STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055215	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Healthcare & Wellness Center	3030 Webster Street Oakland, CA 94609

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36087 Based on observation, interview, and record review, the facility failed to ensure maintenance services to maintain a comfortable, sanitary, and homelike environment when: 1. For Resident 39, room had a missing window covering. 2. For Resident 41, bathroom sink hot water knob was not in good working condition. 3. For Resident 58, room window could not be closed completely. 4. Multiple rooms (Rooms 5, 6, 10, 11,1 2, 16, and 19) had unclean and unpleasant bathroom environments. These failures to ensure a homelike environment had the potential to decrease residents' quality of life, comfort, and well-being. Findings: 1. A review of Resident 39's Admission Record printed on 7/24/24, indicated Resident 39 was admitted to the facility on [DATE]. A review of Resident 39's Minimum Data Set (MDS, an assessment tool used to provide care), dated 7/12/24, indicated Resident 39 had a Brief Interview for Mental Status (BIMS, an assessment tool for a resident's orientation to time and capacity to remember. The BIMS score ranges from 0-15, with 15 as an indication of intact skills) score of 15 who had clear speech, was understood, and was able to understand. During a concurrent observation and interview on 7/22/24, at 9:25 a.m., with Resident 39, inside the resident's room, right panel of the window did not have a window covering. Resident 39 stated he had asked multiple times from several staff members to tell Maintenance to put blinds or some sort of window covering for resident's privacy and protection from outside heat especially with the recent heat wave. Resident stated it had been two weeks since he was admitted to the facility, yet the other panel of the window remained without blinds. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/24, at 10:00 AM, with Maintenance Supervisor (MS), MS stated he had been made aware of Resident 39's request for the resident's room window covering, however, MS was unable to find the time to install the blinds. MS stated the blinds were in the storage room available for installation. 2. A review of Resident 41's Admission Record printed on 7/24/24, indicated Resident 41 was admitted to the facility in 2019. A review of Resident 41's MDS Assessment, dated 5/17/24, indicated Resident 41 had no speech, was rarely/never understood, and was rarely/never able to understand. During an observation on 7/23/24, at 11:36 a.m., inside Resident 41's room, the bathroom sink hot water knob when turned loose was without water flow. During a concurrent observation, interview, and record review, on 7/23/24, at 11:47 a.m., with the Registered Nurse 1 (RN 1), inside Resident 41's bathroom, RN 1 turned the sink hot water knob open and stated it was not working. RN 1 stated if something needed fixing or there was a maintenance issue, depending on the urgency, would report to Maintenance immediately, either verbally or written in the Maintenance Logbook located at the Nurses Station. When RN 1 checked the Maintenance Logbook in Nurses' Station 3, the issue regarding faucet in Resident 41's room was not documented. During an interview on 7/23/24, at 11:58 a.m., with CNA 1, CNA 1 confirmed hot water faucet knob to Resident 41's room had not been working in the last three days. CNA 1 stated she had reported this problem to the license nurse (LN) three days ago. CNA 1 further stated she had been going to the Nurses Station to get hot water for Resident 41's activities of daily living (ADL, the basic self-care tasks an individual does on a day-to-day basis) care. During a concurrent observation and interview on 7/23/24, at 12:01 p.m., with MS, inside Resident 41's bathroom, MS confirmed water did not flow when hot water knob was turned loose. MS stated the hot water valve was closed due to a loud screeching sound when knob was turned loose. MS stated this problem was verbally reported to him by a CNA, but MS was unable to take care of the problem up to this time. A review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, revised date January 1, 2012, indicated, The facility provides residents with a safe, clean, comfortable, and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the resident's comfort, independence, and personal needs and preferences . 49091 3. During a concurrent observation and interview on 7/22/24, at 10:00 a.m., with Resident 58 and Resident 58's family member, the family member stated Resident 58's bedroom window would not close properly. When it was attempted to close the window completely, a 1/4 inch gap was left open to the outside, between the window and the window frame. The family member stated this caused hot and cold air, as well as cigarette smoke from the courtyard smoking area to come into Resident 58's room. The family member stated they were worried about Resident 58's health because of this, and Resident 58 had also complained about cigarette smoke smell. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/23/24, at 1:36 p.m., with the Infection Prevention Nurse (IPN) in the facility courtyard/smoking area, smoking ashtrays were located approximately 20 feet from Resident 58's and other residents' bedroom windows. A large blue shade awning was also located in the courtyard, with the nearest part of the awning measuring approximately 15 feet from resident bedroom windows. The IPN stated facility residents were allowed to smoke during certain times during the day accompanied by activity staff, and smokers were encouraged to stay far away from facility bedroom windows. During a record review of Smoking Schedule for Residents, undated, the schedule indicated, smoking times are 8:30 a.m., 11:00 a.m., 1:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. During an observation on 7/24/24, at 10:30 a.m., in the facility's smoking area/courtyard, a resident in a wheelchair was smoking. The resident was under the large blue shade awning. During an observation on 7/24/24, at 12:30 