STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555313	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Oakland	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49498 Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 30) was treated with dignity and respect when Resident 30 attended activity wearing facility gown and disposable undergarment was soaking wet with urine. This failure had the potential to negatively impact Resident 30's sense of self-worth and self-esteem. Findings: During an observation on 9/9/24 at 12:38 p.m. in the activity room, Resident 30 was sitting on the wheelchair wearing facility gown and liquid was dripping from the wheelchair onto the floor. Other residents in the room were wearing personal clothes. During a concurrent observation and interview on 9/9/24 at 12:40 p.m. with the Activity Director (AD) in the activity room, the AD pulled up Resident 30's gown to check the disposable undergarment. The AD stated Resident 30's diaper was soaking wet with urine. The AD stated Resident 30 wearing gown and soaking wet affected their dignity. During a review of the facility's policy and procedure titled, Resident Rights, dated 1/1/12, indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercises of resident's rights.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on observation, interview, and record review, the facility failed to assist four out of eight sampled residents (Resident 30, 46, 48, 52) with personal hygiene when: 1. Resident 30 and Resident 46's long facial hair was not shaved. 2. Resident 48 and Resident 52's fingernails were not clean and trimmed. These failures resulted in Resident 30 feeling yuck, Resident 46 feeling crutty and unkept and placed Resident 48 and Resident 52 at risk for getting infections from lack of proper hygiene and injuring themselves with long fingernails. Findings: 1.a. During a concurrent observation and interview, on 9/9/24 at 10:14 a.m. with Resident 30 in Resident 30's room, Resident 30's beard was approximately 1 centimeter (cm) long. Resident 30 stated he preferred to keep his mustache long, but his beard shaved. Resident 30 stated staff doesn't offer to help him shave. Resident 30 stated feeling yuck with the long beard. During a concurrent observation and interview, on 9/12/24 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 2 in the activity room, Resident 30 was sitting on the wheelchair with long beard. LVN 2 stated Resident 30's beard looked long and needed to be shaved. During a record review of Resident 30's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) dated 7/11/24, indicated, Resident 30 required Partial/moderate assistance from staff with personal hygiene. b. During a concurrent observation and interview, on 9/9/24 at 9:45 a.m. with Resident 46 in Resident 46's room, Resident 46's beard was approximately 2 centimeters long. Resident 46 stated he doesn't remember when he was last shaved. Resident 46 stated staff doesn't offer to help him shave. Resident 46 stated feeling crutty and unkept with the long beard. During a concurrent observation and interview, on 9/9/24 at 9:52 a.m. with Certified Nursing Assistant (CNA) 5 in Resident 46's room, Resident 46's beard was long. CNA 5 stated Resident 46's beard was long and would assist Resident 46 with shaving. During a record review of Resident 46's MDS dated [DATE], indicated Resident 46 required Partial/moderate assistance from staff with personal hygiene. During an interview on 9/12/24 at 11:07 a.m. with CNA 9, CNA 9 stated there was no option in the Electronic Health Record (EHR) to document staff assistance of resident with shaving. CNA 9 stated a paper documentation of shaving was available at the nursing station one. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 9/12/24 at 11:20 a.m. with LVN 4 at the nursing station one, Resident Skin & Body Check form inside the white Shower Schedule binder was reviewed. The form indicated, date on when the resident was shaved. LVN 4 stated Resident Skin & Body Check form was the only place the staff documented assisting residents with shaving. LVN 4 stated she was unable to find documentation in the shower schedule binder when Resident 30 and Resident 46 was last shaved. LVN 4 stated there was only one shower schedule binder. LVN 4 stated the Director of Staff Development (DSD) kept the old Resident Skin & Body Check forms. During a concurrent interview and record review on 9/12/24 at 1:39 p.m. with the DSD in the DSD office, Resident Skin & Body Check form in a black Completed Shower Sheet Forms 2024 binder was reviewed, the binder indicated the months of June, July, August and September did not have any Resident Skin & Body Check forms. The DSD stated she had to check the completed forms in the DSD box located in the nursing station one. During a concurrent observation and interview on 9/12/24 at 1:46 p.m. with the DSD in the nursing station one, the DSD checked the completed Resident Skin & Body Check forms at the DSD box attached to the wall and inside the cabinet. The DSD stated the completed forms was not in the box nor the cabinet. During a concurrent interview and record review, on 9/12/24 at 1:50 p.m. with the DSD at the nursing station two, Resident 46's Resident Skin & Body Check form dated 8/13/24 in a black shower schedule binder was reviewed, the form indicated, Resident 46 had a bed bath and resident shaved was unmarked. The DSD stated no other documentation of Resident 30 and Resident 46 was in the shower schedule binder. During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated 1/1/2012, indicated, Each resident is allowed to choose activities, schedule, and health care that are consistent with his or her interests, assessments and plans of care, including: Personal care needs such as grooming styles. During a review of the facility's (P&P) titled, Grooming, dated 1/1/12, indicated, The facility will work with residents to improve their ability to groom him/herself to promote independence, hygiene, comfort, self-esteem and dignity. 2a. During a review of Resident 48's admission record dated, 9/12/24, indicated Resident 48 was admitted to the facility on [DATE] with multiple diagnoses that included, surgical after care (treatment and care to ensure healing and prevent infection) following surgery on the digestive system and muscle weakness. During a review of Resident 48's Minimum Data Set (MDS- an assessment tool used to guide care) dated, 8/30/24, indicated Resident 48 had a Brief Interview for Mental Status (BIMS -a tool used to assess mental function) Score of 15. Meaning, Resident 48 was cognitively intact. The MDS also indicated, Resident 48 required substantial / maximal assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 9/10/24 at 1:05 p.m. with Resident 48, Resident 48's toenails were overgrown, thick, and dirty with black matter underneath. Resident 48's fingernails were also long and dirty with brown matter underneath. Resident 48 stated, her toenails hurt, heavy and very uncomfortable. Resident 48 also stated, staff did do anything to clean and/or trim her toenails and fingernails. During a concurrent interview and observation, on 9/10/24 at 1:10 p.m. with Certified Nursing Assistant (CNA) 7, in the presence of Resident 48, CNA 7 acknowledged Resident 48 had thick, long, dirty toenails and dirty fingernails. CNA 7 stated, she did not include toenails and fingernails when she provided Activities of Daily Living (ADL) to Resident 48 because no one asked her to. CNA 7 added, Resident 48 can get infection if dirt from nails got in Resident 48's wound. During a concurrent interview and observation, on 9/10/24 at 1:18 p.m. with Licensed Vocational Nurse (LVN) 1, in the presence of Resident 48, LVN 1 agreed Resident 48 had overgrown, thick, dirty toenails and long and dirty fingernails. LVN 1 stated, it was everyone's responsibility to make sure Resident 48's nails are clean to avoid infection. 