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	10/26/2023

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 27406 Based on observation, interview and record review, the facility failed to respect the rights of two of 11 (Resident 6 and 66) sampled residents when the facility displayed signage above their beds with their personal information visible to those who had no permission or right to see it. This failure resulted in Resident 66 feeling exposed and the Responsible Party (RP 6) for Resident 6 to voice feelings of disrespect. Findings: During a concurrent observation and interview on 10/23/23, at 10:45 a.m., with Resident 6's Responsible Party (RP 6), in the shared room of Resident 66 and Resident 6, the wall above Resident 66's bed had signage which indicated, Do Not Use Pink Chucks; the wall above Resident 6's bed had signage which indicated, Be Careful Turning On Left Side, and, Only Use Latex Free Condoms. The posted signage was visible to any visitors to the room. RP 6 stated she did not want the facility to display Resident 6's personal care information in a public sign, as Resident 6 was a very private person. During an interview on 10/24/23, at 10:00 a.m., with the Director of Nursing (DON), the DON stated the wall signs above the beds of Resident 66 and Resident 6 should be covered to preserve the privacy and dignity of the residents.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 27406 Based on observation, interview, and record review the facility failed to take reasonable care for the protection of one (Resident 6) of eleven sampled residents' clothing from loss or theft. The facility failure to ensure residents clothing was labeled before laundering resulted in an inability to identify specific ownership of clothing and subsequent loss of clothing. Findings: During an interview on 10/23/23, at 11 a.m., in Resident 6's room, a family member (RP 6) stood next to Resident 6's bedside. RP 6 stated Resident 6 had multiple clothing items that had been laundered by the facility and never returned to Resident 6. During an observation on 10/24/23, at 1:15 p.m., in the facility's Laundry Department there was a bin containing unlabeled residents' heel protectors, clothing, and positional aids. During an interview on 10/24/23, at 1:20 p.m., with the Maintenance/Housekeeping Director (MHD) and the Laundry Aide (LA), the MHD stated the items in the laundry bin had been laundered but were unlabeled, so the original owners could not be identified and so the items could not be returned to the original owners. During a review of the facility's policy and procedure (P&P) titled, Personal Property, the P&P indicated, Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits unless doing so would infringe on the right or health and safety of other residents . The Resident's personal belongings and clothing are inventoried, labeled, and documented upon admission and updated as necessary. The belongings are stored in designated areas for safety and retrieval purposes.

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NAME OF PROVIDER OR SUPPLIER All Saint's Maubert		STREET ADDRESS, CITY, STATE, ZIP CODE 15731 Maubert 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27406 Based on observation, interview, and record review, the facility failed to develop/update and implement a comprehensive person-centered care plan for one (Residents 66) of 11 sampled residents when Resident 66 complained of ongoing pain and emotional distress during wound treatments. The facility failure to update and implement Resident 66's care plan to address his pain and anxiety during wound treatments, resulted in Resident 66 experiencing ongoing pain and anxiety. See also tags F 686, F 697, and F 726. Findings: During a review of Resident 66's Admission Record, undated, the Admission Record indicated the facility admitted Resident 66 on 10/9/23, with diagnoses which included but were not limited to chronic osteomyelitis (bone infection), and pressure ulcers (A pressure ulcer develops when one or more layers of skin and tissue are damaged from continuous pressure to the area. The depth of skin and tissue damage determines the stage of the pressure ulcer, which is on a scale of stage I to stage IV, with stage I the most superficial, and stage IV the deepest ulcer, including damaged skin and muscle down to the level of bone.) on both heels and both buttocks (also named the ischial area after the underlying bones). The Admission Record indicated the pressure ulcers on the right and left buttock, and right and left heels were all Stage 4 pressure ulcers. During a review of Resident 66's Minimum Data Set (MDS, an assessment tool used to plan and direct resident care), dated 10/13/23, the MDS indicated Resident 66 spoke English; had intact mental abilities for attention, orientation, and ability to register and recall information; was able to voice his needs; and was totally dependent upon facility staff for all his care needs including mobility in and out of bed, and repositioning. During a concurrent observation and interview on 10/23/23, at 11:15 a.m., with Registered Nurse 1 (RN 1) and Resident 66, in Resident 66's room, RN 1 provided wound care and dressing changes for Resident 66's pressure wounds on the ischium and heels. As RN 1 completed the first of the treatments, Resident 66 stated he had pain at a level of seven out of ten (a pain scale where zero means no pain and ten means the worst pain possible). RN 1 stated to Resident 66, Just hang in there. RN 1 turned Resident 66 to a side-lying position on his right side. Resident 66 stated he was having difficulty breathing. RN 1 stated he should hang in there. Resident 66 stated he had a history of having a collapsed lung, and since that happened, he had trouble breathing when on his right side. Resident 66 requested pain medication. During an interview on 10/23/23, at 11:45 a.m., with Resident 66, Resident 66 stated the wound care was painful when it was done every day, and the nurses should know by now and help him with pain relief. Resident 66 stated he had informed staff several times he had difficulty breathing when on his right side, and he became anxious when he knew he was going to lose his breath when he was turned. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 66's care plan titled, Pain, initiated 10/9/23, the care plan indicated Resident 66 was at risk for pain due to multiple pressure wounds. The resident centered goal was for pain to be relieved to a tolerable pain level as indicated by Resident 66, using verbal or non-verbal communication. Care plan interventions included: assess for pain every shift and as indicated, administer medication as ordered, encourage to verbalize feelings, notify physician if resident experiences unmanageable or intolerable pain. During a concurrent interview and record review, on 10/24/23, at 10 a.m., with the Director of Nurses (DON), Resident 66's Admission Record, October 2023 Medication Administration Record (MAR), pain and pressure wound care plans, and the nurse progress notes dated 10/23/23, and 10/24/23, were reviewed. The DON stated MAR indicated Resident 66 had not received pain medication for the past three days, including yesterday when Resident 66 had complained of seven out of ten pain and requested pain medication. The DON was unable to provide documentation in Resident 66's nurse progress notes which indicated Resident 66 had complained of pain on 10/23/23 or 10/24/23. The DON stated Resident 66's care plans did not identify wound treatments with associated position changes as a potential source of pain and emotional distress. The DON stated she expected nurses to communicate to the medical staff the results of their assessment and to update the plan of care to include interventions to address the resident's complaints. During a review of the facility's policy and procedure (P&P) titled, Pain- Clinical Protocol, last revised October 2022, indicated: Assessment and Recognition: 1. The Physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnoses and conditions that commonly cause pain b. It also includes a review for any treatments that the resident currently is receiving for pain . 4. The Nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, and repositioning.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658 Based on observation, interview and record review, the facility failed to ensure pressure injury (injury due to prolonged pressure over an area) reducing devices were applied for one of 11 (Resident 4) sampled residents. This failure had the potential for Resident 4's existing left heel wound to worsen and for the right heel to develop a new wound. Findings: A review of Resident 4's admission record indicated Resident 4 was admitted on [DATE] for anoxic brain damage (brain damage caused by oxygen deprivation), hemiplegia affecting right side (right side paralysis), moderate protein-calorie malnutrition, muscle wasting and atrophy (breakdown of muscle) on both lower extremities and dependence on ventilator (machine to provide artificial breathing). A record review of Resident 4's minimum data set (MDS, an assessment tool to plan and guide resident care) dated 8/24/23, indicated Resident 4 was dependent on facility staff for all aspects of care including donning and doffing footwear. A record review of Resident 4's physician's order, dated 10/26/23, indicated Resident 4 had an order to apply foam boots at 9AM and remove at 9PM everyday and evening shift .for Pressure Prevention. During an observation on 10/23/23, at 1:58 p.m., Resident 4 was laying in his bed in his room. Resident 4 was unresponsive to voice stimuli. Resident 4's lower extremities were uncovered and there were no foam boots applied to his feet. During a concurrent observation and interview on 10/24/23, at 11:28 a.m., with Certified Nursing Assistant 2 (CNA-2), Resident 4 was lying in bed in his room with covers on. CNA-2 lifted the covers over his feet and observed Resident 4 without foam boots on. CNA-2 stated Resident 4 needed to have his heels floated with foam boots to prevent injury to the heels. CNA-2 went to Resident 4's closet to obtain Resident 4's foam boots and applied them to both feet. During a concurrent interview and record review, on 10/25/23, at 8:58 a.m., with Assistant Director of Nursing (ADON), Resident 4's care plan for left heel debrided blister, dated 10/12/23, was reviewed. The care plan indicated an intervention to apply and remove foam boots as routine order. The ADON stated nursing staff were responsible for application of the foam boots. A review of facility policy and procedure (P&P) titled, Pressure Injuries/Skin Breakdown - Clinical Protocol, dated 04/2018, indicated nursing staff describe and document/report .current treatments, including support surfaces.