STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555486	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Healthcare & Wellness Center	430 Willow Street Alameda, CA 94501

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to develop and implement written policies and procedures that included re-training and re-education of a staff alleged of abuse/mistreatment before returning to work with residents. This failure had the potential to result in exposing vulnerable residents to abuse/mistreatment. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility in December 2022 with diagnoses that included bed confinement status, cognitive communication deficit (reduced awareness and ability to initiate and effectively communicate needs), sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), dependence on respirator status, acute and chronic respiratory failure (condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). During an interview on 1/22/25 at 10:30 a.m. with Administrator (Adm), Adm stated an allegation of mistreatment was reported to the facility on [DATE], and investigation was conducted. Admin stated Registered Nurse (RN) 1 was suspended for five days pending the result of the investigation. During an interview and concurrent review with Director of Staff Development (DSD), the facility's policy and procedure titled Abuse-Prevention, Screening & Training Program last revised July 2018 was reviewed. DSD stated after an employee is suspended for allegation of abuse/mistreatment of a resident and before resuming resident care, abuse prevention re-training should be completed by the employee. The facility's P&P indicated the facility conducts mandatory staff training programs during orientation, annually and as needed on: prohibiting and preventing abuse, neglect, exploitation, misappropriation of resident property or mistreatment; identifying what constitutes abuse, neglect, exploitation misappropriation of resident property, or mistreatment; recognizing signs of abuse .and mistreatment; reporting abuse .mistreatment and injuries of unknown source . (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

Printed: 06/26/2025
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No. 0938-0391

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Alameda Healthcare & Wellness Center	430 Willow Street Alameda, CA 94501

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 1/22/25 at 3:10 p.m. with Admin and Director of Nursing (DON), Admin stated abuse training for employees included having the employee watch the Department of Justice (DOJ) video on abuse prevention and having the employee sign the acknowledgment form indicating the training was completed. Admin stated RN 1 did not complete abuse training and did not sign an acknowledgment that abuse training was completed before returning to work. DON stated, the education provided to RN 1 was to have another staff with her when preparing residents for personal care or repositioning and was not focused on the nature of the allegation. Admin stated the allegation was reported and was investigated as abuse/mistreatment allegation.

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NAME OF PROVIDER OR SUPPLIER Alameda Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Willow Street Alameda, CA 94501	

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 32717 Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to ensure Resident 1 received treatment and care to maintain good foot health when Podiatry service was not provided after Resident 1's left great toenail came off due to fungal infection (disease caused by fungi). This failure had the potential to result in delayed treatment and further spread of fungal infection on Resident 1's toes. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility in December 2022 with diagnoses that included bed confinement status, cognitive communication deficit (reduced awareness and ability to initiate and effectively communicate needs), sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), dependence on respirator status, acute and chronic respiratory failure (condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). During a telephone interview on 1/16/24 at 11:33 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 had fungal infection on the toes but had not been seen by a podiatrist (a doctor devoted to the study, diagnosis and treatment of disorders of the foot, ankle and lower limb). During a review of Resident 1's Order Summary Report as of 6/1/24 indicated a physician's order dated 12/28/22 for Resident 1 to have podiatry services as clinically indicated. The report also indicated the following physician orders; - observe avulsed right fifth toe for signs of bacterial infection every day and night shift, dated 1/9/24. - Social Services to arrange outpatient podiatry appointment and critical care transportation, dated 2/7/24. - cleanse avulsed (a toenail that has been partially or completely torn off) left third toe with normal saline, pat dry, apply triple antibiotic and cover with dressing every day and as needed, dated 2/8/24. During a review of Resident 1's Health Status Note dated 3/1/24, the Health Status Note indicated the podiatrist noted fungal infection on Resident 1's right third toe and removed the toenail exposing the nail bed with minimal bleeding. (continued on next page)

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Progress Note dated 5/5/24, two months after Resident 1's right third toenail was removed due to fungal infection, the Progress Note indicated, during shower, Licensed Vocational Nurse (LVN) 1 noted a mycotic (fungal infection of the nail, mail appears thickened, discolored apperaing white, yeloow, black or green, breaks easily and may separate from the nail bed) nail on the shower bed, Resident 1's Left great toe [nail] is missing, left great toe [nail] avulsed, MD (doctor) made aware, gave order to monitor left great toe. During a telephone interview on 1/24/25 at 5:15 p.m. with LVN 1, LVN 1 stated, during shower on 5/5/24, she noted Resident 1's mycotic nail on the shower bed and noted Resident 1's left great toe was missing. LVN 1 stated she referred Resident 1 for a podiatry visit and had written her request in the Social Services binder. During an interview on 1/22/24 at 11:56 a.m. with Social Services Coordinator, SSC stated residents are seen by an in-house podiatrist (foot doctor who visits and treats residents at the facility) every 61 days. SSC stated if Resident 1 was seen on 3/1/24, the next podiatry visit should have been sometime around May 2024, but the podiatrist returned in July 2024. SSC also stated, if Resident 1 needed a podiatrist appointment sooner than 61 days, the licensed nurse may request for an outpatient visit and Social Services will assist with scheduling the appointment and transportation arrangement. During a review of Resident 1's clinical record, there was no documentation that indicated an outpatient podiatry appointment was arranged for Resident 1 as ordered by the physician on 2/7/24. During a telephoe interview on 1/29/25 at 11:36 a.m. with SSC, SSC stated she was not aware of the physician's order to refer Resident 1 to outpatient podiatry. SSC stated if she had known, she would have referred Resident 1 to another provider and not wait for the in-house podiatrist. During a follow-up telephone interview and concurrent record review on 1/24/25 at 11:57 a.m. with SSC, SSC's Social Services note dated 5/14/24 indicated FM 1 asked SSC what could be done to avoid having Resident 1's toes amputated, SSC told FM 1 podiatrist will see Resident 1 in June 2024 and will give recommendation about FM 1's concern then. SSC stated, Resident 1 was not seen in June 2024 as the podiatrist did not do any visits at the facility until 7/3/24. Resident 1 was transferred to the hospital on 6/29/24 and did not return to the facility. During a review of the facility's policy and procedure (P&P) titled Referrals to Outside Services last revised 12/1/13, the P&P indicated the Director of Social Services is responsible for locating agencies and programs that meet the needs of residents, facilitating the execution of service provider contracts and referring residents to existing contracted providers. The Director of Social Services or his or her designee will coordinate with Nursing Staff to ensure that the Attending Physician's order and referral to outside provider is documented in the resident's medical record. During a telephone interview with Medical Records Staff (MRS) 1 on 1/24/24 at 4:17 p.m., MRS stated there were no podiatry visit notes in Resident 1's medical record.