2b. During a review of Resident 52's admission record dated, 9/12/24, indicated Resident 52 was admitted to the facility on [DATE] with multiple diagnoses that included muscle weakness, reduced mobility, aphasia (difficulty speaking) following Cerebral Infarction (stroke), and need for assistance with personal care. During a review of Resident 52's MDS, dated [DATE], indicated Resident 52 was unable to make self-understood/unable to express ideas and wants. The MDS also indicated, Resident 52 was dependent on helper with personal hygiene. During a concurrent observation and interview on 9/10/24 at 1:30 p.m., with Registered Nurse Regional Consultant (RNRC), Resident 52 had overgrown toenails and fingernails with black matter underneath. RNRC stated, direct care staff should have ensured Resident 52's nails are cleaned. During a concurrent interview and record review on 9/12/24 at 12:05 p.m., with the Director of Nursing (DON), DON confirmed Resident 48 did not have diagnosis of Diabetes Mellitus (DM). DON added, there was no documentation nail care was done for Resident 48. DON stated, the expectation was for staff to ensure Resident 48 and Resident 52 had clean and trimmed nails. DON added, there was no excuse for staff not to keep residents overgrown and dirty nails as there was risk for infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45091 Based on observation, interview, and record review, the facility failed to ensure one of 4 sampled residents (Resident 11), had a Doctor's Order for supplemental oxygen before they received the supplemental oxygen. This failure had the potential for Resident 11 to receive supplemental oxygen inappropriately and in an unsafe manner. Findings: A review of Resident 11's Admission Record printed 9/12/24, indicated Resident 11 was admitted to the facility in 2024 with multiple diagnoses including a primary admitting diagnosis of Acute and Chronic Respiratory Failure (a condition that occurs when the lungs are unable to get enough oxygen into the blood or remove enough carbon dioxide from the blood) with Hypoxia (a condition that occurs when the body's tissues, blood, or cells don't have enough oxygen to function normally). During a concurrent observation and interview on 9/09/24, at 10:48 a.m., Resident 11 was observed as they used an oxygen concentrator (a medical device that gives you extra oxygen) via nasal canula (a thin, flexible tube with two prongs that sit inside the nostrils and delivers oxygen) at a rate of 2L (liters). During a concurrent interview and record review on 9/11/24, at 1:30 p.m., with Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) Coordinator (MDSC), Resident 11's Doctor's orders, were reviewed. MDSC stated Resident 11 did not have a Doctor's Order for an oxygen concentrator. During a concurrent interview and record review on 9/12/24, at 11:07 a.m. with Assistant Director of Nursing (ADON), Resident 11's Doctor's Orders, were reviewed. The orders indicated Resident 11 had a Doctor's Order dated 9/11/24, at 14:39 p.m., for Oxygen 2 liters as needed for SOB (shortness of breath), to keep O 2 (oxygen) above 90% Via N/C (Nasal Cannula). ADON confirmed Resident 11 did not previously have a Doctor's Order for O2. ADON stated Residents needed a Doctor's Order for O2 because it can harm the resident. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, revised November 2017, the P&P indicated, To ensure the safe storage and administration of oxygen in the Facility. The P&P indicated Licensed Nursing staff will administer oxygen as prescribed. The P&P indicated Administer oxygen per physician orders.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 45091 Based on interview and record review the facility failed to ensure 4 Certified Nursing Assistants (CNAs) and 1 Licensed Vocational Nurse (LVN) had the appropriate competencies to care for residents when the facility did not complete Orientation Evaluation Checklists for LVN 1 and CNA 3, and Annual Performance Evaluations for CNAs 1, 2 and 4. This failure had the potential for resident care to be provided in an unsafe and incompetent manner. Findings: During a concurrent interview and record review on 9/12/24, at 11:59 a.m., with Director of Staffing Development (DSD), CNAs 1, 2, and 3 and LVN 1's personnel folders were reviewed. DSD stated CNA 1's personnel folder indicated CNA 1 was hired on 8/17/23 and did not have an Annual Performance Evaluation. DSD stated CNA 2's personnel folder indicated CNA 2 was hired on 5/17/23 and did not have an Annual Performance Evaluation. DSD stated Annual Performance Evaluations had to be done annually and were important to evaluate CNA's competency. DSD stated CNA 3's personnel folder indicated CNA 3 was hired on 5/23/24 and did not have an Orientation Evaluation Checklist. DSD stated Orientation Evaluation Checklists had to be done when staff were hired and were important to evaluate their competency. During an interview on 9/12/24, at 2:20 p.m., with CNA 4, CNA 4 stated they had not done an Annual Performance Evaluation in over a year. During a concurrent interview and record review on 9/12/24, at 2:36 p.m., with DSD, CNA 4's personnel folder was reviewed. DSD stated CNA 4's personnel record indicated her last Annual Performance Evaluation was on 8/4/22. During a concurrent interview and record review on 9/12/24, at 2:51 p.m., with DSD, LVN 1's personnel folder was reviewed. DSD stated LVN 1's personnel folder indicated they were hired on 1/31/24 and did not have an Orientation Evaluation Checklist. During an interview on 9/12/24, at 3:05 p.m., with CNA 1, CNA 1 stated they had not done an Annual Performance Evaluation in over a year. During an interview on 9/12/24, at 3:18 p.m. with Director of Nursing (DON), DON stated DSD was supposed to complete CNA Annual Performance Evaluations for each CNA every year from the date of hire and more often if there were any resident concerns. DON stated during Annual Performance Evaluations DSD was supposed to watch CNAs perform their skills and verify their competency and was important to identify any areas where they needed training. DON stated CNA and LVN Orientation Evaluation Checklists were supposed to be done before they work on the floor. DON stated Orientation Evaluation Checklists were important so staff know their scope of practice, to assess how safe they are practicing and to find any areas where the needed training. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/13/24, at 11:43 a.m., DON stated they did not have a Policy and Procedure on Annual Performance Evaluations or Orientation Evaluation Checklists.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on observation, interview, and record review the facility failed to ensure proper storage and labeling of medication and biologicals (made from a variety of natural sources human, animal, or microorganisms and are used to treat, prevent, or diagnose diseases and medical conditions) for one of one sample medication room and two of two medication carts when: 1. Three opened vials of Tuberculin Purified Protein Derivative (PPD- indicated to aid diagnosis of tuberculosis infection (TB) in persons at increased risk of developing active disease) was unlabeled and undated with an open date. 2. Two activase (a clot-busting medication. It helps the body to produce a substance that dissolves unwanted blood clots.) vials for a discharged resident (Resident 222) were stored in the refrigerator. 