

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Bay View Rehabilitation Hospital, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  516 Willow Street 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48116</b></p> <p>Based on observation, interview, and record review, the facility failed to keep one of three residents (Resident 1) free from physical abuse when Certified Nursing Assistant 1 (CNA1) deliberately poked Resident 1 in the right cheek, smacked Resident 1 in the hand and then forced Resident 1 down in her wheelchair causing her to cry out.</p> <p>This abuse resulted in Resident 1 crying out in pain, hyperventilating (breathing rapidly) and visibly shaking, and had the potential to instill fear in Resident 1 which could result in psychosocial harm. This abuse also had the potential to result in further physical abuse towards Resident 1 and/or other vulnerable residents under CNA1 's care.</p> <p>(Cross Reference F610)</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record dated 5/13/24, the Admission Record showed Resident 1 was admitted to the facility on [DATE] and primarily spoke Tagalog (a language spoken by people of Filipino descent) for communication.</p> <p>During a record review of Resident 1's Admission Minimum Data Set (MDS- An assessment tool to guide care) assessment dated [DATE], MDS assessment showed Resident 1 required partial assistance from another person when walking from room to room. The MDS assessment showed Resident 1 had active diagnoses of Alzheimer's Disease (a disease that affects memory, thinking and behavior), Non-Alzheimer ' s Dementia (memory loss) and difficulty walking.</p> <p>During an interview with the Director of Nursing (DON) on 5/13/24 at 3:33 p.m., DON stated the alleged abuse towards Resident 1 occurred on 5/8/24 at approximately 6:00 p.m. in the hallway outside of room [ROOM NUMBER], which is located at Nursing Unit 1. DON stated CNA1 allegedly sat Resident 1 down forcefully in her wheelchair. DON stated Licensed Vocation Nurse 1 (LVN1) witnessed the incident and felt that CNA1 handled Resident 1 roughly.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator (ADM) on 5/13/24 at 5:40 p.m., ADM stated on 5/8/24, around 6:30 p.m., LVN1 called him to report that she had witnessed CNA1 poke Resident 1 in the cheek, smack Resident 1 in the hand and then forcefully sit Resident 1 down in her wheelchair. ADM stated that he spoke with CNA1 on 5/8/24 around 6:40 p.m. about the alleged abuse toward Resident 1. ADM stated CNA1 told him that she helped Resident 1 sit down in her wheelchair because she was falling. ADM stated CNA1 told him she had applied A&amp;D ointment (Vitamin A&amp;D ointment, a medicated ointment used to protect skin) to Resident 1 ' s face after she was seated in her wheelchair.</p> <p>During an interview with LVN1 in the Medication Room located at Nursing Unit 2 on 5/14/23 at 4:19 p.m., LVN1 stated she was working at Nursing Unit 1 on 5/8/24 during the PM shift. LVN1 stated she was doing her medication pass around 6:00 p.m. at room [ROOM NUMBER]. LVN1 stated CNA1 was sitting in a chair next to Resident 1, who was sitting in her wheelchair in the hallway outside of room [ROOM NUMBER]. LVN1 stated CNA1 got up to help pass out dinner trays to the Nursing Unit 1 residents. LVN1 stated Resident 1 then stood up. LVN1 stated CNA1 helped Resident 1 sit back down in her wheelchair. LVN1 stated Resident 1 stood up again and CNA1 yanked Resident 1 down into her wheelchair. LVN1 stated CNA1 began yelling at Resident 1 in Tagalog (a language spoken by people of Filipino decent) and CNA1 then poked Resident 1 in the right cheek. LVN1 stated Resident 1 then swatted CNA1 ' s hand away from her face. LVN1 stated CNA1 then smacked Resident 1 in the hand. LVN1 stated she also heard the smack to Resident 1 ' s hand. LVN1 stated Resident 1 stood up again and CNA1 then grabbed Resident 1 by her pants and slammed her back down in her wheelchair. LVN1 stated Resident 1 yelled out in pain after being slammed down in her wheelchair by CNA1. LVN1 stated she told CNA1 to stop because her actions were abusive. LVN1 stated she then calmed Resident 1 down and assessed her condition. LVN1 stated she then called the Nurse Consultant (NC) and ADM to report the abuse she had witnessed. LVN1 stated she submitted a written statement to ADM about the abuse incident toward Resident 1 that she had witnessed. LVN1 stated ADM told her to take out the part where CNA1 poked Resident 1 in the cheek and smacked her in the hand because it made CNA1 look bad. LVN1 stated she then re-wrote her statement because she was afraid of being retaliated against by ADM.