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 27406 Based on observation, interview, and record review, the facility failed to provide wound care consistent with professional standards of practice for one (Resident 66) of eleven sampled residents when: the nursing staff inaccurately documented wound status, nursing staff failed to perform hand hygiene before donning gloves before wound treatment, and a certified nursing assistant incorrectly cleaned a wound. These failures placed residents at risk for infection, for wounds to worsen, and new wounds to develop. See also tags F 656, F697, and F 726. Findings: During a review of Resident 66's Admission Record, undated, the Admission Record indicated the facility admitted Resident 66 on 10/9/23, with diagnoses which included but were not limited to chronic osteomyelitis (bone infection), and pressure ulcers (A pressure ulcer develops when one or more layers of skin and tissue are damaged from continuous pressure to the area. The depth of skin and tissue damage determines the stage of the pressure ulcer, which is on a scale of stage I to stage IV, with stage I the most superficial, and stage IV the deepest ulcer, including damaged skin and muscle down to the level of bone.) on both heels and both buttocks (also named the ischial area after the underlying bones). The Admission Record indicated the pressure ulcers on the right and left buttock, and right and left heels were all Stage 4 pressure ulcers. During a review of Resident 66's Minimum Data Set (MDS, an assessment tool used to plan and direct resident care), dated 10/13/23, the MDS indicated Resident 66 spoke English; had intact mental abilities for attention, orientation, and ability to register and recall information; was able to voice his needs; and was totally dependent upon facility staff for all his care needs including mobility in and out of bed, and repositioning. During a review of Resident 66's facility assessment document titled, Braden Scale for Predicting Pressure Sore Risk, dated 10/9/23, the assessment document indicated Resident 66 was at Moderate Risk for developing pressure sores. During a review of the Physician's Orders for Resident 66, initiated 10/19/23, the orders instructed staff to cleanse bilateral ischial wounds with normal saline solution, pat dry, apply antibiotic ointment, lightly pack with dry gauze, and cover with a dry dressing. During a review of Resident 66's care plan titled, Impaired Skin Integrity, initiated 10/9/23, the care plan interventions included: administer treatments as ordered, monitor for effectiveness, check skin during daily care provisions, float heels using pressure relieving device for heels, report abnormal laboratory values to physician, for wound documentation record location, size (length, width, and depth), color, surrounding skin, presence/absence of drainage and signs of healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/23/23, at 11:15 a.m., with Resident 66, Registered Nurse (RN) 1, and Certified Nursing Assistant (CNA) 1, in Resident 66's room, nursing staff prepared to provide wound care for Resident 66's buttocks pressure wounds. RN 1 and CNA 1 donned gloves, without performing hand hygiene prior to donning the gloves. CNA 1 removed the fecal bag (a plastic bag to collect feces) and used gauze to clean the anus and surrounding skin, then used the same gauze to wipe around the perimeter of the right buttock wound. RN 1 stated the buttock wound was a Stage III, because the wound was to the level of bone. RN 1 stated she was still learning how to assess pressure wounds. RN 1 measured the buttock wound, and stated the wound was seven centimeters by 1.5 centimeters. RN 1 stated the measurements did not include wound depth or any tunneling (areas of damage and tissue loss extending under the skin) of the wound. RN 1 performed wound care treatment for Resident 66's bilateral heel deep tissue injury wounds. RN 1 stated the heel wounds were a Stage I pressure ulcer because the skin was not broken. During a concurrent interview and record review on 10/24/23 at 11:04 a.m., with the Director of Nursing (DON), Resident 66's clinical record was reviewed (MDS, care plans, Physician's Orders, laboratory tests, Braden scale assessment, nutrition consult, Medication Administration Record, Treatment Administration Record, and nurse progress notes). The DON confirmed nurses should refer to the National Pressure Ulcer Advisory Panel (NPUAP) for staging, assessment and measuring. The DON stated according to NPUAP if wound has progressed down to the bone, it is a Stage IV not Stage III as RN1 stated. The DON also stated that Resident 66's heels are DTI and according to NPUAP that means they are at least a Stage II or IV. The DON stated CNA 1 should not have used the same gauze to cleanse the rectum and then wipe around the open wound with the same gauze. During an interview on 10/26/23, at 12:06 p.m., with Physician (PH) 1, PH 1 said he performed Resident 66's weekly wound assessments. PH 1 stated Resident 66 had bilateral Stage IV ischial wounds, and deep tissue injury wounds on both heels, which are considered Stage III or Stage IV. PH 1 stated Resident 66 should be assessed and medicated for pain as needed before dressing changes and wound care. PH 1 stated it was important nursing staff accurately assessed wounds during the six days between his visits, as there could be significant changes during the week, including worsening of the wounds. PH 1 stated a wound treatment nurse should be able to accurately document wound assessment, measurement and staging. PH 1 stated there was a certification course available for wound care nurses. PH 1 stated RNs should be utilizing NPUAP Guidelines as a resource and reference for wound assessment and staging. During a review of the facility's policy and procedure (P&P) titled, Pressure Injuries/Skin Breakdown- Clinical Protocol, last revised April 2018, indicated Assessment and Recognition: 1. The nursing staff should assess and document an individual's significant risk factors for developing pressure ulcers, for example, immobility, weight loss, and history of pressure ulcers. 