3. Thirteen expired Influenza (common respiratory illness. Symptoms often include fever, head, and body aches, coughing and a stuffy or runny nose.) vaccine vials were stored in the refrigerator. 4. Expired medications for Resident 13, 14 and 52 was stored in the medication cart. 5. Two opened fluticasone furoate-vilanterol inhalation powder (medication used to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma and chronic obstructive pulmonary (COPD- a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema)) inhaler for Resident 59's was unlabeled and undated with an open date. These failures had the potential to result in unsafe medication administration and storage practices. Findings: 1. During a concurrent observation and interview on 9/9/24 at 3:24 p.m. with the Director of Nursing (DON) in the medication room, three 1 milliliter (mL) multi-dose vial of PPD was in the refrigerator without a vial cap and a label of the open date. The DON stated the nurse who opened the vial should label it with the open date because it expires in 30 days. During a review of the facility's policy and procedure (P&P) titled Storage of Medication, dated 4/2008, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. During a review of the Tuberculin PPD product information from www.fda.gov/media/74862/download?attachment, dated 11/2013, indicated, Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview, on 9/9/24 at 3:28 p.m. with the DON, Resident 222's two 2 mL activase vials with an expiration date of 12/2025 was inside the medication refrigerator. The DON stated Resident 222 had been discharge. The DON stated the vials doesn't need to be stored in the medication destruction container because it was not expired. During a review of Order Summary, dated 4/9/24, the Order Summary indicated, Resident 222 had an order for activase to declog the peripherally inserted central catheter (PICC- a long, thin tube that goes through a vein in the upper arm. The end of this catheter goes into a large vein near the heart to help carry nutrients and medicines into the body.) line. During a review of undated Admission Record, printed on 9/11/24, the Admission Record indicated Resident 222 was discharged on [DATE]. During a review of the facility's (P&P) titled Medication Destruction, dated 12/2017, indicated Discontinued medication and medications left in the facility after a resident's discharge are destroyed . Medication is destroyed within 90 days from the date the medication was discontinued. 3. During a concurrent observation and interview on 9/9/24 at 3:35 p.m. with the DON in the medication room, thirteen unopened 5 mL multi-dose vials of Influenza vaccine with an expiration date of 6/30/24 was in the medication refrigerator. The DON stated the Influenza vaccines should have been stored in the medication destruction container and destructed. During a review of the facility's (P&P) titled Disposal of Medications and Medication-Related Supplies, dated 12/2018, indicated When medications are expired . the medications are stored in a separate location and later destroyed. 4. During a concurrent observation and interview on 9/10/24 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 13's 18 tablets of Sertraline (medication used to treat depression) 25 milligrams (mg) medication bubble pack with an expiration date of 7/1/24, Resident 14's 30 tablets of Metformin (medication that help lower blood sugar levels in people with type 2 diabetes.) 1,000 mg medication bubble pack with an expiration date of 9/8/24 and Resident 52's one uncapped 3 mL vial of Humulin R 100 unit insulin (an essential hormone. It helps the body turn food into energy and manages blood sugar levels.) with an open date of 8/7/24 was in the medication cart 2. LVN 2 stated Residents 13, 14 and 52 were active residents in the facility. LVN 2 stated medication cart was checked for expired medications once a month by the nurses, Assistant DON, and DON. During a review of Order Summary, dated 8/9/24, the Order Summary indicated, Resident 13 had an order for Sertraline 25mg one time a day. During a review of Order Summary, dated 7/24/24, the Order Summary indicated Resident 14 had an order for Metformin 1,000mg two times a day. During a review of Order Summary, dated 4/30/24, the Order Summary indicated Resident 52 had an order for Humulin R 100-unit insulin two times a day. During a review of the Humulin R product information from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/018780s180lbl.pdf, revised 6/2022, indicated, Throw away all opened vials after 31 days, even if there is still insulin left in the vial. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Storage of Medication, dated 4/2008, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. During a review of the facility's (P&P) titled Disposal of Medications and Medication-Related Supplies, dated 12/2018, indicated When medications are expired . the medications are stored in a separate location and later destroyed . Medications are removed from the medication cart or storage area prior to expiration. 5. During a concurrent observation and interview, on 9/10/24 at 11:56 p.m. with LVN 1, Resident 59 had two opened fluticasone furoate-vilanterol inhalation powder 200 mcg/25 mcg inhaler was undated and unlabeled with open date. LVN 1 stated the two inhalers did not have an open date. During a review of Order Summary, dated 7/24/24, the Order Summary indicated Resident 59 had an order for fluticasone furoate-vilanterol inhalation powder 200 mcg/25 mcg inhaler one puff orally one time a day. During a review of the facility's policy and procedure (P&P) titled Storage of Medication, dated 4/2008, indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. During a review of the fluticasone furoate-vilanterol inhalation powder inhaler product information from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/204275s012lbl.pdf, revised 5/2017, indicated, Safely throw away the inhaler in the trash 6 weeks after you open the foil tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40968 Based on observation, interview and document review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when: 1. [NAME] failed to thaw fish safely in a sink. 2. [NAME] failed to report out of range temperatures on 9/9/24. 3. Dietary Manager was not able to state appropriate thawing procedures. 4. Dietary Manager was not able to state the importance of keeping freezer at proper temperature. These failures had the potential to result in food borne illness. Findings: During an interview on 9/9/24, at 10:26 a.m., with Dietary Manager (DM) and [NAME] (CK) 1, DM stated, the fish fillet inside 3-compartment dishwashing sink was going to be served for lunch. CK 1, then stated the fish fillet was taken out of the freezer at around 8:00 a.m. When asked which freezer did the fish fillet came from, CK 1 pointed to the freezer with temperature reading of 30 degrees F. During a concurrent observation and interview on 9/9/24 at 10:46 a.m. with DM, in the presence of Registered Dietician (RD) 1 and Senior [NAME] President of Operations (SVPO). DM stated, if corn on cob was covered in ice it meant freezer was working and everything inside was still good and safe to cook. RD 1 stated, freezer should be at zero degrees Fahrenheit (F) for safe storage of frozen food. RD 1 added, fish especially was a high risk for bacterial growth and could cause serious illness. RD 1 also added, fish prepared for today's lunch was not safe to be served to residents. RD 1 further added, produce that has been crystallized (with freezer burns) like corn on cob, meant it was thawed and re-frozen and should no longer be used for safety. During a concurrent observation and interview on 9/9/24, at 11:03 a.m., with