

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50474</p> <p>Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of one sampled resident (Resident 17), when Resident 17 did not receive a routine medication called levetiracetam (anti-seizure medication) 100 milligrams/milliliter (mg/ml) solution for five consecutive days according to physician's order.</p> <p>This failure had the potential to cause Residents 17 to have unwanted adverse effects such as seizure (abnormal electrical activity in your brain).</p> <p>Findings:</p> <p>During a record review of Resident 17's Admission Record printed on 2/12/25, the Admission Record indicated Resident 17 was admitted to the facility in November 2018 with a diagnosis of epilepsy (a brain disorder that causes recurring, unprovoked seizures).</p> <p>During a review of Resident 17's Brief Interview for Mental Status (BIMS, is 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 zero to seven is an indication of severe cognitive status.), dated 2/3/25, the record indicated Resident 17's BIMS score was 2.</p> <p>During a record review of Resident 17's Physician Orders, dated 2/3/25, the physician order indicated Resident 17 had an active order to take levetiracetam 100mg/ml - 7.5 ml via gastrostomy tube (G-tube, a tube inserted through a surgically created hole through the abdomen to deliver food/medications/fluids directly into the stomach) twice daily for seizure that had a start date of 1/29/19.</p> <p>During a record review of Resident 17's Medication Administration Record, dated 2/1/25 to 2/28/25, the MAR indicated Resident 17 did not receive the levetiracetam medication for five consecutive days starting from 2/7/25 to 2/11/25.</p> <p>During a concurrent interview and record review on 2/12/25 at 11:36 a.m. with the Director of Nursing (DON), Resident 17's electronic health record (EHR) was reviewed. Resident 17's physician order for levetiracetam indicated pending confirmation. The DON stated pending confirmation for Resident 17's levetiracetam medication could have been discontinued by the physician. The DON stated the facility transitioned to a EHR system on 2/6/25 and they prioritized the active and more essential physician orders for all the residents.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/12/25 at 2:50 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 17's physician orders in EHR were reviewed. LVN 2 stated she did not give the levetiracetam medication to Resident 17 because it was not on the list of scheduled medications for Resident 17.</p> <p>During a follow up concurrent record review and interview on 2/12/25 at 2:58 p.m. with the DON, Resident 17's MAR was reviewed. The DON stated Resident 17's physician confirmed that the levetiracetam medication was not discontinued and was still an active order. The DON stated the levetiracetam medication should have been included as part of Resident 17's active medication orders. The DON stated there were no records or documentations that the licensed nurses administered the levetiracetam medication to Resident 17 from 2/7/25 to 2/11/25. The DON stated Resident 17 had been taking the levetiracetam medication since 2019. The DON stated the licensed nurses should have checked the order and clarified with the physician when the order for the levetiracetam indicated pending for confirmation. The DON stated Resident 17 should have been given the levetiracetam medication as ordered by the physician because without it, Resident 17 could have had episodes of epilepsy.</p> <p>During a record review of the facility's policy and procedure (P&P), titled, Medication Administration, revised on 4/11/24, the P&P indicated, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .</p> <p>During a record review of the facility's P&P, titled, Quality of Care, revised on 11/1/24, the P&P indicated, Facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans .Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, psychosocial well-being .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474</p> <p>Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services and procedures that assure accurate dispensing and administration when:</p> <ol style="list-style-type: none"> 1. Resident 108's Lidoderm 5% patch (skin patch used to relieve pain) was not available on hand per physician order. 2. Resident 25's hazardous drugs (medications that pose short or long-term harm upon exposure to human via skin or inhalation) was handled by a licensed nurse without protective measures during medication administration <p>These failures had the potential to cause physical discomfort to Resident 108 and unsafe handling of hazardous medications could pose health risk to staff and residents.</p> <p>Findings:</p> <p>1. During a record review of Resident 108's Admission Records, printed on 2/11/25, the Admission Record indicated Resident 108 was admitted to the facility in January 2025 with diagnosis of chronic kidney disease (long-term condition where the kidneys are damaged and could not properly filter blood).</p> <p>During a review of Resident 108's Brief Interview for Mental Status (BIMS, is 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.), dated 2/2/25, the record indicated Resident 108's BIMS score was 14.</p> <p>During a record review of Resident 108's MAR, dated 2/1/2025-2/28/2025, the MAR indicated Resident 108 had an order to administer Lidoderm patch 5% (skin patch that helps relieve pain) apply topically in the morning at 9:00 a.m. for pain and remove within 12 hours or as directed by doctor with start date on 2/3/25.</p> <p>During a medication pass observation on 2/11/25 at 8:45 a.m. Licensed Vocational Nurse (LVN) 2 prepared and administered Resident 108's oral medication. LVN2 did not apply Resident 108's Lidoderm patch during the medication administration.