STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055292	A. BUILDING _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIELDS RICHMOND NURSING CENTER	1919 CUTTING BLVD RICHMOND, CA 94804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a recertification survey conducted on 5/9/22 through 5/12/22. Representing the Department: HFENs 39383, 40747, 44771, and 45048. Two complaints and one FRI were investigated during the survey. Complaint numbers: CA00743011 and CA00783563. FRI number: CA00783491 No deficiencies were issued for complaint numbers CA00743011 and CA00783563 and FRI number CA00783491.	F 000	Shields Richmond Nursing Center submits this response and Plan of Correction as part of the requirements under State and Federal Law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636	F636 Comprehensive Assessments & Timing How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) In-service was conducted by DON on 5/13/2022 to MDS Coordinator regarding Comprehensive Assessments in accordance with the timeframes specified within 14 calendar days after admission, not less than once every 12 months	

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East Bay District Office

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/19/2022

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.

POC Accepted 7/1/22 Raquel Larson HFES

DPOC Accepted 7/12/22 Raquel Larson HFES

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F 636	Continued From page 1 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,	F 636	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) DON and MRD conducted an audit on 5/23/2022 of all residents Annual Comprehensive Assessments to identify any late annual assessments, NO other residents were identified. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-service was conducted by DON to MDS Coordinator on 5/13/2022 with emphasis on comprehensive assessment & timing of MDS annual comprehensive assessment. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. d) MRD will monitor facility compliance by auditing resident's MDS calendar focusing on Quarterly Assessments, weekly and will bring during the Daily Stand-Up, noncompliance issues identified will be corrected immediately by MDS coordinator. A report will be submitted to the Administrator during the Five days Department managers meeting for review, follow-up and validation. MRD and or DON will do trending/ analysis	

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F 636	Continued From page 2 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete the annual Minimum Data Set (MDS- an assessment tool used in skilled nursing facilities), for one of ten sampled residents (Resident 9). This failure had the potential to delay care planning and care delivery. Findings: Resident 9's annual MDS had an Assessment Reference Date (ARD - the last day to finish the assessment of the resident) of 2/28/22. The annual MDS was submitted and accepted on 5/6/22. During an interview on 5/12/22 at 9:18 a.m., with Director of Nursing (DON), DON stated, Resident 9's annual MDS was submitted late. DON stated, the MDS was required and was a reflection of the resident's condition and care. DON stated, the MDS was an assessment and could pick up changes in the resident's condition and was used to write plan care. DON further stated, staff need to have accurate assessments to provide care.	F 636	and will report to the monthly QAPI committee for further evaluation and or recommendations Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 638	F 638 Qrtly Assessment at Least every 3 Months How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	

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F 638	Continued From page 3 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete quarterly Minimum Data Sets (MDS- an assessment tool used to quid care) timely for eight of ten sampled residents (Residents 10, 11,16, 24, 37, 40, 48, and 49). This failure had the potential to delay care planning and delivery. Findings: During a review of Resident 10's quarterly MDS, the MDS indicated, Assessment Reference Date (ARD - the last day to finish the assessment of the resident) 9/24/21, and completed on 10/26/21. During a review of Resident 10's Quarterly MDS, the MDS indicated ARD 12/25/21, completed 1/4/22. During a review of Resident 10's Quarterly MDS, the MDS indicated, ARD 3/27/22, completed on 5/10/22. During a review of Resident 11's Quarterly MDS, the MDS indicated, ARD 3/26/21, no assessment completed. During a review of Resident 11's Quarterly MDS, the MDS indicated, ARD of 5/30/21, completed on 6/23/21. During a review of Resident 16's Quarterly MDS, the MDS indicated, ARD of 3/11/2022, completed on 5/6/2022.	F 638	a) In-service was conducted by DON on 5/13/2022 to MDS Coordinator regarding Quarterly review assessment using quarterly review instrument specified by the state and approved by CMS not less frequently than once every 3 months. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) DON and MRD conducted an audit on 5/23/2022 of all residents Quarterly Assessments to identify any late quarterly assessments, NO other residents were identified. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-service was conducted by DON to MDS Coordinator on 5/13/2022 with emphasis on quarterly MDS Assessment with emphasis on using quarterly review instrument specified by the state and approved by CMS not less frequently than once every 3 months. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. d) MRD will monitor facility compliance by auditing resident's MDS calendar focusing	

