STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555570	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Heights Nursing and Rehabilitation	2361 East 29th Street Oakland, CA 94606

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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 - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to maintain a safe, comfortable and homelike environment when Resident 18's wall beside the right side of his bed had scattered areas of peeling paint. This failure had the potential to compromise the health and safety of the resident and could negatively impact the resident's psychological health. Findings: Review of Resident 18's Facesheet indicated, Resident 18 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident 18 's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/24/25, indicated that the resident was able to understand others and was understood by others clearly without assistance. During an initial tour on 4/7/25 at 10:33 a.m., Resident 18 was lying in bed and was awake. Resident 18's wall was observed to have scattered areas of peeling paint. Resident 18 stated his wall was ugly. During a concurrent observation and interview on 4/8/25 at 3:31 p.m., with the Maintenance Technician (MT) in Resident 18's room, MT described Resident 18's wall's paint as chipping and acknowledged that Resident 18's wall needed to be repainted. During a concurrent observation and interview on 4/08/25 at 3:49 p.m., with the Director of Nursing (DON) in Resident 18's room, the DON stated the condition of Resident 18's wall was not providing a homelike environment to the resident. During a review of the facility's policy and procedure (P&P) titled, quality of life-Homelike Environment, revised May 2017, the P&P indicated, Residents are provided with a safe, clean, comfortable and home like environment .1. Staff shall provide person-centered care that emphasizes the residents comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible , the characteristics of the facility that reflect a personalized home like setting. These characteristics include: a. clean sanitary and orderly environment .c. inviting colors and décor .

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices were followed when upon inspection of the medication refrigerator, medications for the following discharged residents were found: 1. Eight packets of Veltassa 8.4 grams powder which belonged to Resident 154 (Veltassa is a medication used to correct the high potassium in the body. Potassium is a mineral that your body needs to work properly). 2. One Arexvy 120 micrograms kit which belonged to Resident 37 (Arexvy 120 micrograms kit contains two containers to be mixed to form a vaccine which is given to residents for the prevention of a lung infection caused by a virus called respiratory syncytial virus; a vaccine is a shot that trains your body's immune system to fight off a specific disease. Micrograms or mcg. is a form of measurement). 3. One Arexvy 120 mcg. kit which belonged to Resident 39. 4. One Arexvy 120 mcg. kit which belonged to Resident 157. These failed practices could contribute to unsafe storage of medications and potential for medication error. Findings: 1. A record review for Resident 154 indicated, Resident 154 was admitted to the facility on [DATE] and was discharged from the facility on 5/27/23. During a concurrent observation and interview on 4/8/25, at 10:01 a.m., with the Infection Preventionist (IP), in medication room, eight packets of Veltassa 8.4 grams powder were found which belonged to Resident 154 in the medication refrigerator. The IP confirmed that Resident 154 was already discharged from the facility. During a review of Resident 154's physician order dated 5/11/23 , indicated an order dated 1/29/25 for Parotimer Sorbitex Calcium Oral Packet 8.4 grams, one packet by mouth every Tuesday ,Thursday, Saturday and Sunday. (Veltassa 8.4 grams is the brand name for Parotimer Sorbitex Calcium Oral Packet 8. 4 grams). 2.A record review for Resident 37 indicated, Resident 37 was admitted to the facility on [DATE] and was discharged from the facility on 3/17/25. During a concurrent observation and interview on 4/8/25, at 10:01 a.m., with the IP in the medication room, Arexvy 120 micrograms kit which belonged to Resident 37 was found in the medication refrigerator. The IP confirmed that Resident 37 was already discharged from the facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 37's physician order dated 2/19/25, indicated an order for RSVPreF3 Vac Recomb Adjuvanted intramuscular suspension reconstituted 120 mcg/0.5 ml, inject 0.5 ml for RSV vaccination . (Arexvy is the brand name for RSVPreF3 Vac Recomb Adjuvanted intramuscular suspension reconstituted 120 mcg/0.5 ml). 3. A record review for Resident 39 indicated, Residented 39 was admitted to the facility on [DATE] and was discharged from the facility on 3/10/25. During a concurrent observation and interview on 4/8/25, at 10:01 a.m., with the IP in the medication room, Arexvy 120 mcg. kit which belonged to Resident 39 was found in the medication refrigerator. The IP confirmed that Resident 39 was already discharged from the facility. During a review of Resident 39's physician order dated 2/19/25, for RSVPreF3 Vac Recomb Adjuvanted intramuscular suspension reconstituted 120 mcg/0.5 ml, inject 0.5 ml for RSV vaccination . 