</p> <p>During an interview on 2/11/25 at 2:17 p.m. with LVN2, LVN2 stated she did not give Resident 108's Lidoderm 5% patch because it was not available on hand. LVN2 stated she did not contact the pharmacy to inquire about the missing medication. LVN2 further stated the pharmacy did not deliver Resident 108's Lidoderm's patch because it was not approved by the insurance.</p> <p>During a record review of Resident 108's MAR, dated 2/1-2/28/25, the MAR indicated LVN2 documented Resident 108 refused the Lidoderm 5% patch on 2/11/25 during the 9:00 a.m. scheduled administration.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 9:24 a.m. with Resident 108, Resident 108 stated she did not refuse the Lidoderm patch from LVN2. Resident 108 stated she had not received the Lidoderm 5% patch at all from the facility. Resident 108 stated she wanted to have the Lidoderm 5% patch applied to her because she had lower back and left hip pain.</p> <p>During a concurrent record and interview on 2/12/25 at 11:36 a.m. with the Director of Nursing (DON), Resident 108's MAR was reviewed. The DON stated LVN2 did not document the reason why Resident 108 refused the Lidoderm 5% patch. The DON stated LVN2 should have also notified the doctor if Lidoderm 5% was not available on hand and requested for an alternative. The DON stated Lidoderm 5% patch could have helped Resident 108 ease discomfort and pain.</p> <p>During a phone interview on 2/13/25 at 11:54 a.m. with Consultant Pharmacist (CP), CP sated the pharmacy had not delivered Resident 108's Lidoderm 5% patch ever since it was ordered. CP stated the pharmacy had sent out two to three prior authorizations (request for approval) for Resident 108's Lidoderm 5% patch sent to the facility and the pharmacy had not received it back. CP further stated the Lidoderm 5% patch had also been back ordered and not available for delivery. CP stated the facility should have requested the doctor for an over-the-counter pain patch as an alternative for Resident 108.</p> <p>During a record review of the facility's policy and procedure (P&P), titled, Pharmacy Services, revised on 7/1/24, the P&P indicated, The facility will provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering all of routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.</p> <p>2. During a medication pass observation on 2/11/25 at 9:01 a.m. with LVN2, LVN2 prepared Resident 25's oral medications that included hazardous medication called finasteride (used to treat symptoms of benign prostatic hyperplasia such as difficult urination) labeled by pharmacy with a red sticker that indicated Hazardous Drugs. LVN2 did not use gloves when she removed the drug from bubble pack (a card that packaged doses of medication within a plastic bubbles or blisters) into a pill cup for administration to Resident 25.</p> <p>During a follow up interview on 2/11/25 at 9:10 a.m. with LVN2, LVN2 stated she should have used gloves when she prepared Resident 25's finasteride medication. LVN2 stated finasteride could have caused her unwanted side effects.</p> <p>During a concurrent record and interview on 2/12/25 at 11:39 a.m. with the DON, the DON stated wearing gloves while handling the hazardous medications was very important because it could have directly entered the licensed nurse's system.</p> <p>During a phone interview on 12/13/25 at 11:56 a.m. with CP, CP stated the finasteride medication could have caused birth defect to childbearing women if handled incorrectly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of the facility's P&P, titled, Handling of Hazardous Drugs, revised on 4/11/24, the P&P indicated, A hazardous drug is defined as a drug which poses a significant risk to a healthcare worker by virtue of teratogenic (can cause congenital disabilities), genotoxicity (cause damage to genetic material), carcinogenic (any agent that promotes the development of cancer) .Preparation of Administration of Oral Hazardous Drugs .b. Wear a protective gown, two pairs of chemotherapy gloves, face shield, and eye protection [NAME] administering the medication .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>32717</p> <p>Based on interview and record review, for two of five sampled residents reviewed for unnecessary medications (Resident 4 and Resident 10), the facility failed to ensure irregularities with medication therapy identified by Consultant Pharmacist's (CP) were acted upon when:</p> <ol style="list-style-type: none"> 1.For Resident 4, thyroid assessment (i.e. thyroid profile, blood test that measures the levels of hormones produced by the thyroid gland) was not done to monitor current therapy. 2.For Resident 10, pain assessment and pain level for each prn (as needed) narcotic (A substance used to treat moderate to severe pain. Narcotics are like opiates such as morphine and codeine) pain medication use was not clarified with the prescribing physician. <p>These failures had the potential to result in delayed prevention of adverse consequences related to medication therapy.</p> <p>Findings:</p> <p>1.During a review of Resident 4's Profile Face Sheet, the Profile Face Sheet indicated, Resident 4 was initially admitted to the facility in January 2016. Resident 4 had multiple diagnoses that included hypothyroidism (Condition when the thyroid gland doesn't make enough thyroid hormone also known as underactive thyroid), hyperlipidemia (a condition in which there are abnormally high levels of lipids (fats) in the blood), and age-related osteoporosis (a bone disease that weakens bones, making them more likely to break).