| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555189 | A. Building<br>B. Wing | 03/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mercy Retirement & Care Center | 3431 Foothill Blvd.<br>Oakland, CA 94601 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, for one of four sampled residents (Resident 3), the facility failed to ensure care and services were provided according to professional standards of care when:a. Resident 3's multiple episodes of diarrhea, which represents a change in condition, were not reported to the physician.b. Resident 3's physician-ordered oral medications were not administered as ordered. Colace, a stool softener, was either held or refused repeatedly because of diarrhea, but loperamide, an anti-diarrheal medication, was not administered. This failure had the potential to result in delayed medical management, increasing the risk for dehydration, other serious complications and emotional distress.1. During a review of Resident 3's admission Record (AR) dated 3/25/26, the AR indicated Resident 3 was admitted to the facility in January 2026 with diagnoses that included acute myeloblastic leukemia (fast-growing cancer of the blood and bone marrow and interferes normal blood cell production), severe sepsis (life-threatening medical emergency when an infection causes severe widespread inflammation leading to organ dysfunction/damage) , acute kidney failure (sudden loss of kidney function) and malnutrition (poor nutrition). During a review of Resident 3's Minimum Data Set Assessment (MDS, an assessment tool used to direct resident care) dated 1/27/26, the MDS indicated a Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status on attention, orientation, and ability to register and recall information) score of 12. A BIMS score of eight to 12 is an indication of moderately impaired cognitive status. During an interview on 3/27/26 at 11:30 a.m. with Resident 3, Resident 3 stated having ongoing diarrhea with up to three episodes of large loose stools in 24 hours. Resident 3 stated feeling punished due to staff frustration over frequent bathroom visits. Resident 3 stated refusing Colace, stool softeners, as they worsened her already loose stools. During a review of Resident 3's Order Summary Report (OSR) dated 3/27/26, the OSR indicated the following physician orders; Ensure 237 ml (nutritional supplement drink) with meals for supplement, Colace capsule 100 mg 2 capsules by mouth two times daily, hold for episodes of loose stool, and Loperamide hydrochloride capsule 2 mg 1 capsule by mouth as needed after each loose stool, maximum 8 mg/24 hours. During a review of the Progress Notes (PN) and Medication Administration Record (MAR) for March 2026, the PN and MAR indicated the following:The 9 a.m. Colace dose was held for loose stools, but loperamide was not administered on 3/7, 3/10, 3/12, 3/17, 3/22, and 3/27/26.Both 9 a.m. and 5 p.m. Colace doses were held for loose stools, with no loperamide administered on 3/8, 3/14, 3/18, 3/19, 3/21, 3/23, 3/24, and 3/26/26. During a review of the Social Services Notes (SSN) dated 3/12/26, the SSN indicated Resident 3 reported feeling mistreated by Certified Nursing Assistant (CNA) 1 during care. Resident 3 stated CNA 1 did not show compassion, particularly in response to several episodes of diarrhea. During a concurrent interview and record review on 3/27/26 at 11:01 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 3 still had ongoing loose stools, including that day. RN 1 stated Colace and Ensure were on hold to manage diarrhea, but no care plan was in place for this issue. During a concurrent interview and record review on 3/27/26 with Director of Nursing (DON), Physician Notes from 2/8/26 to 3/24/26 were reviewed. DON stated there was no documentation that Resident 3's physician was informed of repeated loose stools. DON stated that multiple episodes of diarrhea represent a change of condition that must be promptly reported to the physician for immediate<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | management. During a telephone interview on 4/2/26 at 12:57 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated working with Resident 3 only couple of times. LVN 1 stated that multiple diarrhea episodes require a change of condition report for close monitoring. LVN 1 stated he would not have known about Resident 3's loose stools unless it was noted in the 24-hour report. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status last revised February 2001, the P&P indicated a nurse should notify the attending physician when a resident refuses a medication two or more consecutive times. |