STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37393 Based on interview and record review the facility failed to develop a comprehensive care plan for one of 36 sampled residents (Residents 58). Resident 58, who had a history of two prior choking incidents, dysphagia, no teeth, hastily eating, and a risk of aspiration did not have a care plan to address her impulsive behaviors of stealing food. This deficient practice resulted an ineffective plan of care for Resident 58, who stole a contraindicated food item (peanut butter sandwich) from another resident which resulted in her choking and unexpected death on [DATE]. Findings: During a review of Resident 58's Admission Record (Face Sheet), the face sheet indicated the facility admitted Resident 58 on [DATE] and readmitted on the resident on [DATE]. Resident 58's diagnoses included morbid obesity, dysphagia (difficulty swallowing), chronic respiratory failure (syndrome in which the respiratory system fails in proper gas exchange function), diabetes mellitus II (a long-term metabolic disorder that is characterized by abnormally high blood glucose, insulin resistance, and relative lack of insulin), chronic obstructive pulmonary disease [(COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs], and disorganized schizophrenia (disorganized behavior and speech that includes disturbance in emotional expression with hallucinations, delusions, with characteristics of distorted thinking or altered perceptions of reality). During a review of Resident 58's quarterly Minimum Data Set (MDS), a resident assessment and care screening tool, dated [DATE], indicated Resident 58 had mild memory problems, was able to make needs known and understood others. According to the MDS Resident 58 required supervision during eating, and required a mechanically altered therapeutic diet. During a review of Resident 58's care plan initiated on [DATE] and revised on [DATE], identified a problem with COPD related to risk for respiratory distress. The goal indicated that Resident 58 would display optimal breathing pattern daily through review date of [DATE]. The staff interventions included monitor for difficulty breathing (dyspnea) on exertion, and remind Resident 58 not to push beyond endurance, monitor for signs /symptoms of acute respiratory insufficiency, anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, and somnolence. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 58's care plan initiated on [DATE] and revised on [DATE], identified a problem with eating a cheese sandwich and suddenly was gasping for air related to choking episode related to Resident 58 eating too fats, gobbles food in one bite, shoves food in mouth, screams for food, poor safety awareness, and has no teeth. The goal indicated that Resident 58 would be free from complications of aspiration through the next review date of [DATE], and Resident 58 would have no choking episodes daily until the next review date of [DATE]. The staff interventions included dental consultation with follow-up, diet downgraded on [DATE], encourage Resident 58 to take small bites, liquids after solids, chin tuck for swallowing, keep in upright position during eating, follow-up for speech therapy evaluation [DATE], observe for any signs of choking, instruct Resident 58 not to eat so fast or talk with food in her mouth, speech therapy to monitor during mealtime as needed revised on [DATE], initiate Heimlich maneuver (procedure for dislodging an obstructed item from a person's windpipe using strong abdominal thrusts to expel air from the lungs), and call 911 emergency services. During a review of Resident 58's care plan initiated on [DATE], identified a problem with low sodium carbohydrate controlled diet mechanical soft small portion for weight management. The goal indicated Resident 58 would be within an ideal bodyweight. The staff intervention was to monitor meal intake every shift. During a review of Resident 58's clinical records, there was no care plan available to address Resident 58's risk for aspiration related to dysphagia. During a review of Resident 58's clinical records, there was no care plan available to address Resident 58's behaviors of stealing food from other residents. During a review of Resident 58's clinical record indicated Resident 58 had two prior choking incidents at the facility on [DATE] and on [DATE]. During an interview on [DATE] at 5:08 p.m., Registered Nurse (RN 1) stated she has worked with Resident 58 in the past and knew Resident 58 had dysphagia choked before on a cheese sandwich. RN 1 stated Resident 58 grabbed another resident's sandwich and choked while eating the sandwich. RN 1 stated Resident 58 likes to eat a lot. RN 1 acknowledged a care plan should have been created to address Resident 58's behaviors of stealing food from other residents due to Resident 58 having two other choking incidents in the past. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Care Plan, Baseline and Comprehensive, revised ,d+[DATE], the policy indicated it is the policy of this facility to develop, upon admission and following completion of the Admission Nursing Assessment, an interim and comprehensive care plan for the resident. The policy indicated a baseline care plan will be implemented within 48 hours of admission. Addresses immediate resident needs including: Initial goals based on admission orders, Physician Orders, Dietary Orders, Therapy Services, Social Services and PASARR recommendations, if applicable. The policy indicated a comprehensive person-centered care plan consistent with residents' rights will include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment. If applicable, any services provided as a result of PASARR recommendations as well as rationale if facility disagree with the findings of PASARR. Goals for admission and desired outcomes.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37393 Based on observation, interview, and record review, the facility's staff failed to ensure the residents who were at risk for choking and aspiration (breathing in a foreign object [food] into the airway) were supervised during eating and received their prescribed diet for four (4) of 35 sampled residents (Residents 58, 195, 30 and 88). a. Resident 58, who had a diagnosis of dysphagia (difficulty swallowing), had no teeth and exhibited behaviors of stealing food from other residents, had a history of choking that required emergency procedures, was not supervised, and took a sandwich not prescribed on Resident 58's diet texture and choked and was unable to be resuscitated (revived). b. Resident 195, who required assistance with eating and had a diagnosis of dysphagia, dementia (memory loss), gastro-esophageal reflux disease ([GERD] reflux of the stomach contents into the esophagus (the tube that carries food and liquids from your mouth to the stomach), causing heartburn and regurgitation (spitting up of food from the esophagus or stomach]), was observed eating while lying flat in bed with coffee spilled over the resident's clothing. c. Resident 30, who had diagnoses including dementia and dysphagia, a history of taking food and other objects and placing them into his mouth, was documented to be at risk for choking and aspiration. Resident 30 was observed unsupervised while