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F 638	Continued From page 4 During a review of Resident 16's Quarterly MDS, the MDSindicated, ARD of 12/9/21, completed on 2/7/2022. During a review of Resident 16's Quarterly MDS, the MDS indicated, of 9/9/21, completed on 1/21/2022. During a review of Resident 24's Quarterly MDS, the MDS indicated, ARD of 3/9/21, completed on 5/6/22. During a review of Resident 24's Quarterly MDS, the MDS indicated, ARD of 9/6/21, completed on 12/10/21. During a review of Resident 24's Quarterly MDS, the MDS indicated, ARD of 12/7/21, completed 2/7/22. During a review of Resident 37's Quarterly MDS, the MDS indicated, ARD of 8/22/21, completed on 10/14/21. During a review of Resident 37's Quarterly MDS, the MDS indicated, ARD of 11/22/21, completed on 12/29/21. During a review of Resident 37's Quarterly MDS, the MDS indicated, ARD of 2/22/22, completed on 4/26/22. During a review of Resident 40's quarterly MDS, the MDS indicated, ARD of 10/3/21, completed on 1/21/2022. During a review of Resident 40's quarterly MDS, the MDS indicated, ARD of 1/3/22, completed 5/3/2022.	F 638	on Comprehensive annual Assessments, weekly and will bring during the Daily Stand-Up, noncompliance issues identified will be corrected immediately by MDS coordinator. A report will be submitted to the Administrator during the Five days Department managers meeting for review, follow-up and validation. MRD and or DON will do trending/ analysis and will report to the monthly QAPI committee for further evaluation and or recommendations Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022	

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F 638	Continued From page 5 During a review of Resident 48's Quarterly MDS, the MDS indicated, ARD of 11/17/21, completed 1/17/22. During a review of Resident 48's Quarterly MDS, the MDS indicated, ARD of 2/17/22, completed 4/22/22. During a review of Resident 49's Quarterly MDS, the MDS indicated, ARD of 11/16/21, completed on 2/9/22. During a review of Resident 49's Quarterly MDS, the MDS indicated, ARD of 2/16/22, completed on 4/22/22. During an interview on 5/12/22 at 9:18 a.m., with Director of Nursing (DON), DON stated, Resident 9's annual MDS was submitted late. DON stated, the MDS was required and is a reflection of resident's condition . DON further stated, the MDS is an assessment and could pick up changes in the resident's condition and is used to formulate plan of care. DON also stated, staff have to accurately assess resident.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656	F656 Develop/Implement Comprehensive Care Plan How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident 114 Care plan was reviewed and corrected on 5/12/2022. In-service was conducted by DON on 5/23/2022 to Licensed Nurses regarding comprehensive person-centered care plan	

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F 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet the needs for one (Resident 114) of one sampled residents receiving dialysis when the facility did not develop and implement care plan for Resident 114's dialysis (treatment of kidney failure that rids your blood of unwanted	F 656	for each resident consistent with the resident's rights and that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive needs that are identified. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) DON, ADON and MDS conducted an audit on 5/12/2022 of all residents' care plan focusing on residents with ESRD on Hemodialysis and has Port-A-Cath, No other residents were identified. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-service was conducted by DON Licensed Nurses on 5/23/2022 with emphasis on comprehensive person-centered care plan for each resident consistent with the resident's rights and that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive needs that are identified. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is	

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F 656	Continued From page 7 toxins, waste products and excess fluids by filtering your blood) care. This deficient practice may result in Resident 114's physical, psychosocial and functional needs to go unmet. Findings: A review of Resident 114's "Admission Record", dated 5/11/22, the "Admision Record" indicated, Resident 114 was admitted to the facility on 5/4/22 with a diagnosis of acute respiratory failure (condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide). During a record review of Resident 114's doctor's orders, dated 5/11/22, indicated Resident 114 receives dialysis every Mondays, Wednesdays and Fridays at DaVita El Cerrito and has a right chest wall port-a-cath (an implanted device which allows easy access to a patient's veins) used for his dialysis access for his treatments. During a concurrent review of Resident 114's care plan on 5/11/22 at 12:12 p.m. with Director of Nursing (DON), care plan did not ndicate use and care of chest wall port-a-cath. DON stated, there should be a care plan for the use and care of right chest wall port-a-cath. A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", revised December 2016, the policy indicated, "8. The comprehensive, person-centered care plan will: b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial	F 656	integrated into the quality assurance system. d) DON, ADON and or MDS Coordinator will monitor facility compliance by auditing resident's care plans during admission, change of condition, quarterly, annually and significant changes focusing on patients with ESRD on Hemodialysis with Port-A-Cath, noncompliance issues identified will be corrected immediately by MDS coordinator. A report will be submitted to the Administrator during the Five days Department managers meeting for review, follow-up and validation. MRD and or DON will do trending/ analysis and will report to the monthly QAPI committee for further evaluation and or recommendations Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022	