4. A record review for Resident 157 indicated, Resident 15 was admitted to the facility on [DATE] and was discharged from the facility on 1/25/25. During a concurrent observation and interview on 4/8/25, at 10:01 a.m., with the IP in the medication room, Arexvy 120 mcg. kit which belonged to Resident 157 was found in the medication refrigerator. The IP confirmed that Resident 157 was already discharged from the facility. During a review of Resident 157's physician order dated 1/9/25, for RSVPreF3 Vac Recomb Adjuvanted intramuscular suspension reconstituted 120 mcg/0.5 ml, inject 0.5 ml for RSV vaccination . During an interview on 4/9/25 at 1:12 p.m., with the Director of Nursing (DON), DON stated, stated that the medications of discharged residents should had been disposed from the medication refrigerator because of the risk of medication error. Stated a medication nurse would have accidentally given the discharged resident's medication to another resident. During a telephone interview on 4/10/25 at 12:17 p.m., with the Consultant Pharmacist (CP), the CP stated that the medications should be disposed as soon as the residents were discharged . Further stated that the risk of keeping the medications belonging to the discharged residents in the medication refrigerator was medication error because the medications could have been accidentally given to another resident. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications undated, the P&P indicated, The facility shall store all biologicals in a safe, secure, and orderly manner . 4. The facility shall not use discontinued, outdated , or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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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. Based on observation, staff interview, and record review, the facility failed to store food in accordance with professional standards for safety when: 1. Unlabeled and undated food was stored in the kitchen refrigerator. 2. Unlabeled and undated food was stored in the kitchen freezer. 3. Unlabeled, undated and beyond use by date for food items were stored in the resident refrigerator. These failures had the potential for contamination of food resulting in food borne illness for 43 residents who received food from the kitchen and had access to use the resident refrigerator. Findings: During an observation 4/7/25, at 9:40 a.m., in the kitchen, the refrigerator, and freezer and was observed. The refrigerator had one unsealed plastic bag of carrots that was not labeled with date. The freezer had one unsealed plastic bag of tilapia. During an observation on 4/7/25, at 10:25 a.m., the resident refrigerator and freezer was observed with one plastic bag of unsealed carrots and two egg salad sandwiches that were not labeled with resident name and date. The resident refrigerator and freezer had one bulk box of strawberry yogurt with a use by date 3/28/25. During an interview on 04/10/25, at 1:30 p.m., with Certified Dietary Manager (CDM), CDM stated it was important to label all food stored in the kitchen refrigerator and freezer, and the resident refrigerator and freezer so they would have known when to throw the food out. CDM stated unlabeled and undated food could have been old and could have caused the residents to get sick if it was served to them. CDM stated it was important to label food with resident name in the resident refrigerator and freezer to make sure residents got the correct diet. CDM stated food that was beyond it's use by date could have caused the residents to get sick if it was served to them and should have been thrown out. During a review of the facility's P&P titled, Food Storage, revised 7/11/24, the P&P indicated, All products should be . dated upon receipt, when open and when prepared. During a review of the facility's P&P titled, Foods Brought in by Family/Visitors, revised October 2017, the P&P indicated, Perishable foods must be stored in re-sealable containers with tight-fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. The P&P indicated, The nursing staff will discard perishable foods on or before the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, the facility failed to ensure that staff were following isolation precautions to prevent the spread of disease for two of 16 sampled residents when: 1. A Licensed Vocational Nurse (LVN) did not use the proper personal protective equipment (PPE) while giving medications via gastrostomy tube (a gastrostomy is a surgical procedure that creates an opening in the stomach through the abdominal wall. A tube, called a gastrostomy tube is then inserted through this opening to provide nutrition and medication directly into the stomach) to a resident who was on enhanced barrier precaution (Enhanced Barrier Precautions are an infection control strategy that focuses on using gowns and gloves during high-contact resident care activities to reduce the transmission of infection). 2. Two Certified Nursing Assistants (CNAs) did not use the proper personal protective equipment (PPE, equipment worn to minimize exposure to illnesses) when they were giving care and changing the bed linen of a resident on EBP. This failure had the potential for transmission of diseases and infection among residents. Findings: 1. Review of Resident 32's Facesheet (information containing contact details, brief medical history at-a-glance) indicated, Resident 32 was admitted to the facility on [DATE] with diagnoses that included the presence of a gastrostomy. During a medication pass observation and interview with LVN 1 on 4/09/25 at 8:37 a.m., LVN 1 entered Resident 32's room (room [ROOM NUMBER]) without isolation gown and gave the resident's medications via gastrostomy tube with just wearing gloves and mask. Posted on the door outside of room [ROOM NUMBER] was a sign which indicated: STOP Enhanced Barrier Precaution and what to do before entering room and a small plastic cart with PPEs was outside Resident 32's room. On interview, LVN 1 stated she had training on isolation precautions and acknowledged that she should have worn the isolation gown to prevent the spread of infection. 