STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555731	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dept of State Hospitals - Metropolitan Snf	11401 South Bloomfield Avenue Norwalk, CA 90650

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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 - 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** 39605 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infections for six of 22 sampled residents (Residents 7, 36, 1, 35, 11 and 54) when: 1. The trash and linen carts were placed outside of Resident 7's isolation room. 2. Psychiatric Technician (PT) 2 accepted a pitcher handed by Resident 7, who was on isolation precautions, with bare hands. 3. Registered Nurse (RN) 7 performed wound care to Resident 36 wearing gloves as the only personal protective equipment (PPE) used. 4. PT 1 performed wound care to Resident 1 wearing gloves as the only PPE used. 5. Psychiatric Technician Assistant (PTA) 2 and PTA 3 changed Resident 35's linen and provided personal hygiene without wearing a gown. 6. RN 5 and RN Shift Lead (RNSL) 2 performed a dressing change for Resident 11's pressure injury (chronic wound to the skin and underlying tissues) to his left buttock without wearing a gown. 7. RN 5 and RNSL 2 performed a dressing change on Resident 54's left heel without wearing a gown. These failures placed the residents at risk for cross contamination and possible spread of infections. Findings: (continued on next page)

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	1. During an observation on 11/5/24 at 10:15 AM by Resident 7's room, Resident 7 was in the room sitting in her wheelchair listening to the radio. There was a PPE (personal protective equipment) cart outside of the room, with contact (spread of infectious diseases through direct or indirect contact with a person or their environment) and droplet (infectious diseases that are transmitted through respiratory droplets) isolation signage. Trash and linen carts were by the door outside of the room. Psychiatric Technician (PT) 2 wore a gown, gloves and mask and went in Resident 7's room to turn on the radio. PT 2 came out of the room, removed her gown, gloves and mask and threw them in the trash cart by the door, outside of the room. PT 2 stated one cart was for trash and the other cart was for linen. During an interview on 11/6/24 at 9:39 AM with the Interim Nursing Coordinator (NC) 1, NC 1 stated the trash and linen carts should have been inside Resident 7's room. NC 1 stated keeping the linen and trash cart inside the room contained and limited the spread of infection. During an interview on 11/6/24 at 9:48 AM with Interim Infection Preventionist (IIP), IIP stated Resident 7 was on transmission based, droplet precaution for influenza. IIP stated the linen and trash carts should have been inside the room for infection control. The IIP stated keeping the carts inside the room was a precaution for spread of infection. During an interview on 11/7/24 at 9:25 AM with Registered Nurse Shift Lead (RNSL) 1, RNSL 1 stated Resident 7 was on contact and droplet precaution. RNSL 1 stated, Trash and linen [carts] should be inside the room . To contain the infection and not spread it all over the unit. During a review of the policy and procedure (P&P) titled, Transmission Based Precautions - Contact Precautions Guidelines, dated March 2022, the P&P indicated, . Initiation of Precaution . Place biohazardous [biological or chemical substances that can be dangerous to people, animals or the environment] trash in the patient's room Gowns . Discard the gown in the biohazardous trash before leaving the room . 2. During an observation on 11/5/24 at 10:15 AM by the hallway of Resident 7's room, Resident 7 was in the room, sitting in her wheelchair listening to the radio. There was a PPE (personal protective equipment) cart outside of the room, with contact and droplet isolation signage by the door. During a concurrent observation and interview on 11/5/24 at 10:18 AM outside of Resident 7's room, Resident 7 was inside the room by the door. Resident 7 handed her water pitcher to Psychiatric Technician (PT) 2. PT 2 took the water pitcher from Resident 7 with her bare hands. During an interview on 11/5/24 at 10:30 AM with PT 2, PT 2 stated, I should have used gloves . I could get the flu. During an interview on 11/6/24 at 9:39 AM with Interim Nursing Coordinator (NC) 1, NC 1 stated staff (PT 2) should have worn gloves. NC 1 stated, It's contact precaution . risk of staff contacting influenza. During an interview on 11/6/24 at 9:48 AM with Interim Infection Preventionist (IIP), IIP stated Resident 7 was on transmission based and droplet precaution for influenza. IIP stated PT 2 should have worn gloves when receiving items from the isolation room. IIP stated the water pitcher was contaminated and potentially transferred infectious organisms. (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 review of the policy and procedure (P&P) titled, Transmission Based Precautions - Contact Precautions Guidelines, dated March 2022, the P&P indicated, . Personal protective equipment . shall be utilized by staff as warranted by the situation for the protection against all hazards . Gloves . Everyone . shall put on gloves . 