STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056116	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Altos Sub-Acute and Rehabilitation Center	809 Fremont Avenue Los Altos, CA 94024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44583 Based on observation, interview, and record review, the facility failed to implement infection control measures when: 1.Certified nursing assistant B (CNA B) and restorative nurse assistant C (RNA C) did not wear N95 (a mask or a respirator worn over the mouth and nose to protect the respiratory system by filtering out dangerous substances [such as dusts, fumes, or bacteria] from inhaled air) properly; and 2.Certified nursing assistant C (CNA D) did not follow the contact (set of steps to prevent the spread of infection from a patient to others) with bodily fluids precautions posted before the entrance in Resident 2's room, did not follow the proper sequence of putting on personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments), did not remove and discard the dirty gown and gloves prior to leaving Resident 3's room and did not perform hand hygiene before leaving the room. These failures had the potential to result in the transmission and spread of infection throughout the facility. Findings: 1.During the entrance conference with director of nursing (DON) on 1/14/2025 at 9:45 a.m., DON confirmed the facility had COVID-19 cases since December 2024. DON stated it started with one resident that was sent out to the hospital, then followed by a positive COVID-19 test of a certified nursing assistant (CNA) the following day. DON further stated, there were 38-42 patients affected by COVID-19 since December 2024 and their current census was 137. During a concurrent interview with infection preventionist (IP) and record review on 1/14/2025 at 10:15 a.m., IP reviewed the list of COVID-19 residents and staff. IP confirmed the outbreak of COVID-19 started on 12/24/2024 when Patient 1 was transferred out to the hospital due to nausea and vomiting (n /v). IP stated Patient 1 was tested for COVID-19 at the hospital and the result was positive for infection. IP further stated certified nursing assistant A (CNA A) tested positive for COVID-19 infection on 12/25/2024. IP confirmed they had 42 patients and 11 staff affected by COVID-19 infection. IP stated some residents were taken off isolation and other staff had reported to work already. IP confirmed she also tested positive for COVID-19 infection on 1/3/2025 and she just started working at the facility on 1/10/2025. (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/14/2025 at 10:48 a.m., near the exit door towards the smoking area, CNA B was observed standing beside Resident 2 who was sitting on a wheelchair without a facemask, and beside Resident 2 was RNA C who was sitting. Both CNA B and RNA C were having a conversation with their face mask positioned down to their chin while Resident 2 was sitting in between them. Both CNA B and RNA C pulled up their face mask when they observed the evaluator nurse approaching. During an interview with CNA B on 1/14/2025 at 10:50 a.m., CNA B confirmed above observation. CNA B stated she should have covered her nose and mouth with the face mask while talking to RNA C. CNA B confirmed the facility was having COVID-19 outbreak. During an interview with RNA C on 1/14/2025 at 10:55 a.m., RNA C confirmed above observation. RNA C stated she pulled down her mask because she had asthma (a condition in which your airways narrow and swell. This can make breathing difficult and trigger coughing). RNA C stated she should have covered her mouth and nose with the face mask due to COVID-19 outbreak in their facility and Resident 2 was sitting in between them without a facemask in placed. During a phone interview with IP on 1/15/2025 at 9:43 a.m., IP stated staff should wear their N95 properly especially when they were with residents. During a review of the facility's policy and procedure titled, Coronavirus Disease (COVID-19) - Source Control, date revised May 2023, indicated, Source control measures are utilized as part of the core COVID-19 infection prevention and control measures. Source control refers to the use of well-fitting cloth masks, facemasks or respirators that covers the mouth and nose and prevents the spread of respiratory secretions when individuals are breathing, talking, sneezing, or coughing. 