was not initialed and dated by LVN 4.	F 755		

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F 755	Continued From page 12 During an interview on 9/30/2023 at 11:50 a.m., Resident 32 stated the patch is applied in the morning during the med pass for neck pain and then it is removed by the night shift LVN. During an interview on 9/30/2023 at 11:53 a.m., LVN 4 stated she did not initial or date the medication patch for Resident 32 when it was applied. LVN 4 stated the importance of initialing and dating the medication patch was to inform the next shift when it was applied so it could be removed on time. During an interview on 10/01/23 03:21 p.m., the Director of Nursing (DON) stated the importance of labeling a medication patch was the date was to know when it was applied so it can be taken off or new one applied when necessary. B.During a review of 2's admission record (face sheet) indicated Resident 2 was originally admitted to the facility on 2/2/2019 and re-admitted on 3/29/ 2021 with diagnosis of type 2 Diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar for fuel), Hemiplegia and hemiparesis following cerebral infarction affecting the right side (disrupted blood flow to the brain that caused the right side of the body to become paralyzed), and chronic pain (persistent pain that last weeks to years). During a review of the Resident 2's Minimum Data Set (MDS- a comprehensive assessment tool) dated August 10,2023, indicated Resident has intact cognition. Resident 2 required extensive assistance (weight bearing support including lifting limbs by 1 helper) with transfer,	F 755		

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F 755	Continued From page 13 bed mobility(moving in bed), Locomotion on the unit . During a review of Resident 2's Order Summary Report (OSR) for the month of 10/2023 indicated Lidoderm patch 5 % apply to (lidocaine, topical [used on outside of body] pain medication) 5%- apply to left knee topically one time a day for pain, dispose by folding in half and discard in sharps container and remove per schedule apply at 9:00 a.m. ordered 4/29/2023. During a medication pass observation on 9/30/2023 at 9:13 a.m., in room 25A Licensed Vocational Nurse (LVN 3) was observed applying a Lidoderm patch to Resident 2's right knee. The package was disposed of, and the lidocaine patch was not initialed or dated. During an interview on 9 30/2023 at 10:40 a.m., LVN3 stated she forgot to label and date the Lidoderm 5 % patch to Resident 2's Left knee. LVN 3 stated I was taught to label and date the patch in school because it shows proof the task was done. During an Interview on 9/30/2023 at 12:52 a.m. with the Registered Nursing Supervisor RNS), RNS stated the process for administrating the Lidoderm patch 5% is after checking the order and placing the patch to the right site you must sign and date the patch. LVN stated the importance of dating and signing the patch so you will know the next time to administer the patch LVN stated it is the protocol. During an interview on 9/30/2023 at 2:30 p.m. with the Director of Nursing (DON) , DON stated most of my nurses do label the Lidoderm patch .	F 755		

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F 755	Continued From page 14 DON stated the importance of signing and dating the patch, to see the effectiveness of the medication patch and how it absorbs into your blood stream and last for 12 hours. Don stated you will need to know how long the patch has been on. During a review of the facility's policy and procedure (P/P) titled "Specific Medication Administration Procedures" dated 10/2019, the P/P indicated medication patches needed to be labeled with the date and nurse's initial.	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to:	F 812		

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F 812	Continued From page 15 a.Ensure chocolate cream squares in the freezer maintained a temperature of 41 Fahrenheit ([F] unit of measurement) or below. b.Ensure the dishwashing machine was running at the proper temperature. c.Ensure the Cook performed hand hygiene after removal of gloves during food preparation. These deficient practices had the potential to place residents at risk for food borne illness (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites). Findings: a.During the initial observation of the kitchen on 9/29/2023 at 8:10 a.m. with the Cook (CK1), a tray of chocolate cream squares was on the freezer with a temperature of 43 Fahrenheit ([F] unit of measurement). CK 1 stated the chocolate cream squares will be served during dinner. During a concurrent observation and interview on 9/29/2023, at 12:00 p.m. with Dietary Service Supervisor (DSS), chocolate cream squares remained on the freezer with a temperature of 44 F. DSS stated the chocolate cream squares would be thrown out and not served to the residents because it was not the right temperature, and the residents could get sick from it. During a review of facility's policy and procedure (P/P) titled" Sanitation and Infection Control", the P/P indicated to keep cold foods cold (below 41 degrees F) to prevent food borne illness.	F 812		

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F 812	Continued From page 16 b. During a concurrent observation and interview on 9/30/2023, at 8:52 a.m. with Dietary Aide (DA1), DA ran the dishwashing machine with the two dirty coffee pitchers and temperature was 106 degrees Fahrenheit. Observed DA ran the dishwashing machine, and it won't reach the desired temperature. DA run the dishwashing machine for three times to actually reach the temperature of 123 degrees F. DA stated the temperature of the dishwashing machine should be 120 to 140 degrees F to kill the bacteria on the dishes. During an interview on 9/30/23, at 9:00 a.m. with DSS, DSS stated the temperature of the dishwasher should be 120 F to prevent food-borne illness. DSS stated that she will have someone check it. During an observation of the dishwashing machine on 9/30/23, at 9:00 a.m. indicated the dishwashing machine operational requirements should be a minimum temperature of 120 degrees F for wash and rinse. During a review of facility's Dishwashing Operational Manual, the manual indicated once the water level is established temperature should be 120 degrees F as the minimum temperature, but manufactures' manual recommended 140 degrees F. During a review of facility's P/P titled" Sanitation and Infection Control about Dishwashing Machine," undated, the P/P indicated the dish machine may be low or high temperature. The P/P also indicated chemical low temperature dish- machines must reach a water temperature	F 812		

