STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055775	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orinda Care Center, LLC	11 Altarinda Road Orinda, CA 94563

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. 32717 Based on observation, interview and record review, the facility failed to ensure a clean, orderly homelike environment when: -Resident rooms had build-up of white crumbs on the floor and personal items like disposable briefs and pillows were piled on a chair at the bedside. -There was insufficient supply of bath towels, face towels, and bed linens available for residents to use. Based on observation, interview and record review, the facility failed to ensure a clean, orderly homelike environment when: -Resident rooms had build-up of white crumbs on the floor and personal items like disposable briefs and pillows were piled on a chair at the bedside. -There was insufficient supply of bath towels, face towels, and bed linens available for residents to use. This failure had resulted in unsanitary and uncomfortable environment for residents and negatively impact their dignity, comfort and safety. Findings: During a concurrent observation and interview on 3/20/25 at 10:32 a.m. with Resident 3, Resident 3 stated there were not enough supplies at the facility. There were white crumbs on the floor, three pillows and a disposable brief piled on a regular chair at Resident 3's bedside rather than stored appropriately or used for resident comfort. During a review of Resident 3's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 2/14/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen is an indication of intact cognitive status) score of 15. A BIMS score of 13-15 is an indication of intact cognitive status. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/20/25 at 12:25 p.m. with Resident 3, Resident 3 stated they have not cleaned the room yet. The lunch trays were at the bedside, there was still a pile of pillows and disposable brief in the chair. During an interview on 4/9/25 at 11:19 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated there has been shortage of linens and towels since December 2024. CNA 1 stated using disposable dry wipes to dry the residents after shower. She also stated finding mattress covers for eight of her residents was also a challenge, and out of the eight beds she had to make today, CNA 1 stated only three beds were made. During an observation on 4/9/25 at 11:24 a.m., the clean linen closet had several gowns, three pillowcases, three mattress covers, and several top sheets but there were no towels. During an interview on 4/9/25 at 11:32 a.m. with Director of Staff Development (DSD), DSD stated the CNAs have been complaining of not having enough supplies like towels. DSD stated some scheduled showers were moved to the pm shift and pm shift CNAs have complained they did not have enough towels to use for the residents. During a concurrent observation and joint interview and review of monthly inventory on 4/9/25 at 11:42 a.m. with Laundry Aide (LA) and Housekeeping Manager (HM), HM stated there were four scheduled laundry delivery for the resident care areas, first three at 7 a.m., 9:00 a.m., 11 a.m. for the morning shift, and 2 p.m. for the pm shift. LA stated there were no bath and face towels delivered at 7 a.m., 9 a.m., and 11 a.m. because she did not have anything in the laundry. There were two clean, folded bath towels on the folding table, LA stated that was all she had in addition to whatever was in the drier. LA then pulled out the clean and dried laundry from the drier and found four bath towels and two face towels. LA stated she would have 6 bath towels and 2 face towels to deliver to the resident care areas. Review of the Monthly Linen Inventory dated 4/1/25 indicated, for a resident census of 46, the facility needed: 276 bath towels, the facility had total of only 14 towels; 460 wash cloths, facility had 109 wash cloths; 92 bedspreads, facility had 6 bed spreads; 92 blankets, facility had 66 blankets; 138 bath blankets, facility had 62 bath blankets.

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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** 32717 Based on interview and record review, for one of three sampled residents (Resident 3), the facility failed to ensure Resident 2 received treatment and care in accordance with professional standards of practice when: -A stage 2 pressure ulcer (also known as bedsores or pressure sores, are localized skin and soft tissue injuries caused by prolonged pressure, often over bony areas, resulting in reduced blood flow and potential tissue damage) on a bony prominence (a part of the skeleton where a bone is close to the surface of the skin) was assessed as a skin tear. This failure had the potential to result in delayed management of the wound. -Resident 2's foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) was changed from F16 to F18 (Foley catheters are sized using the French (Fr) system, F18 catheter is larger than a F16 catheter) without a physician's order. This failure had the potential to result in unnecessary tissue trauma. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cord compression (occurs when pressure is applied to the spinal cord, the central nervous system pathway connecting the brain to the rest of the body) and benign neoplasm of pituitary gland (a noncancerous growth, also known as a pituitary adenoma, on the pituitary gland. These tumors are extremely common and usually don't spread beyond the pituitary gland). During a review of Resident 3's Braden Scale for Predicting Pressure Sore Risk dated 2/17/25 indicated a score of 13. A score of 13 is an indication of moderate risk to develop pressure sore. During an interview on 3/20/25 at 2:23 p.m. with Treatment Nurse (TN), TN stated, on 2/18/25, a Certified Nursing Assistant (CNA) told her Resident 3 had a wound on the coccyx. TN stated, at the time, the skin on the area appeared thin and had darkened area surrounding the wound, TN thought it was a skin tear. TN stated, two days later, the wound doctor was in the facility and assessed Resident 3's wound as a stage 2 pressure ulcer. During a review of Resident 3's Health Status Note dated 2/18/25, the Health Status Note indicated Resident 3 had a skin tear on the coccyx that measured 7 centimeters (cm) x 7 cm. During a review of Resident 3's Skin & Wound Evaluation dated 3/14/25 (almost 4 weeks later), the Skin & Wound Evaluation indicated Resident 3's coccyx (tailbone) pressure ulcer was a Stage 4 that measured 5.7 cm x 5.7 cm. During an interview on 3/20/25 at 1:29 p.m. with Director of Nursing (DON), DON stated there was no care plan to address Resident 3's risk for development of a pressure ulcer despite the moderate risk and Resident 3's limited mobility. DON also stated the stage 2 pressure ulcer that developed on Resident 3's coccyx was incorrectly identified as a skin tear. (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 review of Resident 3's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 2/14/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen is an indication of intact cognitive status) score of 15. A BIMS score of 13-15 is an indication of intact cognitive status. During an interview on 3/20/25 at 11:54 a.m. with Resident 3, Resident 3 stated feeling concerned about the staff not being able to care for Resident 3's foley catheter. Resident 3 stated the licensed staff did not seem to know what to do with the foley catheter that Resident 3 had to be transferred to the hospital catheter issues. During a joint interview on 4/8/25 at 2:45 p.m. with DON and TN, TN stated when she came to work on 2/25/25, Resident 3's foley catheter was a different size than what was ordered. TN stated a Progress Note dated 2/22/25 indicated, the foley catheter change to a F18 was ordered by a Nurse Practitioner (NP) who was in the facility. TN stated writing the order for F18 and transcribed in the Treatment Administration Record (TAR). Review of the TAR for February 2025 indicated both F16 and F18 foley catheter were signed off every shift by licensed nurses. DON stated there was no written physician's order for the change in foley catheter size in the clinical record. DON also stated the order for F16 should have been discontinued and should have been reflected in the TAR. DON stated having two orders of different sizes of foley catheter could be confusing because licensed nurses would not know which one to use the next time the foley catheter had to be changed. During a telephone interview on 4/10/25 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the NP told Resident 3 that the foley catheter would be changed to F18. LVN 1 confirmed changing Resident 3's foley catheter to a F18 but could not recall how she wrote the verbal order, or if it was written and transcribed at all. LVN 1 stated she did not discontinue the previous order because she did not think the order needed to be discontinued. LVN also stated she did not clarify the order because the NP was Rushing to leave.