2. If a skin issue is noted the nurse should describe and document/report the following: anatomical location, stage, size, (length, width, and depth), sinus tracts, undermining, presence of exudates or drainage, necrotic tissue, (slough/eschar), granulation, and epithelial tissue, skin surrounding the wound; pain, resident's mobility status, current treatments, and active diagnoses that may impact skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Centers for Disease Control (CDC) article titled, Hand Hygiene Guidance, dated 1/30/20, the CDC article indicated, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or the patient's immediate environment; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 27406 Based on observation, interview, and record review, the facility failed to ensure pain management was provided to one (Resident 66) of eleven sampled residents. The facility failed to provide pain medication for Resident 66 prior to a painful procedure and failed to provide pain medication as requested for pain. This failure resulted in Resident 66 having recurrent pain and anxiety during daily wound treatments. See also tags F 656, F 686, F 726. Findings: During a review of Resident 66's Admission Record, undated, the Admission Record indicated the facility admitted Resident 66 on 10/9/23, with diagnoses which included but were not limited to chronic osteomyelitis (bone infection), and pressure ulcers (also called a bed sore, injury to skin and underlying tissue resulting from prolonged pressure on the skin) on both heels and bilateral ischium (the lower, back part of both hip bones). During a review of Resident 66's Minimum Data Set (MDS, an assessment tool used to plan and direct resident care), dated 10/13/23, the MDS indicated Resident 66 spoke English; had intact mental abilities for attention, orientation, and ability to register and recall information; was able to voice his needs; and was totally dependent upon facility staff for all his care needs including mobility in and out of bed, and repositioning. During a review of Resident 66's care plan titled, Pain, initiated 10/9/23, the care plan indicated Resident 66 was at risk for pain due to multiple pressure wounds. The resident centered goal was for pain to be relieved to a tolerable pain level as indicated by Resident 66, using verbal or non-verbal communication. Care plan interventions included: assess for pain every shift and as indicated, administer medication as ordered, encourage to verbalize feelings, notify physician if resident experiences unmanageable or intolerable pain. During a concurrent observation and interview on 10/23/23, at 11:15 a.m., with Registered Nurse 1 (RN 1) and Resident 66, in Resident 66's room, RN 1 provided wound care and dressing changes for Resident 66's pressure wounds on the ischium and heels. As RN 1 completed the first of the treatments, Resident 66 stated he had pain at a level of seven out of ten (a pain scale where zero means no pain and ten means the worst pain possible). RN 1 stated to Resident 66, Just hang in there. RN 1 turned Resident 66 to a side-lying position on his right side. Resident 66 stated he was having difficulty breathing. RN 1 stated he should hang in there. Resident 66 stated he had a history of having a collapsed lung, and since that happened, he had trouble breathing when on his right side. Resident 66 requested pain medication. Resident 66 requested pain medication. Resident 66 stated he felt ignored and was uncomfortable when his pain was not addressed. RN 1 stated she heard Resident 66's complaint of pain, pain level, and location. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/23, at 11:45 a.m., with Resident 66, Resident 66 stated the wound care was painful when it was done every day, and the nurses should know by now and help him with pain relief. Resident 66 stated he had informed staff several times he had difficulty breathing when on his right side, and he became anxious when he knew he was going to lose his breath when he was turned. During a concurrent interview and record review, on 10/24/23, at 10 a.m., with the Director of Nurses (DON), Resident 66's Admission Record, October 2023 Medication Administration Record (MAR), pain and pressure wound care plans, and the nurse progress notes dated 10/23/23, and 10/24/23, were reviewed. The DON stated MAR indicated Resident 66 had not received pain medication for the past three days, including yesterday when Resident 66 had complained of seven out of ten pain and requested pain medication. The DON was unable to provide documentation in Resident 66's nurse progress notes which indicated Resident 66 had complained of pain on 10/23/23 or 10/24/23. The DON stated Resident 66's care plans did not identify wound treatments with associated position changes as a potential source of pain and emotional distress. The DON stated she expected nurses to communicate to the medical staff the results of their assessment and to update the plan of care to include interventions to address the resident's complaints. During an interview on 10/26/23, at 12:06 p.m., with Physician (PH) 1, PH 1 stated he performed Resident 66's weekly wound assessments. PH 1 stated he expected nurses to conduct a pain assessment prior to Resident 66's wound care and dressing changes and medicate Resident 66 as needed. During a review of the facility's policy and procedure (P&P) titled, Pain- Clinical Protocol, last revised October 2022, indicated: Assessment and Recognition: 1. The Physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnoses and conditions that commonly cause pain b. It also includes a review for any treatments that the resident currently is receiving for pain . 