

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER McClure Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 McClure Street Oakland, CA 94609	
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)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47400 Based on interview and record review, the facility failed to follow the facility abuse policy and procedure to protect and prevent further potential abuse for one of four sampled residents (Resident 1) when the facility allowed Certified Nursing Assistant (CNA) 1 to continue to provide direct patient care after Resident 1 made an abuse allegation. The failure to complete a thorough investigation of CNA 1 had pushed and slapped Resident 1 ' s arm during linen change resulted in psychosocial harm for Resident 1 and the potential for physical abuse for other residents. Findings: During a record review of Resident 1 ' s Admission Record dated 8/5/24, the admission record indicated Resident 1 had diagnosis of femoral shaft fracture of left femur (broken thigh bone). During a record review of Resident 1 ' s Minimum Data Set (MDS-an assessment used to guide care) dated 7/22/24, the assessment indicated Resident 1 had a Brief Interview of Mental Status exam (BIMS, is a scoring system used to determine the resident ' s cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status) score of 12 out of 15 and indicated mildly impaired cognition. During a review of Resident 1 ' s care plan dated 7/16/24, the care plan indicated Resident 1 is at risk for ADL [Activities of Daily Living, Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating.] / mobility decline and requires .will have needs anticipated and met by staff .2 person assist with ADLs .encourage to participate in ADLs to promote independence .monitor for changes in condition or declines in ability to participate in ADLs, decreased strength, increased weakness, or changes in cognition . During a phone interview on 9/10/24, at 11:51 a.m., with Resident 1, Resident 1 stated on 8/3/24 at 3 a.m. during a change of soiled bed linen, CNA 1 pushed Resident 1 ' s arm with force and then slapped Resident 1 ' s arm, when Resident 1 told CNA 1 the linen was still wet and dirty underneath her. Resident 1 stated she yelled out in pain and reported to Licensed Vocational Nurse (LVN) that CNA 1 had slapped her. Resident 1 stated she also called 911 and reported it to the police. Resident 1 stated having CNA 1 to continue to work at the facility on that day, made her fearful of retaliation and scared. Resident 1 stated I was ready to call 911 again. (continued on next page)		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 9/13/24 at 11:15 a.m., with CNA 1, CNA 1 stated on 8/3/24, she was removed from caring for Resident 1 by LVN 1. CNA 1 stated she continued to work the remainder of her shift providing care to the other 20 patients. CNA 1 denied the accusation. During a phone interview on 9/13/24, at 11:26 a.m., with LVN 1, LVN 1 stated LVN 1 was the charge nurse on duty on 8/3/24. LVN 1 stated CNA 1 was providing ADL care to Resident 1 and changing the dirty linen, when Resident 1 reported CNA 1 had slapped her arm. LVN stated after the Resident 1 called the police at 3:20 a.m., LVN 1 informed the DON of the incident. LVN 1 stated the DON instructed LVN 1 to remove CNA 1 from providing care for Resident 1 but CNA 1 could continue to work providing care to the other 20 patients for the remainder of the shift. During an interview on 9/10/24, at 12:35 p.m., with the Director of Nursing (DON), the DON stated LVN 1 told the DON of Resident 1 's complaint of being alleged hit on 8/3/24 at 3:30 a.m., by LVN 1. The DON stated she told LVN 1 to remove the CNA 1 from Resident 1 ' s care but let CNA 1 continue to work her full shift providing care to other residents. The DON stated the abuse investigation was completed on 8/6/24. During a review of Resident 1's undated investigation summary report, the report indicated Resident 1's allegation of abuse incident was completed and signed on 8/6/24 by the DON. The report indicated it was faxed to the Department on 8/7/24. During a concurrent interview and review of the facility provided document titled Detail Time and Job undated, with the DON, the DON stated CNA 1 clocked in, and started her shift on 8/2/24 at 11:00 p.m., and clocked out for lunch break on 8/3/24 at 03:00 a.m. The DON stated CNA 1 then clocked back in on 8/3/24 at 3:31 a.m. and clocked out at the end of the shift on 8/3/24 at 8:04 a.m. The DON stated CNA 1 stayed 30 minutes overtime to write a narrative of the incident. During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022, the P&P indicated Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.		