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F 656	Continued From page 8 well-being;". A review of the facility's policy titled, "End-Stage Renal Disease, Care of a Resident with", revised September 2010, the policy indicated, "5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one (Resident 61), of three sampled residents, received effective oxygen therapy when staff did not assess and monitor Resident 61's use of oxygen. This deficient practice may result in ineffective oxygen therapy. Findings: A review of Resident 61's "Admission Record", dated 5/11/22, the "Admission Record" indicated, Resident 61 was admitted to the facility on 1/13/2020 with a diagnosis of seizures (a sudden, uncontrolled electrical disturbance in the brain).	F 695	F695 Respiratory/ Tracheostomy Care and Suctioning How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) In-service by DON on 5/23/2022 to Licensed Nurses regarding respiratory care is provided consistent with professional standards of care plan focusing on administration of Oxygen, monitoring Oxygen Saturation and to assess effectiveness of oxygen therapy. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) An Audit of residents receiving Oxygen therapy has been conducted by DON, ADON and MRD on 5/13/2022, No other residents were identified What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-service by DON on 5/23/2022 to Licensed Nurses regarding respiratory care is	

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F 695	Continued From page 9 A review of Resident 61's "Medication Review Report", dated 5/11/22, the "Medication Review Report" indicated, doctor's order on 2/14/2020 to start oxygen at 1 liters per minute (LPM- flow rate) as needed to titrate oxygen saturation above 90% and to wean or discontinue as tolerated by the resident. During a concurrent observation and interview on 5/10/22 at 10:11 a.m., Resident 61 was in bed receiving oxygen by a nasal cannula at 3 LPM. Registered Nurse (RN) 2 confirmed Resident 61 was on oxygen at 3 LPM. RN 2 stated, Resident 61 usually receives oxygen at 2 LPM and does not know why the oxygen is at 3 LPM. RN 2 further stated, Resident 61 is rarely not on oxygen therapy. During a concurrent record review and interview on 5/11/22 at 11:30 a.m. of Resident 61's "Medication Administration Record" (MAR) for May 2022 with Director of Nursing , the MAR indicated no oxygen assessment. Director of Nursing (DON) stated, staff should document how much oxygen Resident 61 is receiving each time staff checks Resident 61's oxygen saturation the assess the effectiveness of oxygen therapy. A review of the facility document titled, "Oxygen Administration," revised October 2010, the "Oxygen Administration" indicated, "After completed the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 3. The rate of oxygen flow, route, and rationale."	F 695	provided consistent with professional standards of care plan focusing on administration of Oxygen, monitoring Oxygen Saturation and to assess effectiveness of oxygen therapy. All Licensed Nurses will be visually monitored and observed to ensure facility compliance by DON, ADON on resident's receiving Oxygen therapy, issues identified will be corrected immediately, immediate retraining will be provided by DON and or ADON. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. d) All Licensed Nurses will be visually monitored and observed to ensure facility compliance by DON, ADON on resident's receiving Oxygen therapy, issues identified will be corrected immediately, immediate retraining will be provided by DON and or ADON. DON and/or DSD will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022	
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

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SHIELDS RICHMOND NURSING CENTER	1919 CUTTING BLVD RICHMOND, CA 94804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 10 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care for one (Resident 114) that required dialysis (treatment of kidney failure that rids your blood of unwanted toxins, waste products and excess fluids by filtering your blood) when staff did not do a complete assessment before Resident 114's dialysis treatment. This deficient practice resulted in an incomplete assessment of Resident 114's dialysis access site before their dialysis treatment. Findings: A review of the document titled, "Admission Record," dated 5/11/22, the "Admission Record" indicated, Resident 114 was admitted to the facility on 5/4/22, with a diagnosis of acute respiratory failure (condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide). During a review of Resident 114's doctor's orders, dated 5/11/22, the doctor's order indicated, Resident 114 receive dialysis treatments every Mondays, Wednesdays and Fridays at DaVita El Cerrito and has a right chest wall port-a-cath (an implanted device which allows easy access to a patient vein) used for his dialysis access during treatments.	F 698	F698 Dialysis How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident 114 has Port-A-Cath dialysis access on his right chest. Staff have been monitoring the patient's access site every shift and is documented on the electronic medication administration record (EMAR) since admission day 5/4/2022. Revision and update on monitoring to indicate Port-A-Cath on his EMAR was done 5/10/2022. Dialysis Communication form has been reviewed, revised, and updated on 5/13/2022. Training and education was conducted by DON on 5/23/2022 to all licensed nurses regarding new dialysis communication form with emphasis on site monitoring focusing to note if the resident has AV Fistula, AV Shunt or Port-A-Cath or Central Dialysis access. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) DON, ADON, MDS Coordinator and Medical Records Director conducted an audit on 5/16/2022 to identify any residents who have Port-A-Cath, focusing to note if the resident has AV fistula, AV shunt or Port-A-Cath or Central Dialysis access to ensure a completed assessment by a licensed nurses regarding dialysis communication and	

