STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555113	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Park Healthcare Center	1850 Alice Street Oakland, CA 94612

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49091 Based on observation, interview and record review, the facility failed to properly secure medications and sharp instruments when one treatment cart was left unlocked and unsupervised, in an area where residents could access it. This failure had the potential for accidental medication administration, ingestion or injury to residents residing in the facility. During an observation on 11/05/24, at 7:46 a.m., with Licensed Vocational Nurse 1 (LVN 1) in the hallway, a treatment cart containing topical medications, ointments, scissors, nail clippers, and other treatment supplies was observed unlocked. The treatment cart was situated in between six resident bedrooms and the activity/dining room, and multiple residents passed the treatment cart during this time. The cart remained unlocked while LVN 1 went in four separate resident bedrooms to administer medications, until 11:30 a.m. In an interview on 11/5/24, at 11:30 a.m., with LVN 1, LVN 1 stated the treatment cart contained prescribed medications. During an interview on 11/5/24, at 2:07 p.m., with the Director of Nursing (DON), the DON stated the treatment cart contained medications and items that residents should not have access to, and so it should always be locked when unattended. The DON stated residents with dementia might open drawers and take things out, causing them harm. During review of policy and procedure (P&P) titled, Storage of Medications, undated, the P&P indicated compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45091 Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared under safe and sanitary conditions when: 1. Dry food items were stored less than 6 inches above the floor. 2. Refrigerated and frozen food items were unlabeled, and undated. 3. Dry food items were past their use by date. 3. Raw pork was stored directly over ready to eat shrimp. 4. There was dark brownish matter inside the resident ice machine, above the ice bin. These failures had the potential to put residents at risk for food borne illness and cross-contamination (transfer of bacteria or other microorganisms from one substance to another) that could have resulted in infection or spread of infection. Findings: During an observation on 11/04/24, at 9:40 a.m., the kitchen refrigerator had an opened container of raw pork directly above and an opened container of ready to eat shrimp. During a concurrent observation and interview on 11/4/24, at 10:13 a.m., with Registered Dietician (RD), the kitchen and food storage were observed. The dry storage had three bulk boxes of cereal stored less than six inches above the floor. RD stated food stored less than six inches above the floor was a risk for contamination. The Freezer had one opened package of hash browns with use by date of 11/1/24, one undated, opened package of bacon, and three unlabeled, undated, opened packages of unknown meats. RD stated frozen food should be labeled and dated. RD stated unlabeled and undated food needed to be thrown out because they did not know how old it was and it was a risk for food borne illness. In the kitchen there was one turmeric seasoning with a 9/10/24 use by date, one white pepper seasoning with a 7/16/24 use by date, one sesame seed seasoning with a 10/6/24 use by date, and one jug of honey with a 9/21/24 use by date. RD stated the seasonings and honey should have been thrown out because they were past their use by dates, and they were a risk for food borne illness. RD stated ready to eat shrimp should not have been stored below raw pork because it was a risk for food borne illness. During an observation on 11/4/24, at 11:59 a.m., the resident refrigerator- freezer was observed. The refrigerator had one bowl of oranges and one plastic container of cake that was not labeled with a resident identifier. The refrigerator had one opened package of butter, one container of soup, and one pack of yogurt not labeled with a resident identifier or date. The freezer had one container of ice cream and two ice cream sandwiches that were not labeled with a resident identifier or date. The freezer had six instant cold packs for injuries and pain stored among resident food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/04/24, at 12:10 p.m., with the Director of Nursing (DON), the resident refrigerator- freezer was observed. DON stated all food should have been labeled with date and resident name or room number. DON stated food that was not labeled with date and resident name, or room number were a risk for cross contamination. DON stated the instant cold packs for injuries and pain should not have been in the freezer and were a risk cross contamination. During a concurrent observation and interview on 11/07/24, at 8:59 a.m., with Maintenance Director (MD), the resident ice machine was observed. There was a dark brownish matter on the inside of the ice machine where the ice was made, and above the ice bin. MD stated it looked like mold. During a concurrent observation and interview on 11/07/24, at 9:17 a.m., with Dietary Manager (DM), DM stated the ice machine needed to be shut down, and residents would not get ice from there until it was cleaned and sanitized. During an interview on 11/07/24, at 10:32 a.m., with DM, DM stated the ice machine should have been cleaned and sanitized every six months and as needed. DM stated it was important to keep it clean to prevent food borne illness. During a review of the instant ice pack label, the label indicated, Caution: For external use only . Do not swallow contents. If contents accidentally swallowed drink large amounts of water (not milk) and contact Poison Control Center or physician. The label indicated, Ingredients: Urea blend and water. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised October 2017, the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. The P&P indicated, Food Services, or other designated staff, will maintain clean food storage areas at all times. The P&P indicated, Food in designated dry storage areas shall be kept off the floor (at least 18 inches) . The P&P indicated, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The P&P indicated, Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods. The P&P indicated, Food items and snacks kept on the nursing units must be maintained as indicated . All foods belonging to residents must be labeled with the resident's name, the item and the use by date.The P&P indicated, .toxic substances . will not be stored in the kitchen area or in storerooms for food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49091 Based on observation, interview and record review, the facility failed to follow appropriate infection control practice when reusable resident-care equipment was not cleaned/disinfected in between residents. This failure had the potential to cause resident infection via cross-contamination. During a concurrent observation and interview on 11/5/24, at 7:46 a.m., in the resident bedroom hallway with Licensed Vocational Nurse 1 (LVN 1), LVN 1 took the blood pressure machine out of the drawer, did not sanitize the cuff and stated it was the first blood pressure she took that day. LVN 1 obtained resident 84's blood pressure reading, laid the blood pressure machine/cuff on the cart, prepared Resident 84's medications, and administered them. LVN 1 then obtained Resident 19's blood pressure (taken earlier by the Certified Nursing Assistant), then prepared and administered Resident 19's medications. LVN 1 then picked up the blood pressure machine/cuff and obtained Resident 11's (a resident on Enhanced Barrier Precautions [infection control interventions designed to reduce transmission of multidrug-resistant organisms in nursing homes]) blood pressure readings. LVN 1 returned to the hallway and placed the blood pressure machine/cuff on top of the cart, prepared Resident 11's medications, then administered them. LVN 1 did not clean the blood pressure cuff immediately after use on Resident 11. During an interview on 11/5/24, at 2:17 p.m., with the Infection Preventionist (IP), the IP stated multi-use resident care items such as blood pressure equipment should be sanitized or disinfected between residents to prevent the spread of infection, especially since some of the facility residents have compromised immunity and are on enhanced barrier precautions. During a review of the facility's policy and procedure (P & P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/2018, the P&P indicated, Reusable items are cleaned and disinfected or sterilized between residents . During a review of the facility's P & P titled, Enhanced Barrier Precautions, dated 6/20/24, the P&P indicated, The facility shall clean and disinfect the non-critical resident-care items or equipment (such as stethoscope, sphygmomanometer [A device used to measure blood pressure, composed of an inflatable cuff to collapse and then release the artery under the cuff in a controlled manner], or digital thermometer) using EPA [U.S. Environmental Protection Agency] approved disinfectant or in accordance with the manufacturers and current guidelines before and after use with another resident.