STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056103	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Bay Nursing and Rehabilitation Center	508 Westline Drive Alameda, CA 94501

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) received the correct medications and instructions upon discharge. The failure to follow discharge orders for medications had the potential to result in Resident 2 attempting to self-administer an injectable medication for prevention of blood clots without instruction on side effects or administration. This had the potential to result in injury and excessive bleeding. Findings: During a review on 8/28/24 at 3:40 p.m., Resident 2 ' s facility Facesheet was reviewed. The Facesheet indicated Resident 2 was admitted to the facility in July 2024 and discharged [DATE]. Resident 2 had diagnoses of diabetes mellitus (Diabetes is a chronic (long-term) disease in which the body cannot regulate the amount of sugar in the blood.) and chronic kidney disease (when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body ' s needs). A review of Resident 2 ' s facility physician active orders for August 2024 indicated an order for heparin (medication used to prevent blood clot formation) to be given by injection twice a day. During a concurrent interview and record review on 8/28/24 at 3:44 p.m., with the Assistant Director of Nurses (ADON), Resident 2 ' s Discharge Summary and Discharge Instructions were reviewed. The Discharge Summary and Discharge Instructions were sent by fax and dated 8/22/24 at 8:10 a.m. The ADON stated the records showed heparin was not on the ordered discharge medication list. A review of Resident 2 ' s physician Discharge Summary dated 8/22/24, indicated the following medications were to be given after discharge: nicotine (to assist with smoking cessation), insulin (an injectable medication for control of blood sugar), amlodipine (for high blood pressure), acetaminophen (pain medication), docusate (stool softener), bisacodyl (suppository for constipation), trazadone (sleep medication), multivitamins, timolol (eye medication), atorvastatin (cholesterol medication), lantanoprost (eye medication). The Summary did not indicate heparin was to be administered after discharge. (continued on next page)

