STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056479	A. BUILDING _____ B. WING _____	**03/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALAMEDA COUNTY MEDICAL CENTER D/P SNF	**15400 FOOTHILL BOULEVARD 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 -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one (Resident 1) of three sampled residents the facility failed to implement Resident 1's broken television (TV) cord care plan when Resident 1 was not monitored hourly for safety. For Resident 1, this deficient practice placed Resident 1's safety at risk. Findings: Review of the Face Sheet, printed [DATE], indicated Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's quarterly Minimum Data Set assessment (MDS-a tool used to guide care), dated 11/23/19, indicated Resident 1 had [DIAGNOSES REDACTED]. Review of Resident 1's care plan titled TV cord was broken and reported, dated 2/5/20, indicated .12. hourly check provided by the staff for safety During a concurrent interview and record review the Director of Nursing (DON) on [DATE] at 12:34 p.m., she stated Resident 1 had hourly safety checks care planned. DON was not able to show documentation that hourly safety checks were done. Review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, revised 12/16, indicated .1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.