STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555879	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All Saint's Maubert	15731 Maubert 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan (a document that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment), for two of five sampled residents (Resident 1 and Resident 2), when Resident 1 and Resident 2 did not have a care plan to address their antibiotic-resistant infection, Klebsiella Pneumoniae Carbapenemase (KPC, a group of emerging highly drug-resistant Gram-negative bacilli bacteria causing infections associated with significant morbidity and mortality). This failure had the potential for Resident 1 and Resident 2 to not receive person-centered appropriate care, monitoring, and treatment. Findings: During a review of Resident 1 ' s admission Record (AR), printed on 3/14/25, the AR indicated Resident 1 was admitted in February 2025 with diagnoses including encephalopathy (a general condition of brain dysfunction), acute respiratory failure (ARS, results from inadequate gas exchange by the respiratory system), and tracheostomy (a surgically created hole makes through your neck and into your windpipe. It bypasses your nose, mouth and throat to help a person breathe) status. During a review of Resident 1 ' s Laboratory Report, dated 2/27/25, the laboratory report showed, KPC gene detected, indicating Resident 1 tested positive for KPC organism infection. During a review of Resident 2 ' s AR, printed on 3/14/25, the AR indicated Resident 2 was admitted in January 2025 with diagnoses to include encephalopathy, ARS, tracheostomy status, and dependence on ventilator (a machine that helps you breathe). During a review of Resident 2 ' s Laboratory Report, dated 2/27/25, the laboratory report showed, KPC gene detected, indicating Resident 2 tested positive for KPC organism infection. During a review of Resident 1 and Resident 2 ' s Care Plan, Resident 1 and Resident 2 did not have comprehensive care plans to address the KPC infections. (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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 1:58 p.m. with Director of Nursing (DON), DON stated the facility should have developed the care plans for all residents who had infections especially during the outbreak (usually caused by an infection, transmitted through person-to-person contact, animal-to-person contact, or from the environment or other media) in the facility. DON stated he did not think about implementing and creating an individualized care plan for infected residents. DON stated they were only focused on the type of isolation each resident needed and not the specific infection each resident had. DON stated the facility should have had a person-centered or individualized care plan for all the residents who became infected. DON stated a comprehensive care plan should have been created to provide quality care because each resident had different medical conditions and situations. During a review of the facility ' s policy and procedure (P&P), titled, Care Plans – Comprehensive, revised in September 2010, indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, nursing mental, and psychological needs is developed for each resident .3. Each resident ' s comprehensive care plan is designed to .a. Incorporate identified problem areas .b. Incorporate risk factors associated with identified problems .8. Assessments of residents are ongoing, and care plans are revised as information about the resident ' s condition change. 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .a. where there has been a significant change in the resident ' s condition.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, Facility 1 failed to follow infection control practices to prevent the spread of infection in the facility when the following were identified: 1. Facility 1 did not demonstrate infection prevention practices were implemented as evidenced by the line list (a table that contains key information about each case in an outbreak) that showed uninfected residents becoming infected. 2. Facility 1 did not notify California Department of Public Health (CDPH) about the infection outbreak. 3. Facility 1 failed to separate direct care staff (assists with tasks such as bathing, dressing, personal hygiene, and medication management) for non-infected residents and Resident 1 and Resident 2 who were infected with Klebsiella Pneumoniae Carbapenemase (KPC, a group of emerging highly drug-resistant Gram-negative bacilli bacteria causing infections associated with significant morbidity and mortality). These failures resulted in Residents 1, 2, 3, 4, 5, and 6 becoming infected with CROs. These include: 1. Residents 1, 2, and 3 became infected with KPC. 2. Resident 6 became infected with Carbapenem-resistant Acinetobacter baumannii (CRAB, a group of emerging highly drug-resistant Gram-negative bacilli bacteria causing infections associated with significant morbidity and mortality) with New Delhi [NAME]-ß-lactamase (NDM, an enzyme that makes bacteria resistant to a broad range of antibiotics including the carbapenem family). 3. Residents 4 and 5 became infected with Carbapenem-Resistant Pseudomonas aeruginosa (CRPA, a bacteria that can cause pneumonia, bloodstream infections, urinary tract infections, and surgical site infections, and they are particularly dangerous for patients with chronic lung diseases). 