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F 698	Continued From page 10 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care for one (Resident 114) that required dialysis (treatment of kidney failure that rids your blood of unwanted toxins, waste products and excess fluids by filtering your blood) when staff did not do a complete assessment before Resident 114's dialysis treatment. This deficient practice resulted in an incomplete assessment of Resident 114's dialysis access site before their dialysis treatment. Findings: A review of the document titled, "Admission Record," dated 5/11/22, the "Admission Record" indicated, Resident 114 was admitted to the facility on 5/4/22, with a diagnosis of acute respiratory failure (condition in which the lungs have a hard time loading blood with oxygen or removing carbon dioxide). During a review of Resident 114's doctor's orders, dated 5/11/22, the doctor's order indicated, Resident 114 receive dialysis treatments every Mondays, Wednesdays and Fridays at DaVita El Cerrito and has a right chest wall port-a-cath (an implanted device which allows easy access to a patient vein) used for his dialysis access during treatments.	F 698	F698 This tag is under IDR How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident 114 has Port-A-Cath dialysis access on his right chest. Staff have been monitoring the patient's access site every shift and is documented on the electronic medication administration record (EMAR) since admission day 5/4/2022. Revision and update on monitoring to indicate Port-A-Cath on his EMAR was done 5/10/2022. Dialysis Communication form has been reviewed, revised, and updated on 5/13/2022. Training and education was conducted by DON on 5/23/2022 to all licensed nurses regarding new dialysis communication form with emphasis on site monitoring focusing to note if the resident has AV Fistula, AV Shunt or Port-A-Cath or Central Dialysis access. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) DON, ADON, MDS Coordinator and Medical Records Director conducted an audit on 5/16/2022 to identify any residents who have Port-A-Cath, focusing to note if the resident has AV fistula, AV shunt or Port-A-Cath or Central Dialysis access to ensure a completed assessment by a licensed nurses regarding dialysis communication and	

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F 698	Continued From page 11 During a concurrent interview and record review on 5/11/22, at 1:38 p.m. of Resident 114's "Dialysis Communication Record" on 5/9/22 and 5/11/22 with Director of Nursing (DON), the "Dialysis Communication Record" indicated, nursing staff did not assess Resident 114's dialysis site before his dialysis treatment. DON acknowledged Resident 114's dialysis access site was not assessed before his dialysis treatments on 5/9/22 and 5/11/22.	F 698	monitoring of dialysis access. No other residents were identified with the same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	c) Training and education was conducted by DON to all licensed nurses on 5/23/2022 regarding new dialysis communication form with emphasis on site monitoring focusing to note if the resident has AV Fistula, AV Shunt or Port-A-Cath or Central Dialysis access. All resident who has renal disease on Hemodialysis with dialysis access sites will be reviewed by the DON, ADON, MDS nurse during the five days Clinical IDT meeting, issues identified was corrected immediately by DON, ADON and/or MDS Nurse. On the weekends, the Desk Nurse or Admission Nurse is responsible to review. A second review will be done by the IDT headed by the DON during the weekday Clinical IDT meeting. Issues identified will be documented in the resident's EMAR and Dialysis Communication form. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	

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F 880	Continued From page 12 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880	d) DNS and/or designee, MRD will monitor facility for compliance during their five days IDT clinical meeting by reviewing resident admission assessments and dialysis communication form. Non-compliance issues identified will be corrected immediately. A report will be submitted to the administrator during department managers stand-up meeting for review, validation, and immediate resolution. DON, ADON will do trending analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State. e) 6/12/2022 F880 Infection Prevention Control How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) In-service was conducted to licensed nurses by DON on 5/23/2022 "Infection Control-Hand Washing" with emphasis on total time of handwashing procedure should be at least 20 seconds and a return demonstration was conducted by DSD to licensed nurses on 5/23/2022	