CK 1, CK 1 pointed to freezer 2 and confirmed she retrieved the fish being prepared from this freezer. CK 1 further added, freezer 2's temperature was at 30 degrees F when she removed the fish at 8:00 a.m. CK 1 stated, she did not thaw fish under running water. CK 1 added, she washed and left the fish in colander then let it sit to drain. During a concurrent observation and interview, on 9/9/24 at 11:45 a.m., with CK 1 and RD 1, CK 1 was seen frying fish fillet. CK 1 stated, these were the fish that she prepared since 8:00 a.m., and will be served for lunch. RD 1 then stated, fish had to be continuously under running water before cooking. RD 1 further added, there was chance of bacterial growth and the fish may not be safe to serve to residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Rehabilitation Center of Oakland		STREET ADDRESS, CITY, STATE, ZIP CODE 210 40th Street Way Oakland, CA 94611	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/10/24, at 12:35 p.m., with CK 1, CK 1 stated, she did not have competency evaluation with DM since he started employment. CK 1 further added, she has not been evaluated by a supervisor even prior to current DM. During an interview on 9/10/24, at 10:37 a.m., with the DM, DM stated, he was not evaluated by a Registered Dietician when he began his employment. DM also stated, he did not conduct nor completed competency skills check for the dietary staff. During an interview on 9/11/24, at 1:55 p.m., with Dietary Aide (DA) 1, DA 1 stated, she only had competency check done by previous supervisor three years go. DA 1 added, there was no ongoing or annual competency evaluation given by the DM. During an interview on 9/12/24, at 1:21 p.m., with the RD 1, stated she had never performed skills competency performance evaluation for the DM. RD 1, further stated, she has never been asked to do it. During an interview on 9/12/24, at 1:30 p.m., with CK 2, CK 2 stated she worked here for a long time and has not done any competency skills training for many years. During an interview on 9/13/24, at 12:42 p.m., with the Administrator (ADM), ADM stated, the DM was supposed monitor all kitchen staff performance to ensure competency. During a review of the facility's policy and procedure (P&P) titled, Meat Cookery and Storage, dated 7/1/14, indicated, under procedure I. Meat will be stored in a freezer of 0 degrees F or less until pulled for defrosting. II. Meat to be defrosted will be pulled three days prior to service and defrosted in a dry, cool area 41 degrees F or lower.B. If meat is frozen and needs a quick defrost, it may be defrosted in a pan or sink with constant running cold water until adequately defrosted for preparation. During a concurrent interview and record review on 9/11/24 at 10:37 a.m., with the DM, DM stated he did not complete staff competency for kitchen staff since he started employment in March 2024. DM also stated, he was unaware of the policy dietary staff competency. During a review of the facility's job description: Titled, Dietary Services Supervisor/Certified Dietary Manager, (undated) indicated under Administrative: Maintains all records and documentation according to Federal, State and Company requirements. Under Supervisory: .Monitors staff performance and addresses any needs. Evaluates quality of service accomplished by staff. During a review of the facility's P&P titled, Staff Competency Assessment, dated 3/17/22, indicated, Competency assessments will be performed upon hire during the employee's 90-day employment period, annually, or anytime new equipment or a procedure is introduced and as needed.II. All staff are required to have competency assessments by the Director of Staff Development or department manager based on their job description or assigned duties within the first 90 days of employment. III. The competency evaluations or sills checks will be done by an individual who has the licensure education and experience qualifying them to perform the competency assessment. IV. The annual evaluation of an employee will include review of completed competency assessments which may have been done throughout the year. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Rehabilitation Center of Oakland		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 40th Street Way Oakland, CA 94611	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's document titled, Dietary Quality Control Review, dated, 9/4/24, indicated under Clinical/Staffing J. Are all staff and Dietary Manager competencies in place at orientation and reevaluated at least annually - NOT MET. Under Observation indicated, Need competencies on new employees to be completed by the CDM (Certified Dietary Manager).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40968 Based on observation, interview, and document review, the facility failed to store, prepare, and distribute food in a safe and sanitary manner when: 1. Fish being prepared to be served for lunch, which included time/temperature controlled for safety (TCS) foods (foods such as meat, including fish, are high potential for bacteria growth), was stored in the freezer with a temperature of 30 degrees (*) Fahrenheit (F), above 0 *F the food inside a freezer number (#) 2 will not be safe temperature for storage and may be at risk for bacterial growth, spoilage and food borne illness; facility did not ensure staff followed procedures in proper thawing of fish, creating an Immediate Jeopardy [IJ - a situation in which recipient(s) of care has suffered or is likely to suffer from gastrointestinal distress (nausea, vomiting, diarrhea), dehydration (when body loses fluids and body does not have fluids to carry out its normal functions) and/or systemic infections (infection in the bloodstream) from foodborne illness as a result of provider's noncompliance with one or more health safety requirements] situation. On 9/9/24, at 11:56 a.m., an IJ was called. The Administrator was notified of the IJ regarding improper thawing of fish and the temperatures of food stored above 0 *F in the freezer. On 9/9/24, at 12:20 p.m., it was verified fish prepared for lunch was discarded. On 9/9/24, at 3:07 p.m., it was verified the food in the freezer were discarded. On 9/9/24, at 3:20 p.m., an acceptable plan of action was provided by the Administrator. The actions to remove the IJ situation included: removal and discarding the fish prepared for lunch; food items in the freezer with the temperature of 30 *F were discarded; in-service was initiated by the Administrator and Registered Dietician to dietary staff; and corrective action taken; beef stew substitute was served; the freezer with a temperature of 30 *F will not be used for resident food storage until repairs are completed; Dinner menu supplies bought fresh for dinner and stored in other working freezer unit. On 9/9/24, at 3:40 p.m., while on-site the surveyors confirmed the IJ was removed. 2. Three-compartment sink (dedicated to cleaning and sanitizing utensils and equipment) was used as food preparation area; 3. Equipment was dirty and in poor conditions 4. Facility did not ensure storage freezer was at 0 degrees F and foods were not frozen solid; 5. Scoop was stored inside powdered thickener (substance use to thicken liquids to help people with swallowing difficulty); 6. Activity Director (AD) did not wear hair covering in the kitchen; 7. AD , [NAME] (CK) 1, Senior [NAME] President of Operations (SVPO), and Registered Dietician (RD) 2 did not wash hands in the kitchen; 7. Moldy and unusable foods were not discarded; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Rehabilitation Center of Oakland		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 40th Street Way Oakland, CA 94611	

