STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555445	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANAHEIM CREST NURSING CENTER	3067 W ORANGE AVENUE ANAHEIM, CA 92804

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the necessary care and services for two of 35 nonsampled residents (Residents 1 and 3) to ensure the residents maintained their highest physical well-being. * Resident 1 was admitted to the COVID positive unit (identified as the red zone). The facility failed to monitor Resident 1 for vital signs, including the oxygen saturation levels at least once time each shift. * Resident 3 resided in the facility's COVID yellow zone (person under investigation). The facility failed to monitor Resident 3's vital signs, including the oxygen saturation levels at least once per shift. These had the potential for Residents 1 and 3's heath conditions to decline without staff being aware of the changes in their oxygen saturation levels, which was one of the indicators to identify if the residents' respiratory status was negatively affected by the [MEDICAL CONDITION]. Findings: Review of the facility's Mitigation Plan for the CDC- Coronavirus Disease 2019 titled Responding to Coronavirus (COVID-19) in Nursing Homes showed the residents with suspected or confirmed cases of COVID-19 are to be monitored at least three times daily, including assessment of symptoms, vital signs, oxygen saturation levels, and respiratory status. 1. On 7/14/2020 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated the residents residing in the yellow and red zones had their vital signs, including the oxygen saturation levels and respiratory rates checked at least once a day. This was documented in the resident's medical record under the Nursing Progress Notes. Medical record review for Resident 1 was initiated on 7/14/2020. Resident 1 was readmitted to the facility on [DATE] onto the facility's COVID unit. Review of Resident 1's COVID Skilled Note dated 7/10, 7/11, 7/12, and 7/13/2020, showed the following vital signs to be monitored only once day, not every shift as identified above: - The blood pressures were recorded on 7/10/2020 at 2157 hours, 7/11/2020 at 2033 hours, 7/12/2020 at 1904 hours, and 7/13/2020 at 1726 hours - The temperatures were recorded on 7/10/2020 at 2157 hours, 7/11/2020 at 2032 hours, 7/12/2020 at 1904 hours, and 7/13/2020 at 1726 hours - The pulses were recorded on 7/11/2020 at 2032 hours 7/12/2020 at 1904 hours, and 7/13/2020 at 1726 hours - The respiratory rates were recorded on 7/11/2020 at 2032 hours and on 7/13/2020 at 1727 hours - The oxygen saturation levels were recorded on 7/11/2020 at 2033 hours, 7/12/2020 at 1904 hours, and on 7/13/2020 at 1728 hours Review of Resident 1's Medication Administration Record [REDACTED]. On 7/14/2020 at 1514 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated the residents in the red zone should have the vital signs, oxygen saturation levels, and signs and symptoms of coughing or shortness of breath be monitored every two hours. The residents in the yellow zone should have their vital signs, oxygen saturation levels, and signs and symptoms of coughing or shortness of breath at least one time per shift. The DON verified the findings and stated the licensed nurses failed to monitor and document these assessments for Resident 1. 2. On 7/14/20 medical record review for Resident 3 was initiated. Resident 3 resided in the facility's yellow zone. Review of Resident 3's weight and vitals summary notes was reviewed showed the staff were not consistently monitoring the resident's vital signs as follows: - For 7/10/20, the resident's blood pressure, pulse rate, respiratory rate, oxygen saturation level, temperature, and pain level were only documented one time in the 24-hour period. - For 7/11/20, the resident's blood pressure was documented twice; however, the resident's pulse rate, respiratory rate, oxygen saturation level, temperature, and pain level were only documented one time in the 24-hour period. - For 7/12/20, the resident's blood pressure, pulse rate, respiratory rate, oxygen saturation level, temperature, and pain level were only documented one time in the 24-hour period. - For 7/13/20, there was no documented evidence the staff assessed the resident's respiratory rate, pulse rate, or oxygen saturation level. The resident did have their blood pressure, temperature, and pain level documented once in the 24-hour period. On 7/14/20 at 1000 hours, an interview was conducted with LVN 1 and CNA 1. LVN 1 and CNA 1 stated residents' vital signs were to be checked and documented every shift, which included the residents' blood pressure, pulse, respiratory rate, oxygen saturation level, temperature, and pain level. On 7/14/20 at 1515 hours, an interview and concurrent facility policy review was conducted with the DON. The DON stated the residents' residing on the yellow zone were to have their vital signs taken every shift. For the residents residing on the red zone, they were to have their vital signs taken every two hours.