| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055239 | A. BUILDING _____ B. WING _____ | 06/17/2022 |

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| F 000 | INITIAL COMMENTS<br><br>The following represents the findings of the California Department of Public Health during a recertification survey conducted on 6/13/22 through 6/17/22.<br><br>Representing the Department: HFENs 36087, 38534, 39512, 34714. | F 000 | Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency of this 2567. The plan of correction is prepared/or executed solely because it is required by the provisions of the State law. | |
| F 685 SS=D | Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)<br><br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and record review, the facility failed to arrange for a vision consult upon admission for one of 17 sampled residents (Resident 36).<br><br>The failure to refer Resident 36 for eye care upon admission resulted in Resident 36 not receiving an eye exam on 3/30/22, during the routine eye care visit, with a subsequent delay in services for eleven additional weeks. This failure had the potential to result in impairment of Resident 36's vision. | F 685 | **F- 685**<br>Resident 36 vision/eye exam was scheduled on June 27, 2022.<br><br>All Residents have the potential to be affected by the same deficient practice.<br><br>Facility will continue to schedule Optometry consultations every 3 months (quarterly) and as needed.<br><br>Social Services or designee to audit the quarterly optometry consultation list and verify with nursing it is accurate. Any new optometry recommendations will be added to the list for the resident to be seen. | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| [signature] | ADMINISTRATOR | 7/12/22 |

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 acceptable 7/20/22 per HFES Pamela Bennett



DPOC acceptable 8/3/22 by HFES Pamela Bennett

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| F 685 | Continued From page 1<br><br>Findings:<br><br>A review of Resident 36's face sheet, undated, indicated Resident 36 was admitted on 2/8/22, with a diagnosis of a fracture of nasal bones and a Le Fort I fracture (a horizontal facial fracture characterized by the separation of the hard palate from the upper jaw). The face sheet also indicated Resident 36 had a family member, RP, to act as a responsible party and emergency contact.<br><br>A review of Resident 36's, "Physician Order Report," dated 2/8/22, indicated, "Consult-Vision for eye health with follow-up and treatment as indicated."<br><br>A review of the facility document, "Advanced Eyecare Doctor Summary Sheet," dated 3/30/22, indicated there were 22 residents examined by the optometrist; the examination list did not include Resident 36.<br><br>During an interview on 6/15/22, at 12:20 p.m., with the Social Worker (SW), SW stated Resident 36 had not been placed on the list to be evaluated by the optometrist and therefore had not received an eye examination at the facility.<br><br>During an interview on 6/15/22, at 1:38 p.m., with the Director of Nursing (DON), the DON stated Resident 36 should have been evaluated by the optometrist since there was an order from the physician for an optometry consult. The DON stated Resident 36 had not been entered onto the list for vision screening and had not received an eye health evaluation while at the facility. The DON stated it is the responsibility of the SW to | F 685 | IDT will identify the resident upon admission/quarterly and annual assessment and SW will refer them to Optometry.<br><br>Social Services Director or designee to ensure each resident on the list is seen during optometry on site scheduled visits and as needed.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 685 | Continued From page 2<br>enter residents' names onto the list to be screened by the optometrist.<br><br>During a phone interview on 6/15/22, at 3:42 p.m., with RP, RP stated it was important for Resident 36 to have an eye examination. RP stated Resident 36 had fallen and broken multiple bones in his face, which had the potential to affect Resident 36's vision. | F 685 | | |
| F 687 SS=D | Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to follow the physician's orders to refer two of 17 sampled residents (Resident 2 and Resident 54) for podiatry (foot specialty) services. Resident 2 had no podiatry services for four months after one podiatry visit. Resident 54 had no referral for podiatry services for three weeks and three days following admission.<br><br>These failures resulted in Resident 2 and Resident 54 developing long toenails which had | F 687 | F- 687<br>Resident 2 and Resident 54 were referred to Podiatrist and had Podiatry Consult on 06/20/22 and 07/01/22.<br><br>All Residents have the potential to be affected by the same deficient practice.<br><br>Facility will continue to schedule podiatry consultations every 3 months (quarterly) and as needed.<br><br>Social Services or designee to audit the quarterly podiatry consultation list and verify with nursing it is accurate. Any new podiatry recommendations will be added to the list for the resident to be seen.<br><br>IDT will identify the resident upon admission/quarterly and annual assessment and SW will refer them to podiatrist. | |

