STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: All Saint's Subacute & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 1652 Mono Avenue San Leandro, CA 94578	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 50474

Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 40 and Resident 59) received assistance with Activities of Daily Living (ADL, those activities needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) to maintain good grooming and personal hygiene when Resident 40 and Resident 59 had long, thick facial hair.

This failure resulted in Resident 40 and Resident 59 at risk for skin breakdown and irritation.

Findings:

1. During a record review of Resident 59's Resident Face Sheet, printed on 7/11/24, the Face Sheet showed Resident 59 was admitted to the facility in March 2024 and had multiple medical diagnoses including encephalopathy (any brain disease that alters brain function or structure, manifested by declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms) and traumatic hemorrhage of cerebrum (a disease caused by bleeding in the brain that can result in irreversible neurologic damage or sudden death).

During a record review of Resident 59's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/21/24, the MDS section GG (Functional Abilities and Goal) indicated Resident 59 was totally dependent and needed staff's total assistance to maintain personal hygiene and grooming.

During a record review of Resident 59's Care Plan for ADL/Mobility, dated 3/20/24, the record showed Resident 59 was at risk for ADL/mobility decline and required assistance related to bed-bound status, cognitive impairment, and medical conditions.

During an observation and interview on 7/9/24 at 9:15 a.m. in Resident 59's room, with Certified Nurse Assistant (CNA) 1, Resident 59 had long and thick facial hair. CNA 1 stated she was from an agency, and she did not know if it was her responsibility to shave Resident 59's facial hair.

During an interview on 7/9/24 at 9:20 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 59 was non-verbal and unable to communicate needs. LVN 1 stated Resident 59's facial hair was already long and needed to be shaved. LVN 1 stated CNAs were responsible in maintaining Resident 59's personal hygiene and grooming.

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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: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER All Saint's Subacute & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1652 Mono Avenue San Leandro, CA 94578	

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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 - Few	During a phone interview on 7/11/24 at 10:38 a.m. with Resident 59's Family Representative (FR), FR stated Resident 59 would have preferred his facial hair be shaved at least occasionally and not have a long and thick facial hair. 2. During a record review of Resident 40's Resident Face Sheet, printed on 7/11/24, the Face Sheet showed Resident 40 was admitted to the facility in January 2024 and had the diagnoses of encephalopathy and acute and chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a record review of Resident 40's MDS, dated [DATE], the MDS section GG showed Resident 40 was also totally dependent on staff's total assistance to maintain personal hygiene and grooming. During an observation and interview on 7/9/24 at 1:18 p.m. with LVN 1, Resident 40 was lying in bed and had long, thick facial hair. LVN 1 stated Resident 40 was cognitively impaired and non-verbal. LVN 1 stated Resident 40 also needed to have his facial hair shaved. LVN 1 stated having a long and thick facial hair could put residents at risk for skin irritation or breakdown. During an interview on 7/10/24 at 3:10 p.m. with Director of Nursing (DON), DON stated he expected the CNAs to maintain residents' personal hygiene and grooming as needed. DON stated the risk of having long facial hair can affect residents' skin integrity and could compromise their dignity. During a record review of facility's policy & procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 2001, the P&P indicated, Residents who are unable to carry out activities of daily living will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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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 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.

50474

Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 59), received proper tracheostomy (surgically created hole in the trachea or windpipe that provides an alternative airway for breathing) care when Resident 59's tracheostomy tie (a band that goes around the neck and hold the tracheostomy tube in place) was not changed daily as ordered by the physician.

This failure resulted in Resident 59 being at risk for skin irritation and infection.

Findings:

During a record review of Resident 59's Resident Face Sheet, printed on 7/11/24, the Face Sheet showed Resident 59 was admitted to the facility in March 2024.

During a record review of Resident 59's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/21/24, Resident 59's review of section I (Active Diagnoses) indicated Resident 59 had a diagnosis of dependence on ventilator (a type of breathing apparatus that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe or breathing insufficiently).

During an observation on 7/9/24 at 09:15 a.m., Resident 59 was lying in bed and had a tracheostomy tube connected to the ventilator. Resident 59's tracheostomy tie was observed around his neck and was dated 6/14/24.

During a concurrent observation and interview on 7/9/24 at 9:25 a.m. with Registered Nurse Supervisor (RN 1), RN 1 stated licensed nurses and respiratory therapists (RTs) were responsible of providing tracheostomy care to Resident 59. RN 1 stated the tracheostomy ties should be changed every day, after shower or as needed when soiled. RN 1 stated Resident 59's tracheostomy tie was last changed on 6/14/24. RN 1 stated Resident 59's tracheostomy tie should have been changed daily. RN 1 stated the risk of not changing the tracheostomy tie in a timely manner can result in skin irritation, redness, and infection.