putting sugar packets, gloves, and food in his mouth from another resident's tray. d. Resident 88, who had diagnoses including dysphagia, GERD, impaired cognition (thought process), was identified as being at high risk for choking and aspiration, was observed eating another resident's prescribed diet tray while eating unsupervised in the room. This deficient practice resulted in Resident 58, who had two prior choking episodes in the facility ([DATE] [donut] and [DATE] [cheese sandwich]) choked on a peanut butter sandwich and aspirated, leading to Resident 58's unexpected death. This deficient practice placed Residents 195, 30, and 88, who were at risk for choking and aspirating due to dysphagia, at risk for the potential of adverse consequences of harm and/or death. On [DATE] at 5:19 p.m., in the presence of Registered Nurse supervisor (RN 3), Administrator (ADM), and the Director of Nursing (DON), an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation has caused, or likely to cause, serious injury, harm, impairment, or death to a resident) was declared due to lack of adequate supervision to prevent accidents of aspiration and chocking. On [DATE], the facility provided an acceptable Plan of Action (POA), which include the following actions: 1. The facility's licensed nurses will closely supervise residents with a prescribed diet and with behaviors of grabbing food from other residents or eating food incompatible with the prescribed diet during meals and snack times. A list of residents observed with a history of grabbing food will be provided in each nursing station. The licensed nurses will supervise the distribution of meals and snacks to ensure that meals and snacks are given to the correct resident and as prescribed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. The speech therapy (ST) screening was initiated on [DATE] for all residents (total of 60) on an advanced dysphagia diet, completed on [DATE]. 3. Speech Therapy evaluations were initiated on [DATE] for residents identified during the screening process to be completed by [DATE], with remaining residents pending insurance authorizations. The facility will downgrade diets for residents recommended for Speech Therapy evaluation due to the risk of aspiration. Any adverse findings will be communicated to the attending physician and the facility Medical Director. 4. Attending physicians were notified by [DATE] of the choking incident at the facility; physicians will inform the facility of residents at high risk of choking and/or aspiration and collaborate with the facility to update the plan of care during monthly visits. 5. An audit initiated on [DATE] by the Dietician and Assistant Dietician regarding all advanced dysphagia diets to ensure diets are current, food and snacks are labeled appropriately; audit completed on [DATE]. 6. The facility's licensed nurses to check food trays for proper diet before a Certified Nursing Assistant (CNA) distribute food trays to the residents. Director of Staff Development to an in-service facility licensed nurses on diet tray check and supervision during mealtime/nourishments. Initiated in-services on [DATE]; the goal of completion by [DATE]. 7. The Director of Staff Development (DSD) will make rounds and document licensed nurses' compliance and CNA competencies during mealtimes and report any findings to the Quality Assurance (QA) committee for three months. The QA Committee will evaluate results until substantial compliance is attained. 8. The licensed nurses will be stationed in the dining rooms and will round residents' rooms during mealtimes for residents requiring assistance during mealtime. The licensed nurses will also round in residents' rooms during meal and nourishment for three months. 9. In-services initiated by Dietician and the Assistant Dietician on [DATE] for the licensed nurses and CNAs on a review of the dysphagia advanced diet principles; reading meal tickets and snack labels; the importance of supervision and proper positioning during meals; checking for adaptive equipment on a tray, and reporting residents who have any difficulty chewing or swallowing to a nursing supervisor. Re-education was initiated on [DATE] with a goal of completion by [DATE]. 10. Initiated physicians' orders for all residents on advanced dysphagia diets for the head of bead (HOB) to be elevated to (high [NAME] position [lying on back with the head and trunk raised to between 15 and 45 degrees]) [DATE]. The goal is to complete by [DATE]. Occupational and Speech Therapy to reeducate CNAs on proper positioning; will initiate on [DATE]; the goal of completion by [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11. The occupational therapist (OT) and speech therapist (ST) make daily rounds to assess any residents with difficulty swallowing. Rehabilitation Department will document any findings and report them to the Quality Assurance Committee for three months. Findings will be evaluated with the QA committee until substantial compliance is attained or observed. Daily results will be reported to the Administrator and Director of Nursing. 12. The facility's Medical Director will review any incidents related to choking at QA meetings monthly. The ST will assess residents quarterly and report any findings associated with swallowing at the QA committee. The Medical Director will be notified of residents at risk. The ST will report results on residents at risk for dysphagia for any decline or improvement monthly and report findings to the QA committee. 13. For the residents with advanced dysphagia, the facility created a task in the CNA's Plan of Care Daily Task to ensure the head of the bed is elevated during mealtimes and nourishments; initiated [DATE], the goal of completion by [DATE]. In addition, the ST and OT are assigned to do meal rounds to identify residents at risk for choking and to monitor residents who are currently on an advanced dysphagia diet to ensure the plan of care is in practice. The Administrator will monitor to ensure the POA is implemented. The IJ was removed on [DATE] at 6:26 p.m., after the team, while onsite, verified the POA was implemented via observation, interview, and record review. Findings: a. During a review of Resident 58's Admission Record (Face Sheet) indicated the Resident 58 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), chronic respiratory failure (a syndrome in which the respiratory system fails in proper gas exchange function), chronic obstructive pulmonary disease [(COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs], and disorganized schizophrenia (disorganized behavior and speech that includes disturbance in emotional expression with hallucinations, delusions, with characteristics of distorted thinking or altered perceptions of reality). During a review of Resident 58's quarterly Minimum Data Set (MDS), a resident assessment and care screening tool, dated [DATE], indicated Resident 58 had mild memory problems but could make needs known understood others. According to the MDS, Resident 58 required supervision during the meal and required a mechanically altered therapeutic diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 58's untitled care plan, initiated on [DATE], and revised on [DATE], indicated the resident had an episode