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Grease trap under 3-compartment sink had thick yellow/brown greasy residue build up on top and around edges. 9. Garbage disposal was highly malodorous with food particles, white build-up around rubber edges; 10. Garbage bin was dirty with black residue on top of lid and around bin; 11. Dry food item did not have a use by date or open date; 12. Multiple refrigerated items were stored beyond use by. (1 gallon dill pickle opened 7/22/24 use by 8/22/24, 6 pounds (lbs -unit of measurement) container yellow mustard opened 6/17/24 use by 8/17/24). These failures had the potential to cause food borne illness to 65 residents who receive food from the kitchen. Findings: During a concurrent interview and observation on 9/9/24 at 9:24 a.m. with Dietary Manager (DM), a black portable blower fan placed on top of a stainless-steel rolling cart was dirty with white/brown/black residue stuck on the vents blowing air towards steam table (equipment that keep hot foods at safe temperature); DM acknowledged the dirty blower fan and removed from the kitchen. During a concurrent interview and observation on 9/9/24 at 9:30 a.m. with the DM, the reach-in refrigerator stored four tomatoes that were wrinkled with black spots, celery stalks had black spots, six bananas had white/gray spots and were mushy. The DM acknowledged these were unusable foods. DM then removed and discarded all unusable foods. During a review of the facility's policy and procedure (P&P) titled, Food Storage and Handling, dated, 6/4/24, indicated .6. Fresh Fruits Storage a. Fresh fruit should be checked and sorted for ripeness.e. Label and date all food items. During a concurrent interview and observation on 9/9/24 at 9:31 a.m. with DM, a stainless-steel bowl covered with foil was observed resting inside 3-compartment dishwashing sink. DM opened the foil and revealed the bowl containing fish fillet thawing without running water. DM stated, the fish was being prepared for today's lunch. During an observation on 9/9/24 at 9:55 a.m. the AD, AD did not wear hair covering inside the kitchen. AD walked towards kitchen counter, grabbed a food tray from clean stack without performing hand hygiene. During a review of facility's P&P titled, Dietary Department - Infection Control, revised date, 2/29/24, indicated 1. b. Cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas.2. Proper hand washing a. Upon entering the kitchen. b. Immediately before engaging in food preparation, including working with non-prepackaged food, clean equipment and utensils . (continued on next page)