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F 812	Continued From page 17 of 120 degrees F to 140 degrees F. c.During a tray line observation, CK 2 put on gloves to cut up cooked porkchops in a chopping board and placed the chopped pork chops on a plate. CK 2 removed gloves and then proceeded placing food items on residents' plates. CK2 did not do hand washing before donning and after removal of gloves. During an interview on 9/30/2023, at 1:36 p.m. with Registered Dietician (RD), RD stated CK 2 should have washed hands before and after wearing gloves because of cross contamination and residents could be at risk for food borne illness thru ingestion of contaminated food. During a review of facility's policy and procedure(P/P) titled "Sanitation and Infection Control" undated, the P/P indicated food service workers are educated on the importance of handwashing to prevent cross contamination of food supplies and equipment. The P/P stated food service employees should wash hands before and after handling foods and after handling soiled dishes and utensils. During a review of facility's P/P titled "Food Preparation" undated , the P/P indicated hands must be washed prior to putting on gloves and any glove changes.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

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F 880	Continued From page 18 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 19 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to observe infection control measures by failing to: a.Handle soiled linens in a safe and sanitary way by leaving a plastic bag with soiled linens on the floor while providing care to a resident (Resident 1). b.Ensure Laundry Aide did not reuse isolation gown (specialized clothing worn by an employee for protection against infectious materials) when sorting soiled linens in the dirty linen room. These deficient practices had the potential to result in cross contamination(physical movement or transfer of harmful bacteria from one person,	F 880		

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F 880	Continued From page 20	F 880		

object, or place to another) and placed residents and staff at risk for infection.

Findings:

a.During a review of Resident 1's Admission Record indicated resident was admitted on 1/15/2021 with diagnoses that included hypertension (high blood pressure) scoliosis(abnormal curvature of the spine) atherosclerotic heart disease(thickening or hardening of blood vessels that carry oxygen and nutrients to the heart) and rheumatoid arthritis (immune system attacks healthy cells in the body by mistake causing painful swelling in the affected parts of the body).

During a review of Resident 1's Minimum Data Set ([MDS] standardized screening tool) 7/14/2023 indicated resident had severely impaired cognition (deterioration or loss in intellectual capacity that affects thought processes like thinking, remembering, learning new things, concentrating and making decisions) and required one person assist with bed mobility, eating, toilet use and personal hygiene.

During a concurrent observation and interview with Certified Nursing Assistant (CNA1) on 9/29/2023, at 10:48 a.m., observed Resident 1's curtain was closed, and a plastic bag filled with linens was on the floor next to Resident 1's bed. CNA 1 was observed to picked up the plastic bag from the floor and brought them out from the resident's room. CNA1 stated the plastic bag was filled with soiled linens used during Resident 1's bed bath (bathing a patient who is confined to bed and unable to bathe or wash self).

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F 880	Continued From page 21 During an interview on 9/29/2023, at 1:19 p.m. with CNA1, CNA1 stated she forgot that she had placed the plastic bag with soiled linens in the floor. CNA 1 stated she should have placed the plastic bag with soiled linen in the foot of the bed and she should not left it laying on the floor to prevent the spread of infection. During a subsequent interview on 9/29/2023, at 1:41 p.m. and on 10/1/2023, at 12:23 p.m. with Infection Preventionist Nurse (IPN), IPN stated CNA1 should have placed the soiled linens in a hamper or cart and not lay them on the floor because the infection should be contained to prevent spread of infection and cross contamination. During a review of facility's policy and procedure (P/P) titled" Laundry, Bedding and Soiled Linen," revised 1/2020, the P/P indicated all used laundry is handled as potentially contaminated until it is labeled and properly bag for appropriate processing. The P/P indicated contaminated laundry is placed in a container at the location where it is used. b.During a concurrent observation and interview on 10/1/2023, at 8:31 a.m. with Laundry Aide (LA1), a yellow nylon isolation gown was hanging at the back of the door of soiled linen room. LA 1 stated she sorted the dirty linens in this room and reused the same isolation gown hanging at the back of the door for 8 hours. LA 1 stated after she sorted the linens and clothes of residents , she would take off the isolation gown and hang it back on the door, practiced hand hygiene and bring the soiled linens and clothes to the washers.LA 1 stated she was also responsible in placing the washed linens and clothes in the dryer and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555785	A. BUILDING _____ B. WING _____	10/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 22 afterwards folding them in the clean linen room. During an interview on 10/1/2023, at 8:38 a.m. with IPN, IPN stated the Laundry Aide should have not reused the isolation gown when sorting out the soiled linens and should have discarded the used gown. IPN stated LA1 should put a new gown each time soiled linens and clothes are sorted to prevent spread of infection among the residents. During an interview on 10/1/2023, at 4:19 p.m., with Director of Nursing (DON), DON stated reusing isolation gowns when sorting soiled linens in the laundry room is not recommended because of possible spread of infection. During a review of facility's P/P titled "Personal Protective Equipment-Using Gowns" revised 9/2021, the P/P indicated gowns are used to prevent spread of infection, soiling of clothing with infectious material and exposure to blood and body fluids. The P/P indicated to use gowns only once and then discard it into an appropriate receptacle inside the room. During an online article from CDC titled "Linen and laundry Management" Appendix D: Linen and Laundry Management | Environmental Cleaning in Global Healthcare Settings | HAI | CDC reviewed 5/4/2023, indicated never carry soiled linen against the body, always place in a designated container and do not transport soiled linen by hand outside the specific patient care area from where it was removed.	F 880		