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| F 687 | Continued From page 3<br>the potential to result in skin breakdown/injury, infection, and amputation of toes and/or feet.<br><br>Findings:<br><br>A review of Resident 2's face sheet, undated, indicated an admission date in December 2021. The face sheet indicated Resident 2 had diagnoses of weakness of the left side following a stroke, general weakness, and impaired walking and mobility.<br><br>A review of Resident 2's physician order, dated 12/15/21, indicated, "Consult- podiatry as needed," for fungal infection, thick nails and/or skin lesions.<br><br>A review of Resident 2's podiatry services note dated 2/18/22, indicated Resident 2 was a new patient with pain and swelling in both feet, fungal infection of the toenails, and dry skin. The note indicated the toenails on both feet were brittle, discolored, elongated, curved inward, overgrown, painful, and had fungal infections. The note indicated the podiatrist (a doctor specializing in treatment of the foot) trimmed and cleaned Resident 2's toenails.<br><br>During an interview and concurrent observation on 6/13/22 at 11:46 a.m., in Resident 2's room, Resident 2 lay in bed with his lower body under an untucked sheet. Resident 2 stated he wanted to get stronger because he wanted to go home. Resident 2 stated he had a stroke that affected the left side of his body. Resident 2 stated he was in the bed most of the time and exercised his own left arm and leg while he was in bed. Resident 2's feet began to stick out from under the sheet; Resident 2's toenails, on both feet, were yellow, | F 687 | Social Services Director or designee to ensure each resident on the list is seen during podiatry on site scheduled visits and as needed.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 687 | Continued From page 4<br>thick, and protruded beyond the ends of the toes. Resident 2's toenails on toes number one (big toe), three, and four curved around and touched the skin on the bottom of the toe.<br><br>During an interview and concurrent observation on 6/16/22 at 1:02 p.m., with Licensed Vocational Nurse 3 (LVN 3), in Resident 2's room, LVN 3 examined Resident 2's feet. LVN 3 stated Resident 2 needed his toenails trimmed.<br><br>A review of Resident 54's face sheet, undated, indicated Resident 54 was admitted in May 2022, with diagnoses that included end stage renal disease (kidney failure), and chronic respiratory disease.<br><br>A review of Resident 54's physician orders indicated an order dated 5/22/22, for, "Consult-podiatry as needed," for fungal infection, thick nails, and/or skin lesions.<br><br>During an interview and concurrent observation on 6/13/22 at 11:35 a.m., in Resident 54's room, Resident 54 lay in bed with his right foot on top of the covers. Resident 54's right big toenail (toe number one) was gray and thick; the tip of the toenail was pointed and protruded beyond the end of the toe.<br><br>During an interview and concurrent record review on 6/17/22 at 10:25 a.m., with the Social Worker (SW), the physician orders and progress notes for Resident 2 and Resident 54 were reviewed; in addition, Resident 2's podiatry service note was reviewed. SW confirmed Resident 2 was last seen by the podiatrist on 2/18/22. SW confirmed the podiatry referral for Resident 54 had not yet been completed. SW stated the podiatrist came | F 687 | | |

