STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055156	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul's Towers	100 Bay Place Oakland, CA 94610

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50474 Based on observation, interview and record review, the facility failed to ensure standards of professional practice were maintained during medication administration for one of two sampled residents (Resident 80) when licensed nurse left Resident 80's Oxycontin tablet (a controlled substance used to treat moderate to severe pain) on top of the medication cart unattended. This failure had a potential for unauthorized access to the medication that could lead to harm or drug diversion (occurs when a medication is taken for use by someone other than whom it is prescribed). Findings: During a record review of Resident 80's Admission Record (AR) dated 9/12/24, the AR indicated Resident 80 had multiple diagnoses including intervertebral disc disorder of lumbar region (a disease that can cause low back pain) and scoliosis of lumbar region (a condition that caused by abnormal side-ways curve of the spine in the lower back causing pain and discomfort). During a record review of Resident 80's Medication Administration Record (MAR) dated 9/1/24 to 9/30/24, the MAR indicated Resident 80 had a routine order of Oxycontin Oral Tablet ER 12-hour Abuse-Deterrent 10 milligrams (mg) Oxycodone HCl) Give 1 tablet by mouth two times a day for severe pain. During a medication pass observation on 9/10/24 at 8:51 a.m. with Registered Nurse (RN) 2, in the hallway, RN 2 prepared Resident 80's one tablet of Oxycontin 10 mg and transferred to a medication cup. RN 2 placed the medication cup with Oxycontin tablet inside on top of the medication cart. RN 2 stated she forgot to ask Resident 80's pain level prior to preparing the Oxycontin tablet. RN 2 then entered Resident 80's room and left the Oxycontin tablet unattended on top of the medication cart. During a medication pass observation on 9/10/24 at 8:56 a.m. with RN 2, RN 2 came back to the medication cart and prepared the rest of Resident 80's medications. RN 2 was observed placing Resident 80's pills in the same medication cup together with the Oxycontin tablet. RN 2 washed hands and entered Resident 80's room for medication administration. (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/24 at 9:18 a.m. with RN 2, RN 2 stated she should have not left the Oxycontin unattended on top of the cart. RN 2 stated the medication should have been stored inside the locked medication cart or she should have brought the Oxycontin pill with her when she went back inside Resident 80's room to assess her pain level. RN 2 stated leaving the Oxycontin, a controlled substance, unattended was dangerous and had the risk of someone taking it. During an interview on 9/10/24 at 2:34 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse should have never left the medication on top of the medication cart unattended. The DON stated it was not up to their standards of nursing practice to leave the medications out of sight because they could have been taken by another resident or person unauthorized. During a record review of the facility's policy and procedure (P&P), titled, Medication Administration Controlled Substances, dated 1/23, the P&P indicated, Controlled Medications are substances that have an accepted medical use .have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. During a record review of the facility's P&P, titled, Medication Administration General Guidelines dated 1/23, the P&P indicated, During administration of medication, medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on the top of the cart.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50474 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 82) was free from unnecessary drug when Resident 82's PRN (pro re nata [a Latin phrase], meaning as needed, or as necessary) order for Oxycodone-Acetaminophen (a controlled substance used to help relieve moderate to severe pain) had no clear indications when to give one tablet versus two tablets. This failure had the potential to result in unnecessary use of Oxycodone-Acetaminophen medication without proper indication, placing Resident 82 at risk for adverse side effects and health safety issues. Findings: During a record review of Resident 82's Medication Administration Record (MAR), dated 8/1/24 to 8/31/24 and 9/1/24 to 9/30/24, the MAR indicated Resident 82 had an order of Oxycodone-Acetaminophen Oral Tablet 5-325 milligrams/mg (Oxycodone with Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain take one tab to two tabs for pain with