of suddenly gasping for air related to choking episode while eating a cheese sandwich, eating too fast, gobbling food in one bite, shoving food in the mouth, screams for food, had a poor safety awareness, and had no teeth. This care plan goal for Resident 58 was to remain free from complications of aspiration and not to have choking episodes daily until the next review date on [DATE]. This plan of care interventions included for the resident to have a dental consultation with a follow-up, diet downgraded on [DATE], encourage Resident 58 to take small bites, liquids after solids, chin tuck (position used to delayed swallowing reflexes) for eating, keep in the upright position during eating, follow-up for speech therapy evaluation on [DATE] and ST to monitor during mealtime as needed. Per this care plan, the staff's intervention included to initiate the Heimlich maneuver (procedure for dislodging an obstructed item from a person's windpipe using strong abdominal thrusts to expel air from the lungs) and call 911 emergency services. During a review of Resident 58's clinical records indicated no care plan to address Resident 58's risk for aspiration related to dysphagia and behavior of taking other residents' food. During a review of Resident 58's Order Summary Report for [DATE], the report indicated a physician order, dated [DATE], for a diet of consistent carbohydrates for dysphagia with advanced texture and thin liquids consistency. During a review of Resident 58's NPNs indicated that Resident 58 had two prior choking incidents at the facility on [DATE] and [DATE]. During a review of Resident 58's nursing progress note (NPN), dated [DATE] and timed at 3:03 p.m., indicated the staff reported Resident 58 was choking while sitting on a bench on the patio. According to the NPN, the staff initiated the Heimlich maneuver on Resident 58. A crash cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations) was brought, and the staff removed the donut from Resident 58's mouth. A review of the NPN dated [DATE] indicated Resident 58 was given oxygen and could breathe on her own, and a swallow evaluation was ordered. During a review of Resident 58's Interdisciplinary ([IDT] approach with the core team consisting of the resident and various professional team members working toward a common goal for a resident) meeting note, dated [DATE] and timed at 9:49 a.m., the IDT note indicated the IDT met and discussed Resident 58's choking incident. According to this IDT meeting note, staff immediately intervened, performed the Heimlich maneuver, and was able to dislodge the donut from Resident 58's mouth. The IDT recommendations were for staff education on safety, supervision of Resident 58 during meals, and the resident to have a swallowing evaluation. During a review of Resident 58's NPN, dated [DATE] and timed at 10:38 p.m., the NPN indicated Resident 58 had a second choking episode while eating a sandwich and was gasping for air. This NPN indicated the staff immediately paged code blue (a quick way to tell the staff a resident is experiencing a life-threatening medical emergency) and called 911. According to this NPN, the staff initiated the Heimlich maneuvers immediately, and Resident 58 could cough out the sandwich. The NPN indicated Resident 58 was transferred to a general acute care hospital (GACH) via 911 emergency services. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 58's rehabilitation speech therapy (ST) screening, dated [DATE], the ST screening indicated a ST rehab referral was made due to Resident 58's choking incident. The ST rehab screening indicated a change in Resident 58's swallowing status, which required a dysphagia evaluation. Resident 58 required a speech evaluation warranted to assess and determine the least restrictive diet to reduce the risk for future choking or aspiration incidents. During a review of Resident 58's IDT meeting note, dated [DATE] and timed at 10:26 a.m., indicated the IDT met and discussed Resident 58 choking on a cheese sandwich on [DATE]. According to the IDT meeting note, the staff immediately intervened and performed the Heimlich maneuver, and removed cheese sandwich particles from Resident 58's mouth. Resident 58 was transported to GACH. The IDT recommendations included follow-up with a speech evaluation, downgrade diet, and encouraging Resident 58 to take a small bite. During a review of Resident 58's Rehabilitation (rehab) Evaluation and Plan of Treatment, dated [DATE], indicated a referral was made for the evaluation due to dysphagia and choking incidents. A review of the rehab evaluation indicated Resident 58 had a swallowing dysfunction for feeding due to agitation, confusion, and aspiration risk. The rehab evaluation recommendations included a mechanical soft texture diet (foods that can be easier to chew and swallow), thin liquids, and close supervision for all oral intakes. During a review of Resident 58's late entry (L/E) NPN, dated [DATE] and timed at 3:55 p.m., indicated a Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse (LVN 12) on [DATE] Resident 58 was choking once outside on the patio. The NPN indicated LVN 12 went to check on Resident 58 and saw the resident in a wheelchair while the staff attempted to perform the Heimlich maneuver. The NPN indicated Resident 58's was slumped (sit, lean, or fall heavily and limply, especially with a bent back) down, and the resident was not responding to verbal or tactile (touch) stimuli. The L/E NPN indicated Resident 58's mouth was examined, and there were no food particles found. The staff wheeled Resident 58 back to her room and placed Resident 58 on the bed and an assessment was done and indicated Resident 58 was not breathing and had no carotid pulse (pulse felt over the carotid artery on the neck). Resident 58 was placed on the floor, and cardiopulmonary resuscitation ([CPR], an emergency life-saving procedure that is done when a person stops breathing or heartbeat has stopped) was initiated. The NPN indicated a code blue, and 911 was called. According to the NPN, at 8:25 p.m.) the paramedics arrived and took over CPR until 9:13 p. m. Resident 58 expired on [DATE], and the family and physician were informed. During a review of Resident 58's Death Record, dated [DATE], the record indicated Resident 58's body was released to the mortuary at 9:30 p.m. During an interview on [DATE] at 12:44 p.m., the speech language pathologist ([SLP] work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing .) stated Resident 58 required controlled feeding strategies due to having dysphagia. The SLP stated Resident 58 needed more awareness for eating slower and alternate liquids with solids to clear her oral cavity, so there was no food pocketing (keeping some food in the cheeks or back of the mouth rather than swallowing entirely). The SLP stated a care plan for Resident 58's eating fast and gobbling down food was created, but there was no care plan for aspiration related to dysphagia. The SLP stated Resident 58 should have had a care plan to address her dysphagia and the risk for aspiration. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:46 p.m., Licensed Vocational Nurse 12 (LVN 12) stated he was at the nursing station and overheard a staff member call out yelling Resident 58 was choking on the patio. LVN 12 stated he ran out and saw Resident 58 in her wheelchair and saw CNA 1 doing the Heimlich maneuver. LVN 12 stated he asked what happened and was told Resident 58 was choking on food. LVN 12 stated Resident 58 was not breathing, and her head was hanging over with her eyes partially open. LVN 12 stated he checked the resident's mouth and did a finger sweep, and there was no food. LVN 12 stated he, with other staff members, wheeled Resident 58 to her room. LVN 12 stated Resident 58 was transferred to the bed to start CPR. LVN 12 stated code blue was called, and other staff members brought the crash cart. LVN 12 stated he continued to the Heimlich maneuver and removed particles of chewed bread after doing another finger sweep of Resident 58's mouth. LVN 12 stated Resident 58's mouth was checked again, and her mouth was clear. LVN 12 stated they placed Resident 58 on the floor with a backboard after she had no carotid (neck) pulse and started CPR. LVN 12 stated Resident 58 had a physician's order for an advanced dysphagia diet. LVN 12 stated Resident 58 was always hungry, and she would bang on the glass window at the nurses' station while constantly yelling, Where is my food? LVN 12 stated the residents are offered snacks before the cigarette break at 8:30 p.m. LVN 12 stated he does not know where Resident 58 got the peanut butter sandwich. During an interview on [DATE] at 5:08 p.m., Registered Nurse 1 (RN 1) stated she responded to the code blue right away and went to Resident 58's room. RN 1 stated she called 911 while the other staff was performed CPR on Resident 58. RN 1 stated she has worked with Resident 58 and knew Resident 58 had dysphagia and had choked before on a cheese sandwich. RN 1 stated Resident 58 grabbed another resident's cheese sandwich and choked while eating the sandwich. RN 1 stated Resident 58 likes to eat a lot. RN 1 stated the snacks are labeled for special diets. RN 1 stated Resident 58 receives a pudding, and soft bread with peanut butter filling cut into pieces. RN 1 stated a staff member distributes the food snacks for the residents on special diets. RN 1 stated a care plan should have been created to address Resident 58's behaviors of stealing food from other residents due to Resident 58 having two other choking incidents in the past. During an interview on [DATE] at 5:21 p.m., the Kitchen Manager (KM) stated the special diet snacks are labeled for each resident with their name, and the snack choices vary daily. During an interview on [DATE] at 9:17 a.m., the KM stated the kitchen typically serves snacks listed in the Diet and Nutrition Care Manual, including for Resident 58. The KM stated Resident 58's choices included gelatin, pudding, or yogurt for a snack. The KM stated Resident 58 should have never had a sandwich because the item was not listed on her diet ticket, as it was not a part of Resident 58's advanced dysphagia diet. During an interview on [DATE] at 10:57 a.m., the Speech-Language Pathologist (SLP) stated she did not know of Resident 58's behaviors of stealing food from other residents. Still, she was aware of Residents 58's behaviors of eating her food quickly. The SLP stated Resident 58 was on an advanced dysphagia diet and had difficulty eating and swallowing because she had observed Resident 58 at mealtime. The SLP stated she had not evaluated Resident 58 for a swallow evaluation and acknowledged Resident 58 should have received a recent swallow evaluation. The SLP stated the standard of practice for evaluation was quarterly for residents with dysphagia. The SLP reviewed Resident 58's most recent swallow evaluation and stated it was over 11 months ago, on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:39 p.m., CNA 1 stated he had known Resident 58 since 2017 and remembered the resident because he performed the Heimlich maneuver in 2017 when Resident 58 choked on a donut. CNA 1 stated Resident 58 has a behavior of stealing food from other residents, and the resident stole a donut and choked on it. CNA 1 stated they would place Resident 58 separately at another table from other residents because she would grab their food and eat the food very fast. CNA 1 stated that on the night of [DATE], Resident 58 followed him to the patio in her wheelchair and gave her the evening snack. CNA 1 stated he gave Resident 58 a pudding, yogurt, and milk for her snack. CNA 1 stated Resident 58 was supposed to be closely supervised while eating and during the smoking break because she would take food or cigarettes from other residents. CNA 1 stated he went inside the facility to get the cigarette cart and returned to the patio and saw Resident 58 choking. He immediately started to perform the Heimlich maneuver on the resident. (According to the facility's surveillance video, the residents [approximately , d+[DATE] residents] were left unsupervised in the patio at that time). CNA 1 stated he sent another staff member to get the charge nurse (LVN 12). CNA 1 stated he did not give Resident 58 a sandwich and was unsure where Resident 58 got the sandwich. b. A review of Resident 195's Admission Record (face sheet) indicated Resident 195 was admitted to the facility on [DATE] with diagnoses including Gastroesophageal reflux disease ([GERD]) occurs when stomach acid frequently flows back into the tube connecting the mouth and stomach), dysphagia, major depressive disorder ([MDD] a common but serious mood disorder; causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working), schizophrenia (a chronic and severe mental disorder that affects how the person thinks feels, and behaves), and dementia (memory loss). During a review of Resident 195's MDS, dated [DATE], indicated Resident 195's cognition ability for daily decision-making was intact. The MDS indicated Resident 195 required supervision (oversight, encouragement, or cueing) while eating. During a review of Resident 195's physician's order, dated [DATE], indicated that Resident 195 had an order for advanced dysphagia texture (nearly a regular diet, but avoid hard, sticky, or crunchy foods; foods should be foods bite-size) diet, large portions, and thin liquids consistency. During a review of Resident 195's NPN, dated [DATE] and untimed, the NPN indicated Resident 195 required supervision and set-up help while eating. During a concurrent observation and interview on [DATE] at 1:46 p.m., Resident 195 was lying flat in the bed, with the bedside table over his chest, eating an advanced dysphagia diet Resident 195 had light brown fluid on his shirt from his neck to his abdomen. There was no staff assisting Resident 195 to eat or elevate his head of the bed (HOB) while eating food in his room. Resident 195 stated his shirt was wet because he spilled his coffee while trying to drink it. Resident 195 stated the staff usually drops off his meal tray and leaves the room. Resident 195 stated he was not able to eat his food well, lying flat in bed. Resident 195 stated no staff offered to elevate the HOB so he could eat safely. Resident 195 stated the staff rarely helps him with his meal or anything and stated, It makes me feel invisible. The resident bed's crank, used to elevate the HOB, was at the foot of the bed, and Resident 195 could not reach it. Resident 195 stated if he could reach it, he would