

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 03/28/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45091</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure to immediately report alleged abuse allegations to the California Department of Public Health (CDPH) and the Ombudsman within two hours for one of 27 sampled residents (Resident 92), when Resident 92's sister alleged a Registered Nurse (RN) called Resident 92 stupid.</p> <p>These failures had the potential to cause a delay in investigations and affect physical and psychological well-being of residents.</p> <p>Findings:</p> <p>A review of Resident 92's Admission Record printed 3/27/25, indicated Resident 92 was admitted to the facility in September 2023 with a diagnosis of chronic pain.</p> <p>During an interview on 3/26/25, at 1:25 p.m. with RN 1, RN 1 stated, on 2/9/25 Resident 92's sister notified RN 1 that an unknown nurse called Resident 92 stupid. RN 1 stated they did not complete and submit a Report of Suspected Dependent Adult/Elder Abuse (SOC 341), to the ombudsman or CDPH. RN 1 stated they did not notify the ombudsman or CDPH of the alleged abuse.</p> <p>During an interview on 3/26/25, at 3:25 p.m. with Medical Records (MR), MR stated on 2/9/25 Resident 92's sister notified MR an unknown nurse called Resident 92 stupid. MR stated they did not complete and submit a SOC 341, to the ombudsman or CDPH. MR stated they did not notify the ombudsman or CDPH of the alleged abuse.</p> <p>During a concurrent interview and record review on 3/26/25, at 12:03 p.m., with Social Services Director (SSD), Resident 92's SOC 341, dated 2/10/25, was reviewed. SSD stated on 2/10/25, at approximately 5 p. m., Resident 92 notified SSD that RN 1 called Resident 92 stupid. SSD stated they completed the SOC 341, and notified the ombudsman and CDPH of the alleged abuse within 2 hours of the reported abuse. SSD stated their policy was to notify the ombudsman and CDPH within 2 hours of alleged abuse to protect the residents.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Abuse - Reporting & Investigations, revised March 2018, the P&P indicated, Notifications of Outside Agencies of Allegation of Abuse With No Serious Bodily Injury . The Administrator or designated representative will notify within two (2) hours notify, by telephone, CDPH, the ombudsman and Law Enforcement . The Administrator or designated representative will send a written SOC341 report to the Ombudsman and Law Enforcement and CDPH Licensing and Certification within two (2) hours.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717</p> <p>Based on observation, interview and record review, for two of 27 sampled residents (Resident 58 and Resident 90), the facility failed to ensure an environment that is free of accident hazards as possible, and that each resident receives adequate supervision when:</p> <ol style="list-style-type: none"> 1. Resident 58's bed wheels did not lock. This failure had the potential to result in preventable falls. 2. Resident 90 was not supervised while out smoking. This failure had resulted in Resident 90 leaving the facility premises undetected. Resident 90's whereabouts remain unknown. <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 58's Admission Record (AR), the AR indicated, Resident 58 was admitted to the facility in January 2025 with diagnoses that included epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures), hemiplegia (a condition characterized by paralysis or weakness on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) affecting left side, right foot drop and history of falling. <p>During a review of Resident 58's Minimum Data Set Assessment (MDS, an assessment tool used to direct resident care) dated 2/5/25 indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status.</p> <p>During an interview on 3/24/25 at 11:33 a.m. with Resident 58, Resident 58 stated the facility had exchanged her bed with another that had wheels that did not lock. Resident 58 stated being told by the management to wait for another resident to be discharged from the facility for her bed to be switched. Resident 58 stated being afraid she might fall off the bed as the bed moved whenever Resident 58 repositioned while in bed.</p> <p>During an interview on 3/24/25 at 11:36 a.m. with Environmental Service Director (ESD), ESD stated replacing Resident 58's bed frame two weeks ago and did not know of any current issues with the bed.