

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER Crown Bay Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' medical records were updated to show documentation that advanced directives (written statement of a person's wishes regarding the medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor), were discussed with the residents and/or responsible parties for three out of 25 final sampled residents (Residents 4, 47 and 94).</p> <p>This had potential for the facility to provide treatment and services against the residents' wishes.</p> <p>Findings:</p> <p>1. Review of Resident 4's Facesheet (information containing contact details, brief medical history at-a-glance) indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (Muscle wasting, also known as muscle atrophy, refers to the loss of muscle mass and strength).</p> <p>During a review of Resident 4's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 2/25/25 under Section C, indicated a score of 15, meaning Resident 4 was cognitively intact .</p> <p>During a review of Resident 4's Physician Orders for Life-Sustaining Treatment (POLST) form, dated 1/3/16, under information and signatures, it showed the resident had no adv directives. (A POLST is a form that gives instructions for the resident's care in life-threatening medical situations).</p> <p>2. Review of Resident 47's Facesheet indicated, Resident 47 was admitted to the facility on [DATE] with diagnoses that included depression (a mood disorder that causes persistent feelings of sadness), and adult failure to thrive (a syndrome where an adult experiences a decline in overall health, often marked by weight loss, decreased appetite, reduced energy, and a progressive decline in their ability to perform daily activities).</p> <p>During a review of Resident 47's MDS dated [DATE] under Section C, it indicated a score of 7, meaning Resident 47 had severe cognitive impairment .</p> <p>Review of Resident 47's medical records showed a POLST dated 2/18/22, under information and signatures, it showed the resident had no advanced directive.</p> <p>(continued on next page)</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident 94's Facesheet indicated, Resident 94 was admitted to the facility on [DATE] with diagnoses that included Dementia (memory loss and impaired decision-making capacity).</p> <p>During a review of Resident 94's MDS dated [DATE] under Section C, it indicated a score of 6, meaning Resident 94 had severe cognitive impairment .</p> <p>During a review of Resident 94's POLST form, dated 12/20/23, under information and signatures , it showed the resident's advanced directives was not available.</p> <p>During a concurrent interview and record review on 4/29/25, at 11:24 a.m., with the Social Service Director Assistant (SSDA), SSDA reviewed Resident 4,47 and 94's medical records and there were no documentation found that indicated the advance directives were discussed with Residents 4, 47 and 94 and their responsible parties. SSDA also stated that the importance of having an advanced directive was so that the residents' wishes regarding their medical care were respected when the residents could not communicate anymore.</p> <p>During an interview on 4/30/25, at 3:28 p.m., with the Director of Nursing (DON), DON stated that she was not aware of the facility's policy regarding advanced directives.</p> <p>During a review of the facility's policy and procedure (P&P) titled (Advanced Directives),revised 2008, the P&P indicated, Advanced directives will be respected in accordance with state law and facility policy .3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advanced directives 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .7. The interdisciplinary team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident .</p> <p>The CMS Interpretive Guidance states that facilities are required to obtain a written record of resident advance directives upon admission and maintained in the medical record. Importantly, residents have a right to refuse to create an advance directive so the advance directive or the refusal to create an advance directive must be documented.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to maintain a safe, clean, comfortable and homelike environment when:</p> <ol style="list-style-type: none"> 1. The linoleum flooring in Resident 112's bathroom was discolored with areas of black stains that looked like dirt. 2. The toilet seat and toilet cover had multiple gray and black linear scratch marks, and the linoleum flooring was discolored with areas of black stains that looked like dirt in Resident 113's bathroom. <p>This failure placed Residents 112 and 113 at risk for safety and may negatively impact the residents' psychological health when they had to use an unmaintained bathroom that was not homelike.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an initial tour on 4/28/25 at 11:20 a.m. Resident 112 was lying in bed. Resident 112 expressed concerns regarding the dirty floor in her bathroom. Resident 112 also stated she was not using the bathroom, but she could see the bathroom floor when the door opened while she was lying in bed, and the dirty floor made her feel uncomfortable. <p>During an observation on 4/28/25 at 11:27 a.m., the linoleum flooring in Resident 112's bathroom was discolored with areas of black stains that looked like dirt. The linoleum flooring of the bathroom appeared old and worn, discolored with some areas with black stains.