raise himself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview, on [DATE] at 1:50 p.m., CNA 2 entered Resident 195's room and removed Resident 122's meal tray. Resident 122 was Resident 195's roommate. CNA 2 looked at Resident 195 and did not assist Resident 195 with his positioning or tray and exited the room. CNA 2 stated Resident 195 could eat on his own but stated it was unsafe for Resident 195 to eat while lying in bed flat because he could choke. CNA 2 stated was never told to help Resident 195 in eating. CNA 2 stated it looked like Resident 195 did need help because his shirt was wet, and he could barely see his plate. CNA 2 stated, I should have helped Resident 195 by raising the head of the bed and providing a new shirt or towel. During a concurrent observation and interview, on [DATE] at 2:08 p.m., LVN 10 stated Resident 195 was eating while lying flat in bed. LVN 10 stated CNA 2 provided the meal tray to Resident 195 and should have ensured the resident was safe for eating. LVN 10 stated CNA 2 was supposed to assist Resident 195 during meals. LVN 10 stated Resident 195 was on an advanced dysphagia diet, and eating while lying flat placed the resident at high risk for choking. LVN 2 stated Resident 195 could not raise the head of his bed on his own and needed assistance from staff. During an interview on [DATE] at 8:59 a.m., the SLP stated all residents' HOB must be elevated at 90 degrees while eating unless contraindicated. The SLP stated that Resident 195 was a self-feeder, needed occasional supervision while eating, and needed to have HOB elevated. SLP stated that if HOB did not elevate, the resident would be placed at risk for aspiration due to swallowing being impacted while lying flat. During an interview on [DATE] at 9:39 a.m., the DON stated all staff were educated on safety and elevating the residents' heads of bed while eating, which was fundamental in safety. The DON stated improper positioning during meals placed the resident at risk for choking and aspiration. During a review of the facility's policy and procedure (P/P), revised ,d+[DATE] and titled Resident Care, Routine, indicated it was the P/P of the facility that basic nursing care tasks will be provided for each resident based on resident needs. These tasks are associated with the resident's cleanliness, routine activities of daily living, nutrition, elimination, comfort, activity, rest, and sleep. According to the P/P, these nursing activities may be modified to suit each resident's preferences and individual needs. Encourage residents to take meals in the dining room to promote an increased meal intake, socialization, and increased enjoyment of mealtimes. Provide residents with positioning devices and protective devices, as needed. Nursing staff shall check during each shift for the presence and appropriate use of such devices. Note: All nursing managers, supervisors, and charge nurses are expected to ascertain that all the above care activities occur routinely. It is the responsibility of all nursing staff to maintain the care standards of the facility and assist residents in attaining or maintaining their highest practicable level of functioning. c. During an observation on [DATE] at 1:05 p.m., Resident 88 was observed sitting on the edge of the bed with the meal tray on the bedside nightstand, eating honey garlic shrimp and rice pilaf. Resident 88's meal ticket slip indicated a consistent carbohydrate diet [(CCD) controlled sugar intake for diabetics) that belonged to another resident (Resident 218). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 88's Admission Record (face sheet), the face sheet indicated Resident 88 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 88's diagnoses included dysphagia (difficulty swallowing), Type II diabetes (abnormal blood sugar), contracture (permanent shortening of muscle, tendon, or scar tissue producing deformity or distortion) to the left hand, GERD, and schizoaffective disorder (chronic mental health condition characterized by hallucinations or delusions [apparent perception of something, not present]). During a review of Resident 88's MDS, dated [DATE], the MDS indicated the resident was severely impaired in cognitive (thought process) skills for daily decision-making, had impaired vision, and required supervision with eating. During a review of Resident 88's physician order, dated [DATE], the order indicated for a controlled carbohydrate dysphagia (CCD) advanced diet. During a concurrent observation and interview, on [DATE] at 1:10 p.m., LVN 11 stated Resident 88 was supposed to receive a CCD dysphagia advanced diet. LVN 11 stated Resident 88 was eating a CCD diet meal but with regular consistency. LVN 11 validated that the meal ticket slip indicated the meal tray belonged to Resident 218, Resident 88's roommate. LVN 11 stated Resident 88 was on a special diet because he had missing teeth and difficulty swallowing. LVN 11 stated Resident 88 was a risk for choking and aspiration. LVN 11 stated it was his responsibility to compare the meal tray with the physician's order before allowing a CNA to serve the resident his meal tray. LVN 11 admitted he did not check meal trays for diet appropriateness before CNAs distributed the meal trays to the residents. A review of Resident 88's plan of care dental complications and missing teeth revised on [DATE] indicate the staff's interventions included providing supervision and monitoring the resident's tolerance to diet texture. During an interview with the SLP on [DATE] at 8:59 a.m., the SLP stated Resident 88 had impaired swallowing and required focused chewing to help to ensure the safe swallowing of food. During an interview on [DATE] at 1:58 p.m., the registered dietitian ([RD] a health professional with special training in diet and nutrition to keep the body healthy) stated that the advanced dysphagia diet is a special textured diet consisting of ground meat or chopped meat and cooked vegetables. The RD stated residents on a special diet needed to receive the correct meal tray, and if a resident received the wrong tray, there was a risk of choking and aspiration. During an interview on [DATE] at 9:37 a.m., the DON stated the nursing staff's responsibility to ensure residents receive the correct meal tray. The DON stated that the licensed nurse was required to check the diet list against the meal tray before receiving it to ensure the correct diet meal was served. The DON stated it was the licensed nurses' duty to ensure safety during mealtimes. The DON stated it was unacceptable to receive the wrong tray and wrong food consistency, which placed the resident at risk for choking and aspiration. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility's P/P, revised ,d+[DATE] and titled Therapeutic Diets, the P/P indicated all residents have a diet order, including regular, therapeutic, and texture modification the attending physician prescribes that. According to the P/P, a Therapeutic diet was defined as a diet ordered by a physician or delegated registered or licensed dietitian as part of treating a disease or clinical condition. The purpose of a therapeutic diet is to eliminate or decrease specific nutrients in the diet (e.g., sodium), or to increase specific nutrients in the diet (e.g., potassium), or to provide food that a resident can eat (e.g., mechanically altered diet.). The P/P indicated the licensed nurse accepts the diet order from the authorized prescriber. The licensed nurse completes and signs the Diet Requisition Form, including the full diet order, food allergies, and specific food preference requests. Diets are prepared in accordance with the guidelines in the approved Diet Manual and the individualized plan of care. d. During a review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including diabetes mellitus Type 2 (abnormal blood sugar), dysphagia (difficulty swallowing), psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) and dementia (memory loss). During a review of Resident 30's Order Summary Report indicated the order to monitor Resident 30 for taking food from other residents' trays. During a review of Resident 30's history and physical (H/P) indicated Resident 30 could not make decisions. During a review of Resident 30's p[TRUNCATED]

