STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to implement effective infection prevention measures during a Coronavirus Disease outbreak ([COVID-19], an infectious disease that affects a person's organs and tissues that aid in breathing) in the facility. The facility failed to: 1. Minimize Resident 1's exposure to COVID-19. 2. Stock face shields in eight of eight isolation carts (storage unit for personal protective equipment [PPE, protective clothing or equipment designed to protect the wearer's body from infection, such as a gown, gloves, mask, and face shield]) designated for the COVID-19 positive and COVID-19 exposed rooms. 3. Ensure face shields were used by staff members prior to entering Residents 2 and 3 rooms, who were COVID-19 positive. 4. Ensure Activities Assistant (AA) 1 doffed (took off) and disposed of the used PPE, inside Resident 3's room, who was COVID-19 positive. These failures resulted in Resident 1 being unnecessarily exposed and eventually contracted COVID-19 and had the potential to result in the spread of COVID-19 to the rest of the residents' staff and visitors within the facility. Findings: a. A review of Resident 1's Admission Record (Face Sheet), indicated Resident 1 was initially admitted to the facility on [DATE], with diagnoses that included but not limited to cellulitis (an infection of the deeper layers of skin and the underlying tissue) of left lower limb, muscle weakness, and schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 1's Minimum Data Set ([MDS], a standardized resident assessment and care planning tool), dated 6/10/2024, indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent (needs total assistance from staff) on staff for activities of daily living, bed mobility and chair to bed transfers. A review of Resident 1's Progress Notes, dated 7/2/2024, indicated Resident 1 was ordered by facility staff to be changed from Room A to Room B. A review of Resident 1's COVID-19 Laboratory Result, dated 7/9/2024, indicated Resident 1 was positive for the COVID-19 virus. A review of the facility Censuses, dated 7/1/2024 to 7/3/2024, indicated Rooms D, bed C which were not near the exposed Covid -19 residents, was vacant for all three dates. A review of the COVID-19 Tracking Floor Map Diagram, dated 7/2/2024, indicated Room B was in a hallway that showed 10 rooms dedicated to either COVID-19 exposed residents or active, positive COVID-19 cases. During an interview, on 7/15/2024, at 1:54 p.m., with the Infection Prevention Nurse (IPN), The IPN stated when a resident was assigned to move into another room, the normal process was to have the Social Services Director (SSD) notify the IPN or the Director of Nurses (DON), and the DON would approve the room change. The IPN stated it was important for her to know about the change so that she could ensure it would not comprise the health and safety of the residents. The IPN stated she was not made aware that Resident 1 was assigned to be moved to Room B because she was off work due to illness. The IPN stated she would not have approved the room change because Room B was near several COVID-19 positive rooms. The IPN stated there was a high chance that the resident could have contracted the virus when he was moved from an area of the facility that was considered clean to an area of the facility significantly marked by COVID-19 cases. During an interview on 7/15/2024, at 2:04 p.m. with Registered Nurse (RN) 1, RN 1 stated it was important to place COVID-19 positive residents away from clean residents (residents that not tested positive for COVID-19 nor have been exposed) so the virus would not spread to other non-infected residents. RN 1 stated the DON typically approved the decision to move a resident into a specific room. RN 1 stated that it was not safe to reassign Resident 1 in Room B due to the increased risk of Resident 1 contracting the virus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent review and interview, on 7/16/2024, at 12:31p.m., with the DON, the Facility's Census, dated 7/1/2024 to 7/3/2024, and the COVID-19 Tracking Floor Map Diagram, dated 7/2/2024, were reviewed. The census indicated Room D had one vacant bed (for all three days) that was highlighted in green to indicate the room did not house COVID-19 positive residents. The map indicated Room B (the newly assigned room for Resident 1) was in a hallway that showed ten (10) rooms dedicated to either COVID-19 exposed residents or active, positive COVID-19 cases. The DON stated the normal process of conducting a room change was to discuss the proposed change in the morning meetings amongst the department heads. The DON stated proposed room