</p> <p>During an interview with CNA1 at Nursing Unit 1 on 5/14/23 at 4:36 p.m., CNA1 stated on 5/8/24 around 6:00 p.m., she was sitting next to Resident 1 in the hallway outside of room [ROOM NUMBER]. CNA1 stated Resident 1 got up from her wheelchair and attempted to sit in her chair. CNA1 stated she then helped Resident 1 sit back down in her wheelchair. CNA1 stated once Resident 1 was seated in her wheelchair, she applied A&amp;D ointment to Resident 1 ' s face because she had dry skin. CNA1 stated no other physical contact was made with Resident 1 other than to apply the A&amp;D ointment to her face.</p> <p>During a review of Resident 1's Order Summary Report dated 5/15/24, the Order Summary Report did not show that there was an active doctor ' s order to apply A&amp;D ointment to Resident 1 ' s face.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview with the Police Officer (PO) on 5/16/24 at 2:24 p.m., PO stated he received a call for service from police dispatch (a team that works together to take emergent and non-emergent calls) on 5/8/24 around 6:00 p.m. to take a report regarding an alleged abuse incident that had occurred at the nursing facility. PO stated he arrived at the nursing facility on 5/8/24 at around 11:00 p.m. and proceeded to Nursing Unit 1. PO stated he spoke with LVN1 who witnessed the alleged abuse incident. PO stated LVN1 told him that she had called CNA1 over to watch Resident 1 because Resident 1 is a fall risk and she has severe dementia. PO stated LVN1 told him Resident 1 got up from her wheelchair and CNA1 helped Resident 1 sit back down. PO stated LVN1 told him that Resident 1 then stood up again and CNA1 forcefully sat Resident 1 back down in her wheelchair. PO stated LVN1 told him that CNA1 began speaking to Resident 1 in Tagalog. PO stated LVN1 told him that CNA1 then poked Resident 1 in the face. PO stated LVN1 told him Resident 1 then swatted CNA1's hand away from her face. PO stated LVN1 told him CNA1 then smacked Resident 1 ' s hand and Resident 1 yelled. PO stated LVN1 told him Resident 1 then stood up again. PO stated LVN1 told him CNA1 then stood in front of Resident 1 and slammed her back down into her wheelchair causing Resident 1 to yelp out in pain. PO stated LVN1 told him that she sent CNA1 off Nursing Unit 1 after the incident. PO stated after writing down LVN1 ' s statement, he attempted to call ADM three times, but the calls were not answered. PO stated he also interviewed LVN2 on 5/8/24. PO stated LVN2 stated she was using a restroom adjacent to Nursing Unit 1 at the time of the alleged abuse. PO stated LVN2 told him that she heard a gut-wrenching scream coming from Nursing Unit 1. PO stated LVN2 told him that she ran to Nursing Unit 1 after hearing the scream. PO stated he returned to the nursing facility the next morning on 5/9/24 at around 9:00 a.m. to finish interviewing witnesses and to check on Resident 1. PO stated he then spoke with ADM about the alleged abuse incident that occurred the previous night on 5/8/24. PO stated ADM gave him LVN1 ' s written witness statement from 5/8/24 regarding Resident 1 ' s alleged abuse. PO stated that he read LVN1 ' s written statement, but it was vague (not clear) and different than the verbal statement she had given him previously. PO stated he then re-interviewed LVN1. PO stated LVN1 admitted that ADM told her to rewrite her statement because it looks bad. PO stated LVN2 ' s statement corroborated (confirmed) LVN1 ' s original verbal statement.</p> <p>During a telephone interview with LVN2 on 5/17/24 at 11:30 a.m., LVN2 stated she was using restroom [ROOM NUMBER] located adjacent to Nursing Unit 1 on 5/8/24 at approximately 6:00 p.m. LVN2 stated she heard two screams that sounded gut-wrenching, fearful and painful coming from Nursing Unit 1. LVN2 stated she exited the restroom and ran to Nursing Unit 1. LVN2 stated Resident 1 was standing in the hallway outside of room [ROOM NUMBER] hyperventilating (breathing rapidly) and visibly shaking. LVN2 stated she then asked LVN1 what had happened. LVN2 stated LVN1 told her that she witnessed CNA1 poke Resident 1 in the right cheek, smack Resident 1 in the hand and slam Resident 1 down into her wheelchair.</p> <p>During a review of the facility ' s P&amp;P titled, Policy and Procedure on Patient Abuse Allegation Investigation dated October 2019, the P&amp;P showed, .Policy: The facility shall uphold resident ' s right to be free from any form of verbal, sexual, physical, and mental abuse .</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Resident Rights dated April 2019, the P&amp;P showed, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation: .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to .c: be free from abuse, neglect, misappropriation of property, and exploitation .</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of the facility ' s document titled Resignation dated 5/14/24, the Resignation document showed, Effective today May 14, 2024 I am resigning as CNA. The Resignation document was signed by CNA1.