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37393 Based on observation, interview, and record review, the facility's staff failed to implement infection control policies and procedures (P/P) and its mitigation plan which included response testing to prevent the spread of COVID 19 ([Coronavirus] a disease that can triggers a respiratory [lung] tract infection affecting the upper respiratory tract [sinuses, nose, and throat] and/or lower respiratory tract [windpipe and lungs] the virus spreads mainly through person-to-person contact) and Scabies (a contagious skin disease marked by itching and small raised red spots, caused by the itch mite) infections by ensuring the facility's staff practice hand hygiene, donned (put on) and doffed (removed) personal protective equipment ([PPE] equipment worn to minimize exposure to hazards that cause serious workplace injuries) upon exiting the COVID 19 yellow zone (temporarily quarantined residents under surveillance for COVID 19 infection) for 163 of 163 residents. These deficient practices had the potential to spread infection of COVID-19 and scabies to staff, and visitors. During a review of the facility's census, the census indicated the facility had 163 in housed residents. On 10/18/2021 at 5:23 p.m., the State Agency (SA) declared an Immediate Jeopardy ([IJ], a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death of a resident or residents) for F880 and notified the facility's Administrator and Director of Nursing (DON) of the findings. On 10/19/2021 at 5:20 p.m., the SA removed the IJ in the presence of the Administrator and DON, after on-site verification of the implementation of the written Plan of Action ([POA], interventions to immediately correct the deficient practice) through observation, interview, and record review. The acceptable POA included the following: 1. Education initiated 10/18/2021 by Infection Prevention staff regarding process for crossing from yellow to green zone including proper use of face shields, disposal/doffing of PPE, hand hygiene, changing of gloves and gowns between residents and as needed. 2. Education initiated 10/18/2021 by Infection Prevention staff on the use of proper PPE prior to entering a contact isolation room to include proper donning and doffing of PPE: gloves and gown. 3. Education initiated on 10/18/2021 by DON Designee / Assistant DON regarding appropriate hand hygiene before and after resident care in an isolation room to include return demonstration. 4. Education initiated on 10/18/2021 by DON or Designee / Assistant DON to Infection Control Nurses regarding response testing of potential residents having been exposed to COVID-19. 5. Response testing of residents exposed to COVID-19 was completed 10/18/2021. 6. Response testing for all other residents was initiated 10/18/2021 to be completed by 10/20/2021. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. Response testing for staff initiated 10/18/2021 to be completed 10/21/2021. 8. Education initiated on 10/18/2021 by Director of Staff Development to staff regarding redirecting residents to remain in the yellow zone and keep the face mask on all the time. 9. Residents will be visited by Activities staff on 1:1, initiated on 10/18/2021 for residents currently residing in the yellow zone regarding not leaving the yellow zone, and wear face masks at all times. 10. On 10/18/2021 contact isolation signs were placed outside the three resident rooms who had orders for contact isolation. 11. Education initiated on 10/18/2021 by Director of Staff Development regarding staff properly donning when entering a resident yellow room and doffing appropriately when exiting a resident yellow room. This education will be completed by 10/19/2021. 12. Quality Circle Rounds will be utilized as audit tools by Department Managers who will round at least 3 times per week for a minimum of 3 months to ensure compliance with infection control in-services. Findings: a. During an observation on 10/13/2021 at 8:38 a.m., during the initial tour of the facility, accompanied by the Director of Staff Development (DSD), two staff members were observed exiting the yellow zone wearing full PPE including face masks, face shield, gown with gloves, and entering into the green zone to obtain and/or request by yelling for additional supplies to provide care for an unknown resident in the yellow zone. The staff members were verbally informed by the DSD to return to the Yellow zone and supplies would be delivered. The staff returned to the yellow zone and stood by the double doors. During a subsequent observation on 10/13/2021 at 8:46 a.m., a Certified Nursing Assistant (CNA 13) was observed exiting the yellow zone with full PPE on including a face mask, gown, face shield, with gloves, and not practicing hand hygiene before entering the nursing station on the Green zone (COVID free) to request and / or obtain supplies. CNA 13 was standing inside of the nursing station and was notified by a Licensed Vocational Nurse (LVN 18) that The State was also sitting in the nursing station. CNA 13 quickly turned around to walk toward the yellow zone, LVN 18 stated to CNA 13 she would obtain the supplies he needed. During an observation of the Yellow zone on 10/13/2021 at 10:57 a.m., a Social Worker (SW 2) was observed exiting the yellow zone going into the Green zone without practicing hand hygiene. b. During an observation on 10/16/2021 at 4:48 p.m., the charge nurse (LVN 15) was observed sitting at the nursing station (next to the Yellow zone) without a face mask and/or a face shield. LVN 15 stated the mask and face shield both fell off, and she forgot to put them back on. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 10/16/2021 at 4:57 p.m., CNA 5 exited the Yellow zone and entered the dining room wearing a black surgical mask pulled down, with her nose exposed, and the face shield pushed back on her forehead, off her face, without practicing hand hygiene. CNA 5 walked directly into the dining room and sat down on a chair and removed her mask face and used her face shield as a fan to fan her face. CNA 5 was observed unmasked waving the used face shield up and down, while speaking to four unmasked residents who were seated in the dining area. During an interview on 10/16/2021 at 5 p.m., the Assistant Director of Nursing (ADON) stated CNA 5 was unmasked and using her face shield as a fan to cool down. ADON stated CNA 5 was not practicing proper infection control and may expose others to infection. ADON stated all staff should wear a face mask with a face shield all the time while in the facility. ADON stated she would speak with LVN 15 and CNA 5 and provide infection control education right away. c. During an interview with the facility's Infection Prevention Nurse 1 ([IP] responsible for the facility's activities aimed at preventing healthcare associated infections by ensuring that the source of infections were isolated to limit the spread of infectious organisms), on 10/18/2021 at 12:50 p.m., IP 1 stated she was made aware of Resident 62 testing positive for COVID-19 on 10/17/2021 at 7:30 p.m. when the resident was transferred to the general acute care hospital (GACH 1). IP 1 stated IP 3 was on duty on 10/17/2021 and initiated protocols and monitoring of the residents in the Yellow zone. IP 1 stated, Response testing plan was put together today, 10/18/2021, and will be started today. The plan is for 100% of staff to be tested . Response testing of residents will begin testing on 10/18/2021. IP 1 was unable to provide details of scheduling of resident's testing. During a review of Resident 62's Nurses Progress Note (NPN), the NPN indicated GACH 1 reported Resident 62's COVID-19 positive result to the facility on [DATE]. During an interview with IP 2 on 10/20/2021 at 3:58 p.m., IP 2 stated a delay in response testing can cause harm of potential COVID-19 exposure to other residents and staff. IP 2 stated IP 3 did not institute response testing on 10/17/2021 because he prioritized instituting droplet precautions (intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, residents are quarantined to their rooms or designated area. Staff must wear appropriate PPEs). During an interview on 10/21/2021 at 1:25 p.m., IP 3 stated he was working on 10/17/2021, when he received confirmation Resident 62 tested positive for COVID-19 upon admission to GACH 1. IP 3 stated he notified the administrator immediately and ensured there were enough PPEs available and stocked, initiated COVID-19 droplet precautions and established a Yellow zone. IP 3 stated he did not start response testing and should have. IP 3 stated he refers to the guidance provided by the local health department and the facility's practice. IP 3 stated response testing should be started immediately. IP 3 stated immediately meant as soon as possible. IP 3 stated he was the only one working on 10/17/2021 and he would not have been unable to prepare kits to test 300 residents and to put in requisitions for more kits. IP 3 stated the delay in response testing had the potential for unnecessary exposure of COVID-19 to residents and staff. During an interview, on 10/21/2021 at 1:30 p.m., the Assistant Director of Nursing (ADON) stated the facility was short-staffed of IP nurses. The ADON stated the facility had three IP nurses but guidance from the local health department was to have five (5) IP nurses. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of an AFL titled, Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF) dated 8/32021, the AFL indicated Response Testing (repeat testing performed following exposure to COVID-19, goal of testing is to identify asymptomatic infections to prevent further spread of COVID-19.) should be started as soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility. d. During a concurrent observation and interview with CNA 1 on 10/13/2021 at 8:51 a.m., a pink contact isolation sign on Resident 122's door indicated a gown and gloves were to be worn in the room, was observed at the entrance of Room A3. CNA 1 was observed in the contact isolation room wearing goggles, gloves, and a N95 respirator (a particulate-filtering facemask for air filtration [filters 95% of airborne particles]). CNA 1 was observed adjusting Resident 122 in bed and arranging Resident 122's items on the bedside table. CNA 1 then asked the resident's roommate (Resident 195) if he needed anything. CNA 1 was observed removing his gloves, exited the room, and performing hand hygiene. CNA 1 stated that the pink sign at the door of Room A3 indicated the resident in the room was on isolation. CNA 1 stated PPE was required in an isolation room. CNA 1 stated he should wear a gown, in addition to the gloves, goggles, and mask in the resident room. CNA 1 stated he did not wear a gown while in the room because he was rushing and did not put on a gown. CNA 1 stated he was unsure why the residents were on contact isolation. During a concurrent observation and interview on 10/13/2021 at 11:18 a.m., LVN 1 was observed removing the pink sign from Room A3. LVN 1 stated the scabies isolation was complete and was supposed to be removed. LVN 1 stated he was required to check the physician orders before removing the isolation signs. LVN 1 stated the room was previously on contact isolation due to possible scabies exposure. LVN 1 stated for contact isolation, the PPE required to donning prior to entering the room was gown, gloves, googles, and an N95 respirator. During a concurrent observation and interview on 10/14/2021 at 10:28 a.m., LVN 5 stated any resident with possible exposure to scabies was placed on contact precautions and treated with Elimite (medication applied to the skin to treat scabies). LVN 5 stated there was not a contact precautions sign at the entrance of Room A3. LVN 5 stated the contact isolation was possibly discontinued by the infection preventionist (IP). LVN 5 stated since there was no contact isolation sign, the staff do not know what PPE to wear. LVN 5 confirmed there was a physician's order for contact isolation for Residents 122 and 195. LVN 5 stated when the staff do not gown up, it creates risk of spreading scabies infection to ourselves and other residents. During an observation on 10/15/2021 at 9:43 a.m., there was no contact isolation signage at the entrance of Room A3. During an observation on 10/15/2021 at 1:12 p.m., there was no contact isolation signage at the entrance of Room A3. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a concurrent interview and record review on 10/18/2021 at 4:35 p.m., IP 1 stated Resident 122 had a current contact isolation order. IP 1 stated Resident 122's isolation order was to be discontinued 24 hours after the next Elimite treatment. IP 1 stated an Elimite treatment was scheduled for 10/22/2021. IP 1 stated Resident 195 was the roommate to Resident 122. IP stated Resident 195 had an active physician order for contact precautions. IP 1 stated Resident 195's isolation precautions would conclude on 10/22/2021. IP 1 stated the pink signage was to be posted at the entrance of the room to alert all staff what PPE was required prior to entering the room and there was no excuse for staff to not follow isolation precautions. IP 1 stated, I provided the registered nurse supervisors a list of contact isolation rooms daily and it was their responsibility to inform the charge nurses. IP 1 stated charge nurses are required to inform the CNAs. During a review of Resident 122's physician order, dated 10/9/2021, the order indicated for Resident 122 to be placed on contact precautions for diagnosis