During an interview on 7/10/24 at 1:35 p.m. with Respiratory Therapist Director (RTD), RTD stated tracheostomy ties should be changed every 2-3 days, after every shower and as needed when soiled. RTD stated Resident 59's old tracheostomy tie dated 6/14/24 was completely unacceptable. RTD stated the risk of not changing the tracheostomy tie can cause Resident 59 potential for infection of the tracheostomy area and skin breakdown around his neck.

During a record review of Resident 59's Physician Order, dated 3/21/24, the Physician's Order showed Resident 59's tracheostomy tie should be changed every shift, as needed if soiled or dislodged, and after shower.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's policy & procedure (P&P) titled, Tracheostomy Care, dated 2001, the P&P showed Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49983 Based on observation, interview, and record review, the facility failed to ensure accurate accountability of a controlled substance (substances that have an accepted medical use, medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) when: 1. During a random controlled medication use audit, two of two randomly sampled residents (Resident 49 and Resident 15) did not have all administered medications correctly documented on the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medication) and on the Medication Administration Record (MAR) to indicate they were administered to the resident. This failure had the potential to result in misuse or diversion of controlled medications and had the potential to make it more difficult to monitor if medication dosages need to be adjusted. 2. The medication cart was observed to be unlocked on two occasions. This failure had the potential to result in residents accessing medications that are not prescribed to them. Findings: 1. During a record review of the CDR and the MAR for Resident 49, the documents indicated that alprazolam 0.25 mg (an anxiety medication with potential for abuse) was recorded on the CDR and not recorded on the MAR on 7/4/24 and 7/5/24. During a concurrent interview and record review on 7/10/24 at 3:11 p.m. with Director of Nursing (DON), the CDR and MAR for Resident 49 were reviewed. DON stated the records indicate that alprazolam 0.25 mg is documented on the CDR and is not signed on the MAR for 7/4/24 and 7/5/24. DON stated that the expectation is that the nurses enter the medication administration on the CDR and the MAR. DON stated that a potential consequence of not entering the medication on both documents is that there is not a full record of administration. During a concurrent interview and record review on 7/11/24 at 11:29 a.m. with Licensed Vocation Nurse (LVN) 3, the CDR and MAR for Resident 49 were reviewed. LVN 3 stated the record shows she administered alprazolam 0.25 mg on 7/4/24 and entered the medication on the CDR and did not record the medication on the MAR. LVN 3 stated the potential consequence of not entering the medication in both locations is that it becomes harder for the doctor to assess how much of the medication the resident is using. During a review of facility's policy titled Medication Administration Controlled Substances, dated 01/23, the policy indicated that controlled medications should be documented on the MAR. 2. During a record review of the CDR on 7/9/24 and the MAR for Resident 15, the documents indicated Resident 15 was prescribed morphine sulfate 5 mg every one hour as needed and morphine sulfate 5 mg every eight hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/10/24 at 2:49 p.m. with Registered Nurse (RN) 1, the CDR and MAR for Resident 15 were reviewed. RN 1 stated the records show there are two orders for morphine sulfate 5 mg, one order for 5 mg every 8 hours and one order for Morphine Sulfate 5 mg every 1 hour. RN 1 stated there is one CDR for Morphine Sulfate 5 mg every 1 hour as needed and there is no CDR for Morphine Sulfate 5 mg every 8 hours. RN 1 stated there should be two CDR sheets. RN 1 stated there is a risk for confusion if there is only one CDR sheet. During a concurrent interview and record review on 7/10/24 at 3:11 p.m. with DON, the CDR and MAR for Resident 15 were reviewed. DON stated the records show the morphine orders for Resident 15 in the MAR do not match the orders on the CDR and this could increase the risk of medication error. 3. During an observation on 7/9/24 at 3:41 p.m., Medication Cart 1 was unlocked. There was a resident sitting near the medication cart, and there were no staff members observed nearby. During a concurrent observation and interview on 7/9/24 at 3:43 p.m., LVN 4 stated the medication cart was unlocked and that it should be locked. During an observation on 7/9/24 at 3:53 p.m., Medication Cart 1 was unlocked while out of view of LVN 4 during medication pass (when residents are being given medications). During an interview on 07/11/24 at 12:18 p.m. with DON, DON stated that the expectation is that the medication cart should always be locked when out of site of the nurse. DON stated that a potential consequence of not locking the medication car is that a resident or anyone else in the facility could access the medication cart. During a review of facility's policy and procedure (P&P) titled Security of Medication Cart, dated 2001, the P&P indicated medication carts must be locked at all times when out of the nurse's view.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs.