p.m., in the facility's smoking area/courtyard, two residents were smoking in between the ashtray station and the large blue shade awning. During an interview on 7/25/24 at 10:40 a.m. with the Director of Nursing (DON), the DON stated risks of second-hand smoke inhalation include cancer and respiratory problems, and residents should not be exposed to it. During a review of facility's policy and procedure (P&P) titled, Smoking by Residents, effective 8/18/23, P&P indicated, facilities that accommodate residents who smoke will take reasonable precautions by providing a safe environment and protecting the non-smoking residents. In an interview on 7/24/24, at 11:35 a.m., with the Maintenance Supervisor (MS), the MS stated he was aware of Resident 58's window issue. MS stated Resident 58's window would not close, for maybe a month or more. MS stated the facility had tried to find ways to repair the window in-house, and since that didn't work, the facility contacted S.F. Atlas Glass company today for an estimate, and now the plan was to replace Resident 58's window completely. In a review of facility P&P titled, Maintenance Service, undated, P&P indicated, The maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .maintaining the building in good repair and free from hazards . During a record review of SF Atlas Glass invoice #2024225, dated 7/24/24, the invoice indicated two 48 x 48 windows/screens, and one 45 x 45 window/screen would be ordered and installed, and lead time is 4-6 weeks. During an interview with MS on 7/24/24, at 3:30 p.m., MS explained the information printed on S.F. Atlas Glass' invoice, lead time is 4-6 weeks, meant that the work would be started after the parts arrived in 4 to 6 weeks' time. MS stated temporary sealing and taping of the window would be done to ensure that Resident 58's window would close until the whole window could be replaced. 36593 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 7/23/24, at 11:05 a.m., with Maintenance Staff (MS) and Administrator In Training (AIT), Residents' rooms 5, 6, 10, 11,12, 16 and 19 bathroom flooring had cracks and blackish discoloration on floors, toilet bowl with blackish strip marks on the rims, and blackish material around the base of toilet bowl. During a concurrent observation and interview on 7/23/24, at 11:43 a.m., Resident 85 was seated up in wheelchair outside room [ROOM NUMBER]. Resident 85 stated he resided in room [ROOM NUMBER] and used the bathroom. Resident 85 stated he was uncomfortable using the bathroom sometimes. Resident 85 stated when he asked for the bathroom floor to be cleaned, staff did not listen. During an interview on 7/24/24, at 11:39 a.m., with Environmental Supervisor (ES), ES stated facility was aware of cracked flooring, blackish material and discoloration around the toilet in residents' bathrooms. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, revised January 01, 2012, the P&P indicated, The facility provides residents with a safe, clean, comfortable, and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593 Based on interview and record review, the facility failed to ensure four (Resident 32, 47, 57 and 67) of five sampled resident's Pre-Admission Screening Resident Review (PASRR) was referred to the appropriate state mental authority for evaluation and determination when; 1. Facility did not resubmit a new Level 1 PASRR screening for Residents 32, 47, 67 that remained in the facility longer than 30 days. 2. Facility did not refer Resident 57 for level 2 PASRR evaluation. These failures had the potential to prevent residents from receiving appropriate required mental health services. Findings: 1. Review of Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 5/22/24, indicated Resident 32 was admitted to the facility on [DATE], the Preadmission Screening and Resident Review (PASRR) was coded zero-meaning, Resident 32 was not considered by the State PASRR process to have a serious mental illness. The MDS indicated Resident 32's diagnoses included undifferentiated schizophrenia (a mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and a sense of mental fragmentation). Review of the PASRR screening dated 5/11/24 indicated Resident 32 had a serious diagnosed mental disorder such as depression, anxiety disorder, schizophrenia/schizophrenia disorder or symptoms of psychosis, delusional (false beliefs) and or mood disorder. The PASRR indicated if the individual remains in the NF (nursing facility) longer than 30 days, the facility should resubmit a new Level I screening as a Resident Review on the 31st day. Review of MDS, dated [DATE], indicated Resident 67 was admitted to the facility on [DATE], the PASRR was coded zero-meaning, Resident 67 was not considered by the State PASRR process to have a serious mental illness. MDS indicated Resident 32's diagnoses included schizophrenia (a mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and a sense of mental fragmentation). Review of the PASRR screening dated 6/4/24 indicated Resident 67 had a serious diagnosed mental disorder such as depression, anxiety disorder, schizophrenia/schizophrenia disorder or symptoms of psychosis, delusional (false beliefs) and or mood disorder. PASRR indicated if the individual remains in the NF (nursing facility) longer than 30 days, the facility should resubmit a new Level I screening as a Resident Review on the 31st day. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/24/24, at 9:12 a.m., with MDS coordinator (MDSC), and Director of Nursing (DON), MDSC stated Resident 32 and 67 were admitted to the facility with Level I PASSAR screening completed from the hospital. MDSC stated she reviewed PASRRs during MDS process. MDSC stated facility had not resubmitted a new Level I screening when residents remained in the facility longer than 30 days . During a review of the facility's policy and procedure (P&P) titled, Pre-Admission Screening Resident Review (PASRR) revised July 2018, indicated The facility MDS Coordinator will be responsible to access and ensure updates to the PASRR is done per MDS guidelines. 