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| F 687 | Continued From page 5<br>to the facility at least once a month. SW stated she had just started updating her podiatry status logs, as she had been preoccupied with resident COVID cases (a contagious respiratory infection). | F 687 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to ensure one of eight sampled residents (Resident 39) received services to improve mobility and achieve maximum practicable independence when Resident 39 did not receive restorative nursing services for walking with a walker (an ambulation device with two to four wheeled legs, connected by handlebars to provide stability when walking).<br><br>The failure to provide daily services to practice | F 688 | **F-688**<br>DSD in-serviced CNAs to walk resident during the day on 06/14/22 and LN will make document for any refusals.<br><br>Residents to be assessed by rehab department to identify any changes and referred for rehab services as needed.<br><br>Facility has newly hired RNA working full time effective 07/01/22.<br><br>Facility will continue to screen and eval residents for therapy services.<br><br>Director of Nursing or designee to audit monthly in RNA meeting for residents to be seen or orders to be updated.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 688 | Continued From page 6<br>walking with a walker potentially contributed to muscle weakness and decreased mobility for ten weeks.<br><br>Findings:<br><br>A review of Resident 39's face sheet indicated he was admitted to the facility with diagnoses of generalized muscle weakness and difficulty walking.<br><br>A review of Resident 39's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 5/20/22, indicated Resident 39 was understood and could understand others. The MDS indicated Resident 39 had not walked in his room or the unit but had used a wheelchair for locomotion. The MDS indicated Resident 39 needed extensive physical assistance from one person for transfer between surfaces and limited assistance from one person for locomotion. The MDS indicated Resident 39 had not received physical therapy or restorative nursing services during the assessment period.<br><br>During an interview on 6/13/22 at 9:45 a.m., with Resident 39, Resident 39 stated he had been discharged by physical therapy a while ago, and since then, no one had been helping him to walk with a walker. Resident 39 stated he still had muscle weakness and had to either stay in bed or use a wheelchair to go out of his room. Resident 39 said he wished someone would help him learn to walk with a walker.<br><br>During an interview on 6/15/22 at 11:15 a.m., with Director of Rehabilitation (DOR), DOR stated physical therapy (PT) discharged Resident 39 to the Restorative Nursing Assistant (RNA) program | F 688 | | |

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| F 688 | Continued From page 7<br>in March 2022 and the RNAs should provide services to assist Resident 39 to build strength and be able to walk with a walker. DOR stated Resident 39 should have received daily assistance to practice walking with a walker.<br><br>A review of Resident 39's, "Physical Therapy Discharge Summary, Discharge Recommendations and Status," dated 3/31/22, indicated, "...Restorative Ambulation Program...ambulation of short distances to gradually build mobility tolerance with 2WW (Two Wheeled Walker)..."<br><br>A review of Resident 39's, "Point of Care History, Activities of Daily Living (ADL)s," dated 4/1/22 to 6/15/22, indicated there had been no documented attempts to assist Resident 39 with using a walker for locomotion.<br><br>During a concurrent interview and record review on 6/15/22 at 10:00 a.m., with the Director of Nursing (DON), Resident 39's ADL sheets, CNA notes, physical therapy discharge summary, and care plans were reviewed. The DON was unable to provide documentation that showed Resident 39 had received assistance walking, or any care plan for RNA services. The DON stated the facility had dropped the RNA program in March 2022 with a plan for Certified Nurse Assistants (CNA)s to provide the services formerly provided by the RNAs. The DON stated the CNAs should have assisted Resident 39 with practicing walking with a walker.<br><br>During an interview on 6/16/22 at 9:40 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated he was one of the regular CNAs for Resident 39. CNA 2 stated there was no physician order and | F 688 | | |

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| F 688 | Continued From page 8<br>no care plan that indicated Resident 39 should be assisted to practice using the walker.<br><br>A review of the facility policy and procedure, "Restorative Nursing Services," revised July 2017, indicated, "...Residents will receive restorative nursing care as needed to help promote optimal safety and independence...1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care...5. Restorative goals may include, but are not limited to supporting and assisting the resident in...developing, maintaining, or strengthening his/her physiological and psychological resources..." | F 688 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility | F 755 | F- 755<br>DON provided an in-service to licensed nurses on 6/14/22 and 07/13/22 on Medication Administration and specifically passing medications while at the bedside.<br><br>Facility has discussed with MD/Pharmacist who advised to change the order of MiraLAX to mix with 4 to 6 oz of water instead of 8 oz. Orders were updated on 6/28/22.<br><br>DON provided in-service to all LVN on Medication Administration, policy of leaving unattended medication and following prescribed medication orders. | |

