STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555358	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fruitvale Healthcare Center	3020 East 15th Street Oakland, CA 94601

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51642 Based on observation, interview, record review, and facility policy review, the facility failed to provide food at an appetizing temperature, which affected 1 (Resident #32) of 4 residents reviewed for food. Findings included: An undated facility policy titled, Meal Service, indicated, Residents will receive their food at appropriate temperatures and an appetizing appearance; therefore, trays may be set up ahead of time with non-perishable items only. A Resident Face Sheet revealed the facility admitted Resident #32 on 11/04/2014. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/01/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #32 was interviewed on 10/21/2024 at 11:42 AM. Resident #32 stated the food at the facility was not always served hot, and if they were the last one served, the food was cold. During an observation on 10/23/2024 at 8:19 AM, staff passed meal trays on Station 4. The last tray on the food cart was removed from the meal cart at 8:27 AM. The last tray was taken to the dining room. The following temperatures were observed, scrambled eggs were 102 degrees Fahrenheit (F), the sausage patty was 102 degrees F, and the oatmeal was 122 degrees F. The Registered Dietitian (RD) and the Dietary Supervisor (DS) confirmed the temperatures of the eggs, sausage, and oatmeal. The scrambled eggs and sausage patty were lukewarm, and the oatmeal was warm. Resident #32 was interviewed on 10/23/2024 at 9:12 AM. Resident #32 stated that the scrambled eggs served that morning were not hot; they were lukewarm. Resident #32 then stated the scrambled eggs were usually served lukewarm. The Director of Nursing (DON) was interviewed on 10/24/2024 at 8:28 AM. The DON stated the facility followed federal and state requirements for food temperatures. He stated that the food should be served warm to the residents and at the correct internal temperature. (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 10/24/2024 at 9:44 AM about food temperatures. The Administrator stated the food served to residents should be served hot.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35314 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) for 1 (Resident #17) of 4 residents reviewed for pressure ulcers. The facility also failed to ensure staff changed gloves and performed hand hygiene between dirty and clean tasks for 1 (Resident #14) of 1 resident observed during incontinence care. Findings included: 1. An undated facility policy titled, Enhanced Barrier Precautions (EBP) revealed, 1. EBP shall be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that may result in transfer of MRDOs [multidrug-resistant organisms] to staff hands and clothing. 2. EBP are indicated for residents with any of the following, to include b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g. [exempli gratia, for example] adhesive bandages) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure injuries, diabetes foot ulcers, unhealed surgical wounds, and venous stasis ulcers. The policy revealed, 6. For residents for whom EBP are indicated, EBP shall also be used when performing the following high-contact resident care activities, to include Providing hygiene, and Changing briefs or assisting with toileting. A Resident Face Sheet indicated the facility admitted Resident #17 on 12/09/2016. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of functional quadriplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2024, revealed Resident #17 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). According to the MDS, the resident was dependent on staff with toileting hygiene and personal hygiene. The MDS revealed the resident was always incontinent of bowel and bladder. The MDS indicated Resident #17 had one unhealed Stage 2 pressure ulcer at the time of the assessment. Resident #17's Care Plan, included problem statements dated 10/22/2024, that indicated the resident had pressure ulcers to the right heel, right fifth toe, and right lateral foot. The Care Plan revealed a problem statement dated 10/23/2024, that indicated the resident was on EBP. Interventions directed staff to follow EBP (initiated 10/23/2024). An observation on 10/23/2024 at 3:35 PM revealed no EBP signage posted outside of Resident #17's room. There was no PPE located inside Resident #17's room. During an interview on 10/23/2024 at 3:46 PM, Certified Nurse Aide (CNA) #5 revealed she was the assigned CNA for Resident #17 and stated that the resident was not on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/23/2024 at 3:59 PM, CNA #5 and CNA #6 washed their hands and put gloves on before providing incontinence care to Resident #17. CNA #5 and CNA #6 did not wear a gown. The observation ended when CNA #5 and CNA #6 started to undress the resident. During an interview on 10/23/2024 at 4:54 PM, CNA #5 confirmed no additional PPE was worn during the incontinence care by either CNA. CNA #5 stated that there was no signage on the resident's door and that Resident #17 was not on EBP. During an interview on 10/23/2023 at 8:22 AM, CNA #4 revealed that if a resident was on EBP, the staff must wear a gown and gloves when proving care to the resident. CNA #4 stated that residents must have signage outside the door to indicate EBP. During an interview on 10/23/2024 at 7:41 AM, the Infection Preventionist (IP) stated Resident #17 should be on EBP. During a follow-up interview on 10/23/2024 at 4:04 PM, the IP revealed that if a resident had an open wound, then the resident should be placed on EBP. She stated that the CNAs should wear PPE when providing incontinence care to Resident #17. She stated that she had not placed any signage or PPE in Resident #17's room. During an interview on 10/24/2024 at 9:05 AM, the Wound Nurse revealed Resident #17 had four open wounds and the resident was on EBP. During an interview at 10/24/2024 at 10:19 AM, the Director of Nursing (DON) revealed that he expected any resident with open wounds to be placed on EBP and that there should be signage on the resident's door. He stated that the staff should wear a gown and gloves when providing care. During an interview on 10/24/2024 at 11:56 AM, the Administrator revealed that residents with open wounds should be placed on EBP. He stated that staff should wear gowns and gloves when providing care. 51642 2. A facility policy titled, Hand Hygiene, implemented February 2017, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy revealed, Fundamental Information included 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-microbial) and water for the following situations, to include h. Before moving from a contaminated body site to a clean body site during resident care, j. After contact with blood or bodily fluids, and m. After removing gloves. A Resident Face Sheet indicated the facility admitted Resident #14 on 03/30/2016. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of hemiplegia, acquired absence of unspecified leg above knee, and an overactive bladder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2024, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was frequently incontinent of urine and required substantial/maximal assistance from staff with toileting hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's Care Plan, included a problem statement initiated on 12/24/2017, that indicated the resident was occasionally incontinent of urine due to an overactive bladder. Interventions directed staff to clean and dry the resident after each incontinence episode (initiated 02/11/2018). During an observation on 10/23/2024 at 3:58 PM, Certified Nurse Aide (CNA) #7 provided incontinence care to Resident #14. CNA #7 donned gloves and cleansed Resident #14's buttocks and anal area with disposable wipes. Without removing his gloves and without sanitizing or washing his hands, CNA #7 placed a clean incontinence brief under Resident #14, folded the resident's pillow, placed the pillow under the resident's back, and removed the resident's socks and pants. CNA #7 then removed his gloves and washed his hands. CNA #7 was interviewed on 10/23/2024 at 4:13 PM. CNA #7 stated he did not wash or sanitize his hands when going from a dirty task to a clean task while providing incontinence care to Resident #14. The Director of Nursing (DON) was interviewed on 10/24/2024 at 8:53 AM. The DON stated staff were expected to wear gloves and follow standard precautions, including washing hands. He stated that after cleansing a resident, staff were expected to remove their gloves and wash their hands. The Director of Staff Development (DSD) was interviewed on 10/24/2024 at 9:11 AM. The DSD stated that staff were expected to remove their gloves and sanitize their hands, as staff were considered dirty after cleansing a resident, then put on new gloves. The Administrator was interviewed on 10/24/2024 at 9:59 AM. The Administrator stated that staff were expected to wear gloves when providing resident care. He stated that staff were expected to change gloves when going from a dirty task to a clean task when providing care.