3. During an observation on 11/4/24 at 1:10 PM in the hallway by Resident 36's room, the hallway was clear. There was no enhanced barrier precaution (EBP - use of gown and gloves during high contact resident care activities, designed to reduce spread of infections) signage by the door and no personal protective equipment (PPE) cart. During a review of Resident 36's clinical record titled Treatment Plan, dated 10/31/24, the treatment plan indicated, . MEDICAL PROBLEMS . 15. Left Buttock Pressure Injury [a localized area of skin damage caused by prolonged pressure on skin] Unstageable [a localized area of skin damage caused by prolonged pressure on skin] . 16. Right Buttock Pressure Injury Unstageable . During an observation on 11/6/24 at 3:05 PM in Resident 36's room, Registered Nurse (RN) 7 was performing a wound dressing change on Resident 36. RN 7 was assisted by Psychiatric Technician (PT) 3. RN 7 and PT 3 had a mask and gloves on, without a gown. During an interview on 11/7/24 at 8:52 AM with PT 3, PT 3 stated she assisted RN 7 with wound care for Resident 36 on 11/6/24. PT 3 stated, We just used mask and gloves . I am not familiar with [EBP] . I never heard about it. PT 3 stated there was no training which she could remember regarding EBP. During an interview on 11/7/24 at 9:03 AM with RN 7, RN 7 stated he performed wound care on Resident 36 on 11/6/24. RN 7 stated, I used gloves and mask. I always use mask when I do wound care. RN 7 stated, I don't know if there was any training done for that [EBP] . I did not get training on EBP. During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities. During a review of a professional reference found in https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html, dated 4/2/24, the reference indicated, . Enhanced Barrier Precautions (EBP) are an infection control intervention . that employs targeted gown and glove use during high contact resident care activities . indicated . for residents with . Wounds or indwelling medical devices . 47844 4. During a review of Resident 1's Clinical Record, the record indicated that Resident 1 was admitted to the facility on [DATE] with a history of diagnoses that included Huntington's disease (a genetic brain disorder that causes nerve cells in the brain to break down and die. It affects movement, thinking, and mood, and worsens over time), depressive disorder, and history of pressure ulcers (a localized area of damaged skin or tissue caused by prolonged pressure on the skin). (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 observation and interview on 11/5/24 at 9:53 AM with Psychiatric Technician (PT) 1 outside Resident 1's room, observed PT 1 prepare to perform wound care for Resident 1's pressure ulcer. PT 1 stated she was going to perform ordered wound care for a pressure ulcer wound on Resident 1's right foot second toe. Observed no enhanced barrier precaution (EBP- an infection control intervention designed to reduce transmission of resistant organisms by utilizing gown and glove use during high contact resident care activities) signage outside Resident 1's room. During a concurrent observation and interview on 11/5/24 at 9:56 AM with Registered Nurse (RN) 3 in Resident 1's room, observed RN 3 enter room, donned clean gloves and prepared to assist PT 1 with positioning Resident 1 for wound care. RN 3 stated Resident 1 currently has one unstageable pressure ulcer on right toe. During an observation on 11/5/24 at 9:58 AM in Resident 1's room, observed PT 1 wheel in treatment cart with prepared supplies. PT 1 doffed dirty gloves, sanitized hands, and then donned clean gloves. PT 1 proceeded with wound care treatment on Resident 1's right second toe. Did not observe PT 1 using gown per EBP guidance during wound care treatment. During an interview on 11/6/24 at 8:05 AM with RN 3, RN 3 stated that Resident 1 was not on EBP. During an interview on 11/6/24 at 2:25 PM with Interim Infection Preventionist (IIP), IIP stated that wound care was standard precautions unless the resident was on contact precautions. IIP was unaware of EBP guidelines and stated they do not have an EBP policy. During a review of Resident 1's Physician's Orders, dated 10/23/24, the Physician's Orders indicated the physician ordered wound treatment for pressure ulcers on Resident 1's right 2nd toe. During a review of the facility's policy and procedure (P&P) titled Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, .Procedure . Staff are to observe strict aseptic technique when performing wound care and wear appropriate Personal Protective Equipment (PPE) as necessary to control infection. During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities. During a review of a professional reference found in https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html, dated 4/2/24, the reference indicated, . Enhanced Barrier Precautions (EBP) are an infection control intervention . that employs targeted gown and glove use during high contact resident care activities . indicated . for residents with . Wounds or indwelling medical devices . 