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| F 755 | Continued From page 9<br>must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to provide appropriate pharmaceutical services for two of eight sampled residents (Resident 42 and Resident 10) when:<br><br>1. Resident 42's had four medications left unattended on her bedside table; the administration of the medications was delayed for one hour and fifty minutes past the scheduled administration time.<br><br>This failure resulted in Resident 42 not receiving her medications timely, and Resident 10 receiving a more concentrated dose of medication. For Resident 42, the one hour and fifty minutes delay in administration of hydroxyzine (an anti-anxiety drug) resulted in potential stacking of doses as the next dose of hydroxyzine was due in one hour and ten minutes. Stacking of doses had the potential to result in adverse side effects such as seizures. Resident 42's unsupervised medications also had the potential to result in | F 755 | Director of Nursing or designee to audit medication administration 1x per week for 1 month, then monthly for proficient medication administration.<br><br>Director of Staff Development or designee will perform nurse competency skills evaluation test annually.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 755 | Continued From page 10<br>diversion of the medications to other residents, with subsequent adverse side effects such as low blood pressure, fast heart rate, dizziness, drowsiness, seizures.<br><br>2. Resident 10's powdered Miralax (stool softener) was diluted in six ounces of water instead of the eight ounces ordered by the physician.<br><br>This failure had the potential to result in Resident 10's medication to be less effective due to incorrect medication concentration, with the result of constipation.<br><br>Findings:<br><br>1. A review of Resident 42's "Face Sheet" indicated Resident 42 admitted to the facility with a diagnosis of bullous pemphigoid (a disease caused by reaction of the body's own immune system causing itching, hives, and blisters on the skin), and hypertension (high blood pressure).<br><br>During an observation on 6/13/22 at 11:50 a.m., in Resident 42's room, Resident 42 lay in bed sleeping. On top of the bedside table adjacent to Resident 42's bed was a plastic cup with four tablets inside the cup.<br><br>A review of Resident 42's Medication Administration Record (MAR) dated 6/1/22 to 6/15/22, indicated four medications were due for administration at 9 a.m.: hydroxyzine, prednisone (to reduce inflammation), methotrexate (to reduce the body's immune response), amlodipine (to reduce blood pressure). The MAR indicated the hydroxyzine was due three times per day, with administration times of 9 a.m., 1 p.m., and 5 p.m. | F 755 | | |

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| | 055239 | A. BUILDING _____ B. WING _____ | 06/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EAST BAY POST-ACUTE | 20259 LAKE CHABOT ROAD CASTRO VALLEY, CA 94546 |

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| F 755 | Continued From page 11<br><br>During an interview on 6/13/22 at 11:55 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she had left four of Resident 42's medications on her bedside table in a plastic cup. LVN 1 stated the four medications were prednisone, hydroxyzine, methotrexate, and Amlodipine. LVN 1 stated she had left the medications on the bedside table and gone to the resident room next door to help provide care to another resident.<br><br>During an interview on 6/14/22 at 1:04 p.m., with the Director of Nursing (DON), DON stated medications should not be left unattended in resident rooms. The DON stated it was important for a nurse to watch a resident take their medications before the nurse left the resident room, to ensure the resident received their medication and that no other residents had access to medications not prescribed for them.<br><br>A review of the facility's policy and procedure, "Administering Medications," revised April 2019, indicated, " ...Medications are administered within one (1) hour of their prescribed time...The medications shall not be left unattended at the bedside..."<br>2. A review of Resident 10's face sheet indicated an admission date in 2017, with diagnoses of kidney failure and general weakness.<br><br>A review of Resident 10's Physician Order Report indicated an order with a start date of 8/31/21, for 17 grams of Miralax powder (a stool softener) to be given orally. The order indicated, "Special Instructions: For constipation prevention. Mix with 8 oz (ounces) of water or juice. Twice a day ..."<br><br>During an observation on 6/15/22 at 9:45 a.m., | F 755 | | |