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	555313	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Oakland	210 40th Street Way Oakland, CA 94611

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a concurrent interview and observation on 9/9/24 at 9:56 a.m. with the DM, the industrial can opener mounted to countertop next the stove was observed with crusty yellow/orange and black residue build up and blade coating was peeled off. DM acknowledged it was dirty then removed the shank of can opener (a long, narrow part of a tool connecting the handle to the operational end) from the mount. During a review of the facility's P&P titled, Can Opener Use and Cleaning, dated 10/1/14, indicated under II. Sanitation of Equipment .B. Scrub shank, paying special attention to blade and moving parts.F. Inspect the blade and replace if notched. During a concurrent interview and observation on 9/9/24 at 9:57 a.m. with [NAME] (CK) 1, CK 1 entered kitchen door from the hallway wheeling a rolling cart wearing gloves. CK1 then washed a rag in a 3-compartment dishwashing sink, and wiped the rolling cart. CK stated, she did not wash her hands because she was already wearing gloves. During a review of the facility's P&P titled, Dietary Department - Infection Control, revised date, 2/29/24, indicated .2. Proper hand washing a. Upon entering the kitchen.g. During food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing tasks. During a concurrent interview and observation on 9/9/24, at 9:57 a.m., with CK 1, scooper was seen inside powdered thickener container sitting on counter at the food preparation area. CK 1, removed the scooper and stated, it was not to be left inside the container. During an observation on 9/9/24 at 10:00 a.m., with DM, the blender in the food preparation area had white sticky residue around the surface and mobile pan rack (used to hold desserts) between reach-in refrigerator and food preparation area had white/yellow and brown debris on side bars. During a review of facility's P&P titled, Blender Use and Cleaning, dated 10/1/14, indicated, .II. G. Wash the base with detergent solution and clean cloth .H. Rinse the base with clean water and wipe with sanitizing solution using a clean cloth. During a concurrent interview and observation on 9/9/24, at 10:11 a.m., with the DM, reach-in freezer # 2's thermometer reading was 30 degrees F. DM stated the door to the freezer does not fully close. Multiple food items stored were soft to touch that included fish fillets, corn dogs, French fries, meatballs, kernel corn and hash browns. Multiple food items contained moisture inside the bags including spinach, green beans and green peas. Corn on cobs had freezer burn. During a review of the facility's P&P titled, Food Storage and Handling, dated, 6/4/24, indicated 2. Frozen Meat, Poultry and Food a. Frozen products purchased are to be held at a temperature of 0 degrees F or below . b.Examine products for signs of defrosting. c. Store items promptly at 0 degrees F or below.g. Refreezing of defrosted food is not recommended because of the increase in growth of food bacteria and the deterioration in food quality.10. Frozen Vegetable Storage a. Store frozen vegetables as purchased in a freezer with temperature of -10 degrees F to 0 degrees F. During a concurrent observation and interview on 9/9/24, at 10:26 a.m. SVPO walked towards kitchen freezer, did not perform hand hygiene.