36087 A review of Resident 47's Admission Record printed on 7/24/24, indicated resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 47's MDS, dated [DATE], indicated the PASRR was coded zero, meaning Resident 47 was not considered by the State Level II PASRR process to have a serious mental illness. However Resident 47's diagnoses included bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows) and Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements. They may also have mental and behavioral changes, sleep problems, depression, and memory difficulties). A review of Resident 47's Order Summary Report, active orders as of 7/25/24, indicated an order for Depakote Extended Release (ER) 24 Hour oral tablet 250 mg, give three tablets for bipolar disorder. A review of Resident 47s medical record indicated Resident 47 did not have a PASRR. During a concurrent interview and record review on 7/24/24, at 9:10 a.m., with the MDSC and DON, Resident 47's clinical records were reviewed. MDSC stated MDSC reviewed PASRRs during the MDS process. However, MDSC confirmed Resident 47's PASRR was not completed, and resident was not referred to the State Mental Authority for specialized mental health services when resident remained in the nursing facility longer than 30 days. A review of the facility's policy and procedure titled, Pre-admission Screening Resident Review (PASRR), revised date July 2018, indicated, To ensure that all facility applicants are screened for mental illness and intellectual disability (ID) or a related condition (RC) prior to admission. The State of California has adopted a process to submit Pre-admission Screening Resident Review (PASRR) electronically. All facilities must complete the PASRR by midnight of the date of admission . 2. A review of Resident 57's Admission Record printed on 7/24/24, indicated resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 57's MDS dated [DATE], indicated resident's diagnoses included Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 57's Order Summary Report, active orders as of 7/24/24, indicated an order for Seroquel oral tablet 25 mg, give one tablet for Schizophrenia m/b aggressive behavior towards others. A review of Resident 57s medical record indicated Resident 57 did not have a PASRR Level II referral. During a concurrent interview and record review on 7/23/24, at 9:26 a.m., with the MDSC, Resident 57's clinical records were reviewed. Resident's PASRR Level I was completed on 4/3/23, which showed a result of positive for mental illness and a Level II Mental Health Evaluation Referral was required. MDSC stated Resident 57's medical records did not indicate that a Level II PASRR was completed, nor any follow-up appointment was set up to have the evaluation completed was done. A review of the facility's P&P titled, Pre-admission Screening Resident Review (PASRR), revised date July 2018, indicated, .The facility MDSC Coordinator will be responsible to access and ensure updates to the PASRR is done by MDS guidelines .

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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 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** 36087 Based on observation, interview, and record review the facility failed to ensure necessary treatment and care services in accordance with professional standards of practice, comprehensive assessment and care plan for two of two sampled residents (Resident 41 and Resident 85) when: 1. For Resident 41, license nurse (LN) did not assess or offer pain medication before wound dressing change was performed. 2. Resident 85 did not receive pain medication as ordered by the physician. License nurses did not reassess routine use of as needed pain medication. These failures had the potential for Resident 41 and Resident 85 to suffer from unnecessary pain and emotional distress, and to not receive the necessary care and services to ensure effective pain management. Findings: 1. A review of Resident 41's Admission Record printed on 7/24/24, indicated Resident 41 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a brain condition that causes a progressive decline in memory, thinking, learning, and organizing skills), hemiplegia (muscle weakness on one side of the body), and pressure ulcer (an injury that breaks down the skin and underlying tissues) of the sacrum (bottom of the spine or just above the tailbone). It also indicated Resident 41 was on palliative care (a specialized medical care focused on providing relief from pain and other symptoms of a serious illness). A review of Resident 41's Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 5/17/24, indicated Resident 41 had no speech, was rarely/never understood, and was rarely/never able to understand. The MDS also indicated Resident 41 required substantial/maximal assist (helper does more than half the effort) to dependent assist (helper does all of the effort to complete the activity with the assistance of two or more helpers required for the resident to complete the activity) during his activities of daily living, (ADLs, the basic self-care tasks an individual does on a day-to-day basis). A review of Resident 41's Order Summary Report, order date range 7/1/24-7/31/24, indicated: 1. 7/20/24 Morphine Sulfate 20 milligram (mg)/milliliter (ml), give 0.25 ml by mouth every one hour as needed for pain. 2. 7/19/24 Sacrum - cleanse wound with normal saline or sterile water pat dry apply calcium Alginate (AG) to wound bed and dry dressing. Every day shift for wound care and as needed for wound care. A review of Resident 41's Care Plan focused on, The resident is at risk for pain, dated 9/22/21, indicated, Anticipate the resident's need for pain relief and respond immediately to any complaint of pain . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent wound dressing change observation on 7/23/24, at 10:34 a.m., with the Treatment Nurse 1 (TN 1) and Licensed Vocational Nurse 1 (LVN 1), inside Resident 41's room, Resident 41 was positioned lying in bed on his right side, with the sacral wound exposed for wound treatment. Resident 41 was observed tensed and guarded. When TN 1 cleansed Resident 41's sacral wound with normal saline, resident moved his lower body part away with a sudden jerk. During a follow-up interview on 7/23/24, at 10:45 a.m., with TN 1, TN 1 stated she did not assess Resident 41's pain level nor asked the Charge Nurse (CN) if the resident had received pain medication prior to wound treatment. TN 1 stated she would normally ask the CN to give the resident pain medication 30 minutes before wound treatment. During an interview on 7/25/24, at 8:47 a.m., with the Registered Nurse Supervisor (RNS), RNS stated a resident must be assessed for pain and offered pain medication 30 minutes prior to wound treatment, and assessed for the effectiveness of the pain medication before the wound treatment was performed. A review of the facility's policy and procedure (P&P) titled, Pain Management, revised date 5/25/23, indicated, .Pain Assessment .If the resident cannot verbalize the intensity of their pain, the Licensed Nurse will evaluate the resident's pain based on non-verbal cues (Examples of non-verbal cues to include but are not limited to: .guarding of a body part .Pain Management .The Licensed Nurse will assess the resident for pain and document results on the Medication Administration Record (MAR) . 36593 2. During a review of Resident 85's Admission Minimum Data Set (MDS - Resident assessment and care guide tool), dated 5/29/24, the MDS indicated Resident 85's Basic Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15 and indicated intact mental status. The MDS indicated Resident 85 was able to recall the correct year, month, and day of the week. MDS indicated Resident 85 had facial expression of pain (e.g. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth). Resident 85 had protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). Resident 85 complained or showed evidence of pain or possible pain frequency of 1 to 2 days. The MDS indicated Resident 85 had diagnoses that included cellulitis of right lower limb (a common and potential serious bacterial skin infection), bilateral osteoarthritis of knee (a degenerative joint disease) and other chronic pain. During a concurrent observation and interview on 7/23/24, at 9:40 a.m., Resident 85 laid in bed in his room, awake and verbally responsive. Resident 85 stated his pain medication was not relieving his leg pain, and he could not sleep well overnight. Resident 85 stated he received medication every 6 hours as needed for pain and continued to have pain on his knees and legs. During a review of Resident 85's Pain Evaluation, dated 7/22/24, indicated for pain intensity ask resident to rate worst pain on a 0-10 scale, with 0 being no pain and 10 being the worst pain imaginable. Resident 85's pain level was scored at 5. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(The pain scale helps the doctor keep track of how well your treatment plan is working to reduce your pain and help you do daily tasks. Most pain scales use numbers from 0 to 10. A score of 0 means no pain, and 10 means the worst pain you have ever felt) Reference : https://www.healthline.com . During a review of Resident 85's order summary report (physician orders), dated 5/23/24, indicated physician prescribed Acetaminophen (Tylenol) oral tablet 500 mg give 2 tablet by mouth every 6 hours as needed for mild pain (1-4) not to exceed 3 gm in 24 hours. Further review of Resident 85's physician order dated 5/23/24, indicated the physician prescribed hydrocodone-acetaminophen (Norco) oral tablet 10-325 mg give one tablet by mouth every 4 hours as needed for moderate to severe pain (5-9) not to exceed 3 gm of Tylenol in 24 hours. During a review of Resident 85's Medication Administration Record (MAR), dated June 2024 , the MAR indicated Resident 85 was administered Tylenol 500 mg two tablets on 6/17/24 and 6/22/24 for pain score of 5. Further review of June 2024 MAR indicated Resident 85 was administered Norco one tablet by mouth on 6/1, 2, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 21, 23/2024. for pain score of 1 to 3. During a review of Resident 85's MAR dated July 2024, Resident 85 was administered Tylenol 500 mg two tablets on 7/4, 5, 9, 10, 14, 15, 20, 22/2024 for pain score of 6. Further review of Resident 85's MARs dated June and July 2024 indicated Resident 85 received as needed Norco oral tablet pain medication one tablet by mouth 2 to 5 times daily. During a concurrent interview and record review on 7/24/24, at 9:26 a.m., with Licensed Vocational Nurse (LVN 2), Resident 85's MAR dated July 2024 was reviewed. LVN2 stated Resident 85 frequently complained of general pain. LVN 2 stated when resident frequently asks for pain medication, we notify the physician. LVN 2 stated for pain level 6 Resident 85 needed to receive Norco not Tylenol. LVN 2 stated she would call the physician to reevaluate Resident 85's pain. During a concurrent interview and review of Resident 85's MAR dated June and July 2024, on 7/24/24, at 10:16 a.m., with LVN 3, LVN 3 stated when resident received as needed pain medication routinely, license nurse would reassess resident and notify the physician to reevaluate resident's pain medication. During a concurrent interview and review of Resident 85's physician orders and MARs dated June and July 2024, on 7/24/24, at 11:34 a.m., with Director of Nursing (DON), DON stated licensed nurses are expected to notify the physician to reevaluate resident pain status when as needed pain medications are routinely administered. DON stated Resident 85's physician would be notified. During a concurrent interview and review of Resident 85's MAR dated June and July 2024, on 7/25/24, at 8:57 a.m., with Registered Nurse (RN 2), RN 2 stated the expectation was to follow the physician order of pain level parameter before medication administration. RN 2 stated Tylenol was not given per pain scale level indicated on the physician order. During an interview on 7/25/24, at 9:58 a.m., DON stated the expectation was for licensed nurses to follow physician order and administer pain medication as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055215	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Healthcare & Wellness Center	3030 Webster Street Oakland, CA 94609