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

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 4:24 p.m., with the Nurse Supervisor (NS), NS stated she had been the discharge nurse for Resident 2. NS stated the night shift before Resident 2 ' s discharge had completed the Discharge Medication List. NS stated she had been unable to find the Discharge Summary to check the Discharge Medication List. NS stated she had checked the facility active orders and verified the active orders were in agreement with the night shift generated Discharge Medication List. NS stated she discharged Resident 2 with the heparin for home use. During a concurrent interview and record review on 8/28/24 at 4:00 p.m., with the ADON, the paper chart for Resident 2 was reviewed. The ADON stated the facility policy was to provide residents with a list detailing their discharge medications, have them sign it, and to put a copy in the chart. The ADON was unable to provide documentation of a Resident 2 signed copy of written discharge medications list. During a phone interview on 8/27/24 at 11:30 a.m., Resident 2 stated when he was discharged from the facility, he received a blood thinner. Resident 2 also stated his doctor called and told him he should not have received the medication and should not take the medication. During a phone interview on 8/27/24 at 12:00 p.m., the Family Member of Resident 2 (FM 2) stated Resident 2 was sent home with a medication called heparin. During a review of facility policy titled, Discharge and Transfer of Residents, dated [DATE], the policy indicated that during discharge, the licensed nurse should discuss with the resident or their representative his/her pre-placement medications and reconcile to post discharge medications. During a review of facility policy titled, Discharge and Transfer of Residents, revised 10/14, indicated, The Discharge Summary/Post Discharge Plan will include documentation from the IDT (Interdisciplinary Team, a team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.) regarding transfers or discharges, and the following information as applicable: . Medications: Including all prescription and over-the-counter medications to be taken by the resident with information on dosage, frequency of administration, and recognition of common significant side-effects.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on interview and record review, the facility failed to provide assistance for one (Resident 1) of two sampled residents who made reports of lost items. The failure to investigate or assist with replacement of the reported loss of Resident 1 ' s hearing aids resulted in Resident 1 not having use of hearing aids, potentially causing difficulties with medical and social interactions. Findings: During a review of Resident 1 ' s Facesheet, printed 8/28/24, the Facesheet indicated Resident 1 was initially admitted to the facility in July 2024, with a diagnosis of hypertension (high blood pressure). The Facesheet indicated Resident 1 was his own responsible party, with three family members as alternate responsible parties. During a review of Resident 1 ' s facility documents titled, Inventory Lists, dated 7/31/24, 8/2/24, 8/10/24, 8/28/24, the Lists dated 7/31/24, 8/2/24, 8/10/24 all indicated Resident 1 had hearing aids. The List dated 8/28/24 had no listing of hearing aids for Resident 1. During a review of Resident 1 ' s facility document titled, Theft and Loss Report, dated 8/12/24, the Report indicated Resident 1 reported a lost article of hearing aids (one pair) with an estimated value of $2000. The Report indicated staff had searched Resident 1 ' s room and had not been able to locate the hearing aids. During a review of Resident 1 ' s nurse progress notes dated 8/14/24 at 4:09 p.m., the progress note indicated Resident 1 ' s family reported Resident 1 was missing hearing aids. The note indicated the Social Services Director (SSD) was told of the missing hearing aids. During a review of Resident 1 ' s nurse progress notes dated 8/14/24 at 10:52 p.m., the note indicated Resident 1 had told the nurse Resident 1 was missing hearing aids. The note indicated the Social Services Director (SSD) was told of the missing hearing aids. During an interview on 8/28/24 at 1:10 p.m., with SSD, SSD stated she had informed the local police department of the missing hearing aids but was unable to provide supporting documentation or a police case number. During a concurrent interview and record review on 8/28/24 at 1:10 p.m., with the SSD, the Concern and Grievance Log, dated August 2024, and the Theft and Loss Report for the hearing aids, dated 8/12/24, were reviewed. The SSD stated the 8/12/24 Theft and Loss Report for the hearing aids was not complete as the form did not include: the name of the person who made the report, the name of the person taking action, and no entries for follow-up action, police notification or Quality Assurance Committee action. The SSD stated the Concern and Grievance Log did not have a listing for Resident 1 ' s missing hearing aids. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/30/24 at 10:20 a.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s progress notes in the Electronic Medical Record (EMR) and Inventory Lists dated 8/10/24 and 8/28/24 were reviewed. The ADON confirmed Resident 1 had continuously resided in the facility from [DATE] to 8/28/24. The ADON stated the 8/10/24 Inventory List included hearing aids and the 8/28/24 Inventory List did not include hearing aids. The ADON stated the lack of entry for hearing aids on the 8/28/24 belongings list indicated the hearing aids were no longer in Resident 1 ' s possession and the hearing aids loss had occurred while Resident 1 was in the facility. During a concurrent interview and record review on 8/30/24 at 10:45 a.m., with the SSD, the SSD stated she was not responsible for investigating Resident 1 ' s lost hearing aids. During an interview on 8/30/24 at 11:00 a.m. with the ADON, the ADON stated if a resident lost an item, the SSD should be notified, and it was the SSD ' s responsibility to investigate missing items. The resident was not available for interview. During a phone interview on 8/27/24 at 12:30 p.m., with Resident 1 ' s family member (FM 1), FM 1 stated Resident 1 ' s hearing aids had been missing. FM 1 stated the facility had not responded to requests for assistance with the hearing aids. During a review of facility policy titled, Theft and Loss Report, dated November 2017, the policy indicated: 1. Missing property not located by nursing staff or the laundry department within 24 to 48 hours is to be referred to the Social Services department. 2. A THEFT/ LOSS MONITORING REPORT will be completed with every referral given to Social Services. 3. If the value of the item is over $100, the local law enforcement must be notified. 4. Social Services or a designee will investigate report, interview staff and residents and provide the Executive Director with information regarding the missing item(s). 5. SSD will determine if the item was listed on the resident's inventory sheet. If the item is on the resident's inventory list and has a value greater than $25, a Report will be given to the Executive Director. b. The signature from the ED is required to begin reimbursement process. c. The SSD will request family to submit a receipt for a replacement or similar item. i. The SSD will provide the business office manager with a copy of the report and receipt to be processed for reimbursement. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Social Services will inform resident and family of their right to file a grievance with: facility administration; local police department; Ombudsman. 7. All facility department heads are responsible for follow-up of missing item complaints received by resident/ family members and to notify the Executive Director.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49983 Based on observation, interview, and record review, the facility failed to ensure the resident environment was safe and comfortable when the patio area had refrigerator parts, a circular concrete pad approximately two feet across, two pieces of broken concrete, and two leaking water hoses puddling water by two resident patio doors. The failure to maintain the facility patio without clutter and hose-generated puddles had potential to cause ambulatory residents using the patio to trip and fall. Findings: During an observation on 8/28/24 at 11:32 a.m., there was a green hose (hose 1) leaking a small amount of water, eight feet away was a puddle approximately 12 inches by 12 inches on the ground approximately 4 feet away from a resident door which exited onto the patio. There was a black hose (hose 2) leaking water which had puddled directly in front of another resident door which exited onto the patio. Hose 2 continued to drain from the puddle area for 20 feet down the patio to a drain. On the other side of the patio there were several square pieces of plastic, approximately 3 feet across lying on the ground that resembled refrigerator parts. There was a concrete round pad, approximately two feet across with a approximately 18 inches high metal post in the middle of the pad. Two edges of the concrete pad were broken, and one piece lay adjacent to the pad, the other piece lay on top of the pad. During a concurrent observation and interview on 8/28/24 at 11:43 a.m., with Maintenance Worker (MW), MW stated hose 2 had water actively draining because the water faucet had not been completely turned off. During an interview on 8/28/24 at 11:50 a.m., MW stated the plastic pieces on the ground were broken parts from a refrigerator, and they should not have been left on the patio in the patient area. MW stated the refrigerator parts have been on the patio longer than a day but he did not know exactly how long the parts had been on the patio. During an observation on 8/28/24 at 11:50 a.m., with MW, on the patio, MW stumbled while walking over the refrigerator parts. During a concurrent observation and interview on 8/28/24 at 12:00 p.m., with the Director of Nursing (DON), the DON stated the refrigerator parts on the ground and the pooling water were trip hazards. The DON stated the refrigerator parts should be thrown away and there should not be standing water on the patio. During a concurrent observation and interview on 8/28/24 at 12:30 p.m., with the Environmental Supervisor (ES), on the patio, ES stated the broken concrete stand and refrigerator parts should be removed from the patio. ES stated water faucets should always be fully turned off after use.