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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056170 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/21/2024 |
| NAME OF PROVIDER OR SUPPLIER Excell Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 High Street Oakland, CA 94619 | |

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) |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49983</p> <p>Based on observation and interview, the facility failed to prepare food in accordance with professional standards of food service safety when the Facility [NAME] (COOK) used a cleaning cloth instead of a potholder to remove an item from the oven.</p> <p>This failure had the potential to result in cross-contamination, resulting in the potential for food-borne illness for 83 out of 90 residents who receive food from the kitchen.</p> <p>Findings:</p> <p>During an observation on 11/19/24 at 10:33 a.m. in the kitchen, the Facility [NAME] (COOK) removed a tray of chicken from the oven using a pot holder on her left hand and a red cloth to cover her right hand. The red cloth was observed to come into contact with liquid on the tray.</p> <p>During an interview on 11/19/24 at 10:40 a.m., COOK stated she used the red cloth and the pot holder to remove the chicken from the oven. COOK stated the chicken was heavy and required two hands.</p> <p>During an interview on 11/19/24 at 10:42 a.m., with the Dietary Services Manager (DSM), DSM stated the red cloth should be used for cleaning and pot holders should be used for food. Dietary Manager stated sanitizer chemical could have been on cloth and it could have come in contact with food.</p> <p>During an interview on 11/21/24 at 9:21 a.m. with the Infection Preventionist (IP), IP stated a cloth used for cleaning counters should not also be used to handle items that contain food because of the risk for cross-contamination (potentially dangerous bacteria could be spread around the kitchen, which could lead to food poisoning).</p> <p>During a review of the 2022 Food Code by the U.S. Food and Drug Administration, dated 1/18/23, the Food Code section 3-304.14 indicated that cloths used for wiping food spills should be used for no other purpose.</p> |

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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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>38534</p> <p>Based on observation, interview and record review, the facility failed to ensure to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of five sample selected residents (Resident 84, 48 and 43) when:</p> <ol style="list-style-type: none"> 1. The facility's staff left the disconnected feeding tube uncapped and exposed to the air on the pole (pole was holding feeding liquid bags and water) and then staff touched the feeding bag and put the cap on the tip of tube with bare hand (no gloves). 2. The facility's staff did not change the gloves between clean and dirty supplies during the wound care for 48. 3. The facility's staff touched the equipment and belonging with bare hand (no gloves) for Resident 43. <p>Residents 84, 48 and 43 were on EBP care (Enhanced Barrier Precautions is an approach to the use of personal protective equipment (PPE) to reduce transmission of Multi-Resistant Organisms (MDROs) between residents in skilled nursing facilities).</p> <p>Findings:</p> <p>A review of Resident 43's Admission Record indicated, Resident 43 admitted to the facility with multiple diagnosis including Immunodeficiency (Inability to produce an adequate immune response because of an insufficiency or absence of antibodies, immune cells, or both).</p> <p>A review of Resident 43's Order summary report indicated . Resident on EBP, R/T (due to) upper abd (Abdomen) cholecystostomy (a surgical procedure that creates an opening in the gallbladder to drain bile and relieve symptoms) .</p> <p>A review of Resident 84's Admission Record indicated, Resident 64 admitted to the facility with multiple disease including Gastrectomy (surgical removal of a part or the whole of the stomach) .</p> <p>A review of Resident 84's Order summary report indicated . Resident on EBP, R/T long term use of indwelling medical device GTF (Gastric Tube Feeding) .</p> <p>A review of Resident 48's Admission Record indicated, Resident 48 admitted to the facility with multiple disease including pressure ulcers (damaged skin and tissue caused by constant pressure on the skin for a prolonged period).</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a concurrent observation and interview on 11/18/24 at 11:25 a.m., with the Registered Nurse (RN)1 at Resident 84's room, observed the feeding tube connected to the formula bag was hang from the poll with no cap, RN1 confirmed and touched the formula bag and tube with bare hands while the resident was on EBP care. RN1 put the cap on the tip of the tube with bare hand and no gloves. RN1 stated she should have wear gloves before touching the supplies to prevent the infection, because Resident 84 is on EBP care due to having Gtube (Gastric Tube).</p> <p>During an observation and interview on 11/18/24 at 11:30 a.m., Infection Preventions (IP) entered to the room, IP had mask only, no gloves, IP touched the Resident 43's side table and moved it, then removed the communication board from the resident's bed which was touching the Resident 43's abdomen and then opened the board and started to talk to the resident with the board. IP confirmed that the Resident 43 is on EBP care and staff need to wear gloves, gown and mask when they are working with the residents on EBP care, and IP should have wear gloves when touched Resident 43's belonging specially when they were touched the Resident 43's body, due the infection prevention.</p> <p>During a consecutive observation and interview on 11/19/24 at 01:51 p.m., observed Licensed Vocational Nurse (LVN) changed the dressing on Resident 48's coccyx, (The small bone at the bottom of the spine). LVN removed the old dressing and with the same gloves opened new gauze and saline solution, cleaned the wound and dry pat with the same gloves, LVN confirmed that did not change gloves between old dressing and cleaning the wound and stated LVN was supposed to change gloves between dirty and clean supplies for the infection prevention matter.</p> <p>During an interview on 11/21/24 at 09:11 a.m., with IP, IP stated the nurses after disconnecting the tube from the Gtube they need to put the cap on the tip of tube for the infection control. If nurses, see the tube with no cap they should replace the tube and not recap it. Stated the nurses should change the gloves after removing the old dressing because the gloves can transfer the bacteria from old dressing to the wound when they clean the wound with the same gloves.</p> <p>A review of the facility's policy and procedure (P&P) Clean Dressing Change revised 12/19/2022, indicated . 9. Loosen the tape and remove the existing dressing . 10. Remove gloves .11. Wash hands and put on clean gloves. 12. Cleans the wound as ordered .</p> <p>A review of the facility's policy and procedure Personal Protective Equipment revised 12/19/2022, indicated . 1. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious material is likely .</p> <p>A review of the facility's policy and procedure Enhanced Barrier Precautions revised 12/19/2022, indicated . PPE for enhanced barrier precautions is only necessary when high contact care activities .High-contact resident care activities include . g. Device care or use: central lines, urinary catheters, feeding tubes, . It may be acceptable to use gloves, alone, for some uses of a medical device that involve only limited physical contact between the healthcare worker and the resident .</p> <p>During an interview on 11/21/24 at 09:11 a.m., with IP, IP stated that the facility does not have any specific P&P for Tube Feeding connected to the feeding bag's set up and keep the tube clean.</p> | | |