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	09/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on observation, interview and record review the facility failed to follow infection control practices to prevent the spread of infection in the facility during a Coronavirus Disease (COVID-19 - an infectious disease caused by the SARS-CoV-2 virus) outbreak when the following was observed:The facility did not notify the California Department of Public Health they had a COVID-19 outbreak.The facility did not have signs at their front entrance to notify visitors, residents or anyone coming into the facility about their COVID-19 outbreak. One [NAME] Aid (CA 1), and one Laundry Aid (LA 1) wore a surgical mask in the resident hallways.Three facility staff including one receptionist, one Certified Nursing Assistant (CNA 1), and one Restorative Nursing Assistant (RNA 1), did not appropriately wear their face masks. These failures had the potential for increased risk of infection for the 152 residents at the facility.During a review of Resident 1's admission Record, printed 9/4/25, the admission Record indicated Resident 1 was admitted to the facility with multiple diagnoses, including cognitive communication deficit. During a review of Resident 2's admission Record, printed 9/4/25, the admission Record indicated Resident 2 was admitted to the facility with multiple diagnoses, including immunodeficiency (when your immune system is too weak to fight off infections and diseases effectively, leading to more frequent, severe, or long-lasting illnesses) . During a review of Resident 2's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.), dated 8/3/25, the record indicated Resident 2's BIMS score was 15. During a review of Resident 3's admission Record, printed 9/4/25, the admission Record indicated Resident 3 was admitted to the facility with multiple diagnoses, including encounter for screening for COVID-19 (medical visit to test for potential health issues in people who are not currently showing symptoms). During an observation on 9/4/25, at 9:50 a.m., the facility's front entrance was observed. The entrance did not have any signs that indicated there was a COVID-19 outbreak in the facility. During a concurrent observation and interview on 9/4/25, at 9:58 a.m., in the lobby, the receptionist did not state the facility had a COVID-19 outbreak. The receptionist was wearing an N95 mask (a type of respirator that forms a seal around the nose and mouth and helps protect the wearer from inhaling airborne particles for infection control) below their nose with their nose open to air. During an observation on 9/4/25, at 10:26 a.m., in the resident hallway, CA 1 was wearing a surgical mask. During a concurrent observation and interview on 9/4/25, at 10:30 a.m., CNA 1 was in Resident 1's room wearing an N95 mask below their nose with their nose open to air. CNA 1 stated they were changing Resident 1's linens, gown and brief. During a concurrent observation and interview on 9/4/25, at 10:47 a.m., in the resident hallway, LA 1 was wearing a surgical mask while they stocked the clean linen closet. LA 1 stated they should have been wearing an N95 and put one on. During a concurrent observation and interview on 9/4/25, 11:17 a.m., RNA 1 was in Resident 2's room wearing an N95 mask below their nose with their nose open to air. RNA 1 stated they were taking Resident 2's weight. During an interview on 9/4/24, at 11:30 a.m., with Resident 2, Resident 2 stated staff did not always wear their face masks correctly. During an interview on 9/4/24, at 12:46 p.m., with Director of Nursing (DON), DON stated they were having a COVID-19 outbreak. DON stated Resident 3 was COVID-19 positive. During an interview on 9/4/24, at 1:45 p.m., with the Administrator (ADM) and the Regional Quality Management Consultant (RQMC), ADM stated everyone was required to wear an N95 upon facility entrance, while in the hallways and in resident rooms because of their COVID-19 outbreak. ADM stated it was important to wear an N95 because it offered more protection than a surgical mask and to prevent the spread of infection. RQMC stated the proper way to wear an N95 was to seal it over the mouth and nose, and it was important to wear it correctly to prevent the spread of infection. RQMC stated their policy was to have a sign at the front entrance to inform visitors and staff about their COVID-19 Outbreak. RQMC stated the sign was important so everyone could have been informed of the outbreak and so they could have taken the necessary precautions to prevent the spread of infection. During an interview on 9/4/24, at 4:46 p.m., DON stated they did not report the facility's COVID-19 outbreak to the California Department of Public Health.