</p> <ol style="list-style-type: none"> 2. During a review of Resident 90's AR, the AR indicated Resident 90 was admitted to the facility on [DATE] with diagnoses that included old myocardial infarction (a medical emergency that occurs when blood flow to the heart muscle is blocked, causing damage or death of heart tissue), need for assistance with personal care, depression (a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels) and history of traumatic brain injury (TBI, a brain injury caused by an external force, such as a blow to the head. TBIs can cause physical, cognitive, emotional, and behavioral effects). <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 90's Clinical admitted d 12/29/24, the Clinical Admission indicated Resident 90 was alert oriented x 3 (the patient knows their own identity/name, where they are/place, and the approximate time of day, date, and year).</p> <p>During a concurrent interview and record review on 3/27/25 at 2:27 p.m. with Regional Quality Management Consultant (RQMC), Resident 90's Elopement Evaluation dated 12/29/24 was reviewed. The Elopement Evaluation indicated an elopement score of 1.0 (score value of 1 or higher indicates risk of elopement). The Elopement Evaluation did not indicate any clinical suggestions or comments as these sections of the evaluation were left blank. RQMC stated the fact that Resident 90 was a new admit and was not accepting of current living condition added more risk for elopement. RQMC stated there should have been a baseline care plan to address elopement risk but there was no care plan in the clinical record.</p> <p>The following were documentation by multiple staff on 12/30/24.</p> <p>-At 13:32, Orders-Administration Note, Resident eloped from facility.</p> <p>-At 13:33, Orders-Administration Note, Resident eloped from facility.</p> <p>-At 14:46, Case Management, late entry, CM (Case Manager) spoke with resident earlier in the day and introduced herself and arranged for an IDT (Interdisciplinary team, a group composed of individuals from different departments of the facility) meeting for this afternoon. Resident agreed to meeting and time. Once CM went to inform resident of meeting Charge Nurse made CM aware that resident had requested to have a cigarette around noon and resident has not been seen since.</p> <p>-At 15:35, Physician/PA (Physician Assistant)/NP (Nurse Practitioner) Note, [Resident 90] was seen and examined .IDT, SS, and nursing notes reviewed .</p> <p>-At 17:21, Health Status Note, Resident alert and verbally responsive, VS (vital signs) within normal limits. All due meds (medications) given and tolerated well. Resident left facility around 12 noon. MD, Administrator, and police notified.</p> <p>-At 19:46, Orders-Administration Note, Resident out for elopement.</p> <p>-At 22:17, Orders-General Note from eRecord, There is no patient to chat.</p> <p>-At 22:53, Orders-Administration Note, Resident elope & didn't come back to the facility.</p> <p>-At 00:21, Orders-General Note from eRecord, Patient is not available.</p> <p>During a concurrent interview and review of Resident 90's clinical record on 3/27/25 at 2:49 p.m. with RQMC, RQMC stated the staff's documentation was incomplete and did not indicate details on how and when Resident 90 left the facility. RQMC also stated the Social Services Director (SSD) at the time should have called the resident or any family member listed on file to know where Resident 90 was. The clinical record did not indicate if there was any investigation done to find Resident 90. RQMC stated, at the time of survey, facility did not know where Resident 90 was.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled Wandering and Elopement last revised 1/31/23, the P&P indicated, the licensed nurse will assess the resident upon admission to determine their risk of elopement and preventative interventions will be documented in the resident's clinical record. The facility staff member who finds the resident is missing will alert facility staff, the charge nurse will make an announcement in the facility and organize a search including common areas, bathrooms, showers, closets, other residents' rooms, and outside areas. A staff will be assigned to perform a perimeter search around the exterior of the building to ensure the missing resident is not behind any structures. If the resident cannot be found, the charge nurse will notify the Administrator, Director of Nursing, Attending Physician, Responsible Party, and Local Law Enforcement. The Administrator will continue to work with law enforcement and the responsible party until the resident is located. The licensed nurse most familiar with the incident will document in the resident's clinical record the details of the elopement.</p>