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	555313	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Oakland	210 40th Street Way Oakland, CA 94611

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(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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49498

Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices when:

1. Certified Nursing Assistant (CNA) 6 picked up a soiled linen on the floor of Resident 37 and Resident 58's room and disposed the soiled linen in the cart across Resident 37 and Resident 58's room.

2. Licensed Vocational Nurse (LVN) 3 did not perform hand hygiene and did not put on a new pair of gloves prior to administering eye drops to Resident 51.

3. LVN 3 did not remove gloves after applying topical medication (a medication that is applied to a particular place on or in the body.) to Resident 20.

4. Resident 17, 22 and 44's nasal cannula tubing was undated, unlabeled and was touching the floor.

These failures had the potential for cross contamination and spread of infections among residents at the facility.

Findings:

1. During an observation on 9/9/24 at 12:32 p.m. in Resident 37 and Resident 58's room, CNA 6 picked up a white linen on the floor with a gloved hand and proceeded to walk out of the room.

During a concurrent observation and interview, on 9/9/24 at 12:33 p.m. with CNA 6, CNA 6 walked out of Resident 37 and Resident 58's room holding the white linen and threw the linen in the cart labeled soiled linen across Resident 37 and Resident 58's room. CNA 6 stated the linen was dirty. CNA 6 stated the dirty linen should be placed inside a plastic bag during transport or the soiled linen cart should be placed in front of the resident's room door to prevent the spread of infection.

During a review of the facility's policy and procedure (P&P) titled Soiled Laundry & Bedding, dated 9/2016, indicated Facility staff handle soiled laundry and bedding in a manner that prevent gross microbial contamination of the air and those handling the linen . Contaminated laundry is placed in a bag or container at the location where it is used to prevent contamination during transport.

2. During medication administration observation on 9/10/24 at 8:19 a.m. with LVN 3 in Resident 51's room, LVN 3 moved Resident 51's bedside table away from Resident 51's bed and pulled the privacy curtain with her left gloved hand. LVN 3 informed Resident 51 that she would give the eye drops. LVN 3 proceeded to pull Resident 51's left lower eyelid with the same left gloved hand to administer the Dorzolamide HCl Solution (used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision.) 2% eye drop. Resident 51 stated he did not want the eye drop.

During an interview on 9/10/24 at 8:50 a.m. with LVN 3, LVN 3 stated a new pair of gloves should have been worn before giving the eye drops to prevent spread of infection.

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The Rehabilitation Center of Oakland	210 40th Street Way Oakland, CA 94611