45875

Based on interview and record review the facility failed to act upon consultant pharmacist's recommendations to add the correct indication of use for quetiapine (a medication used to treat certain mental/mood disorders) for one of five sampled residents (Resident 19).

This deficient practice resulted in Resident 19 receiving unnecessary medication without proper indication and had the potential to negatively impact the resident's well-being.

Findings:

During a review of Resident 19's Admission Record Report, printed on 7/11/24, the report indicated Resident 19 was admitted to the facility in October 2018.

During a concurrent interview and record review on 7/10/24 at 3:11 p.m., with Director of Nursing (DON), Consultant Pharmacist's Medication Regimen Review (MRR) for April 2024 was reviewed. The MRR, dated on 4/27/24, indicated the following: [Resident 19] only taking quetiapine due to failed GDR of quetiapine. Fix diagnosis to dementia with behaviors- biting. The recommendations have not been reviewed by physician as of 7/10/24.

During a concurrent interview and record review on 7/10/24 at 3:49 p.m., with Director of Nursing (DON), Resident 19's Physician Orders were reviewed. The Physician Orders indicated Resident 19 was still receiving quetiapine 50 mg for biting. DON also stated the indication for use of quetiapine should have been dementia with behaviors as manifested by biting as per recommendation. DON confirmed the pharmacist recommendations were not carried out for Resident 19. DON also stated he believes they should carry out the recommendations within 30 days. DON also stated it is important to have correct indications to ensure resident safety and not use medication for wrong reasons as they can have lot of side effects.

During a review of the facility's undated policy and procedure (P&P) titled, Medication Regimen Review and Reporting, the P&P indicated Procedures .6. Resident specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician .8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols.

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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 49983

Based on observation, interview, and record review, the facility failed to store and label mediations in accordance with manufacturer specifications and currently accepted professional principles when:

1. Two containers of acetylcysteine (a medication used to break up mucus in people with lung disease) were not labeled with an open date.

2. An unopened insulin pen was stored in the medication cart.

3. Four bottles of eyedrops were not correctly labeled with a patient identifier.

4. Oral (taken by mouth) medications were stored in the same compartment in the medication cart as eye drops.

These failures had the potential to result in eight residents potentially receiving an incorrect or expired medication.

Findings:

1. During a concurrent observation and interview on [DATE] at 11:45 a.m. with Licensed Vocational Nurse (LVN) 2, there were two open containers of acetylcysteine for Resident 18 and 23 in the medication refrigerator that did not have an open date. LVN 2 confirmed there was no open date or time and stated the medications should be labeled with the open date. LVN 2 stated that if medications are not labeled with the open date there is a risk that residents could receive medication that is no longer effective.

A review of Lexicomp, a nationally recognized drug information resource, indicates that acetylcysteine should be used within 96 hours of opening.

During an interview on [DATE] at 12:32 p.m. with Director of Nursing (DON), DON stated acetylcysteine should have an open date because it is only good for 96 hours once it is opened. DON stated that without an open date, it is unknown if it would be effective.

2. During a concurrent observation and interview on [DATE] at 12:10 p.m. with LVN 2, there was an unopened Basaglar KwikPen 100 unit/mL insulin pen (a device to deliver insulin to lower blood sugar) for Resident 50 in Medication Cart 2 without a date indicating when it was removed from the refrigerator. LVN 2 stated that insulin pens should be stored in the refrigerator prior to being opened as it could cause the pen to expire earlier and lose effectiveness.

A review of Lexicomp indicated the following for storage of Basaglar KwikPen: Store in-use prefilled pens at room temperature . and use within 28 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] with DON, DON stated that unopened insulin products should remain in the refrigerator until they are opened. If an unopened insulin pen is kept in the medication cart, it could be less effective when it is used. A review of the facility's policy and procedure (P&P) titled Medication Storage, dated ,d+[DATE], indicated insulin products should be stored in the refrigerator until opened. 3. During a concurrent observation and interview on [DATE] at 12:56 p.m. with the Assistant Director of Nursing (ADON), vitamin E aqueous oral drops (a vitamin supplement taken by mouth) for Resident 6 were stored in the same compartment in Medication Cart 1 as eye drops. ADON stated that oral medications should be stored separately from eye drops because they are taken by different routes and storing them in the same compartment increases the risk that the mediations could accidentally be given by the wrong route. A review of the facility's P&P titled Medication Storage, dated ,d+[DATE], indicated medications should be stored so that various routes of administration are separated. 4. During a concurrent observation and interview on [DATE] at 12:56 p.m. with ADON, four bottles of artificial tears lubricant eye drops were labeled only with the resident room numbers for Residents 39, 41, 32, and 17. ADON stated there was a risk that residents could change rooms and then the medication could be given to the wrong resident.