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| F 755 | Continued From page 12<br>Licensed Vocational Nurse 2 (LVN 2) prepared the Miralax powder for administration to Resident 10. LVN 2 measured a capful (17 grams) of Miralax powder into a plastic cup and added water into the cup to a level one-half inch below the rim. LVN 2 went into Resident 10's room and gave the cup to Resident 10, who drank the medication.<br><br>During an interview on 6/15/22 at 10:12 a.m., LVN 2 stated she thought the plastic cup used to administer Resident 10's Miralax held eight ounces of fluid. LVN 2 used a one-ounce medication cup to measure water into the plastic cup and found the cup could only contain a maximum of six ounces.<br><br>A review of the facility policy, "Administering Medication," revised April 2019, indicated, "Medications are administered in accordance with prescriber orders..." | F 755 | **F- 790**<br>Resident 36 was referred for dental consultation on 06/15/22 and had dental consultation at the facility on 06/17/22.<br><br>All Residents have the potential to be affected by the same deficient practice.<br><br>Facility will continue to schedule dental consultations every 3 months (quarterly) and as needed.<br><br>Social Services or designee to audit the quarterly dental consultation list and verify with nursing it is accurate. Any new dental recommendations will be added to the list for the resident to be seen. | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an | F 790 | IDT will identify the resident upon admission/quarterly and annual assessment and SW will refer them to the dentist.<br><br>Social Services Director or designee to ensure each resident on the list is seen during dental on site scheduled visits and as needed.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 790 | Continued From page 13<br>additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to arrange for a dental consult upon admission for one of 17 sampled residents (Resident 36).<br><br>The failure to refer Resident 36 for a dental exam upon admission resulted in Resident 36 not receiving a dental exam on 3/30/22 or 3/31/22, during the routine dental care visit, with a subsequent delay in services for eleven additional weeks. This failure had the potential to result in difficulty eating and weight loss. | F 790 | | |

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| F 790 | Continued From page 14<br>Findings:<br><br>A review of Resident 36's face sheet, undated, indicated Resident 36 was admitted on 2/8/22 with multiple diagnoses including a fracture of nasal bones and a Le Fort I fracture (a horizontal facial fracture which is characterized by separation of the hard palate from the upper jaw). The face sheet also indicated Resident 36 had a family member as responsible party and emergency contact, RP.<br><br>A review of Resident 36's "Physician Order Report," dated 2/8/22, indicated, "Consult-Dental for oral hygiene with follow-up and treatment as indicated."<br><br>A review of Resident 36's Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 2/14/22, indicated Resident 36 had, "obvious or likely cavity or broken natural teeth."<br><br>During an observation on 6/13/22, at 11:26 a.m., in Resident 36's room, Resident 36 sat up in bed and smiled. Resident 36 was missing an upper front tooth and had a broken upper tooth.<br><br>A review of facility document titled, "Patients seen for dental exams at last screening ...on March 30 and 31, 2022," undated, indicated the dentist had examined 29 residents; the examination list did not include Resident 36.<br><br>During an interview on 6/15/22, at 12:20 p.m., with the Social Worker (SW), SW stated the dentist examined residents at the facility on 3/30/22 and 3/31/22, but Resident 36 had not been placed on the list to be evaluated by the dentist and therefore did not receive a dental | F 790 | | |

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| F 790 | Continued From page 15<br>screening.<br><br>During an interview on 6/15/22, at 1:38 p.m., with the Director of Nursing (DON), the DON stated Resident 36 should have been evaluated by the dentist since there was an order from the physician for a dental consult. The DON stated Resident 36 had not been entered onto the list for dental screening and had not received a dental evaluation while at the facility. The DON stated it is the responsibility of the SW to enter residents' names onto the list to be screened by the dentist.<br><br>During a phone interview on 6/15/22, at 3:42 p.m., with RP, RP stated it was important for Resident 36 to have a dental examination because Resident 36 had fallen and broken bones in his face. RP was concerned about the condition of Resident 36's teeth and his ability to eat. | F 790 | | |
| F 803 SS=E | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident | F 803 | F- 803<br>Dietary Supervisor in-serviced staff and cooks on following menu, specifically for pureed diet orders on 7/1/22.<br><br>All Residents have the potential to be affected by the same deficient practice.<br><br>Dietary Supervisor or designee to audit tray line and ensure that menu is being followed 1x per week for 1 month, then monthly.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 803 | Continued From page 16<br>groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure the menu was followed for seven of seven residents when Cook 1 prepared white rice for residents on a pureed diet instead of the Spanish rice listed on the menu.<br><br>This failure had the potential to result in less appetizing and nutritious food, and less food consumption, nutritional imbalance, and weight loss.<br><br>Findings:<br><br>A review of the posted facility menu for Week 1 from June 12 to June 18 for Tuesday (6/14/22), indicated lunch included Spanish rice.<br><br>A review of the facility's Daily Cook's Menu for Week 1, Tuesday, indicated the facility was supposed to serve Spanish rice for pureed diet.<br><br>During a concurrent observation and interview on 6/14/22 at 12:10 p.m., in the kitchen, Cook 1 pureed white rice for residents on a pureed diet. Cook 1 stated he thought white rice was the | F 803 | | |