4. The cross-contamination resulted in Residents 1, 2, 3, 4, 5, and 6 becoming infected with Carbapenemase-Resistant Organisms (CRO, are bacteria that are resistant to a class of antibiotics called carbapenems which are typically used as a last-line treatment for serious infections). An Immediate Jeopardy situation (IJ, a situation in which a facility's actions places one or more residents/patients in jeopardy of being significantly harmed up to the point of possible death if not immediately corrected) was identified and called due to the failure of Facility 1 to follow infection control practices to prevent further spread of infection among all 11 residents in Facility 1. The Administrator (ADM) was verbally notified of the IJ situation on 3/13/25 at 7:45 p.m. During a visit to Facility 1 on 3/25/25, Facility 1 provided an acceptable plan of action and the IJ was removed at 2:50 p.m. Findings: (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. During an interview on 3/13/25 at 12:56 p.m. with Facility 2 ' s Infection Preventionist (IP), IP stated she was the only IP for Facility 1 and Facility 2 even though both facilities have separate licenses and the regulations say otherwise. During an interview on 3/13/25 at 1:16 p.m. with Administrator (ADM), ADM stated there was only one shared IP for both Facility 1 and Facility 2. ADM stated he was not aware of the regulation that each facility should have an IP. ADM also stated that he thought one IP was enough because Facility 1 and Facility 2 are owned by one organization. During an interview on 3/14/25 at 3:31 p.m. with Facility 2 ' s IP, IP was requested to provide an updated line list for Facility 1 and Facility 2 with laboratory test dates (date laboratory results were reported), the residents tested positive for CRO infections. During a follow up interview and record review on 3/14/25 at 3:45 p.m. with Facility 2 ' s IP, IP provided an updated line list with laboratory test dates for Facility 2 but did not provide the line list for Facility 1. IP was requested to provide Facility 1 ' s line list record with laboratory test dates. During a phone interview on 3/20/25 at 8:04 a.m. with Facility 2 ' s IP, IP was requested to provide another updated line list for Facility 1 and Facility 2 with the laboratory test dates included. During a review of an undated document, titled, CRO List sent via email by Medical Record Director (MRD) on 3/20/25 at 10:09 a.m., the CRO List only included Facility 2 ' s line list and did not include Facility 1 ' s updated line list. During a communication sent via email on 3/21/25 at 8:47 a.m. to MRD, MRD again was requested to provide an updated line list for Facility 1. During a review of the undated document, titled, Facility 1 Multi-Drug Resistant Organisms (MDROs, are bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria) Line List, the line list sent via email on 3/21/25 at 10:17 a.m. by MRD, the Facility 1 line list was still not updated and did not include the laboratory test dates. During a record review of the undated document, titled, Facility 1 MDRO Line List, the line list indicated Residents 1, 2, and 3 were infected with KPC, Resident 4 and Resident 5 were infected with CRPA infection, and Resident 6 was infected with NMD infection. There were no laboratory results provided for Residents 3, 5, and 6 to confirm the date infection was identified. 2. During an interview on 3/13/25 at 3:15 p.m. with Facility 2 ' s IP, IP stated Facility 1 had a recent CRO outbreak last February 2025 and CDPH was only notified on 3/12/25 that there were new cases of infection identified. IP stated she forgot to inform CDPH about the two new cases because she was already overwhelmed with the CRO outbreak. IP further stated she did not think that the two new cases of infection noted in February were reportable. IP stated she should have reported it to the CDPH because more than one case of communicable infection was considered an outbreak. (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of Facility 1 ' s Policy & Procedure (P&P) titled, Outbreak of Communicable Diseases, dated 2001, the P&P indicated, An outbreak is defined as one of the following .a. One case of an infection that is highly communicable or has serious health implications . During a review of Facility 1 ' s undated P&P titled, Reporting Communicable Diseases, the P&P indicated, The infection preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state specific reportable diseases . 3. During an interview on 3/13/25 at 12:36 p.m. with Facility 2 ' s IP, IP stated Facility 1 ' s CRO outbreak started around January 2025 when direct care staff from Facility 2 were assigned to Facility 1 on the same day. IP stated that she identified the previous scheduling coordinator assigned staff to work in Facility 2 then work in Facility 1. IP stated she informed the previous scheduling coordinator that sharing staff between Facility 1 and Facility 2 was not allowed because Facility 2 had an outbreak and Facility 1 did not have an outbreak. IP stated despite her instructions, the previous scheduler continued to assign direct care staff to work double shifts in Facility 1 after working in Facility 2 during January 2025. IP stated sharing staff between Facility 1 and Facility 2 contributed to Facility 1 ' s CRO infection outbreak. During an interview on 3/14/25 at 3:09 p.m. with Director of Nursing (DON), DON stated floating staff between Facility 1 and Facility 2 is not highly recommended. DON stated staff would start in Facility 2 and then move to clean buildings, including Facility 1. DON stated it was acceptable for staff to work from dirty buildings to clean