STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555313	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION CENTER OF OAKLAND	**210 40TH STREET WAY OAKLAND, CA 94611**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 implement their policies and procedures for infection control which included failure to: 1. Screen seven of 33 staff upon initial entry to the facility for symptoms of COVID-19 infection (Coronavirus Disease 2019, a highly contagious virus that causes breathing difficulty and other complications. Symptoms include: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea). 2. Cohort (group) residents to prevent exposure of established non-infected (negative) COVID-19 residents to residents of unknown COVID-19 infection status (PUI, Person Under Investigation). The failure to quarantine a newly admitted resident (Resident 2), resulted in the potential exposure of Residents 3, 4, 7, 8, and 9. 3. Two employees did not perform hand hygiene when entering the facility, one walked through a hallway to clock in for work. 4. Provide trash receptacles inside each PUI resident room for staff to dispose of used PPE. 5. Keep the doors to PUI resident rooms closed. 6. Post signage on or near the entrance to one of 13 rooms with PUI residents, to provide information to direct care staff about the type of isolation precautions (standardized protocols and procedures to prevent transfer of infective organisms based on how the organisms transfer from one person to another) and personal protective equipment (PPE, devices such as gowns, gloves, masks, and face shields used to prevent exchange of infective organisms, such as bacteria [MEDICAL CONDITION]) needed for the residents' care. These failures had the potential to result in the spread of COVID-19, and COVID-19 related complications, up to and including death. Findings: 1. During an observation on 7/16/20 at 09:30 a.m., a staff member entered the facility, bypassed the COVID-19 screening station without stopping, and went down the hallway to clock-in. During an interview on 7/16/20, at 9:35 a.m., with the Receptionist (RS 1), RS 1 stated staff usually entered the facility and clocked in, and then go back to the entrance reception desk for COVID-19 screening. During an interview on 7/16/20, at 10:30 a.m., with the Infection Preventionist (IP), IP stated the facility's policy was for all employees and visitors to immediately stop at the receptionist desk upon entry to the facility for COVID-19 screening. During a concurrent interview and record review on 7/16/20 at 11:00 a.m., with the Director of Nurses (DON) of the facility, the Screening Log and the Daily Work Schedule, dated 7/16/20, was reviewed. DON stated the log indicated that six of 33 employees present for duty at the facility were not screened for COVID-19 that day. During an interview on 7/16/20, at 12:15 p.m., with the Admission Director (AD), the AD stated he had not been screened for COVID-19 today because a resident asked for help when he entered the facility, and he forgot to get screened after assisting the resident. During an interview on 7/16/20, at 12:40 p.m., with the Payroll Manager (PM), PM stated she had not been screened for COVID-19 today because she forgot to stop by the front desk to get screened. During a review of the facility's policy and procedure (PNP), Guidance for Infection Prevention and Control for Residents with Suspected or Confirmed COVID -19, dated 3/16/20, the PNP indicated, All staff will be screened for signs and symptoms of [DIAGNOSES REDACTED]-Cov-2 (COVID-19) infection prior to starting their shift. If they have symptoms they will not be permitted to work . 2. During a concurrent interview and record review on 7/16/20, at 10:00 a.m., with the IP, the census, face sheet, and facility map were reviewed. The IP stated rooms [ROOM NUMBERS] were designated for use by COVID-19 positive residents (Red Zone). IP stated the current area for COVID-19 negative (no infection) residents (Green Zone), also contained 13 rooms with PUI residents (rooms 7, 9, 10, 11, 12, 17, 21, 22, 23, 25, 27, 28, 29). IP stated Resident 2 was newly admitted to the facility on [DATE], in a PUI status. On 7/15/20, Resident 2 moved into a Green Zone room (room [ROOM NUMBER]) with Resident 3 and Resident 4, who were both negative for COVID-19 infection, potentially exposing both Resident 3 and 4 to infection. On 7/16/20, Resident 3 was moved into another room (room [ROOM NUMBER]) with two negative residents (Resident 7 and Resident 8); Resident 4 was also moved into another room (room [ROOM NUMBER]) with two negative residents (Resident 6 and Resident 9). IP confirmed these room changes resulted in all residents in these rooms being changed to a PUI status. During a review of the facility document, Infection Prevention Quality Control Plan, dated 5/20/20, the document indicated, Upon admission, new and readmitted residents with unknown COVID-19 are placed in a separate observation unit or wing for 14 days. 3. During an observation on 7/16/20, at 9:30 a.m., two employees entered the facility, and without performing hand hygiene, walked past the designated Alcohol Based Hand Sanitizer stations located in the lobby entrance. One employee walked directly to the receptionist for screening; one employee went directly to the punch-clock located down the hall. During an interview on 7/16/20 at 10:30 a.m., with the Infection Preventionist (IP), the IP stated the facility's policy was for all employees and visitors to perform hand hygiene upon entering the facility, and prior to stopping at the receptionist desk for screening. During a review of the facility policy and procedure (PNP), Infection Prevention Quality Control Plan, dated 5/20/20, the PNP indicated, Prior to entering and exiting the unit and a resident room, healthcare personnel must perform hand hygiene by washing hands with soap and water or applying alcohol-based sanitizer. 4. During a concurrent observation and interview on 7/16/20, at 10:15 a.m., with the IP, a healthcare provider wearing a gown and gloves exited PUI room [ROOM NUMBER], removed the gown and gloves, and discarded the items in a trash can located outside room [ROOM NUMBER]. IP stated the trash can for disposal of used PPE should be located inside the PUI room. During a review of the facility policy and procedure (PNP), Infection Prevention Quality Control Plan, dated 5/20/20, the PNP indicated, Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE while inside the resident room . 5. During an observation on 7/16/20 at 10:15 a.m., the doors to all 13 PUI resident rooms were maintained in an open position. During a review of the facility policy and procedure (PNP), Infection Control Manual, COVID-19 (coronavirus disease 2019), dated 2/28/20, the PNP indicated, Precautions if COVID-19 is suspected .Place a facemask on the resident and close the door to the room . 6. During an observation on 7/16/20, at 11:00 a.m., with the IP, of the entrance area to room [ROOM NUMBER], IP confirmed room [ROOM NUMBER] was considered a PUI room and there was no signage on or near the door to the room to indicate type of isolation precautions or PPE needed to provide direct resident care. During a review of the facility document, Infection Prevention Quality Control Plan, dated 5/20/20, the document indicated, Post signs on the door or wall outside of the resident's room that clearly describe the type of precautions needed and required PPE.

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.