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, and facility COVID-19 MP, the facility failed to implement their infection control program as evidenced by: * The facility failed to ensure the licensed nurse assigned to the COVID unit were not assigned to non-COVID unit/residents. * The facility failed to ensure the rehabilitative staff followed the procedures for reusing their N95 facemasks. * The facility failed to ensure the housekeeping staff followed the procedures of donning a gown when entering a resident room, who was on droplet isolation precautions. These failures posed the risk of transmitting of COVID and other to other residents and staff in the facility. Findings: 1. Review of the facility's Mitigation Plan dated 5/21/2020, showed the facility will dedicate staff including primary nursing assistants and licensed nurses to care for residents who have been confirmed to have COVID-19 and reside in the red zone. The staff who are assigned to the red zone will have access to a restroom, break room, and work area that are completely separate from other staff who are not assigned to the red zone. On 7/14/2020 at 0950 hours, during the initial tour of the facility, a fire door was observed to be closed between the yellow and red zones. Review of the facility's census dated 7/14/2020, and floor plan showed the facility divided the facility into red zone (residents confirmed to have [MEDICAL CONDITION]), yellow zone (residents with possible [MEDICAL CONDITION]) and green zone (non-COVID residents). The red zone included Resident Rooms C, D, E & F and three residents were currently residing on this unit. The yellow zone included five resident shared rooms, including Rooms B and G. There were eight residents current residing in the yellow zone. On 7/14/ at 1200 hours, an interview was conducted with the DON. The DON was asked about the assignment of the licensed nurses to the red zone. The DON stated LVN 1 was assigned to both the yellow and red zones. On 7/14/2020 at 1215 hours, an interview was conducted with the Administrator. The Administrator verified only one CNA was assigned to the residents on the red zone and the licensed nurse was assigned to care for residents in the yellow and red zones. The Administrator confirmed the red zone was designated for the residents with confirmed cases of COVID-19 and on strict isolation precautions. The yellow zone was for the residents who had been recently admitted or readmitted and were in quarantine for possible COVID-19. The Administrator stated the facility planned to assign a licensed nurse to care of residents in the red zone; however, because there were only three residents with confirmed COVID positive, the licensed nurse was assigned to both units. On 12/14/2020 at 1230, an interview was conducted with LVN 1. LVN 1 stated today she was working both on the yellow and red zones. LVN 1 stated she passed the medications to the residents in the red zone at 0830 hours, then she went onto the yellow zone to

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) administer the residents' medications. LVN 1 was asked whether any residents needed to have medications administered today at noon time. LVN 1 stated Resident 1 who resided in the red zone needed their blood sugar checked everyday before the lunch, and she needed to check it. LVN 1 was observed entering the red zone by going through a closed fire door which was located between the yellow and red zones. On 7/14/2020 at 1248 hours, LVN 1 was observed inside resident Room E (located in the red zone). LVN 1 then observed to exit the resident's room, remove her gown and place it into of a trash bin located in the hallway, outside of Room E. LVN 1 then removed her face shield and disinfect it with the Lysol spray and let it air dry. LVN 1 then removed her gloves, performed hand hygiene using alcohol based hand sanitizer, donned a new pair of gloves, and then clean the glucometer. LVN continued wearing her N95 facemask. LVN 1 was then observed to return to the yellow zone through the closed fire door. On 7/17/2020 at 0938 hours, a telephone interview was conducted with the Orange County Local Public Health Nurse. The Nurse verified the facility should not float the staff, including licensed nurses from the confirmed COVID unit (red zone) to any other units in the facility on the same day. This creates a higher risk of cross-contamination of the COVID-19 virus. 