

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2024
NAME OF PROVIDER OR SUPPLIER  The Rehabilitation Center of Oakland		STREET ADDRESS, CITY, STATE, ZIP CODE  210 40th Street Way Oakland, CA 94611	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>40968</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two sampled Residents (Resident 1) had staff identify themselves with name badges while they received care.</p> <p>This failure had the potential to cause Resident 1 emotional distress and anxiety.</p> <p>Findings:</p> <p>During a review of Resident 1's face sheet, dated 4/12/24, face sheet revealed Resident 1 was admitted to the facility in 1/2024.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- an assessment tool used to guide care) dated 2/1/24, the MDS indicated Resident 1 had multiple diagnoses that included arthritis (swelling and tenderness of one or more joints) and anxiety disorder. The MDS also revealed Resident 1 had a Brief Interview for Mental Status (BIMS -a screening tool used to assess cognition) score of 15/15. Meaning, Resident 15 was able to understand and understood others.</p> <p>During a telephone interview on 4/12/24, at 8:26 a.m. with the Responsible Party (RP), RP stated there were multiple issues with staff members that included leaving Resident 1 in bloody bed sheets. RP further stated, she did not know name of staff assigned because they do not wear name badges. RP also stated, staff members did not identify themselves when asked.</p> <p>During an interview on 4/12/24 at 10:47 a.m. in Resident 1's room, Resident 1 stated, there were several issues with staff member that included neglecting his request to shower. When asked which staff in particular, Resident 1 stated, it was hard to remember staff members assigned to him because they do not wear identification (ID) badges.</p> <p>During a concurrent observation and interview on 4/12/24 at 11:07 a.m., CNA 1 entered Resident 1's room, and was observed without a name badge. CNA 1 stated, he was a registry staff assigned to Resident 1. CNA 1 further added, the facility did not provide registry staff ID badge. CNA 1 also stated, Resident 1 had the right to know who was taking care of him.</p> <p>(continued on next page)</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/12/24 at 11:58 a.m., CNA 2 was seen in the hallway entering communal dining room. CNA 2 did not have ID name badge. CNA 2 stated, she was registry assigned to help residents in the dining room. CNA 2 also stated, the facility did not supply ID name badge. CNA 2 further added, it was important to wear name badge, so residents know who they are working with. Residents have the right to know who's caring for them.</p> <p>During an interview on 4/12/24 at 12:00 p.m. with Facility Staff (FS), FS 1 stated, he was responsible for scheduling staff including registry. FS 1 also stated, it was important for residents to be able to identify staff taking care of them. FS 1 further added, registry staff were not required to wear ID name badge.</p> <p>During an interview on 4/12/24 at 12:27 p.m. with the facility Administrator (ADM), ADM stated, the facility received deficiency in the past related to staff not wearing ID name badges. ADM also stated, all facility staff, regular and registry are supposed to wear name badge at all times. ADM further added, name badges are to be worn for residents to be able to identify employee and their designated role.</p> <p>During a review of facility schedule dated 4/12/24, revealed CNA 1 was employed as Registry (R) and was assigned to Resident 1. The facility schedule also showed, CNA 2 (R) was assigned to social dining.</p>