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/25/24, at 12:33 p.m., with Licensed Vocational Nurse (LVN6), LVN 6 stated he was Resident 85's on duty nurse in June 2024. LVN 6 stated he was on duty evening and night shift. LVN 6 stated Resident 85 consistently complained of lower leg pain. LVN 6 stated Resident 85 said that his pain level was at 10 when asked. LVN 6 stated he documented Resident 85's pain level as 1 on MAR on 6/1, 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, 17, 20, 23, 24, 25, 26/2024 because LVN 6 stated he felt Resident 85 just wanted the pills and did not have pain. During a review of the facility's policy and procedure (P&P) titled, Administration of Pain Medication, date revised November 2016, indicated, The Licensed Nurse will only administer pain medications according to the physician's order. Review the physician order and administer the pain medications as ordered. Some physician orders may have different medications indicated for different levels of pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50146 Based on observation, interview, and record review, the facility failed to ensure that two of three sampled residents (Residents 54 and 58) were administered medication to meet their needs. Resident 54 was not given two medications as ordered during an observed medication pass and Resident 58 was not giving prescribed eye drops for two days. These failures had the potential to result in residents' medical conditions worsening. Findings: A review of the Admission Record (a document containing the most pertinent information for a resident) for Resident 54, undated, indicated the resident was admitted on ,d+[DATE] with a diagnosis of heart failure. A review of the Physician's Orders for Resident 54, dated July 2024, indicated the resident had orders for Minoxidil 10 milligrams (mg) once daily for hypertension, and Potassium Chloride 20 milliequivalents (mEq) once daily for supplement. A review of the Admission Record for Resident 58, undated, indicated Resident 58 was admitted on , d+[DATE]. A review of the Physician's Orders for Resident 58, dated March 2024, indicated Resident 58 had an order for Latanoprost Ophthalmic Solution 0.005 % Instill 1 drop in both eyes at bedtime for Glaucoma OU, primary open angle. During a concurrent observation and interview on 7/24/24, at 9:05 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed passing medication to Resident 54. Resident 54 was noted with an order for potassium chloride (a medication designed to increase a person's potassium). LVN 3 looked through the medication cart and storage area and was unable to locate the potassium chloride. LVN 3 stated the medication was ordered from the pharmacy and had not arrived yet, so LVN 3 was unable to administer the medication to the resident. LVN 3 then completed the rest of the medication preparation and administered the medications to Resident 54. During a concurrent interview and record review on 7/24/24, at 10:30 a.m., with LVN 3, Resident 54's medication orders for the observed medication pass were reviewed. Resident 54 was noted as having an order for Minoxidil (a medication designed to lower blood pressure). This medication was not observed as being passed to the resident. LVN 3 confirmed that the Minoxidil was not administered to the resident. (continued on next page)

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	055215	A. Building B. Wing	07/25/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/25/24, at 9:41 a.m., with the Director of Nursing (DON), Resident 58's Medication Administration Record (MAR) for March 2024 was reviewed. During the review, the DON stated the MAR indicated Resident 58 did not receive Latanoprost eye drops on 3/29 and 3/30, with two progress notes attached stating that the medication was not available at the time of administration. The DON stated this was a medication error and that all residents should receive medications as ordered by the physician.

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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. 50146 Based on observation, interview, and record review, the facility failed to ensure it maintained a medication error rate of five percent or less. The facility medication error rate was 8.1%, with three errors observed during 37 opportunities. This failure had the potential to result in residents' medical conditions worsening. Findings: During a concurrent observation and interview on 7/24/24, at 9:05 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed passing medication to Resident 54. Resident 54 was noted with an order for potassium chloride (a medication designed to increase a person's potassium). LVN 3 looked through the medication cart and storage area and was unable to locate the potassium chloride. LVN 3 stated the medication was ordered from the pharmacy and had not arrived yet, so LVN 3 was unable to administer the medication to the resident. Continuing the medication pass, LVN 3 prepared two tablets of Vitamin D3 (a medication designed to strengthen bones) 1000 units to administer to Resident 54. LVN 3 then completed the rest of the medication preparation and administered the medications to Resident 54. During a concurrent interview and record review on 7/24/24, at 10:30 a.m., with LVN 3, Resident 54's medication orders for the observed medication pass were reviewed. Resident 54 was noted as having an order for Vitamin D3 2000 [units] 0.5 tab, which is equivalent to 1000 units. LVN 3 stated he believed he had only put one tablet of Vitamin D3 in the medication cup. The surveyor informed LVN 3 that two tablets were observed by both the writer and the consulting pharmacist during observation. Resident 54 was noted as having an order for Minoxidil (a medication designed to lower blood pressure). This medication was not observed as being passed to the resident. LVN 3 confirmed that the Minoxidil was not administered to the resident. LVN 3 stated that not administering medications as ordered to a resident placed them at risk of getting sicker or having a change in condition.

