STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555067	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McClure Post Acute	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32717 Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to ensure a complete medical records when Resident 1's Treatment Administration Record (TAR) had missing signatures. This failure had the potential to result in uncoordinated care, and unnecessary, painful duplicate wound care. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility in October 2024 with diagnoses of malnutrition, cancer of the kidney, anemia (abnormally low level of red blood cells) and diabetes mellitus (condition of uncontrolled high blood sugar). During a review of Resident 1's progress notes dated 10/10/24, the progress notes indicated Resident 1 had a wound from pressure on the sacrum (large triangular bone at the base of the spine) diagnosed as a stage 4 pressure ulcer (also know as bed sore, most severe stage of a pressure sore, where the damage extends through all layers of skin and tissue, exposing underlying muscle, tendon, or bone, often with significant tissue loss and a high risk of infection). During a review of Resident 1's pressure ulcer care plan dated 10/11/24, the care plan indicated for treatments to be performed as ordered. During a review of Resident 1's Order Summary Report dated 10/13/24, the Order Summary Report indicated the treatment for Resident 1's sacrum pressure ulcer was: every day shift was to cleanse wound with normal saline, pat dry, apply santyl (ointment, treatment of choice to remove damaged tissue from chronic wounds) and cover with optifoam (type of foam dressing). During an interview on 11/22/24 at 10:20 a.m. with Resident 1, Resident 1 stated he had a wound on his buttock which needed to be cleaned and re-dressed every day. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 10/16/24, the MDS indicated Resident 1 had a score of 12 on the Brief Interview for Mental Status (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 eight to 12 is an indication of moderate impairment; a score of 13 to 15 is an indication of intact cognitive status). During a review of Resident 1's TAR for October 2024, the TAR indicated the dates, times, and initials of the nursing staff who completed wound care treatments. The TAR inidcated no entries os the data for the following dates: 10/11/24, 10/14/24, 10/15/24, 10/20/24, 10/21/24, and 10/28/24. During a telephone interview on 11/25/24 at 1:04 p.m. with Treatment Nurse (TN), TN stated TN had been on duty as the treatment nurse on the days Resident 1's TAR was missing initials in October. TN stated she had forgotten to enter the date, time and her initials after providing Resident 1's treatment. During a review of the facility's policy and procedure (P&P) titled, Wound Care, revised October 2010, the P&P indicated, after wound care was provided, The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason (s) why. 10. The signature and title of the person recording the data. During a review of the facility's P&P titled, Charting and Documentation, undated, indicated information to be documented in the resident's medical record included treatments and services performed. The P&P also indicated the documentation of the treatments and services performed will include specific details including date and time the procedure was performed, the name and title of the individual who provided the care, and the signature and title of the individual documenting the treatment.