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48116</b></p> <p>Based on observation, interview and record review, the facility failed to protect residents in the facility from physical abuse when Certified Nursing Assistant 1 (CNA1) deliberately poked one resident (Resident 1) in the right cheek, smacked Resident 1 in the hand and then forced Resident 1 down in her wheelchair causing Resident 1 to cry out. The facility failed to protect 16 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16) assigned to CNA1, from possible physical abuse when the Administrator (ADM) returned CNA1 to direct care duty before completion of a thorough abuse investigation, including interviewing all witnesses. CNA1 was permitted to have access to Resident 1 and continued to work with other vulnerable residents.</p> <p>This failure resulted in Resident 1 crying out in pain, hyperventilating (breathing rapidly) and visibly shaking, and had the potential to result in further physical abuse towards Resident 1 and/or other vulnerable residents under CNA1's care.</p> <p>An Immediate Jeopardy situation (IJ, a situation in which a facility's actions places one or more residents/patients in jeopardy of being significantly harmed up to the point of possible death if not immediately corrected) was identified and called due to the failure of the facility to protect residents from further abuse by returning CNA1 to direct care duty before completion of a thorough abuse investigation. The ADM was verbally notified of the IJ situation on 5/14/24 at 6:09 p.m.</p> <p>During a visit to the facility on [DATE], the facility provided an acceptable plan of action and the IJ was removed at 12:59 p.m.</p> <p>Findings:</p> <p>During an interview with the Director of Nursing (DON) on 5/13/24 at 3:33 p.m., DON stated the alleged abuse towards Resident 1 occurred on 5/8/24 at approximately 6:00 p.m. in the hallway outside of room [ROOM NUMBER], which is located at Nursing Unit 1. DON stated CNA1 allegedly sat Resident 1 down forcefully in her wheelchair. DON stated Licensed Vocation Nurse 1 (LVN1) witnessed the incident and felt that CNA1 handled Resident 1 roughly. DON stated LVN1 reported the alleged abuse to ADM on 5/8/24. DON stated CNA1 was suspended by ADM on 5/8/24 and returned to duty on 5/10/24 after the facility completed an abuse investigation. DON stated the abuse allegation towards Resident 1 was unsubstantiated.</p> <p>During a concurrent interview and record review on 5/13/24 at 3:35 p.m. with the DON and Assistant Administrator (AA), the facility's undated Investigative Summary document, pertaining to Resident 1's abuse investigation, was reviewed. The Investigative Summary showed .upon completion of investigation, she [CNA1] was re-educated by D.S.D. [Director of Staff Development] and is returning to her PM shift today following her suspension. DON and AA confirmed the Investigative Summary was completed on 5/10/24 at 2:32 p.m.</p> <p>During an interview with the DSD on 5/13/24 at 3:58 p.m., DSD stated CNA1 reported to work on 5/10/24 and worked both the AM and PM shifts on Nursing Unit 1. DSD also stated CNA1 is scheduled to work on Nursing Unit 1 today.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/13/24 at 5:33 p.m. with the DON, the facility's undated Investigative Summary document and Resident 1's Interdisciplinary Team [IDT] Conference Record document dated 5/9/24 were reviewed. The Investigative summary showed .Interventions: 7. IDT performed post-incident 72 hour assessment . The Interdisciplinary Team Conference Record did not show that an IDT post-incident 72 hour assessment had been completed. The DON confirmed that the Interdisciplinary Team Conference Record did not show that an IDT post-incident 72 hour assessment had been completed.</p> <p>During a concurrent interview and record review on 5/13/24 at 5:38 p.m. with the DON, CNA1's timecard dated 5/13/24, was reviewed. The DON confirmed the timecard showed CNA1 worked at the facility on 5/10/24 from 6:58 a.m. until 11:28 p.m.</p> <p>During an interview with ADM on 5/13/24 at 5:40 p.m., ADM stated on 5/8/24, around 6:30 p.m., LVN1 called him to report that she had witnessed CNA1 poke Resident 1 in the cheek and then CNA1 forcefully sat Resident 1 down in her wheelchair. ADM stated that he spoke with CNA1 on 5/8/24 around 6:40 p.m. about the alleged abuse toward Resident 1. ADM stated CNA1 told him that she helped Resident 1 sit down in her wheelchair because she was falling. ADM stated CNA1 told him she had applied A&amp;D ointment (Vitamin A&amp;D ointment, a medicated ointment used to protect skin) to Resident 1's face after she was seated in her wheelchair. ADM stated CNA1 was suspended on 5/8/24 and returned to duty on 5/10/24 after the he completed Resident 1's abuse investigation. ADM then stated Resident 1's abuse allegation was unsubstantiated.