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	055215	A. Building B. Wing	07/25/2024

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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** 50146 Based on observation, interview, and record review, the facility failed to ensure drugs were stored and disposed of in the proper manner. Three boxes of rectal suppositories were expired, and one emergency medication kit was left open and not replaced. These failures had the potential to result in residents receiving ineffective medication. Findings: During an observation on [DATE], at 1:41 p.m., the medication storage room was observed by two Health Facilities Evaluators (HFEs). During the observation, one emergency medication kit (e-kit) was observed as having been opened. The kit contained controlled substances, insulin, and temperature-sensitive suppositories. Further along the observation, three boxes of Bisacodyl suppositories were observed as having an expiration date of ,d+[DATE]. This was confirmed with Licensed Vocational Nurse (LVN) 1. The expired medication was placed with the rest of the over-the-counter medications used by the facility. LVN 1 then checked the reorder log for the e-kits, which revealed a reorder date of [DATE] for the e-kit. LVN 1 stated the expired medication placed residents at a risk of receiving medication that would be ineffective at treating their conditions. During a review of the policy and procedure (P&P) titled, Medication Storage in the Facility, dated [DATE], the policy indicated Outdated, contaminated, or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49091 Based on observation, interview, and facility document review, the facility failed to ensure the oversight of food service operations when the facility did not employ a full-time qualified Dietary Services Supervisor, defined as working 35 hours per week, to manage and oversee food operation services for the facility. This failure had the potential to jeopardize the health and well-being of the 92 of 93 residents who received food prepared in the kitchen. Findings: According to the California Code, Health and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. During an interview on 7/22/24, at 9:15 a.m., with [NAME] 1 (CK 1), CK 1 stated the Kitchen Manager (KM) was not onsite for the initial kitchen tour, and that the KM only worked part-time. During an interview on 7/24/24, at 1:00 p.m., with KM, KM stated she was still in school for the Dietary Services Supervisor (DSS) certification. When asked to present proof of education to manage and oversee facility food operation services, KM showed a ServSafe (foodborne illness and food sanitation training accredited by the National Restaurant Association) certification. KM also stated she was a full-time employee of the facility; and worked in the facility 35 to 40 hours each week. During an interview on 7/24/24, at 1:10 p.m., the Registered Dietitian (RD) stated registered dietary staff were physically onsite at the facility two days a week. During a review of untitled timecard report dated 5/24/24 through 7/24/24 for KM, the report indicated that KM worked the following total hours per week for the last eight weeks: 29.45 hours during the week of 5/27/24 through 6/1/24 27.77 hours during the week of 6/2/24 through 6/9/24 29.68 hours during the week of 6/10/24 through 6/16/24 12.82 hours during the week of 6/17/24 through 6/23/24 17.48 hours during the week of 6/24/24 through 6/30/24 31.72 hours during the week of 7/1/24 through 7/7/24 34.99 hours during the week of 7/8/24 through 7/14/24 16.43 hours during the week of 7/15/24 through 7/21/24 (continued on next page)

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	055215	A. Building B. Wing	07/25/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled,Dietary Services Supervisor/Certified Dietary Manager - Job Description, undated, P&P indicated, Qualifications: Graduate of a California State approved DSS course, CDM certification with title 22 coursework bachelor's degree in a related clinical nutrition field. For a complete list see California Safety Code 1265.4. During an interview on 7/25/24, at 11:31 a.m., with the Administrator (ADM), the RD, and the DON, the ADM acknowledged the RD and KM had been working part-time at the facility, and stated awareness that a ServSafe certification did not qualify the KM to oversee the facility's Dietary Services Department.

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	055215	A. Building B. Wing	07/25/2024

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared and served in a safe and sanitary manner when: 1. A ,d+[DATE] full container of Teriyaki sauce labeled refrigerate after opening was stored in un-refrigerated dry- goods storage 2. A dry food bin marked polenta was ready for use with an expired use-by date, and dry food bins for flour, thickener and grain rice had no use-by dates 3. Two of five cutting boards had deep white scratches 4. A knife rack had sticky brown residue on top 5. An air conditioner unit had thick grey dust on top, and in the air vents 6. The corner of kitchen floor was unclean with food debris buildup These failures placed the residents at risk for food-borne illnesses. Findings: 1. During an initial observation on [DATE], at 9:15 a.m., in the kitchen, a ,d+[DATE] full container of Teriyaki sauce was observed in the dry-storage food pantry, ready for use. On inspection of the back of container, it indicated refrigerate after opening. During an interview on [DATE], at 1:00 p.m., with the Kitchen Manager (KM) and the Registered Dietitian (RD), the KM stated the cook threw out the container of sauce today. KM stated some un-refrigerated liquids can spoil and cause resident illness. During a review of facility's policy and procedure (P&P) titled, Food Storage and Handling, dated [DATE], P&P indicated, Purpose: to store, thaw and prepare food to avoid foodborne illnesses. 2. During an initial observation on [DATE], at 9:17 a.m., in the kitchen, a dry food storage bin labeled polenta was observed in the dry-storage food pantry ready for use, with an expiry date of [DATE]. In addition, three dry food storage bins labeled flour, thickener and grain rice were observed in the dry-storage food pantry ready for use, labeled with open dates only. There were no use-by dates listed on these three bins. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 12:50 p.m., with KM and RD, KM stated the expiration dates on food should be checked to prevent resident foodborne sickness and for the best food flavor and quality. KM also stated there should be use-by dates on all food to monitor how old the food is. KM stated old, expired food can cause illness to the facility residents and make food taste bad. According to USDA (U.S. Department of Agriculture) Food Safety and Inspection Service Food Dating https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating, Microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil .There are two types of bacteria that can be found on food: pathogenic bacteria, which cause foodborne illness, and spoilage bacteria, which do not cause illness but do cause foods to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food not wholesome. When spoilage bacteria have nutrients (food), moisture, time, and favorable temperatures, these conditions will allow the bacteria to grow rapidly and affect the quality of the food. Food spoilage can occur much faster if food is not stored or handled properly. During a review of facility's P&P titled, Food Storage and Handling, datedd [DATE], P&P indicated, Dry Storage Area: label and date all storage products. 3. During an initial observation on [DATE], at 9:17 a.m., in the kitchen, two of five cutting boards were observed with deep white scratches and gashes on them. The cutting boards were in the ready-for-use area next to other clean utensils. During an interview on [DATE], at 12:47 p.m. with KM and RD, RD stated the cutting boards should be changed frequently, and food particles might get into the crevices and cause food-borne illness. A review of the U.S. Food and Drug Administration Federal Food Code 2022 indicated, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. Materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to foods, and under normal use conditions shall be . d. finished to have a smooth, easily cleanable surface; and e. resistant to pitting, chipping crazing, scoring, distortion and decomposition. 4. During a concurrent interview and observation on [DATE], at 9:47 a.m., with KM in the kitchen, a knife-rack on the wall was seen covered in a brown sticky residue. Several of the knives had been removed from the rack. The KM stated the area was unclean, and that dirt and germs may get on the knives, and onto resident food. A review of the U.S. Food and Drug Administration Federal Food Code 2022 indicated, in order to effectively clean and sanitize food contact surfaces, where and when required to satisfy the requirements in Parts , d+[DATE] and ,d+[DATE] of the Food Code, the surface must be first cleaned properly to remove organic material. In most cases this requires use of detergents or other cleaners such as described in Section , d+[DATE].14 of the Food Code. After the surface is clean to sight and touch, a sanitizing solution of adequate temperature with the correct chemical concentration should then be applied to the surface. The sanitizing solution must stay on the surface for a specific contact time as specified in this Code and in accordance with the manufacturer's EPA-registered label, as applicable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055215	A. Building B. Wing	07/25/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an initial observation on [DATE], at 9:20 a.m., in the kitchen, a wall air conditioner unit located opposite the entrance door had grey dust on top and inside all the vents. The air conditioner was blowing air into the kitchen above multiple machines and surfaces. During a concurrent interview and observation on [DATE], at 9:50 a.m., with KM in the kitchen, the air conditioner vents were free of dust. KM stated she had directed staff to clean the dust the day prior, to ensure dust and dirt did not blow onto food or food preparation surfaces. A review of the U.S. Food and Drug Administration Food Code 2022 indicated, Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. 6. During an observation on [DATE], at 8:00 a.m., the kitchen floors were inspected. In one corner, a pest trap and a three-inch area of food and dirt buildup was observed. Directly above this area was a large aluminum countertop, with a ,d+[DATE] inch gap between the right edge of the countertop and the adjacent wall. During a concurrent interview and observation on [DATE], at 9:50 a.m., with KM in the kitchen, the floors were freshly mopped and still wet. The corner area was again seen with the pest-trap and the food/dirt debris. KM stated both the kitchen and the housekeeping/maintenance staff were responsible for cleaning the kitchen, and this area should have been cleaned thoroughly to prevent insects and pest infestation. During are review of facility's P&P titled, Maintenance Service, undated, P&P indicated, as part of their duties, maintenance staff will comply with established infection control precautions. During a review of facility's P&P titled, Cleaning Schedule, undated, P&P indicated, Policy: The dietary staff will maintain a sanitary environment in the dietary department . A review of the U.S. Food and Drug Administration Food Code 2022 indicated, equipment that is fixed because it is not easily moveable shall be installed so that it is: (1) Spaced to allow access for cleaning along the sides, behind, and above the equipment; (2) Spaced from adjoining equipment, walls, and ceilings a distance of not more than 1 millimeter or one thirty-second inch; or (3) sealed to adjoining equipment or walls, if the equipment is exposed to spillage or seepage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36087 Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for one of 40 sampled residents (Resident 41) when Resident 41's Hospice Care (a medical care for people focused on palliation [focused on providing relief from pain and other symptoms of a serious illness] of a terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) Notes were not readily accessible and Hospice Care Visits/Assessments were not accurately documented in resident's electronic medical record. These deficient practices had the potential for Resident 41 to not receive the needed care, services, and treatments due to lack of availability of information to facilitate