buildings if wearing personal protective equipment (PPE, any piece of clothing or equipment that ' s worn by the employees to minimize exposure to biological, chemical, or any physical hazards on work site.) During a review of Facility 1 ' s document titled, Nursing and CNA Staffing Sign-in Sheet - Facility 1, dated 3/13/25, the document indicated Certified Nurse Assistant (CNA) 3 worked in Facility 1 from 7:00 a.m. to 3:30 p.m. and was assigned to Resident 1 and Resident 2 who were infected with KPC. During a concurrent observation and interview on 3/13/25 at 2:46 p.m. with CNA 3 in Facility 1, CNA 3 was observed in Resident 1 and Resident 2 ' s room that had signage indicating contact precautions (an infection control measures used to prevent the spread of diseases that are transmitted through direct or indirect contact with an infected person or environment) posted on the door. CNA 3 stated Facility 1 scheduled her in the afternoon to work in Facility 2 after her morning shift in Facility 1. During a review of Facility 2 ' s document titled, Nursing and CNA Staffing Sign-in Sheet, dated 3/13/25, the documented indicated CNA 3 worked in Facility 2 for evening shift (3:00 p.m. to 11:30 p.m.) after working the morning shift (7:00 a.m. to 3:30 p.m.) in Facility 1. During a phone interview on 3/14/25 at 10:36 a.m. with Scheduling Coordinator (SC), SC stated CNA 3 should have stayed in Facility 1 when CNA 3 worked a double shift. SC stated there was too much going on and she did not have time to check the staffing schedules for Facility 1 and Facility 2 on 3/13/25. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a follow up interview on 3/14/25 at 11:57 a.m. with Facility 2 ' s IP, IP stated she informed SC multiple times CNAs should not be shared between Facility 1 and Facility 2. IP stated CNA 3 worked on 3/13/25 in Facility 1 in the morning and continued the evening shift in Facility 2 ' s unit that did not have an outbreak. IP stated CNA 3 who provided direct care to Resident 1 and Resident 2 who were on contact precautions for KPC was also assigned to residents who did not have the infection and were not on contact precautions in Facility 2. IP stated the Local Public Health Department (LPHD) recommended that if staff were to work a double shift, staff should have stayed in one building or should have been allowed to have a gap of 8 hours in between shifts. IP stated the 8-hour gap in between shifts would have been an opportunity for staff to go home, take a shower, and change clothing. IP stated sharing staff between Facility 1 and Facility 2 could have exposed the residents to transmission of different infections such as CRAB, CRPA, NDM, KPC, etc. During an interview on 3/14/25 at 3:08 p.m. with DON, DON stated the facility ' s staff should have provided care to residents who did not have an infection first before being assigned to infected residents. DON stated sharing staff between buildings had the risk of transmission of bacteria to other residents who did not have an infection. DON stated residents who were exposed to an infection could have had resistance to antibiotics that could have potentially led to sepsis or death. During a review of Facility 1' s P&P titled, Multi-Drug Resistant Organisms (MDROs), dated 2001, the P&P indicated, MDROs are bacteria and other microorganisms that have developed resistance to one or more classes of antimicrobial drugs .Resident admission and Room Placement .3. When transmission continues despite adherence to standard and contact precautions and cohorting residents, assign dedicated nursing and ancillary service staff to the care of MDRO residents only.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, Facility 1 failed to ensure that a designated Infection Preventionist (IP) that adequately assesses, develops, implements, monitors, and manages the facility's Infection Prevention Control Program (IPCP) was employed at the facility . This failure resulted in an increase of Carbapanemase-Resistant Organism (CPO, are bacteria that are resistant to a class of antibiotics called carbapenems which are typically used a last-line treatments for serious infections) infections in the Facility 1. Furthermore, the cross-contamination resulted in transmission of the infections to non-infected residents. Cross reference to F880 Findings: During a review of the facility provided undated letter from the local health department (LPHD), the document indicated, The increase in cases in the Facility 2 and now in the Facility 1 has raised concerns about the current implementation of infection control measures place following recommendations given .the increase in CPOs calls for strategic discussion to better minimize transmission occurring withing and across these two buildings . During a review of Facility 1's undated document, titled, Facility 1 MDRO (Multi-Drug Resistant Organims) Line List (a table that contains key information about each case in an outbreak), the line list indicated three residents with Klebsiella Peumoniae Carbapenemase (KPC, a group of emerging highly drug-resistant Gram-negative bacilli bacteria causing infections associated with significant morbidity and mortality), one resident with New Delhi [NAME]-ß-lactamase (NDM, an enzyme that makes bacteria resistant to a broad range of antibiotics including the carbapenem family) and two residents with Carbapenem-Resistant Pseudomonas aeruginosa (CRPA, a bacteria that can cause pneumonia, bloodstream infections, urinary tract infections, and surgical site infections, and they are