

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/10/2026
NAME OF PROVIDER OR SUPPLIER  Shields Richmond Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1919 Cutting Blvd Richmond, CA 94804	

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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was discharged in a safe manner to another skilled nursing facility when discharging facility did not receive confirmation of agreement to admit Resident 1 from the receiving facility before Resident 1 was discharged and transferred. This failure resulted in the inability for Resident 1 to be accepted for admission at the receiving facility and for Resident 1 being sent to the GACH emergency department. During a review of Resident 1's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/2/25, the MDS indicated Resident 1'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 fifteen is an indication of intact cognitive status.) score was 09 and indicated moderately impaired mental status. MDS indicated Resident 1 was not able to recall the correct year, month, and day of the week. MDS indicated Resident 1 had clear speech, was able to express ideas and wants, made self understood and understood others. MDS indicated Resident 1's diagnoses included Traumatic Brain Injury, hemiplegia and hemiparesis (stroke). During a review of Resident 1's Notice of Proposed Transfer/Discharge (T&amp;D), dated 1/2/26, the T&amp;D indicated, Transfer or discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by this facility During an interview on 3/5/26, at 11:15 a.m., with Social Services (SS), SS stated Resident 1's responsible party (RP), requested facility transfer Resident 1 to another nursing home. SS stated RP did not want Resident 1 to stay at the facility. SS stated RP did not like facility in the first instance. During an interview on 3/5/26, at 1:37 p.m., with SS, SS stated facility did not receive confirmation from receiving facility of Resident 1's admission before Resident 1 was discharged and transferred. During an interview on 3/10/26, at 12:20 p.m., with Director of Nursing (DON), DON stated Resident 1's RP requested Resident 1 receive more rehabilitation therapy (a process of regaining independence and quality of life). DON stated facility provided Resident 1 physical, occupational therapy including speech therapy as ordered by the physician. DON stated Resident 1 was referred for more therapy and was denied. During an interview on 3/10/26, at 12:51 p.m., with Administrator (Admin), Admin stated RP did not want Resident 1 to reside at the facility and requested discharge. Admin stated facility sent letter of admission agreement to the receiving facility. Admin could not provide documentation of confirmation of admission before facility discharged and transferred Resident 1. During a review of the facility's policy and procedure (P&amp;P) titled, Transfer or Discharge, Facility-Initiated, dated October 2022, the P&amp;P indicated, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified.</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interview and record review, the facility failed to provide services to maintain grooming and personal hygiene for one of three sampled residents (Resident 1) when; Resident 1 was not given showers as scheduled by the facility. This failure placed Resident 1 at risk for poor hygiene, body odor, infection, and transmission of diseases. During a review of Resident 1's admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/2/25, the MDS indicated Resident 1'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 BIM score of fifteen is an indication of intact cognitive status.) score was 09 and indicated moderately impaired mental status. MDS indicated Resident 1 needed maximal assistance for shower, helper does more than half the efforts, helper lifts, holds trunk or limbs and provides more than half the efforts. MDS indicated Resident 1's diagnoses included Traumatic Brain Injury, hemiplegia and hemiparesis (stroke). During a review of Resident 1's care report titled, Documentation Survey Report, dated December 2025, indicated Resident 1 did not receive a shower on 12/6/25, 12/13/25, 12/17/25, and 12/24/25. During an interview on 3/5/26, at 1:46 p.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated facility process was to provide residents shower as scheduled, complete shower sheets, document refusal of showers and notify the charge nurse. During a concurrent interview and record review on 3/5/26, at 1:38 p.m., with Director of Nursing (DON), the facility's schedule titled, AM Shift Shower Schedule, dated 5/2020, and documentation survey report dated December 2025 were reviewed. The schedule indicated Resident 1 was scheduled to receive a shower twice a week, on Wednesdays and Saturdays. The DON stated staff should offer Resident 1 shower two times a week and if Resident 1 refused, notify charge nurse and document in Resident 1's record. DON could not provide documentation that CNAs offered Resident 1 showers as scheduled and reports Resident 1's refusal to shower to charge nurses. During a review of facility's policy and procedure (P&amp;P) titled, Bath, Shower/Tub, revised February 2018, the P&amp;P indicated, Documentation if the resident refused the shower/tub bath, the reason(s) why and the intervention taken. The signature and title of the person recording the data. Notify the supervisor if the resident refuses the shower/tub bath. Notify the physician of any skin areas that may need to be treated. Report other information in accordance with facility policy and professional standards of practice.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor. This failure placed facility residents at risk of unplanned weight loss, a consequence of poor food intake. During an interview on 3/5/26, at 10:45 a.m., with Resident 2, Resident 2 lay in bed in his room awake and verbally responsive. Resident 2 stated that he has his own stack of food kept at his bedside because sometimes the food served is not edible. Resident 2 stated, for example, French fries were hard and unable to be eaten, meat served for dinner was very tough. Resident 2 stated he was not able to cut the meat with a knife. Resident 2 stated he had reported to nursing staff and Dietary Supervisor (DS). During an interview on 3/5/26, at 11:52 a.m., with Dietary Supervisor (DS), DS stated she was recently hired. DS stated she was not aware of any food concerns. During an interview on 3/5/26, at 2:10 p.m., with Consultant Dietician (RD), RD stated she was aware of complaint about food served being salty. RD stated she discussed the food complaint with the former DS. RD stated she was recently hired. During a concurrent observation and interview on 3/10/26, at 12:40 p.m., with DS, a sample tray was tested. The brussels sprouts were bland, the turkey was salty and the mashed potato was not creamy. During test tray, DS stated brussels sprouts were bland. DS stated mashed potato was not creamy because bagged frozen potato was used to make the mashed potato.</p>		