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F 880	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene between giving medications to two residents (Resident 21 and Resident 119) of 20 sampled residents This failure had the potential to cause or spread infections which can lead to hospitalization for Resident 21 and Resident 119, as well as the rest of the residents in the facility. Findings: 1. During concurrent observation and interview on 05/11/2022, at 4:08 p.m., with Registered Nurse 1 (RN1), in room 20, RN1 was observed giving medications to Resident 21. RN1 then went back to the medication cart and prepared medications for Resident 119 without performing hand hygiene. RN1 stated, she should have sanitized her hands between passing medications to different residents because it could spread infections. During an interview on 05/11/2022, at 12:05 p.m., with Director of Staff Development/Infection Preventionist (DSD/IP), DSD/IP stated, her expectation is that all staff perform hand hygiene between giving residents care, coming in and going out of resident rooms, and between glove changes. During a review of the facility handwashing/hand hygiene policy, dated August 2019, the policy indicated, "2. All personnel shall follow the handwashing/handhygiene procedures...7. c. Before preparing or handling medications...m.	F 880	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken b) DON, ADON and DSD/IP Nurse conducted observation of licensed nurses hand washing on 5/23/2022, no other licensed nurses were identified with the same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-service was conducted to licensed nurses by DON on 5/23/2022 regarding "Infection Control Hand Washing" with emphasis on total time of handwashing procedure should be at least 20 seconds and a return demonstration was conducted by DSD to licensed nurses on 5/23/2022. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. d) DSD/IP Nurse will conduct observation of all staff hand washing during her five days a week rounds, issues identified will be corrected immediately and a report will be submitted to the DON for review and validation. DSD/IP Nurse will monitor facility compliance by conducting observation of all staff hand washing during her five days a	

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F 880	Continued From page 14 after removing gloves..."	F 880	week rounds, non-compliance issues identified will be corrected immediately and a report will be submitted to the DON for review and validation.	
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide 80 square foot of space per resident for 30 residents who occupied 12 multi-bed bedrooms. This condition had the potential to result in lack of sufficient space for the provision of care both routine and emergency and for residents to have their personal belongings at bedside. Findings: During multiple room observations on 5/9/22 through 5/12/22, there were three residents in Rooms 22, 24, 27, 31, 33, and 35 and a two residents occupying three-bedroom rooms in Rooms 23,25,26,30,32, and 34. 1. Room 22 measured 11.3 feet by 19 feet which equaled 71.56 square feet per resident. 2. Room 23 measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 3. Room 24 measured 19.3 feet by 11.4 feet which equaled 73.34 square feet per resident. 4. Room 25 measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident.	F 912	Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022 F 912 Bedrooms Measure at Least 80 sq Ft/Resident How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) A room waiver has been completed and submitted for approval. No complaints or adverse effects were noted for these residents. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) No other residents identified to be affected by the deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:	

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F 912	Continued From page 15 5. Room 26 measured 19.1 feet by 11 feet which equaled 70.03 square feet per resident. 6. Room 27 measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 7. Room 30 measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 8. Room 31 measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 9. Room 32 measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 10. Room 33 measured 18.9 feet by 11.3 feet which equaled 71.19 square feet per resident. 11. Room 34 measured 18.1 feet by 11.7 feet which equaled 70.59 square feet per resident. 12. Room 35 measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident. During random observations of care and services from 5/9/22 to 5/12/22, there was sufficient space for the provision of care for the residents in all rooms. There were no heavy equipment in the rooms that might interfere with residents care and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. During an interview on 5/12/22, at 9:58 a.m., with Resident 11, Resident 11 stated, she had sufficient space in her room. Resident 11 stated, she liked her room.	F 912	c) Department managers will conduct room rounds daily to ensure the room space is clear of unnecessary clutter (i.e., equipment, wheelchair, and commodes). How the facility plans to monitor its performance to make sure that solutions are sustained. d) Findings identified will be reported to QAA committee monthly x3 until compliance is met. Include dates when corrective action will be completed. The corrective action completion date must be acceptable to the State e) 6/12/2022	

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F 912	Continued From page 16 During an interview on 5/12/22, at 10:31 a.m., Resident 37 stated, she liked her room and had room for her personal belongings. There were no negative consequences resulted from decreased space. No safety concerns or residents in the six rooms. Granting of room size waiver recommended.	F 912		