start date of 8/18/24. During a record review of Consultant Pharmacist's (CP) Medication Regimen Review (MRR, includes review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities) for Resident 82, dated 8/21/24, the MRR indicated Nursing staff should have clear indications when to give one dose versus another. for Resident 82's Oxycodone-Acetaminophen order. During a concurrent interview and record review on 9/12/24 at 8:30 a.m. with Registered Nurse 1 (RN 1), CP's MRR for Resident 82 was reviewed. RN 1 stated she received and reviewed the MRR for Resident 82. RN 1 stated Resident 82's PRN Oxycodone-Acetaminophen order was not corrected according to the CP's recommendation. RN 1 stated they should have followed the CP's recommendation because Resident 82 could have received an unnecessary dose of Oxycodone-Acetaminophen. During a phone interview on 9/12/24 at 10:12 a.m. with CP, CP stated Resident 82's PRN Oxycodone-Acetaminophen order should have included a clear indication when to give one tablet versus two tablets of Oxycodone-Acetaminophen for Resident 82's pain. CP stated the order was confusing for the licensed nurses to follow and Resident 82 had the potential to receive unnecessary dose of Oxycodone-Acetaminophen that could have led to adverse effects like sedation. During a record review of the facility's Policy and Procedures (P&P), titled, Medication Therapy revised in June 2023, the P&P indicated, Each resident's drug/medication regimen must be free from unnecessary drugs .An unnecessary drug is any drug when used . d. Without adequate indications for its use . The P&P further indicated, Upon or shortly after admission and periodically thereafter, the staff and practitioner (assisted by consultant pharmacist) will review an individual's current medication regimen to identify .a. There is a clear indication for treating that individual with the medication .b. The dosage is appropriate .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50474 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 10) was free from unnecessary psychotropic drugs (medications that are capable of affecting the mind, emotions, and behavior) when Resident 10's PRN (pro re nata [a Latin phrase], meaning as needed, or as necessary) order for Temazepam (used on a short-term basis to treat difficulty falling asleep or staying asleep) had no end date and rationale for continued use beyond 14 days. This failure had the potential to result in unnecessary prolonged use of a psychotropic medication, placing Resident 10 at risk for adverse side effects and health safety issues. Findings: During a record review of Resident 10's Order Summary Report (OSR), dated 5/20/24, OSR indicated, Temazepam Oral Capsule 15 milligrams (mg) . Give 1 capsule by mouth every 24 hours as needed for insomnia related to primary insomnia The OSR further indicated, Communication Method - Prescriber Written, with Order Status that indicated Active, and Start Date of 5/15/24. The OSR End Date was blank. During a record review of Resident 10's History and Physical (H&P), dated 5/28/24, the H&P indicated past medical history of L3 compression fracture (a break in one of the bones in lower spine). The H&P also included an Assessment, that indicated, Insomnia - continue with Temazepam as needed . During a record review of Consultant Pharmacist's (CP) Medication Regiment Review (MRR, includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities) dated 6/13/24, the MRR indicated, per regulation, all PRN psychotropic medications required a stop date and if longer than 14 days was required, a rationale and a new stop date was required from the physician. MRR further indicated to include a stop date to Resident 10's PRN Temazepam order. During a record review of MRR, dated 7/29/24, the MRR indicated CP had the same recommendation from the previous MRR to include a stop date for Resident 10's PRN Temazepam. During a record review of Resident 10's Care Plan, dated 5/22/24, the care plan indicated The resident is on sedative/hypnotic therapy (Temazepam) related to insomnia manifested by inability to sleep. During a concurrent interview and record review on 9/12/24 at 8:23 a.m. with Registered Nurse (RN) 1, the MRR was reviewed. RN 1 stated she received the recommendation from the CP on 8/7/24. RN 1 stated she sent an e-mail to Medical Doctor 1 (MD 1) for advice regarding the stop date for Resident 10's PRN Temazepam. RN 1 stated MD 1 ordered to discontinue the Temazepam instead of putting a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/12/24 at 9:48 a.m. with the Director of Nursing (DON), the DON stated she did not find a documentation