4. The Nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, and repositioning.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 27406 Based on observation, interview and record review, the facility failed to ensure nursing staff had sufficient skills and competencies to perform wound care treatments for one (Resident 66) of 11 sampled residents. The failure to ensure Registered Nurse 1 (RN 1) was able to accurately assess and document Resident 66's pressure wounds had the potential to result in development or worsening of Resident 66's pressure ulcers. (A pressure ulcer develops when one or more layers of skin and tissue are damaged from continuous pressure to the area. The depth of skin and tissue damage determines the stage of the pressure ulcer, which is on a scale of stage I to stage IV, with stage I the most superficial, and stage IV the deepest ulcer, including damaged skin and muscle down to the level of bone.) See also tags F 656, F 686, and F 697. Findings: During a review of Resident 66's Admission Record, undated, the Admission Record indicated the facility admitted Resident 66 on 10/9/23, with diagnoses which included but were not limited to chronic osteomyelitis (bone infection), and pressure ulcers on both heels and both buttocks (also named the ischial area after the underlying bones). The Admission Record indicated the pressure ulcers on the right and left buttock, and right and left heels were all Stage 4 pressure ulcers. During a review of Resident 66's Minimum Data Set (MDS, an assessment tool used to plan and direct resident care), dated 10/13/23, the MDS indicated Resident 66 spoke English; had intact mental abilities for attention, orientation, and ability to register and recall information; was able to voice his needs; and was totally dependent upon facility staff for all his care needs including mobility in and out of bed, and repositioning. During a review of the Physician's Orders for Resident 66, initiated 10/19/23, the orders instructed staff to cleanse bilateral ischial (both buttocks) wounds with normal saline (dilute salt) solution, pat dry, apply antibiotic ointment, lightly pack with dry gauze, and cover with a dry dressing. During a concurrent observation and interview on 10/23/23, at 11:15 a.m., with Resident 66, Registered Nurse (RN) 1, and Certified Nursing Assistant (CNA) 1, in Resident 66's room, nursing staff provided wound care for Resident 66's buttocks pressure wounds. CNA 1 removed the fecal bag (a plastic bag to collect feces) and used gauze to clean the anus and surrounding skin, then used the same gauze to wipe around the perimeter of the right buttock wound. RN 1 stated the buttock wound was a Stage III, because the wound was to the level of bone. RN 1 stated she was still learning how to assess pressure wounds. RN 1 measured the buttock wound, and stated the wound was seven centimeters by 1.5 centimeters. RN 1 stated the measurements did not include wound depth or any tunneling (areas of damage and tissue loss extending under the skin) of the wound. RN 1 performed wound care treatment for Resident 66's bilateral heel deep tissue injury wounds. RN 1 stated the heel wounds were a Stage I pressure ulcer because the skin was not broken. (continued on next page)

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	555879	A. Building B. Wing	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All Saint's Maubert	15731 Maubert 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/24/23 at 11:04 a.m., with the Director of Nursing (DON), Resident 66's clinical record was reviewed (MDS, care plans, Physician's Orders, laboratory tests, Braden scale assessment, nutrition consult, Medication Administration Record, Treatment Administration Record, and nurse progress notes). The DON confirmed nurses should refer to the National Pressure Ulcer Advisory Panel (NPUAP) for staging, assessment and measuring of pressure ulcers. The DON stated according to NPUAP if a wound has progressed down to the bone, it is a Stage IV wound. The DON stated Resident 66's heels were a deep tissue injury wound (injury from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss) and according to NPUAP were considered to be a Stage II to Stage IV wound. The DON stated CNA 1 should not have used the same gauze to cleanse the rectum and then clean around an open wound. The DON stated gloves should be changed after removing dirty dressings and before applying a clean dressing. During an interview on 10/26/23, at 12:06 p.m., with Physician (PH) 1, PH 1 said he performed Resident 66's weekly wound assessments. PH 1 stated Resident 66 had bilateral Stage IV ischial wounds, and deep tissue injury wounds on both heels, which are considered Stage III or Stage IV. PH 1 stated Resident 66 should be assessed and medicated for pain as needed before dressing changes and wound care. PH 1 stated it was important nursing staff accurately assessed wounds during the six days between his visits, as there could be significant changes during the week, including worsening of the wounds. PH 1 stated a wound treatment nurse should be able to accurately document wound assessment, measurement and staging. PH 1 stated there was a certification course available for wound care nurses. PH 1 stated RNs should be utilizing NPUAP Guidelines as a resource and reference for wound assessment and staging. During a review of the National Pressure Ulcer Advisory Panel article, Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, copyright 2014, the article indicated, Stage 1 Pressure Injury: Non-blanchable erythema (redness) of intact skin Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis (the layer of skin just below the surface tissue) . The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible . Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer . The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed .Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location .Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister . This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic (dead) tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER All Saint's Maubert		STREET ADDRESS, CITY, STATE, ZIP CODE 15731 Maubert Avenue San Leandro, CA 94578	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Pressure Injuries/Skin Breakdown- Clinical Protocol, last revised April 2018, indicated, Assessment and Recognition: 1. The nursing staff should assess and document an individual's significant risk factors for developing pressure ulcers, for example, immobility, weight loss, and history of pressure ulcers. 2. If a skin issue is noted the nurse should describe and document/report the following: anatomical location, stage, size, (length, width, and depth), sinus tracts, undermining, presence of exudates or drainage, necrotic tissue, (slough/eschar), granulation, and epithelial tissue, skin surrounding the wound; pain, resident's mobility status, current treatments, and active diagnoses that may impact skin. During a review of the National Institute of Health National Library of Medicine article, The Prevention and Management of Pressure Ulcers in Primary and Secondary Care, dated April 2014, the article indicated, The measurement of pressure ulcer size can be used by healthcare professionals for recording and monitoring the progression and healing of a pressure ulcer. Recording this accurately can allow an assessment to be made as to whether a treatment is effective in promoting healing, by reducing the size of the pressure ulcer. It is important for healthcare professionals to understand that a pressure ulcer does not only affect the visible skin but that it also has a cavity underneath it with depth and volume. As well as the visible cavity, a cavity under the skin that cannot be directly observed (undermining) may be present. This would need to be considered in addition to any measurement of visible damage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46658 Based on observations, interviews, and record review, the facility failed to ensure a medication error rate below five percent for two of 11 (Resident 8 and 65) sampled residents when: 1. Resident 8 was administered multi-vitamin with minerals tablet instead of multi-vitamin with minerals liquid 15 mL (mL, a unit of liquid measurement) as prescribed by physician's order; 2. Resident 65 did not receive erythromycin ophthalmic ointment 5mg/gm (mg/gm, a measurement of medication concentration) as prescribed by physician's order. This failure resulted in 2 medication errors out of 33 opportunities during observation of medication administration which resulted in the facility having a medication error rate of 6.06%. This failure also resulted in residents not receiving the correct medication or receiving the medication as prescribed. Findings: 1. A review of resident 8's admission record indicated Resident 8 was admitted on [DATE] for protein-calorie malnutrition, muscle wasting and atrophy, and dysphagia. During a medication pass observation and interview on 10/24/23, at 8:45 a.m., with Registered Nurse 2 (RN-2), RN-2 administered to Resident 8, one tablet of multi-vitamin w/ minerals. RN-2 stated the tablet of multi-vitamin was for the order for multi-vitamin w/ minerals liquid 15 mL. Multi-vitamin liquid 15 mL was not given to Resident 8. During an interview and record review on 10/24/22, at 1:25 p.m., with RN-2, Resident 8's Medication Administration Record (MAR), dated 10/2023, was reviewed. RN-2 identified a bottle of multi-vitamin w/ minerals tablets and stated a tablet was given for Resident 8's order for multi-vitamin liquid 15 mL. When asked to verify on the MAR if Resident 8 had an order for multi-vitamin tablet, RN-2 stated Resident 8 did not have an order for multi-vitamin tablet. During an interview on 10/25/23, at 9:04 a.m., with the Assistant Director of Nursing (ADON), the ADON stated nursing staff assigned to medication administration are expected to administer medications according to physician orders. A review of facility policy and procedure (P&P) titled, Administering Medications, dated 04/2019, indicated medications are administered in accordance with prescriber order and the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration. 2. During a medication pass observation and interview on 10/24/23, at 9:32 a.m., with RN-2, RN-2 administered one ribbon of erythromycin ophthalmic ointment 5mg/gm to Resident 65's right eye. RN-2 did not apply ointment to Resident 65's left eye. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 65's physician's order, dated 10/23/2023, indicated Resident 65 had an order for erythromycin ophthalmic ointment 5mg/gm with instructions to instill 1 ribbon in both eyes two times a day for eye infection for 7 days. During an interview on 10/25/23, at 9:04 a.m., with the ADON, the ADON stated nursing staff assigned to medication administration are expected to administer medications according to physician orders. A review of facility policy and procedure (P&P) titled Administering Medications, dated 04/2019, indicated medications are administered in accordance with prescriber order and the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration.