</p> <p>Review of Resident 112's Minimum Data Set (MDS, an assessment tool) dated 3/18/25, indicated she had a Brief Interview for Mental Status or BIMS of 15 (BIMS score of 13-15 suggests intact cognition).</p> <ol style="list-style-type: none"> 2. During an interview on 4/28/25, at 1:25 p.m., with Resident 113, the resident was lying in bed with a bedside commode by her bedside. Resident 113 stated she did not want to use the bathroom because the bathroom was dirty and gross. <p>During an observation on 4/28/25 at 1:30 p.m., in Resident 113's bathroom, the linoleum flooring of the bathroom appeared old and worn, discolored with some areas with black stains. The toilet seat and cover had multiple gray and black linear scratch marks.</p> <p>Review of Resident 113's MDS dated [DATE], indicated she had a BIMS of 15 (intact cognition).</p> <p>During an interview on 4/29/25 at 12:12 p.m. with the Housekeeping Supervisor (HKS) , HKS acknowledged that Resident 112 and 113's bathroom did not appear homelike. HKS agreed that the linoleum flooring in Resident 112 and 113's bathrooms were old and worn and further stated that the housekeepers tried to scrub the scattered black discoloration in the floor with disinfectants but was unsuccessful in removing them. Also stated she knew of the gray and black scratch marks in Resident 113's bathroom toilet seat and cover but was not reported yet to the Maintenance Supervisor (MS).</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/30/25 at 10:17 a.m. with the MS, MS stated he was not aware of the multiple gray and black scratch marks in Resident 113's bathroom toilet bowl seat and cover. Acknowledged that Resident 113's bathroom did not provide a homelike environment. Further stated that housekeeping department was assigned to the facility bathrooms' linoleum floorings.</p> <p>During an interview on 4/30/25 at 10:53 a.m. with the Administrator (Adm), Adm stated resident 113's bathroom toilet bowl will be replaced and the linoleum flooring in Resident 112 and 113's bathroom will be replaced.</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, Homelike Environment, the P&P indicated, Residents are provided with a safe, clean, comfortable and home like environment .1. Staff shall provide person-centered care that emphasizes the residents comfort, independence and personal needs and preferences. 2. The facility and management maximizes, to the extent possible , the characteristics of the facility that reflect a personalized homelike setting. These characteristics include a. clean sanitary and orderly environment .c. inviting colors and d&eacute;cor .</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident 45), Minimum Data Set (MDS-Resident Assessment and Care Screening tool used to guide care), was accurate when Resident 45 MDS section E was not coded accurately to reflect Resident 45's wandering behavior.</p> <p>This failure had the potential for residents to not received appropriate care.</p> <p>Findings:</p> <p>During an observation on 4/28/25 at 10:52 a.m. Resident 45 wandered in hallways with a front wheeled walker looking into other residents rooms.</p> <p>During an interview on 4/30/25 at 8:33 a.m. with Certified Nursing Assistant (CNA1), CNA1 stated Resident 45 wandered around the facility goes into other residents rooms . CNA1 stated Resident 45 was very confused, wanders into other residents rooms, switch off the light in the room and get agitated when redirected.</p> <p>During a review of Resident 45's Annual Minimum Data Set (MDS), Resident Assessment and care guide tool, dated 3/17/25, indicated MDS section E wandering presence and frequency was coded zero meaning wandering behavior was not exhibited.</p> <p>During a concurrent interview and record review on 4/30/25 at 12:53 p.m. with Social Services Director (SSD), Residents 45's MDS section E behavior, dated 3/17/25 was reviewed. The MDS indicated, Wandering presence and frequency, has the resident wandered coded zero, behavior not exhibited. SSD stated she was responsible for completion of Resident 45's MDS section E. SSD stated Resident 45's MDS section E for wandering was not coded accurately.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for one of three sampled residents (Resident 45), the facility failed to developed and implement adequate person-centered interventions to prevent Resident 45 with dementia from wandering into the rooms of other residents.</p> <p>Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptom and rates of progression. (Adapted from: About Dementia. Alzheimer's Foundation of America. 30).</p> <p>This failure cause Resident 45 falls, injuries, and had the potential to cause residents increased confusion and emotional distress.</p> <p>Findings:</p> <p>During a review of Resident 45's Annual Minimum Data Set (MDS), Resident Assessment and care guide tool, dated 3/17/25, indicated Resident 45'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.). Resident 45's score was 05 meaning poor cognition. MDS indicated Resident 45 is Chinese and preferred language is Mandarin. MDS indicated Resident 45 had no potential indicators of psychosis, no hallucination, no delusions. MDS indicated Resident 45 had fall with injury with admission to facility. Resident 45's diagnoses included Non-Alzheimer's Disease (a group of diseases characterized by progressive deficits in behavior, executive function or language).</p> <p>During a review of Resident 45's care plan, titled, Behavioral Symptoms, initiated 4/14/23, care plan indicated Resident 45 had physical and verbal behavioral symptoms manifested by wandering episodes, Resident 45 tends to wander around facility.