STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055539	A. BUILDING _____ B. WING _____	**03/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARTESIA CHRISTIAN HOME INC.	**11614 E. 183RD ST 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.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 3 residents (206), who was dependent on staff for activities of daily living, was provided with complete personal privacy. This deficient practice resulted in Resident 206 private parts exposed to others from the hallway, which violated the resident's right to personal privacy. Findings: a. A review of Resident 206's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool dated 3/4/20 indicated Resident 206 had severe cognitive (ability to learn, remember, understand and make decisions) impairment with daily decision making and was dependent on staff for activities of daily living including bathing, dressing, and toileting. On 3/7/20 at 7:10 a.m., Resident 206 was observed in bed uncovered with exposed adult brief. Resident 206's privacy curtain was open and the resident's exposed private parts were visible from the hallway to passerby. During an interview on 3/7/20 at 7:12 a.m., a Certified Nursing Assistant (CNA 3) confirmed Resident 206's did not have privacy curtain closed around the bed and the resident's body was exposed. CNA 3 stated that it was a violation of the resident's dignity and should not ever happened. During an interview on 3/7/20 at 8:01 a.m., CNA 4 stated it was a violation of Resident 206's dignity when privacy curtains were not fully drawn and resident's private parts were fully exposed to any passerby. CNA 4 stated Resident 206 should not be expose and should be provided with personal privacy at all times. CNA 4 stated Resident 4's diaper should be fastened, and the private parts should not be exposed where anybody can see it when passing by in the hallway. During an interview on 3/8/20 at 9:32 a.m., the Director of Staff Development (DSD) stated the residents have to have their privacy protected and not to have their bodies exposed and visible to passerby. The privacy curtain must be closed to ensure the residents dignity. DSD stated the staff has the responsibility to provide privacy and protect the residents' dignity. A review of the facility's policy titled Quality of Life-Dignity revised on 8/2009, indicated that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy indicated residents shall be treated with dignity and respect at all times. The policy indicated staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. b. On 3/08/20 at 8:49 a.m., in Resident 41's room, the registered nurse 2 (RN 2) was observed administering medication by mouth and through Resident 41's nares (nose) while the resident's privacy curtain was open and the resident was visible to passerby in the hallway. On 3/08/20 at 9:09 a.m., in Resident 49's room, RN 2 was observed administering medication to Resident 49 while the resident's privacy curtain was only partially close and the resident was visible to passerby in the hallway. During an interview on 3/08/20 at 3:55 p.m., RN 2 confirmed Resident 41's privacy curtain was open at the time of medication administration to Resident 41. RN 2 concurred she did not close the privacy curtain all the way for Resident 49 while she was administering medication to resident 49. RN 2 stated the residents should be provided with privacy during medication administration. A review of the facility's policy titled Quality of Life-Dignity revised on 8/2009, indicated that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy indicated residents shall be treated with dignity and respect at all times. The policy indicated staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on interview and record review, the facility failed to develop and implement the comprehensive care plans for the [DIAGNOSES REDACTED]. These deficient practice placed the resident at risk of not receiving nursing interventions related to the [DIAGNOSES REDACTED]. Findings: A review of Resident 18's clinical records indicated there was a physician's orders [REDACTED]. A review of Resident 18's History and Physical completed by the physician and dated 12/29/19, indicated the resident had [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool dated 12/31/19, indicated Resident 18 had an impairment in cognitive skills for daily decision making. During an interview on 3/08/20 at 2:27 p.m., the License Vocational Nurse (LVN 1) stated dementia and [MEDICAL CONDITION] are not the same. The residents with dementia are forgetting most of the things while the residents with [MEDICAL CONDITION] are having mental problems. For residents who has dementia, they usually keep repeating themselves, keeps asking, keeps bringing up something that is not there anymore. Residents with [MEDICAL CONDITION] would display behavioral manifestations such as spitting out, aggressiveness, cursing or has the tendency that they could harm themselves and others. A review of Resident 18's clinical record indicated there was no care plan developed for the resident's [DIAGNOSES REDACTED]. During an interview on 3/08/20 at 2:48 p.m., LVN 2 verified that the care plan for Resident 18's [MEDICAL CONDITION] had not been developed. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated December 2016, included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implements for each resident, will incorporate identified problem areas, reflect the currently recognized standards of practice for problem areas and conditions. A review of the facility's policy titled Use of Psychotherapeutic Drugs, dated 10/10/17, indicated there must be a primary [DIAGNOSES REDACTED]. The policy indicated symptoms must be significant enough that the resident is experiencing inconsolable or persistent distress (fear, continuous yelling, screaming), significant decline in function and substantial difficulty receiving needed care (i.e. not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that continuous oxygen therapy (treatment that delivers oxygen and increases the amount of oxygen in the lungs) was administered to one of one resident (Resident 48). This deficient practice had the potential to cause an adverse consequence, including respiratory complications. Findings: On 3/7/20 at 8:15 a.m., a Certified Nurse Assistant 1 (CNA 1) was observed in the restroom assisting Resident 48. Resident 48 was standing while holding on a grab bar while CNA 1 was fastening her diaper. Resident 48 was observed having difficulty breathing and had no supplemental oxygen therapy. At the resident's bedside, an oxygen concentrator was

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) observed running and the oxygen cannula was on the resident's bed. CNA 1 was observed to walk to the resident's bed and turn off the oxygen concentrator. During a concurrent interview, CNA 1 stated she turns off the oxygen when the resident goes to the bathroom because the resident did not need supplemental oxygen. On 3/7/20 at 8:22 a.m., Resident 48 was observed in the restroom panting (breathing with short, quick breaths) while CNA 1 was providing assistance with personal hygiene. CNA 1 assisted the resident from the toilet to the wheelchair and brought the resident back to bed. CNA 1 was observed to apply the nasal cannula (a device consisting of a lightweight tube which on one end splits into two prongs which are placed in the nostrils and from which a mixture of air and oxygen flows to deliver supplemental oxygen) on to the resident and turned the oxygen flow on. During a concurrent interview, CNA 1 stated the resident was receiving two (2) liters per minute (LPM) of oxygen. During a concurrent interview with Resident 48, the resident stated she felt terrible. Resident 48 stated she received supplemental oxygen all the time, even at night and her breathing was worse without the oxygen. During an interview on 3/7/20 at 8:30 a.m., Licensed Vocational Nurse 3 (LVN 3) stated CNA 1 should have taken the oxygen to the restroom with the resident because she had a continuous oxygen order. LVN 3 stated the charge nurse (licensed nurse) should be the one to remove and turn the oxygen back on. LVN 3 stated licensed staff are responsible for assessing the need for oxygen, the amount ordered and to ensure the oxygen nasal cannula and amount is applied on correctly. During a review of Resident 48's clinical record, a physician order (MD) dated 8/1/19 indicated an order of oxygen at two liters per minute (LPM) via nasal cannula and may titrate up to 5 LPM as needed for comfort. During an interview on 3/8/20 at 8:13 a.m., CNA 2 stated CNAs are not allowed to turn on or turn off an oxygen concentrator because the charge nurse knows the amount of oxygen ordered and are the ones who administer oxygen to the residents. During an interview on 3/8/20 at 8:38 a.m., CNA 3 stated for a resident who is having shortness of breath, we call the licensed nurses. CNA 3 stated CNAs administer oxygen or turn on or turn off an oxygen concentrator (a device that concentrates the oxygen from a gas supply by selectively removing nitrogen to supply an oxygen-[MEDICATION NAME] product). CNA 3 stated when a resident who is on continuous oxygen needs to use the restroom, the oxygen tank brought with the resident. During an interview on 3/8/20 at 8:54 a.m., Registered Nurse 1 (RN 1) stated CNAs cannot turn on or off an oxygen machine, they have to get the license nurses and the license nurse will assess the situation. RN 1 stated the decision for a CNA to remove or disconnect a resident from supplemental oxygen due to using the restroom was unsafe because the resident could have respiratory distress. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool dated 2/15/20, indicated Resident 48 had moderate cognitive impairment (ability to think, understand and make daily decisions), required limited assistance with transfer, personal hygiene and required extensive assistance with locomotion on and off unit, dressing and toilet use. Resident 48's [DIAGNOSES REDACTED]. A review of the care plans indicated Resident 48 was at risk for respiratory distress such as shortness of breath (SOB) related to [MEDICAL CONDITION] and asthma. One of the interventions indicated to administer oxygen at 2 liters per minute via nasal cannula. A review of the facility policy titled Administering Medications, dated 12/2012, indicated medications must be administered in accordance with the orders, including any required time frame.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to ensure daily staff posting was complete and had the required components available to residents and visitors. This deficient practice had the potential to not identify inadequate nursing personnel and required nursing hours to meet the facility's residents needs. Findings: On 3/07/20 at 6:10 p.m., a nurse staffing posting was observed posted across from the North nursing station indicating on 3/7/20 7 a.m. to 3 p.m. there were three (3) licensed and 11 unlicensed nurses; and for 3 p.m. to 11 p.m., there were 3 licensed and eight (8) unlicensed nurses working at the facility. There was no indication of the resident census (count) on the form. During an interview with Licensed Vocational Nurse 9 (LVN 9) on 3/07/20 at 6:18 p.m., the LVN stated the charge nurse from the North station updated the staffing list every shift. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 3/07/20 at 6:22 p.m., the LVN stated for the nurse staffing posting, the number of licensed staff did not indicate whether the nurses were Registered Nurses (RN) or Licensed Vocational Nurse (LVN). During an interview with the Director of Nursing (DON) on 3/08/20 at 10:30 a.m., the DON stated the nurse staffing form format had been used for many years. The DON stated the current form did not indicate the resident census and did not specify how many RNs and LVNs were scheduled per shift. The DON stated the census was needed to determine how many residents were currently being taken cared of. The DON stated she will update the posting form. A review of the facility policy titled Posting Direct Care Daily Staffing Numbers dated 2001 and revised 7/16, indicated within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two multi-dose vials and two inhalation medications were labeled with the date first opened for two of two residents (15, 36). This deficient practice placed the residents at risk to receive expired medication with related outcome. Findings: a. During a medication storage room observation on on [DATE] at 3:18 p.m. with the licensed vocational Nurse 4 (LVN 4), there was an opened vial of [MEDICATION NAME] solution (medicine that destroys or dissolves mucus that is usually given by inhalation) and an Influenza vaccine (a biological preparation that provides active immunity to a specific infectious disease) vial without a label to indicate the date first opened. Concurrently, during an interview, LVN 4 stated the vials had to be labeled with the date first opened to ensure medications were not stored beyond expiration date. A review of the facility's policy titled Injectable Medications, dated ,[DATE], indicated that all injectable medications must be dated when first opened/ punctured. b. During a medication storage room observation with the licensed vocational nurse 8 (LVN 8) on [DATE] at 4:28 p.m., one foil pouch of [MEDICATION NAME] for Resident 15 and foil pouch of [MEDICATION NAME] for Resident 36 were opened without a labeled to indicate the date first opened on the foil pouches or the outer box. During a concurrent interview, LVN 8 stated all medications have to have an open date. A review of Resident 15's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 36's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. to function independently).
