

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Bay Marina Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>45091</p> <p>Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received Gabapentin (a medication used to treat nerve pain) as ordered by their physician.</p> <p>This failure had the potential to cause Resident 1 unnecessary pain.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, printed 1/10/25, the record indicated Resident 1 was admitted to the facility in December 2024 with a diagnosis of Neuralgia (a sharp, shock-like pain that follows the path of a nerve) and Neuritis (inflammation of the nerves).</p> <p>During a review of Resident 1's Doctors Order, dated 12/6/24, the Order indicated Resident 1 had a prescription for Gabapentin Oral Capsule 100 MG . Give 2 capsule by mouth in the evening for Neuropathy pain. The Order indicated it was Everyday.</p> <p>During a concurrent interview and record review on 1/10/25, at 2:03 p.m., with Assistant Director of Nursing (ADON), Resident 1's Progress Notes, dated 12/23/24 and 12/28/24 were reviewed. Resident 1's Progress Note, dated 12/23/24 indicated Gabapentin . on order. Resident 1's Progress Note, dated 12/28/24, indicated Gabapentin . on order. ADON stated the Progress Notes indicated Gabapentin was not available on 12/23/24 and 12/28/24. ADON stated the nurse should have notified the doctor and got and a doctor's order to skip a dose or give the dose late if Gabapentin was not available. ADON stated Resident 1's pain may not have been controlled if they missed a dose of Gabapentin.</p> <p>During an interview on 1/10/15, at 3:33 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 1 missed their evening doses of Gabapentin on 12/23/24 and 12/28/24 because the medication was not available. RN 1 stated they did not notify the doctor of the missed doses or get a Doctor's Order to skip a dose on either day.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Medication - Administration, revised 1/1/2012, the P&amp;P indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The P&amp;P indicated, Medications will be administered one hour before or after the scheduled medication administration time.</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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