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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. 27406 Based on observation, interview, and record review, the facility failed to develop and implement policies and procedure (P&P) designed to prevent contamination of food during preparation and storage when: 1. Two kitchen staff did not wear hair nets in the kitchen. 2. The facility's dry storage room contained cans of food with no use-by date. 3. The facility's refrigerator had bloody red meat dated 10/18/23, with no indication of what the date meant. These failures placed residents of the facility at risk to consume outdated food and to develop food borne illness. Findings: 1. During an observation on 10/23/23, at 10:15 a.m., in the facility kitchen, the Kitchen Manager/Registered Dietitian (RD) and the facility cook (Cook 1) were not wearing hair nets. During a review of the facility's policy and procedure (P&P) titled, Personnel: Personal Hygiene and Appearance Policy No. 210, undated, indicated, Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed foods. During a review of the facility's policy and procedure (P&P) titled, Personnel: Personal Hygiene and Appearance, Policy No. 210, undated, indicated, Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed foods. 2. During an observation (during the initial tour of the kitchen) on 10/23/23, at 10:15 a.m., with the Kitchen Manager and [NAME] 2, in the facility's kitchen, the following undated cans were in the facility's dry storage area: two seven-pound cans of diced tomatoes; one seven pound can of mandarin oranges; one seven pound can of fruit cocktail. During an interview on 10/24/23, at 1:15 p.m., with the facility's Infection Preventionist (IP), the IP stated the undated canned goods should have a use by date. During a review of the facility's policy and procedure (P&P) titled, Storage of Food and Non-Food Supplies, (Policy 510), dated 2014, the P&P indicated, Canned goods are removed from cardboard boxes and like items stored together with labels turned outward and marked with received date upon receipt. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview (during the initial tour of the kitchen) on 10/23/23, at 10:15 a.m., with the Kitchen Manager and [NAME] 2, the facility's refrigerator contained bloody meat in a metal pan, covered with plastic wrap, dated 10/18/2023, on the bottom shelf of the refrigerator. [NAME] 2 stated the meat had been placed in the refrigerator to thaw, and she must have written the wrong date on the meat label. During an interview on 10/24/23, at 1:15 p.m., with the facility's Infection Preventionist (IP), the IP stated thawing meat should have two dates: the date the meat was placed in the refrigerator to thaw, and the date the thawing should be completed. The IP stated if the meat was set in the refrigerator five days ago on 10/18/23, the meat should not be eaten but should be discarded. During a review of the facility's policy and procedure (P&P) titled, Food Service Management- Food Preparation: Meat, Poultry and Fish, (Policy No. 524), dated 2014, the P&P indicated, Recommended method of thawing frozen meat is in the refrigerator. This may take one to three days. Meat is not thawed at room temperature. Place thawing meat on leak-proof trays on the lowest refrigerator shelf. Date thawing meat with freezer pull date and with use-by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 27406 Based on observation, interview and record review, the facility failed to develop and implement infection control and prevention policies and procedures as evidenced by the following: 1. The facility laundry room contained: Clean mop heads, unused cleaning cloths, and unused Restorative Nurses Aids (RNA) Slings (a vest used by staff when assisting residents with mobility), stored in the same area as items waiting to be laundered. Staff personal use items: sweater, shawl, and a cup of coffee were in the area designated for clean resident linens. 2. Laundry Aide (LA) mopped the clean and dirty laundry room areas with the same mop head, using a solution with unknown chemicals. 3. The Soiled Utility Room had liquid medical waste (used suction canisters) containers stored together with biohazardous sharps (used needles, scalpels, scissors, etc.) containers. 4. The facility's Infection Control Program did not include a water management program to prevent exposure to Legionella (a bacteria commonly found in water systems which can result in serious illness, including pneumonia and death). These failures placed residents, staff, and visitors of the facility at risk for development and transmission of communicable diseases and infections. Findings: 1. During a concurrent observation, and interview on 10/24/23 at 1:15 p.m., in the facility's Laundry Department, with the facility's LA, Maintenance/Housekeeping Director (MHD) and Infection Preventionist (IP), and an interpreter to translate for non-English speaking staff, in the area dedicated to dirty laundry, were multiple hampers with dirty clothing and linen, the area also had a bin which contained clean, laundered mop heads, cleaning cloths, and Restorative Nurses Aids (RNA) slings, with no demarcation to indicate separation of clean and dirty items. The area dedicated to clean laundry had a sweater, shawl on a chair, and a cup of coffee was on a shelf which also held clean, laundered linen. LA stated the sweater, shawl, and coffee cup in the clean laundry room belonged to her. During a review of the facility's P&P titled, Maintenance Policy & Procedure, dated 12/31/15, indicated, maintenance of a safe, and sanitary environment ensures safety, affords protection, and enhances the well-being of the residents, public, and staff. Maintenance activities include providing a functional, sanitary, and comfortable environment. Ensuring that all equipment, buildings, spaces, and fixtures are kept in operable condition. 