particularly dangerous for patients with chronic lung diseases). During a record review of Facility 1 ' s undated MDRO Line List, the line list indicated Residents 1, 2, and 3 were infected with KPC, Resident 4 and Resident 5 were infected with CRPA infection, and Resident 6 was infected with NMD infection. During a review of Resident 1 ' s admission Record (AR), printed on 3/14/25, the AR indicated Resident 1 was admitted in February 2025 with diagnoses including encephalopathy (a general condition of brain dysfunction), acute respiratory failure (ARS, results from inadequate gas exchange by the respiratory system), and tracheostomy (surgical procedure that creates an opening in the windpipe and inserts a tube to provide airway) status. During a review of Resident 1 ' s Laboratory Report dated 2/27/25, the laboratory report showed, KPC gene detected, indicating Resident 1 tested positive for KPC organism infection. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 2 ' s AR, printed on 3/14/25, the AR indicated Resident 2 was admitted in January 2025 with diagnoses to include encephalopathy, ARS, tracheostomy status, and dependence on ventilator (a machine that helps you breathe). During a review of Resident 2 ' s Laboratory Report dated 2/27/25, the laboratory report showed, KPC gene detected, indicating Resident 2 tested positive for KPC organism infection. During a review of Resident 3 ' s AR, printed on 3/14/25, the AR indicated Resident 3 was admitted in December 2024 with traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head), tracheostomy status, and encephalopathy, and dependence on ventilator. During a review of Resident 4 ' s AR, printed on 2/12/25, the AR indicated Resident 4 was admitted in February 2025 with a diagnosis of spastic quadriplegic cerebral palsy (is a severe type that is characterized by paralysis of both arms and both legs, with muscle stiffness). During a review of Resident 5 ' s AR, printed on 3/14/25, the AR indicated Resident 5 was admitted in February 2025 with diagnoses to include acute and chronic respiratory failure (typically caused when the volume of air flowing in and out of the lungs is uneven with the flow of blood to the lungs), tracheostomy status, and dependence on ventilator. During a review of Resident 6 ' s AR, printed on 3/14/25, the AR indicated Resident 5 was admitted in January 2025 with diagnoses to include myotonic muscular dystrophy (is a common multi-system disorder that affects the skeletal muscles (the muscles that move the limbs and trunk) as well as smooth muscles (the muscles that control the digestive system) and cardiac muscles of the heart), tracheostomy status, and dependence on ventilator. During a review of Resident 6 ' s Laboratory Report dated 2/12/25, the laboratory report showed, NDM detected, indicating Resident 6 tested positive for NDM organism infection. During an interview on 3/13/25 at 12:36 p.m. with Facility 2's Infection Preventionist (IP), IP stated when she was hired, she had been assigned the IP role for both Facility 1 and Facility 2. IP stated Facility 1 and Facility 2 were two different entities and operating under two different licenses. IP stated Facility 1's CRO outbreak started around January 2025 when direct care staff from Facility 2 were assigned to Facility 1 on the same day. IP stated that she identified the previous scheduling coordinator assigned staff to work in Facility 2 then work in Facility 1. IP stated she informed the previous scheduling coordinator that sharing staff between Facility 1 and Facility 2 was not allowed because Facility 2 had an outbreak and Facility 1 did not have an outbreak. IP stated despite her instructions, the previous scheduler continued to assign direct care staff to work double shifts in Facility 1 after working in Facility 2 during January 2025. IP stated sharing staff between Facility 1 and Facility 2 contributed to Facility 1's CRO infection outbreak. (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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/13/25 at 12:56 p.m. with Facility 2's IP, IP stated she asked upper management why the IP role was being shared between Facility 1 and Facility 2. IP stated the CRO outbreak between the two facilities was overwhelming and required a lot of monitoring. IP stated she worked 45 hours average in a week as an IP between Facility 1 and Facility 2. IP stated having one designated IP role for each facility required at least 40 hours per week. IP stated a designated IP in each facility could have helped focus on infection control and could have helped contain the outbreak. IP further stated she was the only IP for Facility 1 and Facility 2 even though both facilities have separate licenses and the regulations say otherwise. During an interview on 3/13/25 at 1:16 p.m. with Administrator (ADM), ADM stated there was only 1 shared IP for both Facility 1 and Facility 2. ADM stated he was not aware of the regulation that each facility should have an IP. ADM also stated that he thought 1 IP was enough because Facility 1 and Facility 2 are owned by one organization. During a review of the facility ' s policy and procedure (P&P), titled, Infection Preventionist, dated September 2022, the P&P indicated, The IP is responsible for coordinating the implementation and updating the Infection Prevention Control Program .The IP is employed on site and at least part time .The IP is scheduled with enough time to properly assess, develop, implement, monitor, and manage the IPCP, address training requirements .