2. Medical record review for Resident 2 was initialed on 7/14/2020. Resident 2 was admitted to the facility on [DATE], readmitted on [DATE] and was currently residing on the yellow zone. On 7/14/2020 at 1000 hours, EVS 1 was observed wearing a facemask and face shield and entered Room B without donning on a gown. EVS 1 donned on a pair of gloves and began cleaning the sink and emptied the trash can. EVS 1 then removed the soiled gloves, performed hand hygiene with an alcohol gel, and donned new gloves. While remaining inside Room B, EVS 1 cleaned the resident's overbed table, bed rail, and call-light without wearing a gown. This had might have allowed her clothing to come in contact with potentially COVID-19 contaminated surfaces which could be carried onto other residents' rooms. EVS 1 then mopped the room floor and afterwards she removed the soiled gloves, washed hand with soap, and water and left the room. EVS 1 was asked the reason she did not wear a gown before entering the resident's room. EVS 1 stated the sign was not marked what type of PPE equipment or precaution to use. EVS 1 stated she acknowledged Resident 2 was in the yellow zone. On 7/14/2020 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated the residents in the yellow zone were either readmitted from the acute care hospital or had recovered from COVID and were moved off from the red zone to the yellow zone. LVN 1 verified Resident 2 was readmitted and should be in quarantine for a minimum of 14 days; the isolation included droplet precautions. LVN 1 verified the staff should wear all PPE, including a gown when entering the residents' rooms on the yellow and red zones. 3. Review of the protocol on how to wear and reuse an N95 mask showed all direct care facility staff will be issued five brown paper bags for storage of their N95 masks. The bags will be labeled with the employee's name and numbered one thru from one to five. First day at work, the employee will use the N-95 mask from Bag 1. At the end of their shift, this mask will be returned to Bag 1. On the next day, the employee will wear the N-95 mask in the Bag 2. This process will be repeated each day they work until they work their way back to the N-95 mask that is in Bag 1. This process is to ensure there is at least 72 hours before a mask is reused. On 7/14/2020 at 1100 hours, the tour to the red zone was initiated with the DON. The entrance of the red zone was separated from the main entrance of the facility. There were multiple plastic bags observed in a large plastic box labeling Rehab Staff. The plastic bags were labeled the names of various rehab staff and contained a face shield and N95 masks. There was no evidence the rehab staff were provided brown paper bags and labeled them for the week to ensure there was at least 72 hours between reusing the same mask. The DON verified the findings. The DON stated the rehab staff should put their N95 in a brown paper bags and label them as the nursing staff does. The DON stated she would re-inservice the rehab staff on the reuse process of the N95 masks. On 7/14/2020 at 1325 hours, an interview and concurrent facility document review was conducted with Infection Control Preventionist (IP). The IP stated he provided the inservices titled Masking Guidance to all staff, which included the protocol for how to re-use the N95 masks. 4. Review of the facility's Mitigation Plan dated and signed on 5/21/20, showed residents admitted from the hospital and being tested prior to admission and if they test negative, will be quarantined for 14 days and then retested . The facility's mitigation plan also includes: newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Review of resident 4's face sheet showed the resident had been readmitted from the hospital on [DATE]. Resident 4 was observed to be in the green zone with only contact precautions signage outside of the room. On 7/14/20 at 0950 hours, EVS 1 was observed to enter Resident 4's room while cleaning the floor and high-touch surfaces. The room had a contact isolation sign outside of the resident's door. EVS 1 was observed to clean the room without donning a gown prior to entering the resident's room. On 7/14/20 at 1040 hours, during an interview and concurrent observation while walking through the the facility with the DSD/IP the isolation signage posted outside of two resident rooms in the yellow zone were observed to incorrectly have only the droplet precautions box indicated but did not include contact precautions. The contact precautions box was unchecked. This was discussed with DSD/IP who reported that he would correct it immediately. On 7/14/20 at 1325 hours, DSD/IP reported that it was the facility's policy to quarantine the readmitted residents and convalescing residents in the yellow zone for 14 days and transition residents to the green zone upon receiving two consecutive negative PCR COVID-19 test results. The DSD/IP reported Resident 4 met the criteria for discontinuing COVID-19 transmission-based precautions. On 7/15/20 at 1024 hours, DSD/IP was contacted via email to follow up on the COVID-19 PCR test results for Resident 4. The DSD/IP replied via email with testing history, which included one negative test from the hospital that had been performed on 7/2/20, and one negative test that had been performed at the facility on 7/10/20. The DSD/IP stated there was a typo on some of the signs posted, and Resident 4 was now in the yellow zone.