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| F 803 | Continued From page 17<br>correct food.<br><br>During an interview on 06/14/22 at 12:10 p.m., with Dietary Supervisor (DS), DS stated that residents on pureed diet should have the same menu as the regular diet, and to prepare the pureed food, Spanish rice, according to the facility recipe for the pureed diet Spanish rice.<br><br>A review of the facility's policy and procedure "Therapeutic diet" revised October 2017, indicated "... if a mechanically altered diet is ordered such as mechanically chopped meat and puree, the provider will specify the texture modification and follow the recipe..."<br><br>A review of the facility's pureed recipe for Week 1 Standard VE Spring 2022, dated 3/15/22, indicated, "Sauté chopped onions, green peppers and celery in vegetable oil. Add uncooked rice and stir over heat until coated with oil. Stir in salt, chili powder and garlic powder. Place in 12X20X4 counter pan ...Pour a mixture of tomato juice and water over rice. Bake ...Place portions needed of prepared product in blender/food processor. Add 2 TBSP (tablespoons) milk for each portion. Cover securely. Blend until smooth ...Reheat ..." | F 803 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | F- 812<br>Cabinet repaired and painted on 7/5/22.<br><br>New shelf purchased and bins with covers for storing portion scoops.<br><br>Muffin pans moved to clean pots and pan storage area.<br><br>In-service provided on infection control and sanitation in kitchen on 7/1/22.<br><br>Dietary Supervisor or designee to audit infection control and cleaning logs 1x per week for 1 month, then monthly.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |

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| F 812 | Continued From page 18<br>and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to maintain kitchen cabinets in good repair when an undercounter cabinet had doors with chipped and peeling paint (interior and exterior sides), unpainted wooden interior walls were chipped and peeling, the cabinet floor had chips of paint and wood and irregular white, green, yellow, and black stains.<br><br>The failure to maintain the cabinets in good repair and sanitary conditions had the potential to result in food contamination and food borne illness for any resident eating food.<br><br>Findings:<br><br>During a concurrent observation and interview on 6/13/22 at 11:30 a.m., with Dietary Supervisor (DS) in the kitchen, there was a wooden cabinet under the dishwashing three-compartment sink. DS confirmed the condition of the wooden cabinet was as follows: the cabinet doors had chipped and peeling paint (interior and exterior sides), the unpainted wooden interior walls were chipped and peeling, the cabinet floor had chips of paint and wood and irregular white, green, yellow, and | F 812 | | |

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| F 812 | Continued From page 19<br>black stains. Inside the cabinet was a wooden shelf with two plastic bins filled with clean scoops for measuring resident portions wood; the shelf also had chips of wood and paint. Below the shelf was the floor of the cabinet which had seven stacked clean muffin tins and a plastic bin which held clean spatulas.<br><br>A review of the facility's policy and procedure, "Sanitization," revised October 2008, indicated, "The food service area shall be maintained in a clean and sanitary manner... 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning, seals, hinges and fasteners will be kept in good repair..." | F 812 | F- 880<br>Infection Prevention (IP) Nurse provided Inservice to staff on 06/20/22 and 06/23/22 on proper hand washing.<br><br>All Residents have the potential to be affected by the same deficient practice.<br><br>Infection Prevention Nurse will monitor staff during their shift and do on the spot training and return demonstrations to ensure proper hand hygiene and educate as needed.<br><br>Infection Prevention Nurse or designee to audit proper hand washing 2x per week for 1 month, then monthly to ensure proper hand hygiene.<br><br>Infection Prevention Nurse or designee will complete skill checks on hand washing annually.<br><br>Any issues identified will be discussed and reported in writing at the QAPI meeting.<br><br>All steps will be completed by 7/18/2022. | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, | F 880 | | |