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(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	During an interview on 9/11/24 at 2:10 p.m. with the DON, the DON stated the staff should perform hand hygiene before wearing clean gloves and not touch resident's surroundings. The DON stated administering eye drops was a clean procedure and a clean glove should be used to prevent infection. During a review of facility's P&P titled Eye Drops, dated 1/1/12, indicated Gloves are worn when contact with body fluids or secretions are expected . Wash hands before and after administration of eye drops. During a review of facility's P&P titled Hand Hygiene, dated 9/1/20, indicated, The facility considers hand hygiene as the primary means to prevent the spread of infections . Wearing gloves does not replace the need for hand hygiene. 3. During medication administration observation on 9/10/24 at 8:42 a.m. with LVN 3 in Resident 20's room, LVN 3 used her gloved left hand to open Resident 20's right and left lower abdominal fold and shook the Nystatin (treats fungal or yeast infections of the skin) powder bottle with her right gloved hand to apply the powder. LVN 3 proceeded to move Resident 20's bedside table closer to the resident with the same gloved hands. During an interview on 9/10/24 at 8:50 a.m. with LVN 3, LVN 3 stated gloves should be removed after the Nystatin powder was applied. During an interview on 9/11/24 at 2:13 p.m. with the DON, the DON stated gloves should be removed after applying the powder, perform hand hygiene and not touch anything in between. During a review of facility's P&P titled Medication Administration-General Guidelines, dated 10/17, indicated Hands are washed before and after administration of topical medications. During a review of facility's P&P titled Personal Protective Equipment, dated 1/1/12, indicated Hands are washed before and after removing gloves. 4. During a review of Resident 22's admission record, dated 9/13/24, indicated Resident 22 was admitted to the facility on [DATE], with multiple diagnoses that included Chronic Respiratory Failure (a condition that occurs when the lungs are unable to get enough oxygen into the blood or remove enough carbon dioxide from the blood) with Hypoxia (a condition that occurs when the body's tissues, blood, or cells don't have enough oxygen to function normally) During a review of Resident 44's admission record, dated 9/10/24, indicated Resident 44 was admitted to the facility on [DATE], with multiple diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - ongoing lung condition caused by damage to lungs), Chronic Respiratory Failure with Hypoxia. During a review of Resident 17's admission record, dated 9/10/24, indicated Resident 17 was admitted to the facility on [DATE] with multiple diagnoses that included COPD, wheezing, dependence on supplemental oxygen. (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 concurrent observation and interview on 9/10/24, at 12:46 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 22's room. Resident 22's oxygen tubing was on the floor, kinked and stuck under wheel of Resident 22's wheelchair. LVN 2 acknowledged the oxygen tubing was not labeled and removed the tubing from the floor. LVN 2 stated, it was infection control issue. During a concurrent observation and interview on 9/10/24, at 12:50 p.m. with LVN 2, in Resident 44's presence, LVN 2 picked up oxygen tubing from the floor and stated the tubing was too long that's why it was easy to fall on the floor. LVN 2 stated, Resident 44's oxygen tubing was not labeled. During a concurrent observation and interviews on 9/10/24, at 12:55 p.m. with LVN 2, in Resident 17's presence, Resident 17's oxygen was not labeled. LVN 2 stated, if oxygen tubing are not labeled it was unknown when the tubing was changed, and when it was due to be changed. LVN 2 further added, this was infection control issue. During an interview on 9/12/24 11:22 p.m. with the Director of Nursing (DON), DON stated oxygen tubing must be labeled with date when changed. DON also stated, if tubing was not dated, nursing staff will not know when it will be due to be changed. DON added, oxygen tubing should not be touching the floor, must be secured to head of bed. DON further added, it was both infection control issue when the oxygen tubing is touching the floor and/or if unlabeled. During a review of facility's policy and procedure (P&P), titled Oxygen Therapy, dated November 2017, indicated, Oxygen is administered under safe and sanitary conditions to meet resident needs. The P&P also indicated, under Procedure I.E. The humidifier and tubing should be changed no more than every 7 days and labeled with the date of change. II.C. Oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. The supplies will be dated each time they are changed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a patient to signal his or her need for assistance) was within reach for one of three sampled Residents (Resident 56). This deficient practice resulted in the delay of care and services. Findings: During a review of Resident 56's face sheet dated, 9/10/24, indicated Resident 56 was admitted to the facility on [DATE]. During a review of Resident 56 Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 8/13/24, the MDS indicated, Resident 56 had multiple diagnoses that included, muscle weakness, polyneuropathy (nerve damage causing problems with sensation, coordination, or other body functions). The MDS also indicated Resident 56 had a Brief Interview for Mental Status (BIMS - is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status) Score of 13, meaning Resident 56 had intact cognition. During a concurrent observation and interview on 9/9/24 at 10:18 a.m. Resident 56's call light was on the floor behind the bed. Resident 56's urinary collection bag measured 1600 cubic centimeter (cc - measure of volume). Resident 56 stated, staff did not empty drainage bag and it felt heavy. Resident 56 also stated, he could not ask for help because staff took his call light from within reach. During a concurrent observation and interview on 9/10/24 at 10:23 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated, she was not aware Resident 56 needed assistant. CNA 8 then picked up the call light from the floor behind Resident 56's bed and stated, I should have checked call light when I came this morning. During an interview on 9/12/24, at 11:22 a.m., with the Director of Nursing (DON), DON stated the expectation for the nursing staff was to ensure call light for Resident was within reach. DON further added, especially for Resident 56 who required extensive assistance. During a review of Resident 56's care plan dated 8/6/24, indicated Resident 56 was at risk for fall related to diabetes, polyarthritis (swelling of one or more joints), chronic pain, CKD (chronic kidney disease - gradual loss of kidney function) . One of the interventions is: Be sure the Resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a review of facility's policy and procedure, titled Communication-Call System, dated 1/1/12, indicated, Under Purpose: To provide a mechanism for residents to promptly communicate with Nursing Staff. Under Policy: The facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities.Under Procedure II. Call cords will be placed within the resident's reach in the resident's room.