

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Lake Merritt Healthcare Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 309 MacArthur Boulevard Oakland, CA 94610	

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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>36593</p> <p>Based on observation, interview and record review the facility failed to ensure one (Resident 1) of 3 sample residents with diagnosis of schizophrenia, a mental health condition, received appropriate treatment to address Resident 1 ' s paranoid delusions when Resident 1 ' s psychiatry recommendation to increase Olanzapine (antipsychotic medication) dosage was not implemented.</p> <p>{Paranoid delusions are fixed, false beliefs that others are intentionally trying to harm, deceive, or persecute the individual}</p> <p>This failure had the potential to cause Resident 1 increased emotional distress, decline in mental and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment and care guide tool), dated 12/9/24, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, 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.) Resident 1 ' s score was 13. Resident 1 had clear speech, able to express ideas and wants, make self-understood and understood others. Resident 1 ' s diagnoses included schizophrenia a disorder that affects a person ' s ability to think, feel and behave clearly.</p> <p>During a review of Resident 1 ' s Level I Preadmission Screening and Resident Review (PASRR, a federal requirement to ensure that residents are not inappropriately placed in nursing homes for long term care), dated 8/31/23, the PASRR indicated, Resident 1 ' s Level I screening result was positive for suspected MI (mental illness) and indicated a Level II mental health evaluation was required.</p> <p>During a review of Resident 1 ' s progress notes, dated 1/16/25, the progress notes indicated , Resident 1 alleged that staff were calling her names.</p> <p>During a concurrent observation and interview on 1/28/25 at 10:20 a.m. Resident 1 laid in bed, awake and verbally responsive. Resident 1 stated she did not want to discuss her allegation regarding staff calling her names. Resident 1 suddenly became upset, agitated and started yelling.</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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/28/25 at 10:28 a.m. with Certified Nursing Assistant (CNA1), CNA1 stated she was Resident 1 ' s care giver. CNA1 said Resident 1 got easily agitated, screamed and sometimes aggressive with staff.</p> <p>During a review of Resident 1 ' s Order Summary Report dated 6/3/24, the report indicated physician prescribed Resident 1 to receive Olanzapine tablet 10mg give one tablet by mouth one time a day for schizoaffective disorder bipolar type, manifested by paranoid delusion as exhibited by constant screaming to the point of exhaustion.</p> <p>During a review of Resident 1 ' s psychiatry follow up note and recommendations, dated 10/14/24, the psychiatry recommended to increase Resident 1 ' s Zydys (Olanzapine) to 15 mg by mouth every day for schizoaffective disorder, uncooperative with care, irritable, paranoid delusions, yelling.</p> <p>During a concurrent interview and record review on 1/28/25 at 11:40 a.m. with DON, Resident 1's positive PASRR Level 1 screening dated 8/31/23 and psychiatry recommendation dated 10/14/24 were reviewed. DON stated Resident 1's was not referred for Level II mental health evaluation. DON stated she was hired in December 2024 and was not aware of Resident 1 ' s psychiatry recommendation to increase Resident 1 ' s Olanzapine dose to 15 mg daily. DON stated the facility ' s process was that the medical record department received psychiatry consult reports , medical records gives copies of residents ' psychiatry reports to Licensed Nurses, who call the physician to approve or decline residents ' psychiatry recommendation and DON was primarily responsible for the follow-ups.</p> <p>During a concurrent interview and record review on 1/28/25 at 12:03 p.m. with Licensed Vocational Nurse (LVN1), Resident 1 ' s psychiatry recommendation dated 10/14/24 was reviewed. LVN1 stated she was a charge nurse. LVN 1 stated she was not aware of Resident 1 ' s psychiatry recommendation. LVN 1 stated the Director of Nursing (DON) followed up with residents psychiatry recommendations.</p> <p>During a concurrent interview and record review on 1/28/25 at 12:30 p.m. with DON, Resident 1 ' s Psychiatry recommendations report dated 10/14/24, physician orders, medication administration records, progress notes were reviewed with DON. DON stated there was no indication that Resident 1 ' s psychiatry recommendation dated 10/14/24 to increase Resident 1 ' s Olanzapine to 15 mg by mouth every day was followed up. The DON stated she was unable to find documentation if facility notified physician of Resident 1 ' s psychiatry recommendations.</p>		