STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555657	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Healthcare Center	2140 Carlmont Drive Belmont, CA 94002

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 - Few	Provide and implement an infection prevention and control program. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) and wore the appropriate personal protective equipment (PPE) while providing care for 1 (Resident #25) of 2 residents reviewed for tube feedings. Findings included: A facility policy titled, Enhanced Barrier Precautions, revised 11/14/2024, revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy indicated, 2. Initiation of Enhanced Barrier Precautions: included b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g. [exempli gratia, for example] chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [peripherally inserted central catheter] lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO [multi-drug resistant organism]. The policy revealed, 3. Implementation of Enhanced Barrier Precautions: included b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. According to the policy, 4. High-contact care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters. An Admission Record indicated the facility readmitted Resident #25 on 11/09/2020. According to the Admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) following cerebral infarction (stroke) and gastrostomy status (feeding tube). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/23/2024, revealed Resident #25 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident had a feeding tube and received 51% of their total calories and 501 cubic centimeters (cc) of fluid a day through the feeding tube. (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
	555657	A. Building B. Wing	12/05/2024

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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 - Few	Resident #25's care plan included a focus area revised 08/03/2024, that indicated the resident required EBP due to having a gastrostomy tube. Interventions directed staff to clean their hands before and when leaving the room; to wear gloves and a gown for device care and when using feeding tubes; and to instruct certified nurse assistants (CNAs) and licensed nurses regarding proper use of personal protective equipment. Resident #25's Order Summary Report for active orders as of 12/05/2024 revealed an order dated 08/01/2024 for enhanced barrier precautions related to the presence of a gastrostomy tube. During an observation on 12/04/2024 at 12:33 PM, Registered Nurse (RN) #1 entered Resident #25's room wearing a surgical mask and gloves, with no gown. RN #1 checked the placement of the resident's gastrostomy tube and residual. RN #1 also connected the resident's feeding to a pump and started the pump, while still not wearing a gown. During an interview on 12/05/2024 at 10:58 AM, RN #1 confirmed that he did not wear the proper PPE when setting up the tube feeding for Resident #25. He stated he was nervous and forgot. RN #1 stated he should have worn a gown while providing care to help prevent the spread of infection. During an interview on 12/05/2024 at 10:52 AM, the Infection Control Preventionist (ICP) stated EBP should be used for any resident that had an indwelling device, and the staff should wear a gown and gloves when providing care. He stated he provided training on EBP in November 2024. During an interview on 12/05/2024 at 11:56 AM, the Director of Nursing (DON) stated if a resident was on EBP, the staff should wear a gown, gloves, and a mask to help prevent the spread of infection to staff and other residents. She stated EBP was needed for residents that had feeding tubes. She stated RN #1 should have put on a gown and gloves prior to providing care to Resident #25. During an interview on 12/05/2024 at 12:16 PM, the Administrator stated EBP should be used for the safety of the residents, and he expected that the staff to use the appropriate PPE when providing care for a resident that was on EBP.