</p> <p>Further review of care plan, titled, Going into other residents rooms initiated 5/21/24 indicated problem included Resident 45 going into other resident's room, verbally aggressive when asked to leave. Care plan goal indicated Resident 45 will be free of avoidable complication, interventions included monitor closely, provide redirection as needed.</p> <p>During an observation on 4/28/25 at 10:52 a.m. Resident 45 wandered in hallways with a front wheeled walker looking into other residents rooms.</p> <p>During a review of Resident 45's clinical notes, dated 1/18/25, the clinical notes indicated, at 6:20 a.m. Resident 45 was seen on the floor in the hallway. Last seen ambulating from station 1 to station 2 and going from room to room. Upon assessment Resident 45 sustained a bump on the right side of forehead. Resident 45 was transferred to hospital.</p> <p>Further review of Resident 45's clinical notes, dated 1/2/25, the clinical notes indicated Resident 45 had an unwitnessed fall.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/29/25 at 11:43 a.m. with Director of Nursing (DON), DON stated Resident 45 wander in hallways. DON stated that on 1/18/25, Resident 45 had a fall in the hallway was found sitting on the floor with bump on the right side of her forehead. DON stated Resident 45 was sent to the hospital for evaluation and came back with closed fracture of the temporal bone (skull fracture).</p> <p>During an interview on 4/30/25 at 8:33 a.m. with Certified Nursing Assistant (CNA1), CNA1 stated Resident 45 wandered around the facility goes into other residents rooms . CNA1 stated Resident 45 was very confused, wanders into other residents rooms, switch off the light in the room and get agitated when redirected.</p> <p>During an interview on 4/30/25 at 8:37 a.m. with CNA 2 , CNA 2 stated Resident 45 roams around the facility. CNA 2 stated CNA2 checked on Resident 45 as she was at risk for falls and sometimes found her in another resident's room. CNA 2 stated Resident 45 liked to check light and switch it off.</p> <p>During a concurrent observation and interview on 4/30/25 at 8:55 a.m. with staff Interpreter (IT), Resident 45 sat up in bed in her room, walker by bedside. Resident 45 with hand gesture instructed both surveyor and IT to leave her room.</p> <p>During an interview on 4/30/25 at 12:07 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 45 wanders around the facility, into other residents rooms and turn off the light. LVN 1 stated Resident 45 continued to wanders into other resident rooms despite redirection.</p> <p>During an interview on 4/30/25 at 12:11 p.m. with Resident 25, Resident 25 stated Resident 45 wanders into his room, switch off light in the room and take ensure supplement that did not belong to her. Resident 25 stated he was not comfortable with Resident 45 coming into his room.</p> <p>During a review of Resident 25's MDS, dated [DATE], indicated Resident 25's BIMS score was 15 meaning intact cognition.</p> <p>During an interview on 5/1/25 at 8:20 a.m. with Resident 66, Resident 66 stated Resident 45 wanders into her room, cuts all our lights off. Resident 66 stated Resident 45 had an habit of taking things, she has taken my roommates clothes, she has taken my clementines before but staff was able to take it from her, feels like invasion of privacy. Resident 66 said she pressed the call light when Resident 45 wandered inside her room.</p> <p>During a review of Resident 66's MDS, dated [DATE], indicated Resident 66's BIMS score was 15 meaning intact cognition.</p> <p>During an interview on 5/1/25 at 8:45 a.m. with CNA 3, CNA 3 stated Resident 45 get agitated when redirected from other residents room. CNA 3 stated Resident 45 was redirected from male residents room to prevent her from getting hurt.</p> <p>During a review of Resident 1's physician order sheet, dated 2/28/24, physician order indicated to monitor Resident 45's behavior of going into other residents room, taking other patient's food/clothes, pulling curtains in other patients room, closing doors , turning off lights, removing other patient's food tray, taking belongings from other residents and monitor Resident 45 every hour episodes of going into other residents rooms for safety.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/1/25 at 12:16 p.m. with Social Services Director (SSD) , SSD stated Resident 45 wandered around the facility. SSD stated facility had discussed Resident 45's transfer to appropriate facility because of Resident 45 dementia status. SSD stated Resident 45's responsible party did not want Resident 45 transferred from facility.</p> <p>During an interview on 5/1/25 at 12:26 p.m. with Director of Nursing (DON), DON stated Resident 45 needed one-on-one monitoring or memory care placement. DON stated facility had discussed with Resident 45' daughter need for placement in a small building. DON stated Resident 45 continued to wander in the hallways and into other residents rooms despite interventions.</p> <p>During a review of Resident 45's Interdisciplinary team noted (IDT), dated 2/26/24, the IDT indicated, Plan of action would be to move Resident 45 to a facility that can better manage her behaviors. SSD will make list of closeby places that accept memory care residents. Discussed how Resident 45 requires a higher level of care due to her constant behaviors towards other residents and staff like hitting, spitting, rummaging in personal items.</p> <p>(An interdisciplinary team is a group of professional from different fields who collaborate to achive a common goal often focusing on patient care).</p>		