

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 01/24/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50474</p> <p>Based on observation, interview, and record review, the facility failed to treat one of four sampled residents (Resident 1) with respect and dignity when the Rehabilitation Coordinator (RC) informed Resident 1 he was being kicked out from the facility.</p> <p>This failure resulted in Resident 1 feeling upset and disrespected.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record, printed on 1/13/25, the record indicated, Resident 1 was admitted to the facility in November 2023 with diagnosis of end stage renal disease (last stage of long-term kidney disease).</p> <p>During a review of Resident 1 ' s Brief Interview for Mental Status (BIMS, is 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.), dated 11/8/24, the record indicated Resident 15 ' s BIMS score was 15.</p> <p>Based on concurrent observation and interview on 1/9/25 at 11:11 a.m. with Resident 1, Resident 1 was in his room. Resident 1 stated he had been living in the facility for about two and a half years. Resident 1 stated he had amputated (to cut off a body part) left toes and Resident 1 needed dialysis (treatment that removes extra fluid and waste product from the blood when kidneys stop working properly) three times a week. Resident 1 stated the facility had been trying to kick him out from the facility. Resident 1 stated he did not have any place to go because he lost his apartment and belongings when he was hospitalized . Resident 1 stated there was an incident when RC came to his room and told him, You need to get out of here! and The Administrator (ADM) is kicking you out. Resident 1 stated he felt very upset and disrespected by how RC spoke to him. Resident 1 stated he felt he was being treated differently by the management because he advocated for himself unlike the other residents who did not have the capacity to speak for themselves. Resident 1 stated the licensed nurse who was on duty that day witnessed the incident.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/25 at 12:08 p.m. with Registered Nurse (RN), RN 1 stated she witnessed the incident between Resident 1 and RC. RN 1 stated she saw RC entered Resident 1 ' s room. RN 1 stated RC and Resident 1 were having an argument. RN 1 stated she witnessed RC told Resident 1 ADM wants to kick you out. RN 1 stated the way RC said it to Resident 1 was not very polite. RN 1 stated when RC left Resident 1 ' s room, she observed Resident 1 very upset and stressed.</p> <p>During an interview on 1/9/25 at 1:39 p.m. with Social Worker (SW), SW stated prior to discharging a resident from the facility, a care conference should have been discussed to determine if a resident was ready to be discharged . SW stated Resident 1 was a long-term resident of the facility. SW stated Resident 1 was not ready to be discharged yet due to his condition and Resident 1 did not have any place to go home to. SW stated it would have been an unsafe discharge for Resident 1 if he was discharged from the facility without a home or a place to stay.</p> <p>During an interview on 1/9/25 at 3:48 p.m. with the Director of Nursing (DON), the DON stated the SW or the case manager had the responsibilities in discussing discharge plans with all of the residents. The DON stated RC should have not talked to Resident 1 about his discharge because it was not part of her job. The DON stated RC's action towards Resident 1 was not acceptable. The DON further stated Resident 1 must have felt depressed and hurt when RC told Resident 1 that he was being kicked out from the facility.</p> <p>During a record review of the facility ' s policy and procedure, titled, Resident Rights, dated 1/1/12, the P&P indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents ' rights.</p> <p>During a record review of the facility ' s P&P, titled, Discharge and Transfer of Residents, revised in February 2018, the P&P indicated, I. The resident/resident representative will be provided with a Notice of Proposed Transfer and Discharge 30 days prior to discharge or as soon as practicable .IV. Prior to discharge, Social Service Staff or Nursing will provide the resident/resident representative with the Notice of Proposed Transfer and Discharge document.</p> <p>Based on observation, interview, and record review, the facility failed to treat one of four sampled residents (Resident 1) with respect and dignity when the Rehabilitation Coordinator (RC) informed Resident 1 he was being kicked out from the facility.</p> <p>This failure had the potential to result in Resident 1 feeling upset and disrespected.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record , printed on 1/13/25, the record indicated, Resident 1 was admitted to the facility in November 2023 with diagnosis of end stage renal disease (last stage of long-term kidney disease).</p> <p>During a review of Resident 1's Brief Interview for Mental Status (BIMS, is 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.), dated 11/8/24, the record indicated Resident 1's BIMS score was 15.</p> <p>(continued on next page)</p>		

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