from MD 1 with rationale for continued use of the PRN Temazepam for Resident 10. The DON further stated they were just following MD 1's order to continue the use of PRN Temazepam with no stop date. During a concurrent phone interview and record review on 9/12/24 at 10:03 a.m. with CP, the MRR was reviewed. CP stated she made the recommendations twice to the facility to put a stop date on Resident 10's PRN Temazepam because per regulation of psychotropic use, it should have had a stop date when it was first ordered by MD 1. CP stated MD 1 should have had a valid rationale for the continued use of Temazepam. CP further stated it was necessary to put a stop date for PRN Temazepam because an indefinite use of this medication could have had an unnecessary side effect in Resident 10's brain. During an interview on 9/12/24 at 10:22 a.m. with MD 1, MD 1 stated the use of PRN Temazepam was indicated to treat Resident 10's inability to sleep. MD 1 stated he reviewed the CP's recommendation to put a stop date for Resident 10's PRN Temazepam. MD 1 stated he did not order a stop date for Temazepam because it was not a psychotropic drug. During a record review of the facility's Policy and Procedures (P&P), titled, Medication Therapy revised in June 2023, the P&P indicated, Each resident's drug/medication regimen must be free from unnecessary drugs .An unnecessary drug is any drug when used . b. for excessive duration; or . f. a psychotropic drug is any drug that affects brain activities with mental processes and behavior. These drugs include . j. Hypnotic. The P&P further indicated, Excessive Duration means the medication is administered beyond .the length of time advised by current standards of practice, clinical practice guidelines .and/or without either evidence of additional therapeutic benefit for the resident or clinical evidence that would warrant the continued use of the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46487 Based on observation, staff interview, and record review, the facility failed to store and prepare food in accordance with professional standards for safety when: 1. A braising pan, a rolling pin, three storage bins, a citrus juicer, a kitchen drawer, and a juice dispenser machine had black particles/residue or chipped paint, 2. Nine balsamic dressing containers, cut lettuce, cut tomatoes, mayonnaise, bag of bread, mozzarella cheese, burrata cheese, and a bag of prosciutto had no use-by date or had beyond use-by-dates, 3. Three compartment sink's pipe had a leak and a toilet plunger was stored under the three-compartment sink (a sink with three compartments that allows kitchen staff to wash, rinse, and sanitize dishes), and 4. Gloves used to wash dishes in the three-compartment sink were stored on top of the left corner of the three-compartment sink wastewater tank (a wastewater tank stores and treats wastewater from the sink in the tank before releasing the wastewater to the environment). These failures had the potential for contamination of food resulting in food borne illness for 24 residents who received food from the kitchen. Findings: 1. During an observation and interview with Dietary Manager (DM) during the kitchen's initial tour, on 9/9/24, at 9:37 a.m., a rectangular braising pan was observed with black residue build-up around its outer sides and black residue built up around its inner upper third surface. DM stated the pan was used as a braising pan (a pan that can be used for browning and simmering food). A rolling pin was observed with scattered black discoloration all over the body and handles of the rolling pin. The DM stated the rolling pin was used for baking. Three white bins with scattered grayish dust residue build up in front of the bins were observed. DM stated the bins were used to store molds and scoops that were used for preparing food. Upon opening the bins' drawers, an orange-colored manual citrus juicer with paint peeling off all over the outside and the inside parts of the juicer was observed in one drawer. Another drawer used to store 2 scoop spoons had scattered small black particles on the bottom of the drawer. During an observation of the kitchen and interview with the DM 9/9/24, at 10:30 a.m., the juice dispenser machine was observed with scattered black particles on the bottom of the surrounding area where the juice dispenser containers were attached. When DM wiped the black particles with his finger, he agreed it was dirt. DM stated they did not have a documentation of dates when the juice machine was cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 Federal Food Code, food-contact surfaces are to be clean to sight and touch, the food-contact surfaces of cooking equipment and pans are to be kept free of encrusted grease deposits and other soil accumulations, and nonfood-contact surfaces of equipment is to be kept free of an accumulation of food residue and other debris. 