changes were finalized and approved by the entire team. The DON stated it was important to evaluate the appropriateness of the room to ensure the resident would be comfortable and safe. The DON stated she expected the RN Supervisor and the Charge Nurse to intervene with any room change if it affected resident safety. The DON stated the Admission Coordinator, or the Social Worker usually referred to the census to decide which room to place residents into. The DON stated there was an error in the identification and highlighting color of Room A for three days (7/1/2024 through 7/3/2024). The DON stated Room B should have been highlighted as yellow, instead of green, so that staff would know that Room B had occupants that had been exposed to the virus. The DON stated Resident 1's room change was not a safe room change because it placed Resident 1 at an increased likelihood of contracting COVID-19. The DON stated Room D (the clean room with one vacant bed) would have been a better alternative for Resident 1's room change. A review of the facility's policy and procedure (P&P) titled, COVID-19, Prevention and Control, revised 6/10/2024, the P&P indicated, This facility follows current guidelines and recommendations for the prevention and control of COVID-19. b. During an observation on 7/15/2024 at 10:47 a.m., in the hallway of the facility, eight individual isolation carts were stationed outside of COVID-19 positive and exposed resident rooms. The isolation carts contained disposable gowns, gloves, and disinfectant wipes. There were no face shields inside or on top of the isolation carts. During an interview on 7/15/2024 at 11:05 a.m., with the Treatment Nurse (TN), the TN stated the facility provided face shields to the staff and should be available to anyone who had to enter a COVID-19 positive or exposed room. The TN stated the IPN, or central supply usually stock the isolation carts with the face shields, so they were readily available for use. During a concurrent observation and interview on 7/15/2024 at 2 p.m., with the IPN, in the storage room, there were three unopened boxes of face shields that were ready for use. The IPN stated the facility had adequate stock of PPE, including the face shields. A review of the facility's Inventory of PPE, dated 7/16/2024, the Inventory of PPE indicated the facility had 200 face shields available for use. During an interview on 7/16/2024 at 12:15 p.m., with the IPN, the IPN stated the isolation carts outside the COVID-19 positive and exposed rooms should have masks, face shields, gowns, and disinfectant wipes readily available to the staff. The IPN stated the purpose of the face shield was to protect the individual from any respiratory droplets from the resident if they were to sneeze or cough. The IPN stated face shields should be readily available to the staff in the event they have to enter a COVID-19 positive or exposed room. The IPN stated if the face shields were not readily available, the staff could enter the COVID-19 positive or exposed room without it and would put them at risk of contracting the virus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/16/2024 at 12:33 p.m., with the DON, the DON stated face shields should be stocked in the isolation carts so they can be used by the staff to protect themselves when inside a COVID-19 positive or exposed room. The DON stated the face shields provide additional protection for the staff and if they were not stocked, they would not be used. The DON stated the staff could potentially contract COVID-19 without the proper PPE. A review of the facility's P&P titled, Personal Protective Equipment, revised October 2022, the P&P indicated, Personal protective equipment appropriate to specific task requirements is available at all times. c. A review of Resident 2's Admission Record (Face Sheet), indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning). A review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 cognition was moderately impaired. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) with toileting, bathing, dressing, and personal hygiene. A review of Resident 2's History and Physical (H&P) Note, dated 10/5/2023, the H&P indicated Resident 2 did not have the mental capacity to make medical decisions. A review of Resident 2's Laboratory Report, dated 7/9/2024, the Laboratory Results indicated Resident 2 was positive for COVID-19. A review of Resident 2's Order Summary Report, dated 7/16/2024, the Order Summary Report indicated to place Resident 2 on contact and droplet isolation (type of isolation to prevent germs from spreading from one person to another) for ten days, starting on 7/11/2024. During an observation on 7/15/2024 at 10:10 a.m., outside of Resident 2's room, with Certified Nursing Assistant (CNA 2), donned (put on) a disposable gown and gloves prior to entering Resident 2's room. CNA 2 did not wear a face shield prior to entering Resident 2's room as stated in the facility P&P. d. A review of Resident 3's Admission Record (Face Sheet), indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), type two (2) diabetes mellitus (a condition that results in too much sugar circulating in the blood), and dementia. A review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired. The MDS indicated Resident 3 was dependent on staff with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. A review of Resident 3's H&P, dated 7/18/2023, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 3's Laboratory Report, dated 7/9/2024, the Laboratory Report indicated Resident 3 was positive for COVID-19. A review of Resident 3's Order Summary Report, dated 7/16/2024, the Order Summary Report indicated to place Resident 3 on contact and droplet for ten days, starting on 7/11/2024. During a concurrent observation and interview. on 7/15/2024 at 10:15 a.m., outside of Resident 3's room, with Activities Assistant (AA), AA donned a disposable gown and gloves prior to entering Resident 3's room. AA did not wear a face shield prior to entering Resident 3's room. AA doffed her gown and gloves outside of Resident 3's room, in the hallway, and threw away the used gown and gloves into the Housekeeper's trash cart. The AA stated before entering Resident 3's room, she was supposed to don a gown, gloves, and face shield. The AA 1 stated there were no face shields available in the isolation cart, therefore did not wear one prior to entering Resident 3's room. AA stated she was supposed to doff her used PPE inside Resident 3's room and dispose of the PPE in the designated trash bin inside the room. The AA stated doffing and disposing of the PPE inside the room was to prevent the spread of COVID-19 to the other residents and staff. During an observation on 7/15/2024 at 11 a.m., outside of Resident 3's room, CNA 1 donned a disposable gown and gloves prior to entering Resident 3's room. CNA 1 did not wear a face shield prior to entering Resident 3's room. During an interview on 7/15/2024 at 11:30 a.m., with CNA 1, CNA 1 stated prior to entering Resident 3's room, she was supposed to don a gown, gloves, and a face shield. CNA 1 stated she did not wear a face shield because there was not one available in the isolation cart. During an interview on 7/16/2024 at 12:15 p.m., with the IPN, the IPN stated prior to entering a COVID-19 positive or exposed room, the staff member was supposed to don a gown, mask, face shield, and gloves. The IPN stated a face shield was supposed to be worn to protect the individual from any respiratory droplets in the air if the resident were to cough or sneeze. The IPN stated once the staff member was finished with the care inside the resident's room, they were supposed to doff inside the resident's room and dispose of the contaminated PPE in the designated trash bin. The IPN stated anything inside the room was considered dirty and to prevent the spread of COVID-19 to other residents and staff, the contaminated PPE needed to stay inside the room until it was disposed of properly by the housekeeping staff. The IPN stated not wearing the proper PPE and improper doffing of PPE increased the risk of COVID-19 spreading to the other residents and staff within the facility. During an interview on 7/16/2024 at 12:33 p.m., with the DON, the DON stated prior to entering a COVID-19 positive room, the nurse was supposed to don a gown, gloves, and face shield. The DON stated the face shield provided additional protection for the wearer from the respiratory droplets in the air. The DON stated without a face shield, the individual would be at risk of contamination from the respiratory droplets and could contract COVID-19. The DON stated before exiting the room, the contaminated PPE should be doffed and be thrown away in the trash bin inside the room. The DON stated there was no reason to doff nor to throw the contaminated PPE outside of the room. The DON stated this placed a risk of the spread of COVID-19 to others. A review of the Centers for Disease Control and Prevention (CDC)'s sign titled, How to Safely Remove PPE, undated, the sign indicated, Remove all PPE before exiting the patient room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Department of Public Health (DPH)'s Novel Respiratory Precautions sign, revised August 2021, the sign indicated, Wear a N-95 (type of mask) and face shield or goggles.