communication among the Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their patients). Findings: A review of Resident 41's Admission Record printed on 7/24/24, indicated Resident 41 was admitted to the facility in 2019. A review of Resident 41's Physician's Order indicated resident was admitted to hospice care on 5/10/24 for terminal diagnosis of Cerebrovascular Disease (a condition that affects flow of blood in the brain and spine). A review of Resident 41's electronic medical record did not indicate any documentation of Hospice Visits/Assessments. During a concurrent interview and record review on 7/23/24, at 10:40 a.m., with Licensed Vocational Nurse 1 (LVN 1), Hospice Communication Binder (HC Binder) revealed a total of five Hospice Notes documentations dated 5/17/24, 5/24/24, 5/30/24, 6/6/24, 6/28/24, and 7/23/24. LVN 1 stated Hospice Nurse visited the resident in the facility on Mondays, Wednesdays, and Fridays, and documented on their tablet (a small portable computer), later signed digitally by the facility nurse on duty. LVN 1 stated there were no Progress Notes entered by facility nurses on resident's electronic medical record. During a concurrent telephone interview and record review on 7/25/24, at 10:27 a.m., with the Hospice Clinical Director (HCD), facility's Hospice Communication Binder (HC Binder) was discussed via the telephone. HCD stated Resident 41 should have Hospice Notes available in the HC Binder. HCD further stated Hospice Nurses were expected to write notes of each resident visit on the HC Binder and facility could request copies of Hospice Progress notes via fax thru the Hospice Medical Records (HMR). A review of the facility's policy and procedure (P&P) titled, Hospice Care of Residents, revised date January 1, 2012, indicated, Documentation .Hospice Notes will be included in the Facility Progress Notes .All documentation concerning hospice services will be maintained in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055215	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Healthcare & Wellness Center	3030 Webster Street Oakland, CA 94609

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49983 Based on observation, interview, and record review, the facility failed to provide effective pest control for two out of 93 residents. This failure had the potential to result in residents being bothered by roaches. Findings: During an interview on 07/22/24, at 10:18 a.m., Resident 88 stated there was an issue with roaches in her room. Resident 88 stated she noted a roach under her lunch tray several days ago and she notified the MDS Coordinator (MDSC). During an interview on 7/22/24, at 10:49 a.m., MDSC stated that Resident 88 notified her about roaches several days ago and MDSC brought it up in the facility 24 hour meeting and in a group message that included Maintenance Staff (MS) and Environmental Supervisor (ES). During a concurrent observation and interview on 7/22/24, at 11:57 a.m., Resident 55 stated there were roaches in his room, and he had reported them on several occasions to staff members, including to Licensed Vocational Nurse 6 (LVN6). A small live roach, approximately the length of a dime, was observed on the floor in Resident 55's room. During an interview on 7/22/24, at 3:01 p.m., LVN6 stated that Resident 55 had complained of roaches in his room. During an observation on 7/23/24, at 10:10 a.m., in the shared bathroom between the rooms for Resident 55 and Resident 344, two small roaches, about four millimeters long, and one-inch-long dead cockroach were observed on the bathroom floor. A buildup of old dirt in the corners of the bathroom, approximately six inches wide by four inches high, was observed. During an interview on 7/24/24, at 11:40 a.m., MS stated that if a resident reported a cockroach to staff, the staff should record it in the maintenance log. MS stated that if a report is not made in the maintenance log, there is a risk that he could forget. MS stated that cockroaches were recently discussed in the 24 hour meeting and in a group text message. MS stated that after the resident found roaches, the pest elimination company should have been called right away. During a concurrent interview and record review on 7/24/24, at 11:50 a.m., with MS, the Maintenance Log for the past several months was reviewed. MS stated that the Maintenance Log indicated that Resident 88's report of roaches was not recorded. MS stated that the report should have been included in the maintenance log so that it is not missed. During an interview on 7/24/24, at 12:03 p.m., with ES, ES stated that he saw cockroaches in Resident 88's room several days ago and he notified MS. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 7/25/24, at 9:02 a.m., with the Pest Control Technician (PCT) from Matrix Pest Control, PCT stated the facility is scheduled for two pest control visits each month. PCT stated they would have only gone into the rooms listed on the invoice. During a concurrent interview and record review on 7/25/24, at 9:55 a.m., with the Director of Nursing (DON), the pest control invoices from 7/11/24, 6/27/24, 6/14/24, 5/28/24, 5/13/24, 4/25/24, 4/12/24, 3/26/24, 3/14/24, 2/16/24, 2/6/24, 1/19/24, and 1/11/24 were reviewed. The DON stated Resident 55's room was not listed on the invoices. During an interview on 7/25/24, at 10:50 a.m., Resident 55 stated that he had never refused to allow the pest control company to enter his room. Resident 55 stated that he desired to have pest control services provided. During an interview on 7/25/24, at 10:59 a.m., with the Social Services Director (SSD), SSD stated that Resident 55 had repeatedly complained of roaches in his room. During an interview on 7/25/24, at 11:13 a.m., with PCT, PCT stated that all rooms he was requested to service were treated for pests and no residents refused pest control services during his last visit on 7/11/24. During a review of the facility's policy and procedure (P&P) titled, Pest Control, dated January 1, 2012, P&P indicated, facility staff will report to the Housekeeping Supervisor any sign of rodents or insects, including ants, in the Facility. The Housekeeping Supervisor takes immediate action to remove the pests from the Facility. If necessary, after informing the Administrator, the Housekeeping Supervisor will call the extermination company for assistance.