</p> <p>During an interview with LVN1 in the Medication Room located at Nursing Unit 2 on 5/14/23 at 4:19 p.m., LVN1 stated she was working at Nursing Unit 1 on 5/8/24 during the PM shift. LVN1 stated she was doing her medication pass around 6:00 p.m. at room [ROOM NUMBER]. LVN1 stated CNA1 was sitting in a chair next to Resident 1, who was sitting in her wheelchair in the hallway outside of room [ROOM NUMBER]. LVN1 stated CNA1 got up to help pass out dinner trays to the Nursing Unit 1 residents. LVN1 stated Resident 1 then stood up. LVN1 stated CNA1 helped Resident 1 sit back down in her wheelchair. LVN1 stated Resident 1 stood up again and CNA1 yanked Resident 1 down into her wheelchair. LVN1 stated CNA1 began yelling at Resident 1 in Tagalog (a language spoken by people of Filipino decent) and CNA1 then poked Resident 1 in the right cheek. LVN1 stated Resident 1 then swatted CNA1's hand away from her face. LVN1 stated CNA1 then smacked Resident 1 in the hand. LVN1 stated she also heard the smack to Resident 1's hand. LVN1 stated Resident 1 stood up again and CNA1 then grabbed Resident 1 by her pants and slammed her back down in her wheelchair. LVN1 stated Resident 1 yelled out in pain after being slammed down in her wheelchair by CNA1. LVN1 stated she told CNA1 to stop because her actions were abusive. LVN1 stated she then calmed Resident 1 down and assessed her condition. LVN1 stated she then called the Nurse Consultant (NC) and ADM to report the abuse she had witnessed.</p> <p>During a record review on 5/14/24 at 4:34 p.m. at Nursing Unit 1, the facility's document titled [NAME] Work Assignment dated 5/14/24 showed CNA1 was assigned to care for 10 residents (Residents 4, 5, 8, 9, 10, 11, 13, 14, 15,16) during the AM shift and 10 residents (Residents 6, 7, 10, 11, 12, 13, 14, 15, 16) including Resident 1 during the PM shift.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA1 at Nursing Unit 1 on 5/14/23 at 4:36 p.m., CNA1 stated on 5/8/24 around 6:00 p.m., she was sitting next to Resident 1 in the hallway outside of room [ROOM NUMBER]. CNA1 stated Resident 1 got up from her wheelchair and attempted to sit in her chair. CNA1 stated she then helped Resident 1 sit back down in her wheelchair. CNA1 stated once Resident 1 was seated in her wheelchair, she applied A&amp;D ointment to Resident 1's face because she had dry skin. CNA1 stated no other physical contact was made with Resident 1 other than to apply the A&amp;D ointment to her face.</p> <p>During an observation on 5/14/24 at 6:24 p.m. at Nursing Unit 1, CNA1 was observed entering Resident 13 and Resident 14's room and performed patient care.</p> <p>During an observation on 5/14/24 at 7:18 p.m. at Nursing Unit 1, the DON was observed interviewing 11 residents (Residents 2, 3, 6, 7, 10, 12, 13, 14, 16, 17, 18) about the abuse incident that occurred on 5/8/24 towards Resident 1.</p> <p>During a concurrent interview and record review on 5/16/24 at 2:50 p.m. with the Medical Records Director (MRD), CNA1's timecard dated 5/15/24, was reviewed. The MRD confirmed the timecard indicated CNA1 worked at the facility on 5/14/24 until 6:49 p.m.</p> <p>During a telephone interview with LVN2 on 5/17/24 at 11:30 a.m., LVN2 stated she was using restroom [ROOM NUMBER] located adjacent to Nursing Unit 1 on 5/8/24 at approximately 6:00 p.m. LVN2 stated she heard two screams that sounded gut-wrenching, fearful and painful coming from Nursing Unit 1. LVN2 stated she exited the restroom and ran to Nursing Unit 1. LVN2 stated Resident 1 was standing in the hallway outside of room [ROOM NUMBER] hyperventilating (breathing rapidly) and visibly shaking. LVN2 stated she then asked LVN1 what had happened. LVN2 stated LVN1 told her that she witnessed CNA1 poke Resident 1 in the right cheek, smack Resident 1 in the hand and slam Resident 1 down into her wheelchair. LVN2 stated she called NC at 6:15 p.m. to report the screams she heard.</p> <p>During review of an additional undated document titled Summary of Investigation received on 5/15/24 at 6:57 p.m., the Summary of Investigation showed .Interventions/Plan of Action: .The facility completed their preliminary summary of investigation and continued their investigation and decided to bring back the certified nursing assistant .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Policy and Procedure on Patient Abuse Allegation Investigation dated October 2019, the P&amp;P showed, .Policy: .The facility shall ensure thorough and extensive investigation of different types of incidents including but not limited to those that may constitute abuse .e: Thorough investigation shall include: .Suspend staff if he/she is the alleged perpetrator pending final and thorough investigation .</p>		