2. Review of Resident 44's Facesheet indicated, Resident 44 was admitted to the facility on [DATE] with diagnoses that included the presence of a gastrostomy. During an observation on 4/09/25, at 10:39 a.m , in Resident 44's room (room [ROOM NUMBER]), Resident 44 was in his bed when CNA 1 and CNA 2 were not wearing isolation gowns while changing the resident's bed linen . Posted on the wall outside of room [ROOM NUMBER] was a sign which indicated; STOP Enhanced Barrier Precaution and what to do before entering room and a small plastic cart with PPEs was outside Resident 44's room. During a joint interview on 4/09/25, at 10:45 a.m., with CNA 1 and CNA 2, both of them stated they had trainings on isolation precautions, and both acknowledged they should have worn the isolation gown when they gave care to Resident 44 to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the EBP signs posted outside Resident 32 and 44's rooms, the signs indicated .Providers and Staff must also: Wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy . During an interview on 4/10/25 , at 12:54 p.m., with the Director of Nursing (DON),the DON stated the staff should have worn the appropriate PPEs when giving care to Residents 32 and 44 to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, Revised 3/6/25, the P&P indicated, . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .11. Prevention of Infection a. Important facets of infection prevention include . (3) educating staff and ensuring that they adhere to proper techniques and procedures .(7) implementing appropriate isolation precautions when necessary .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review , the facility failed to ensure the designated Infection Preventionist (IP is a professional who ensures healthcare workers and patients are doing all the things they should to prevent infections) had completed and received certification for specialized training in infection prevention and control program in accordance with the facility's policy and procedure and CMS (Centers for Medicare and Medicaid Services) requirement. This failure resulted in the infection control and prevention program of the facility not having the benefit of a fully qualified and competent IP and possibly negatively affecting the quality of care provided to all residents. Findings: During an interview on 4/09/25 at 3:01 p.m., with the Director of Nursing (DON), the DON stated the IP had been working as designated IP for the facility since September of 2024. DON stated IP could not provide proof of IP certification. During an interview on 4/10/25 at 10:30 a.m., with IP, IP stated she had two roles in the facility since September of 2024: 1) IP and; 2) Nursing Supervisor. The IP stated she was aware of the requirement to complete Infection Prevention training. She stated she had completed taking the Centers for Disease Control and Prevention (CDC) Infection Control Preventionist Training for Infection Control but was unable to provide proof that she completed the IP certification. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, Revised 3/6/25, the P&P indicated, . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .5. Coordination and Oversight a. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). b. The qualifications and job responsibilities of the Infection Preventionist are outlined in the Infection Preventionist Job Description . During a review of the facility's undated Job Description of Infection Preventionist/Nurse Supervisor, indicated that one of the qualifications for the infection preventionist was, .Certifications: Infection Preventionist (IP) certification . During a professional reference review from https://www.cms.gov titled specialized infection prevention and control training for nursing home staff dated 3/11/19 indicated specialized training for infection prevention and control. CMS and the CDC collaborated on the development of a free online training course in infection prevention and control for nursing home staff. The course includes information about the core activities of an infection prevention and control program, with a detailed explanation of recommended practices to prevent pathogen transmission and reduce healthcare associated infections and antibiotic resistance in nursing homes. Completion of this course will provide specialized training in infection prevention and control . (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the AFL 21-51 indicated Effective January 1, 2022, AB 1585 expands existing eligibility and minimum qualifications for a SNF's IP. The IP must have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other health care related field. The IP must be qualified by education, training, clinical or health care experience, or certification, and must have completed specialized training in infection prevention and control (Skilled Nursing Facility is a health facility and is also called a SNF; An All Facilities Letter or AFL is a letter that was sent from the California Department of Public Health to all health facilities that are licensed or certified).