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F 0802

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

48616

Based on observation, interview, and record review, the facility failed to ensure kitchen staff were competent regarding job duties when:

1. A cook did not know the appropriate method for calibrating the thermometer.

2. A dietary aide did not demonstrate appropriate procedures for testing the sanitizer on the dish machine.

3. Kitchen staff did not know the appropriate sanitizer for sanitizing food contact surfaces.

This failure had the potential to result in contamination of kitchen equipment and/or utensils leading to food borne illness caused by pathogens (harmful organisms) for 22 residents who received food from the kitchen.

Findings:

1. During a concurrent observation and interview on 7/11/24 at 9:45 a.m. with [NAME] in the kitchen, [NAME] stated she was responsible for the food thermometer's calibration to ensure accuracy. [NAME] showed how to calibrate the food thermometer by filling a stainless cup with cold water and ice cubes, then she added hot water. She inserted the stem of the thermometer into the contents of the stainless cup. [NAME] stated the thermometer stem would remain on the contents until the dial would indicate a temperature range of 30-40 degrees Fahrenheit (F).

During an interview on 7/11/24 at 9:50 a.m. with the Registered Dietician (RD), RD stated that Cook's method of adding hot water was wrong because she should fill it with half water then half crushed ice. RD also stated that not following the correct procedure of food thermometer calibration would lead to inaccurate readings of food temperatures.

During a review of the facility's Policy and Procedure (P&P) titled, Calibrating Bi-Stem and Digital Thermometer, dated 2017, the P&P indicated, To calibrate bi-stem thermometer(s) using the ice point method to ensure the accuracy .Fill an insulated container such as Styrofoam cup or thermos with crushed ice and water .if the dial reading indicates 32 F the thermometer is accurately calibrated.

2. During a concurrent observation and interview on 7/11/24 at 9:00 a.m. with Dietary Aide (DA) 1 in the kitchen, DA 1 was washing dishes using the dish machine. DA 1 stated she would check the sanitizer strength for the sanitizer used in the dish machine once a week. DA 1 demonstrated process for testing dish machine sanitizer concentration. After the dish machine completed the rinse cycle, DA 1 opened the door to the dish machine and touched a chlorine sanitizer test strip on the surface at the bottom of the dish machine.

During an interview on 7/11/24 at 11:09 a.m. with RD, RD stated in checking the sanitizer strength of the dish machine, the chlorine strip should touch the surface of the wet plate not the bottom of the dish machine.