2. During an observation on 10/24/23 at 10 a.m., Laundry Assistant (LA) mopped the floor in the area for contaminated laundry (dirty floor). LA moved into the area for clean laundry and mopped the floor without changing the mop head or mopping solution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation, and interview on 10/24/23 at 1:15 p.m., in the facility's Laundry Department, with the facility's LA, Maintenance/Housekeeping Director (MHD) and Infection Preventionist (IP), and an interpreter to translate for non-English speaking staff, LA stated she did not know what chemicals had been in the mop water solution she had used to mop the laundry room floor as she had not mixed the mopping solution. MHD and IP stated specific chemicals needed to be used to ensure floors were properly sanitized, so it was important to know what chemicals were in the mopping solution. 3. During a concurrent observation, and interview on 10/24/23, at 1:45 p.m., on 2-South, with MHD, IP, the Director of Nursing (DON), and Administrator (Admin), in the facility's Soiled Utility Room, a biohazardous waste red bin contained used suction cannisters and full Sharps containers. MHD was unable to provide a date when the vendor would remove the biohazardous waste bin. IP stated Sharps containers must be placed in separate bins from liquid biohazardous waste containers. IP stated the current red bin storage was improper and not in accordance with facility policy and procedure (P&P). During a concurrent interview and record review on 10/24/23, at 2:15 p.m., with the IP, DON, Respiratory Manager (RM), MD, RD, and Admin, the facility's Infection Control and Prevention Plan (IC/IP), undated, and the P&P titled, Medical Waste- Segregating and Separating, last revised May 2012, were reviewed. The Medical Waste- Segregating and Separating P&P indicated, medical waste from this facility will be segregated from general waste in accordance with current federal and state guidelines. Policy Interpretation and implementation: Designated individuals will be responsible for separating (to the extent practical) medical waste generated: a. sharps (needles, glass, scalpels, and syringes). b. Other regulated medical waste. c. other items per state specific regulation. 4. During a concurrent interview and record review on 10/25/23, at 11a.m., with the IP and MHD, the facility policy and procedure (PNP) titled, Legionella Water Management program, revised 2/2022, was reviewed. The MHD confirmed the facility had no process in place to monitor and test the facility's water system to ensure the water was free of Legionella. During a review of the facility policy and procedure (PNP) titled, Legionella Water Management program, revised 2/2022, the PNP indicated, The facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 27406 Based on interview and record review, the facility failed to implement their vaccine Policy and Procedure (P&P) for one (Resident 66) of eleven sampled residents. The facility failure to offer a Covid vaccination to Resident 66 had the potential to result in Covid-19 infection, worsened symptoms in the event of infection, and spread of infection. Findings: During a review of Resident 66's Admission Record, undated, the Admission Record indicated the facility admitted Resident 66 on 10/9/23, with diagnoses which included but were not limited to chronic osteomyelitis (bone infection), and pressure ulcers (also called a bed sore, injury to skin and underlying tissue resulting from prolonged pressure on the skin) on both heels and bilateral ischium (the lower, back part of both hip bones). During a review of Resident 66's Minimum Data Set (MDS, an assessment tool used to plan and direct resident care), dated 10/13/23, the MDS indicated Resident 66 spoke English; had intact mental abilities for attention, orientation, and ability to register and recall information; was able to voice his needs; and was totally dependent upon facility staff for all his care needs including mobility in and out of bed, and repositioning. During a concurrent interview and record review on October 25th, 2023, at 11AM, with the Infection Preventionist (IP) vaccination records for residents were reviewed. IP was unable to provide documentation Resident 66 had been offered the opportunity to receive COVID-19 vaccination. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Vaccine Policy for Residents and Staff, undated, the P&P indicated, Facility residents: all residents and staff will be offered am approved COVID-19 vaccine, unless medically contraindicated after assessment. All residents, or their legal representative, could accept or refuse a COVID-19 vaccine, or to change their decision. Policy Interpretation and Implementation: 1. Residents and staff will be educated on the benefits, assessed for eligibility and offered the COVID-19 vaccine series unless medically contraindicated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 27406 Based on observation, interview and record review, the facility failed to maintain a safe, functional, and sanitary environment when there were broken lights in the hallway. This failure placed residents at risk of receiving the wrong medication due to inadequate light for reading the medication labels and placed residents and visitors at risk of falling. Findings: During a concurrent observation, and interview on 10/24/23, at 1:45 p.m., with the Infection Preventionist (IP) and the Maintenance/Housekeeping Director (MHD), on in the hallway of 2-South, the overhead lights were nonoperational. During an interview on 10/24/23, at 2 p.m., with the Director of Nursing (DON) and the Administrator (Admin), and MHD, the DON stated the broken lighting in the hallway created a safety risk because nurses depended upon the overhead lights to read labels when pouring and passing medications. During a review of the facility's policy and procedure (P&P) titled, Interior General Maintenance, dated 12/31/15, the P&P indicated, Replace immediately all defective light bulbs or buzzers. During a review of the facility's P&P titled, Maintenance Policy & Procedure, dated 12/31/15, the P&P indicated, maintenance of a safe, and sanitary environment ensures safety, affords protection, and enhances the well-being of the residents, public, and staff. Maintenance activities include providing a functional, sanitary, and comfortable environment. Ensuring that all equipment, buildings, spaces, and fixtures are kept in operable condition.