2. During an observation and interview with Dietary Manager (DM) during the kitchen's initial tour on 9/9/24 at 9:32 a.m., in the salad refrigerator, nine small containers of balsamic dressing were found with no use-by date. Also, cut lettuce, cut tomatoes and mayonnaise in separate metal containers were found with no use-by date. During an observation on 9/9/24 at 9:53 a.m., the cheese box refrigerator was observed with one opened bag of bread with use-by date of 9/4/24; one container of mozzarella cheese labeled with use-by date of 8/30/24; and one opened container of burrata cheese not labeled with the use-by date. During an observation and interview on 9/9/24 at 10:00 a.m., with the DM, one opened bag of prosciutto meat with no label of the use-by date was found in the meat box refrigerator. DM stated all opened food in the fridge should have use-by dates once opened and should not be kept in refrigerator after the use by date. During an interview on 9/10/24 at 1:37 p.m., with Registered Dietician (RD), RD stated food in the refrigerators should have use by dates. RD stated the residents were at risk of salmonella (a bacteria that can make one sick) if the cheeses and prosciutto did not have a use by date. RD further stated the juice dispenser should had been cleaned to prevent residents' sickness due to the risk of juice contamination. 3. During a kitchen observation and interview with DM on 9/9/24 at 9:42 a.m., the three-compartment sink was observed. The bottom right pipe under the third sink was leaking and a rectangular metal tray on the floor was used to capture the pipe's leaking water. The floor under and around the three-compartment sink was observed to be wet. A black toilet plunger was stored under the sink. DM stated he had already reported the leak and was waiting for repairs. During an interview on 9/10/24 at 12:46 p.m. with DM, DM stated the plunger was probably used by the kitchen staff when the three-compartment sink was clogged. DM acknowledged the toilet plunger should not be stored in the kitchen due to risk of cross contamination. During an interview on 9/10/24 at 1:37 p.m., with RD, RD stated risk of the leaking pipe, the wet floor and the toilet plunger stored under the sink was cross contamination. 4. During an observation on 9/9/24 at 9:42 a.m., a pile of dishwashing gloves was observed on top of the left corner of the three-compartment sink wastewater tank. During an interview on 9/10/24 at 12:46 p.m. with DM, DM stated it was a bad habit of the kitchen staff to store the gloves on top of the wastewater tank after they were used to wash the dishes. DM stated the staff used the gloves again to wash the dishes the following day. DM stated the risk of this bad habit of the kitchen staff was cross contamination. According to the 2022 Federal Food Code, multiuse gloves must be washed, rinsed, and sanitized between activities that contaminate the gloves.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46487 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when the dumpsters were not closed and a laundry bin was used as garbage receptacle. This failure had the potential of harborage and feeding of pest. Findings: During an observation on 9/9/24 at 11:10 a.m., with Environmental Services Manager (ESM), three dumpsters located by the side of the facility were full of trash bags and were not closed or covered. A laundry bin designated for use of the residents' soiled laundry was filled with bags of trash. During an interview on 9/09/24 at 10:53 a.m., with ESM, ESM stated the dumpsters should be covered. ESM stated the laundry bin for soiled laundry should not be used as a garbage receptacle. During an interview on 9/10/24 at 1:37 p.m., with Registered Dietician (RD), RD stated the garbage dumpsters' lids should be closed to prevent pests and rodents' infestation. During a review of the facility's policy and procedure (P&P) titled, Food-Nutrition Services, revised August 2022, the P&P indicated, . The SNF (skilled nursing facility) will properly dispose of garbage and refuse, maintaining containers in good condition (no leaks) with lids or otherwise covered .Garbage storage areas will be maintained in a sanitary condition to prevent harboring and feeding of pests. According to the 2022 Federal Food Code, receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing FOOD residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.