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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 - Some	During a review of facility's P&P titled Temperature and Chlorine Testing, dated 2017, the P&P indicated, To record chlorine data on a daily basis for all three mealtimes .a. Using the appropriate strip: take the test strip and brush over the wet plate to moisten .c. The water in the dish machine will not be tested . This is an improper method of testing. 3.During a concurrent observation and interview on 7/11/24 at 9:15 a.m. with DA 1, DA 1 stated she would sanitize the tabletop on the dishwashing area after all the dishes had been washed. DA 1 also stated the sanitizer she would use and pointed to a white spray bottle located below the dishwashing table area. The spray bottle had a faded sticker and labeled with a handwritten black marker that read Sanitizer. DA 1 further stated she filled the spray bottle with a prepared mixture of 50% sanitizer solution and 50% water per the instruction of the sanitizer's original container, however DA 1 was unable to locate the container. DA 1 also did not test and did not know the strength of the sanitizer. DA 1 stated it was DA 2 who prepared the sanitizer. During a concurrent observation and interview on 7/11/24 at 9:20 a.m. with DA 2, DA 2 stated he prepared the sanitizing solution that was in the white spray bottle. DA 2 stated the sanitizer was color purple but unable to remember what type of sanitizer because he disposed the empty container. DA 2 stated he prepared the sanitizer on the spray bottle with 80% sanitizer diluted with 20 % water, per the container's instruction. He also stated he did not know the correct strength of the sanitizer on the bottle. DA 2 tested the sanitizer using the QUAT (quaternary ammonium) test strips, the test strip turned into a dark ocean blue color. He compared the test strip on the color chart behind the test strip's container. DA 2 stated that the test strip color was not on the color chart. During an interview on 7/11/24 at 9:40 a.m. with RD, RD stated that the kitchen staff used the prepared sanitizer to sanitize tray carts and dishwashing table areas. During a concurrent observation and interview on 7/11/24 at 11:15 a.m. in the kitchen with Territory Representative (TR) from [Company], TR stated she diluted the sanitizer with water. TR also stated that the purple sanitizer solution on the spray bottle was a daily disinfectant cleaner. She also stated it should not be prepared by the facility's kitchen staff because they don't know the exact ratio of preparation. TR tested the sanitizer on the spray bottle using the QUAT test strip and the color remained dark ocean blue. TR stated the sanitizer was too concentrated. TR further stated that sanitizer on the spray bottle was not the recommended sanitizing solution for a food contact surfaces such as tray carts and any tabletops in the kitchen area. During a review of the daily disinfectant cleaner manufacturer's information sheet, the information sheet indicated, use on hard, non-porous and nonfood contact surfaces. During a review of the facility's P&P titled, Cleaning and Sanitizing Basics, dated 2023, indicated All Sanitizers must be EPA and State Department of Food and Agriculture approved products for use in food service areas .Never increase sanitizer concentration levels above manufacturer's recommendations due to potential safety hazards to employees, individuals or the general public.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: All Saint's Subacute & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 1652 Mono Avenue San Leandro, CA 94578	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48616 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food safety when the following was noted: 1. Expired and beyond use by date of eight various dry seasonings were available for use. 2. A tabletop can opener was not clean. These failures placed 22 residents who received food from the kitchen at risk for food borne illnesses. Findings: 1. During a concurrent observation and interview on [DATE] at 9:32 a.m. with Registered Dietician (RD) in the kitchen, there were opened and used seasonings noted on a wall shelf behind the cooking area. These seasonings were in their original containers, labeled with open, expiration, and use-by dates. Six (6) seasonings were found to be expired: sweet basil, tarragon, ground cloves, crushed Italian Seasoning, Cajun seasoning, and ground ginger, with expiration dates of [DATE], [DATE], [DATE], [DATE] and [DATE] respectively. Additionally, two (2) seasonings were beyond their use-by date: ground black pepper and ground cinnamon, with use-by date of [DATE]. RD confirmed expiration and use-by dates of the identified items. During an interview on [DATE] at 8:10 a.m. with RD, RD stated that kitchen staff should dispose and not use seasonings past the expiration date, per facility's food storage chart. During a review of facility's document titled Food Storage Chart, dated 2023, the document indicated, opened spices and herbs recommended storage times was six (6) months .These storage time assume that safe food handling practices have been followed. 2. During a concurrent observation and interview on [DATE] at 9:34 a.m. with RD in the kitchen, an observation of a tabletop can opener stored in a holder mounted on a table was made. The can opener's gear (gear-a toothed wheel designed to grip and rotate the metal lid of a can) and gear's cavity had a white and deep brown residue build-up. When contact to the gear and cavity was made, a sticky and oily brown substance adhered to finger. RD stated it was dirty and should be clean after each use. According to U.S. Food and Drug Administration Federal Food Code 2022, equipment nonfood-contact surfaces of equipment shall be kept free of an accumulation of food residue and other debris. During a review of facility's policy and procedure (P&P) titled Sanitization, dated 2008, the P&P indicated, The food service area shall be maintained in a clean and sanitary manner .All equipment shall be washed to remove or completely loosen soils.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER All Saint's Subacute & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1652 Mono Avenue San Leandro, CA 94578	

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45875 Based on observation, interview, and record review, the facility failed to provide 80 square foot of space per resident for 13 residents who occupied 6 multi-bed bedrooms. This condition had the potential to result in lack of sufficient space for the provision of care both routine and emergency and for residents to have their personal belongings at bedside. Findings: During an observation on 7/8/24 at 10:23 a.m., the following rooms and corresponding square footage (sq. ft) per bed were identified: Room Activity Room Size Floor Area 2 -TCU Resident room [ROOM NUMBER].12 sq ft 77.56 sq ft/bed 3 -TCU Resident room [ROOM NUMBER].12 sq ft 77.56 sq ft/bed 9 -TCU Resident room [ROOM NUMBER].74 sq ft 72.87 sq ft/bed 7-North Resident room [ROOM NUMBER].5 sq. ft 79.75 sq ft/bed 12-North Resident room [ROOM NUMBER].4 sq ft 77.2 sq ft/bed 16-North Resident room [ROOM NUMBER].75 sq ft 77.9 sq ft/bed During random observations of care and services from 7/8/24 to 7/11/24, there was sufficient space for the provision of care for the residents in rooms 2, 3, 9, 7, 12, and 16. There was no heavy equipment kept in the rooms that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the four rooms. Granting of room size waiver recommended.