STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056280	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Marina Post Acute	2919 Fruitvale Ave Oakland, CA 94602

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 2) was free from physical abuse when Resident 1 threw a flower vase to her roommate Resident 2. This failure resulted in Resident 2 having a wound in her lip and transfer to an acute care hospital for treatment. Findings: Review of Resident 1's Facesheet (information containing contact details, brief medical history at-a-glance) indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (memory loss and impaired decision-making capacity) and delusional disorder (a serious mental illness characterized by a person having one or more false beliefs). Review of Resident 1's Minimum Data Set (an assessment tool) dated 9/17/24, indicated she had a brief interview for mental status or BIMS of 12 (BIMS score of 8 to 12 indicates moderate cognitive impairment). The MDS also indicated Resident 1 had physical and verbal behavior symptoms directed toward others. Review of Resident 2's Interdisciplinary Team (IDT, a group of individuals representing different departments of the facility) notes dated 9/21/24, indicated at around 2:27 p.m., there was a commotion in Resident 1 and Resident 2's' room and Resident 2 was found bleeding from her mouth. The IDT notes also indicated that Resident 1 was very loud during that time and was accusing Resident 2 of stealing from her. The notes indicated the nurse applied pressure to Resident 2's mouth and the paramedics (persons trained to give emergency medical care to people who are injured or ill) came and brought the Resident 2 to the hospital at 3:17 p.m. for treatment. The IDT notes further indicated a housekeeping staff witnessed Resident 1 hit Resident 2 with a flower vase. Review of Resident 1's Facesheet indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included muscle weakness. Review of Resident 2's MDS dated [DATE], indicated she had a BIMS of 13 (BIMS score of 13 to 15 indicates cognition is intact). The MDS also indicated Resident 2 had no physical and verbal behavior symptoms directed toward others. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056280	A. Building B. Wing	12/04/2024

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Housekeeper (HK)1 on 11/13/24 at 10:50 a.m., HK 1 stated, when the incident happened on 9/21/24, HK1 was outside the door of Resident 1 and Resident 2's room. Stated she saw Resident 1 was standing with a walker and was closing the sliding door shades while Resident 2 was lying in her bed situated beside the sliding door. HK 1 stated, after Resident 1 closed the shades, she heard Resident 2 tell Resident 1 not to close the shades. Then Resident 1 got angry and started banging her walker to the floor. HK 1 stated she went inside the residents' room to see what was happening, and then she saw Resident 1 get a glass flower vase with flowers from Resident 2's bedside table and threw it to Resident 2. HK1 stated she saw Resident 2 with a lot of bleeding in her upper lip, so she ran to the nurses' station to get the nurse and the nurses went to the residents' room and attended Resident 2. During an interview with Certified Nursing Assistant (CNA) 1 on 12/4/24 at 1:41 p.m., CNA 1 stated that prior to the incident on 9/21/24, Resident 1 and Resident 2 were not getting along because Resident 1 wanted their room's sliding door shades to be closed and Resident 2 wanted the shades to be opened. During an interview with another CNA (CNA 2), on 12/5/24 at 1:19 p.m., CNA 2 also stated that prior to the incident on 9/21/24, Resident 1 and Resident 2 were not getting along because Resident 1 wanted their room's sliding door to be closed and Resident 2 wanted the sliding door to be opened. CNA 2 stated she told the charge nurses that the residents were not getting along but could not remember the names of the charge nurses she reported to. During an interview with the Director of Nursing (DON) on 11/13/24 at 2:15 p.m. and concurrent review of Resident 1's Departmental Notes, the notes indicated that there was a precedent incident when Resident 1 had an altercation with another resident (Resident 3), on 9/12/24 at 2:30 p.m. (this happened nine days before the incident with Resident 2 on 9/21/24). The notes indicated: Resident 3 stated, she sat beside Resident 1 during activity time, but she was told by Resident 1 that the table belonged to Resident 1 and then grabbed and threw a box of tissues to Resident 3 which landed on Resident 3's hand. Upon further review, the DON could not find a care plan that addressed Resident 1's altercation and behavior with Resident 3 on 9/12/24. DON acknowledged a plan of care should have been developed on 9/12/24, to monitor and prevent Resident 1's aggressive behavior towards other residents. DON also could not find IDT meeting notes which addressed or discussed Resident 1's altercation with Resident 3. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention, Screening and Training Program, revised July 2018, the P&P indicated, . The facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment and develops facility policies, procedures, training programs, and screening and prevention systems to promote an environment free from abuse . The facility conducts resident pre-admission, admission, and ongoing assessments (screening) and care planning for appropriate interventions and monitoring of residents with needs and behaviors that might lead to conflict or neglect .