51225 5. During an observation on 11/6/24 at 8 AM outside Resident 35's room, no signage was present to indicate Resident 35's requirement for enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms). (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 observation and interview on 11/6/24 at 3:55 PM in Resident 35's room, Psychiatric Technician Assistant (PTA) 2 and PTA 3 changed Resident 35's linens and provided personal hygiene. Resident 35 had a gastrostomy tube, (GT - tube through the abdomen directly into the stomach), both PTA 2 and PTA 3 did not wear a gown during the observation. PTA 2 and PTA 3 both stated they had never heard of EBP. During a concurrent observation and interview on 11/7/24 at 9:45 AM in Resident 35's room, Registered Nurse (RN) 6 and Licensed Vocational Nurse (LVN), provided personal hygiene and changed linens for Resident 35. RN 6 and LVN did not wear a gown during the observation. Resident 35 displayed an intermittent cough throughout the observation. RN 6 and LVN both stated that they did not know anything about enhanced barrier precautions. During an interview on 11/7/24, at 10:14 AM with Registered Nurse Shift Lead (RNSL) 1, RNSL 1 stated a gown was not required when providing personal hygiene and linen changes for Resident 35. RNSL 1 stated that he had not heard of EBP. During a review of Resident 35's Treatment Plan, dated 10/14/24, the Treatment Plan indicated, Resident 35 had a GT. The Treatment Plan further indicated, Resident 35's GT was replaced on 9/28/24 due to cellulitis (infection caused by bacteria) at the insertion point. Resident 35 also tested positive for MRSA (Methicillin-resistant Staphylococcus Aureus - bacterial infection which is resistant to multiple antibiotics) in the nares (nostrils). During a review of Resident 35's MRSA Screen (laboratory test for presence of MRSA), dated 10/7/24, the MRSA Screen indicated Resident 35 was positive for MRSA of the nares. During a review of the facility's policy and procedure (P&P) titled, Duodenostomy [artificial opening into the stomach through the abdominal wall], Gastrostomy, Jejunostomy [artificial opening into the small intestines through the abdominal wall], Enteral Tubes: Feeding and Care, dated June 2022, the P&P indicated, . personal protective equipment (PPE) (e.g. mask, face shield, gown) as clinically indicated . During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities. During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 6. During an observation on 11/5/24 at 9:29 AM outside of Resident 11's room, no enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms) signage was posted. (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 observation on 11/6/24 at 8:13 AM in Resident 11's room, Registered Nurse (RN) 5 and Registered Nurse Lead (RNSL) 2 performed a dressing change for Resident 11's pressure injury (chronic wound to the skin and underlying tissues) to his left buttock. RN 5 and RNSL 2 did not wear gowns. During an interview on 11/7/24 at 10 AM with RN 5, RN 5 stated a gown was not needed for a dressing change. When asked about EBP, RN 5 stated, I have never heard of that. During a review of Resident 11's Treatment Plan, dated 9/17/24, the Treatment Plan indicated on 9/16/24, Resident 11 was diagnosed with a pressure injury on his left hip area. During a review of the Medication and Treatment Record, dated 11/6/24, the Medication and Treatment Record indicated Resident 11 had a pressure ulcer on the left hip area which required daily dressing change. During a review of facility's policy and procedure (P&P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, . Staff are to observe strict aseptic technique [procedure used by medical staff to prevent spread of infection] when performing wound care and wear appropriate personal protective equipment as necessary to control infection . During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities. During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 7. During an observation on 11/5/24 at 9:29 AM outside of Resident 54's room, no enhanced barrier precautions (EBP - a set of infection control measures that requires gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms) signage was posted. During an interview on 11/5/24 at 9:29 AM Registered Nurse (RN) 4, RN 4 stated that Resident 54 had a pressure injury on his left heel that required dressing change. During an observation on 11/6/24 at 8:13 AM in Resident 54's room, RN 5 and Registered Nurse Shift Lead (RNSL) 2 performed a dressing change on Resident 54's left heel. RN 5 and RNSL 2 did not wear a gown. During an interview on 11/7/24 at 10 AM with RN 5, RN 5 stated a gown was not needed for a dressing change. When asked about EBP, RN 5 stated, I have never heard of that. During a review of Resident 54's Treatment Plan, dated 9/26/24, the Treatment Plan indicated Resident 54 had a pressure injury to his left heel. (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 review of Resident 54's Medication and Treatment Record, dated 11/6/24, the Medication and Treatment Record indicated Resident 54 had a pressure injury on his left heel which required daily dressing change. During a review of facility's policy and procedure (P&P) titled, Assessment, Prevention and Treatment of Pressure Injuries and Wounds, dated February 2024, the P&P indicated, . Staff are to observe strict aseptic technique [procedure used by medical staff to prevent spread of infection] when performing wound care and wear appropriate personal protective equipment as necessary to control infection . During a review of the All Facilities Letter (AFL- memo issued by the California Department of Public Health) dated 6/13/2024, the AFL indicated skilled nursing facilities should implement EBP per CDC guidance as part of infection control for certified skilled nursing facilities. During a review of CDC recommendations dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).