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 observation, interview and record review, the facility failed to ensure: 1. One Licensed Vocational Nurse (LVN) removed a dirty pair of gloves after touching resident's environment, or performed hand hygiene prior to administering an injection to one of 1 resident (Resident 14). 2. One LVN performed hand hygiene prior to the administration of an eye medication to one of 1 resident (Resident 14). 3. One Licensed Vocational Nurse (LVN) changed gloves after preparing treatment supplies and prior to performing wound care to one of 1 resident (Resident 30) These deficient practices had the potential for cross contamination and spread of infection. Findings: a. On 3/8/20 at 7:37 a.m., during a medication pass (process of administering medications)preparation observation, Licensed Vocational Nurse 5 (LVN 5) withdrew [MED] (medication to control high blood sugar) from a vial into a syringe, then walk to Resident 14's bedside and drew the privacy curtain while wearing a pair of gloves. LVN 5 proceeded to disinfect the resident's right arm with an alcohol swab, and was observed to administer a subcutaneous (under the skin) injection on Resident 14's right upper arm while wearing the same gloves. b. On 3/8/20 at 8:22 a.m., during a medication pass observation for Resident 14, LVN 5 proceeded to Resident 14's bedside holding the artificial tears plastic tube (eye drops) on one hand, closed the curtain with bare hands, and administered the eye drops without hand hygiene prior to administration. During an interview on 3/8/20 at 8:06 a.m., LVN 5 stated bacteria could have been in the curtain and could have been harbored by touching it. LVN 5 stated by not washing

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) hands after the curtains had been touched and before the eye medication was given, I could have passed the bacteria to Resident 14. During an interview on 3/8/20 at 8:31 a.m., Certified Nurse Assistant 3 (CNA 3) stated after touching curtains either with gloves or bare hands, we should wash our hands after for protection and infection control. A review of the facility policy titled Infection Control Guidelines for all Nursing Procedures, dated 8/2012, indicated employees must wash their hands under the following conditions: 1. Before and after direct contact with the residents. 2. After removing gloves. 3. After handling items potentially contaminated with blood, body fluids or secretions. 4. Before donning gloves. 2. A review of Resident 30's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool dated 1/21/20, indicated Resident 30 had no impairment in cognitive skills (ability to learn, remember, understand and make decisions) for daily decision making. During an observation on 3/7/20 at 2:45 p.m., the licensed vocational nurse 5 (LVN 5) was observed wearing a pair of gloves while preparing treatment supplies for Resident 30 outside the resident room. LVN 5 entered Resident 30's room and provided wound care treatment to the resident's lip without hand washing or changing gloves. During an interview on 3/7/20 at 2:48 p.m., LVN 5 stated not washing hands and changing gloves before providing wound care treatment was an infection control issue and had the potential to transfer bacteria from the contaminated glove. During an interview on 3/8/20 at 4:13 p.m., LVN 4 stated, by not changing gloves or performing hand hygiene prior to a resident's treatment, placed the resident at high risk for lip infection. A review of the facility's policy titled Infection Control Guidelines for all Nursing Procedures, dated 8/2012, indicated employees must wash their hands under the following conditions: 1. Before and after direct contact with the residents. 2. After removing gloves. 3. After handling items potentially contaminated with blood, body fluids or secretions. 4. Before donning gloves.
F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet the space requirement to provide 80 square feet per resident in six of 31 resident bedrooms (34, 35, 36, 37, 38, 39). This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents in 34, 35, 36, 37, 38, 39 bedrooms. Findings: During a discussion with the Director of Nursing (DON) on 3/7/20 at 4:30 p.m., stated the facility had several rooms that measured less than the required square footage. The DON stated the facility had requested a room waiver variance for the following resident rooms: room [ROOM NUMBER]: (4 beds) 305.5 sq. ft. room [ROOM NUMBER]: (4 beds) 303.5 sq. ft. room [ROOM NUMBER]: (2 beds) 151 sq. ft. room [ROOM NUMBER]: (2 beds) 152 sq. ft. room [ROOM NUMBER]: (2 beds) 152 sq. ft. room [ROOM NUMBER]: (2 beds) 151 sq. ft. During an interview with Resident 30 on 3/7/20 at 11 a.m., stated there was no concerns regarding the size of the bedrooms and care being provided. During observations on these rooms throughout the survey period 3/7/20 and 3/8/20, there were no problems observed with the residents having access in and out of the rooms, the space for their furniture, and no problems with staff being able to administer or assist with the care.