2.During an observation in Station AA on 1/14/2025 at 11:18 a.m., CNA D was observed standing in front of Resident 3's door, donning (put on) a new pair of gloves first, then CNA D pulled out the isolation cart's drawer, took a gown and wore it. CNA D entered Resident 3's room without eye coverings or face shield and started talking to Resident 3. Resident 3 was in bed wearing the facility's gown without face mask. CNA D closed the door to provide privacy. During an interview with licensed vocational nurse E (LVN E) on 1/14/2025 at 11:27 a.m., LVN E did not know Resident 3's precaution, but she was aware Resident 3 had human immunodeficiency virus (HIV, a virus that attacks the body's immune system). LVN E stated the sequence in donning Resident 3's PPE: mask first, then gown, face shield, and gloves. LVN E further stated gloves should be worn last. LVN E confirmed CNA D was cleaning up Resident 3. During a concurrent observation and interview with IP on 1/14/2025 at 11:32 a.m., in front of Resident 3's room, IP confirmed the signage on top of Resident 3's isolation cart indicated Resident 3 was on contact and bodily fluid precautions. IP stated all staff should enter Resident 3's room with full PPE (N95, gown, face shield, and gloves). IP checked the isolation cart for face shields, and she did not find one. IP stated, It's my fault because the isolation cart does not have face shield, but staff knew where to find the face shields. IP further stated, staff should wear face shield prior to entering Resident 3's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up observation on 1/14/2025 at 11:43 a.m., CNA D stepped out of Resident 3's room still with PPE in placed. CNA D threw a plastic with garbage at the hallway's garbage container near Resident 3's isolation cart. CNA D started to remove the gown and gloves and threw them into the same hallway's garbage container. CNA D did not perform hand hygiene after, then walked to Station AA's hallway to get the Hoyer lift (a medical device that helps caregivers move patients from one place to another). During a concurrent observation and interview with CNA D on 1/14/2025 at 11:47 a.m., in front of Resident 3's room door, CNA D was pushing the Hoyer lift towards Resident 3's room. CNA D confirmed above observation, and stated he did not wear a face shield because he couldn't find one in the isolation cart. CNA D stated he did not wash or sanitized his hands because he needed to get the Hoyer lift for Resident 3. CNA D further stated, he should have worn a face shield prior to entering Resident 3's room, removed and threw his PPE prior to going out of the room and performed hand hygiene. Review of Resident 3's clinical record titled, Admission Record, indicated Resident 3 was admitted to the facility with diagnoses including paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), colostomy status (an opening into the colon from the outside of the body), bacteremia (a condition where bacteria are present in the blood), resistance to multiple antibiotics (when a microorganism, like bacteria, virus or parasite is resistant to more than one antimicrobial drugs), HIV, methicillin resistant staphylococcus aureus (MRSA, a type of bacteria that is resistant to mangy antimicrobial drugs), other specified bacterial agents as the cause of diseases classified elsewhere, and osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection). Review of Resident 3's clinical record titled, Order Summary Report, an order dated 5/31/2024, indicated Resident 3 was on contact isolation precaution due to Carbapenem-resistant Enterobacterales (CRE, bacteria that are resistant to some or all antibiotics in the carbapenem class. CRE infections can be serious and difficult to treat). Further review indicated, Resident 3 had suprapubic catheter (a flexible tube that drains urine from the bladder through a small cut in the lower abdomen). Review of Resident 3's clinical record titled, Infectious Diseases, dated 1/8/2025, indicated Resident 3 had chronic hip and penile wounds, HIV, left hip decubitus ulcer (a skin injury caused by prolonged pressure on an area of the body), and osteomyelitis. During a review of the facility's policy and procedure titled, Infection Prevention Manual for Long Term Care, Isolation Precautions: Standard Precautions, date revised May 2024, indicated, It is the policy of this facility to use Standard Precautions for resident care based on anticipated blood or body fluids (BBF) excretions and secretions exposure other than sweat which are considered potentially infectious .include a group of infection prevention practices that apply to all patients, regardless or suspected or confirmed infection status . These practices include hand hygiene; use of gloves, gown, mask, eye protection, or face shield . Further review indicated, Personal Protective Equipment (PPE) .Remove, discard PPE, and perform hand hygiene in room when activity is complete. PPE is provided to all employees. Each employee is responsible for knowing where the equipment is kept in the department. Review of Centers for Disease Control and Prevention's (CDC, national public health agency of the United States) Sequence for Putting on Personal Protective Equipment (PPE), indicated, 1. GOWN; 2. MASK OR RESPIRATOR; 3. GOGGLES OR FACE SHIELD 4. GLOVES.