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| F 880 | Continued From page 20<br>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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | | |

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| F 880 | Continued From page 21<br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, for one of 8 sampled residents (Resident 16), the facility failed to ensure Treatment Nurse 1 (TN 1) performed hand hygiene (wash hands with soap and water or use an alcohol-based hand rub) on two occasions during a wound dressing change.<br><br>The staff failure to change gloves during a wound treatment when moving from wound care (a dirty procedure) to application of a new dressing (a clean procedure), and to sanitize hands after removing gloves had the potential to result in infection and spread of infection.<br><br>Findings:<br><br>A review of Resident 16's Face Sheet, dated 6/16/22, indicated Resident 16 was admitted to the facility in 2021 with diagnoses of dementia (a chronic progressive disease marked by memory loss, personality changes and impaired reasoning), and a stage IV pressure ulcer. (A pressure ulcer develops when one or more layers of skin and tissue are damaged as a result of continuous pressure to the area. The depth of skin and tissue damage determines the stage of the pressure ulcer, which is on a scale of stage I to stage IV, with stage I the most superficial, and | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055239 | A. BUILDING _____ B. WING _____ | 06/17/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST BAY POST-ACUTE | 20259 LAKE CHABOT ROAD CASTRO VALLEY, CA 94546 |

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| F 880 | Continued From page 22<br>stage IV the deepest ulcer, including damaged skin and muscle down to the level of bone.)<br><br>A review of Resident 16's Minimum Data Set (MDS, a resident assessment tool used to guide care), dated 4/4/22, indicated Resident 16 was admitted with one Stage 3 pressure ulcer, and one Stage 4 pressure ulcer.<br><br>A review of Resident 16's physician order with a start date of 6/11/22, indicated a treatment order for a pressure ulcer on Resident16's sacrococcyx (sacrum and tailbone). The order indicated a daily wound care regimen for the ulcer: clean with normal saline (dilute salt water), pat dry, cover with Triad paste (a substance that helps maintain a moist wound environment ideal for healing) and cover the wound with a foam dressing for protection.<br><br>During an observation on 6/15/22, at 1:25 p.m., TN 1 performed Resident 16's sacrococcyx wound dressing change. TN 1 used gloved hands to remove the old wound dressing, cleaned the wound with normal saline, patted the area dry with clean gauze. Without changing gloves, TN 1 used a swab stick to apply Triad paste to the wound and covered the area with a foam dressing. TN 1 then removed her gloves, and without performing hand hygiene, immediately went to the treatment cart, unlocked and opened the cart, removed a new foam dressing, closed the cart, and carried the supplies back to Resident 16's bedside. TN 1 sanitized her hands, donned new gloves and started another dressing change for Resident 16.<br><br>During an interview on 6/16/22, at 11:35 a.m., TN 1 stated it was important to do hand hygiene in | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 23<br>between dirty and clean procedures, and different wound sites to avoid contaminating the wound and avoid spreading any contamination to a different wound site.<br><br>During an interview on 6/17/22, at 10:19 a.m., with the Director of Staff Development (DSD), the DSD stated staff should change gloves after removing an old dressing and before placing a new dressing and perform hand hygiene and/or handwashing in between glove changes to prevent infection and cross contamination.<br><br>A review of the facility's policy and procedure (P&P )titled, "Handwashing/Hand Hygiene," revised August 2019, indicated, "...The facility considers hand hygiene the primary means to prevent the spread of infections...Use of an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...after handling used dressings...after removing gloves; ...the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand washing/hand hygiene is recognized as the best practice for preventing healthcare-associated infections...." | F 880 | | |