of an unknown rash. During a review of Resident 195's physician order, dated 10/9/2021, the order indicated the resident was supposed to be on contact precautions for diagnosis of exposure to peer with an unknown rash. During an interview on 10/19/2021 at 9:40 a.m., the DON stated all staff have been educated on contact isolation precautions and donning and doffing. The DON stated staff should be donning a gown and gloves prior to entering a contact isolation room and in addition should already be wearing shield/goggles and a mask. The DON stated PPE should be worn inside the room even if not providing direct resident care. The DON stated if staff was not gowning up prior to entering the room, there was a high risk of transmitting infection. During a review of the facility's policy and procedure (P/P), revised 1/10/2019 and titled, Enhanced Standard Precautions, the P/P indicated a sign will be posted outside the resident's room to indicate special precautions are in place and needed when coming within three (3) feet of the isolated resident's environment. Resident's name and infectious organism will NOT be posted on the sign. Personal Protective Equipment will be stocked on or in a covered cart (to avoid contamination before use) outside the isolated resident's room for easy access before caring for isolated resident. Cart for PPE should not block egress from resident room. Hand hygiene before donning personal protective equipment. Don the appropriate PPE (gloves, gown at a minimum and add a mask if indicated) if planning to be within 3 feet of the resident or the resident's environment. Contact with environmental surfaces such as side rails, cubicle curtains etc. require donning of PPE as does contact with any of the resident care equipment. During care, change gloves after having contact with infective material (i.e. fecal material or wound drainage which may contain high concentrations of microorganisms). Change gloves when moving from one site to another (i.e. oral care, dressing change). The P/P indicated double-gloving is not an acceptable practice to avoid a glove change or a hand hygiene opportunity. Hand hygiene should be performed before donning and after removal of gloves each time gloves are used. Before leaving the room, remove gloves, gown, and other PPE. e. During an observation on 10/13/21 at 11:23 a.m., Residents 141 and 151's room was observed to have a sign outside the door indicating contact precaution (for patients with known or suspected infections that represent an increased risk for contact transmission) and there were no gowns, gloves, or masks available outside the door before entering the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 10/13/2021 at 11:24 a.m., LVN 18 stated the residents in Room F6 were on contact isolation for skin issues. During an observation on 10/13/2021 at 12:20 p.m., CNA 8 was observed entering Resident 141's room (an isolation room) to assist with feeding. CNA 8 did not perform hand hygiene prior to entering the room or put on a gown or gloves prior to assisting Resident 141. After CNA 8 was done assisting Resident 141 with his meal, CNA 8 was observed exiting the room without performing hand hygiene. During an interview on 10/13/2021 at 12:29 p.m., CNA 8 stated when entering a room with contact precautions, the first thing she needed to do was wash her hands. During a review of the facility's P/P, dated 1/10/2021 and titled, Hand Hygiene, the P/P indicated all employees are required to practice effective hand hygiene. Employees are encouraged to promote good hygiene with residents, visitors, and family members when appropriate. During a review of Resident 141's physician's orders, dated 10/5/2021, the order indicated Resident 141 was on contact precautions for a suspicious rash on his stomach and right arm. During an observation on 10/14/2021 at 10 a.m., CNAs 6 and 7 were observed assisting Resident 151 to the shower. CNA 7 was not wearing a gown. During an observation on 10/14/2021 at 10:04 a.m., CNA 7 was observed not wearing a gown while making up Resident 151's bed. During a review of Resident 151's physician's orders, dated 10/9/2021, the physician's orders indicated the resident was on contact precautions for diagnosis of unresolved rashes to both hands and arms, stomach, butt and both thighs. During an interview on 10/18/2021 at 12:47 p.m., IP 1 was asked what the process was for entering contact isolation rooms, IP 1 stated all staff should use hand sanitizer, wash hands, and put on a gown and gloves when entering the room. During a review of the facility's COVID-19 Mitigation Plan Manual updated on 8/5/2021 indicated the following: 1. Staff will be trained on proper donning and doffing procedures. 2. Necessary PPE will be made available directly outside of resident rooms in the red and yellow zones in accordance with current CDC (Centers for Disease Control and Prevention) guidance. 3. All staff will wear recommended PPE while in the building percurrent, CDC or CDPH PPE guidance. 4. Residents leaving their room will be asked to wear a facemask, all residents leaving the facility for medical appointments will be sent with a facemask. (continued on next page)

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	555565	A. Building B. Wing	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of the facility's P/P titled, Hand hygiene Policy and Procedure revised on 1/10/2019, the P/P indicated that all employees are required to practice effective hand hygiene. Employees are encouraged to promote good hand hygiene with residents, visitors, and family members when appropriate. Employees are required to wash their hands thoroughly before beginning the workday, between patients, between procedures on the same patient, after touching objects that may be soiled and after removing gloves, after removing gloves and any time hands become soiled, before meals, and after restroom use. During a review of the facility's P/P, dated 1/10/2019 and titled, General infection Prevention & Control, the P/P indicated infection surveillance shall cover the care center as a whole or targeted to specific buildings or nursing stations if the building or stations are separated geographically. Standard practice precautions will be practiced by all personnel and will be used for all residents all times. Intensified interventions is the third tier suggested for implementation by the CDC under circumstances such as when an unusual infectious agent is circulating in the community, or when the incidence of new cases of a specific infectious agent is either increasing or fails to decrease despite the implementation of and adherence to standard infection prevention procedures. Strategies to consider such as hand hygiene being the single most important precaution to prevent the transmission of infection from one person to another. Alcohol based hand rubs can be used as an adjunct to handwashing at times when soap and water are not easily accessible. Gather all equipment and supplies needed before entering the residents' rooms, only take needed supplies into the room. All PPE should be used once and either discard in the trash or used linen receptacle before leaving the room. Before leaving the room, remove gloves, gown, and other PPE. 44958 44234 44898