</p> <p>During an interview and concurrent record review on 2/12/25 at 3:03 p.m. with Director of Nursing (DON), DON stated the last Medication Regimen Review (MRR, or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for Resident 4 was done 11/26/24. DON stated there was no record that another MRR was done after that time. The MRR titled Note To Attending Physician/Prescriber printed 11/26/24 indicated Resident 4 was receiving Levothyroxine (used to treat hypothyroidism) without a recent thyroid assessment in the clinical record. The MRR recommended for the physician to consider a routine thyroid profile and TSH (Thyroid Stimulating Hormone, plays a crucial role in regulating the function of the thyroid gland), annually in order to monitor the current therapy. The Note to Attending Physician/Prescriber, under Physician/Prescriber Response, did not indicate a response from the prescribing physician.</p> <p>During an interview and concurrent record review on 2/13/25 at 9:48 a.m. with Licensed Vocational Nurse (LVN) 5, Physician Orders was reviewed. The Physician's Orders indicated an order dated 9/30/24 for Levothyroxine 50 microgram (mcg) tablet one tablet by mouth daily. LVN 5 stated Resident 4's clinical record did not indicate any blood test was done to check Resident 4's thyroid profile.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During another interview and concurrent record review on 2/13/25 at 10:23 a.m. with LVN 5, SNF [Skilled Nursing Facility] Visit Note dated 12/5/24 was reviewed. The SNF Visit Note indicated the care plan was for Resident 4 to have blood tests that included TSH, Free T4 (a test that measures the amount of active thyroid hormone (thyroxine) in the bloodstream) every June and December, Fasting Lipid Panel (a blood test that measures the levels of various fats (lipids) in the blood after a period of fasting) and Vitamin D every December. LVN 5 stated Resident 4's clinical record did not indicate that any of these blood tests was done in December 2024. LVN 5 stated it was her first time reviewing the SNF Visit Note.</p> <p>During a telephone interview on 2/13/25 at 12:22 p.m. with Consultant Pharmacist (CP), CP stated MRRs were done monthly but the facility was not very organized with their records that CP had to re-send MRRs that were already done. CP stated, after the recommendations in November 2024 were not addressed, recommendations had to be followed up in December 2024 because the blood tests (labs) were not done. CP stated if thyroid labs were not done, there would be no way to check if levothyroxine was within therapeutic level. CP stated, Resident 4 may experience unpleasant symptoms like thyrotoxicosis (a condition characterized by excessive thyroid hormone production, leading to a hypermetabolic state, [if receiving higher than required dose]) or irritability and sleep changes (if receiving lower than required dose).</p> <p>During a review of MRR titled Not to Attending Physician/Prescriber dated 12/13/24, the MRR indicated Resident 4 was receiving medications which need routine lab work that included the following: lipid panel, LFT (Liver Function Test, a blood test that measures liver function), TSH and Vitamin D. The MRR, under Physician/Prescriber Response, indicated, there was no response from the physician.</p> <p>2. During a review of Resident 10's Profile Face Sheet, the Profile Face Sheet indicated Resident 10 was admitted to the facility in January 2016.</p> <p>During review of Resident 10's Order Summary Report dated 2/12/25, the Order Summary report indicated a physician order dated 2/4/25 for Acetaminophen oral tablet 325 milligrams (mg) give two tablets by mouth every six hours as needed for mild pain, assess for pain every shift dated 2/7/25, and oxycodone-acetaminophen oral tablet 5-325 mg give two tablets by mouth every four hours as needed for pain. The MRR did not indicate if the recommendation was followed through.</p> <p>During review of the MRR titled Consultant Pharmacist's Medication Regimen Review dated 12/13/24, the MRR indicated for licensed nurses to assess pain using the 1-10 pain scale and to clarify the pain level for each PRN dose.</p> <p>During a review of Resident 10's Medication Record (MR) for December 2024, the MR indicated oxycodone-acetaminophen was administered 54 times from 12/1/24 to 12/31/24, without indicating the pain level for each dose. The MR did not indicate pain assessment using 1-10 pain scale was done.</p> <p>During another review of Resident 10's MR for January 2025, the MR indicated oxycodone-acetaminophen was administered 64 times from 1/1/25 to 1/31/25 without indicating pain level for each use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled Medication Regimen Review and Reporting last copyrighted 2007, the P&P indicated the following; The findings are communicated to the Director of Nursing and the Medical Director, Resident-specific MRR recommendations are documented and acted upon by the nursing care center and/or physician, the nursing care center follows up on the recommendations to verify that appropriate actions have been taken and shall be acted upon within 30 calendar days.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>50474</p> <p>Based an observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 37 and Resident 108) received medications without an error. The facility's medication pass observation during the survey resulted in two errors out of 31 opportunities and indicated a medication error rate of 6.45 percent (%).</p> <p>This failure placed Resident 37 and Resident 108 at risk for not getting the full therapeutic effect of their prescribed medications and had the potential to result in undesired health care outcomes.</p> <p>Findings:</p> <p>1. During a record review of Resident 37's Admission Records, printed on 2/11/25, the Admission Record indicated Resident 37 was admitted to the facility in February 2025 with diagnosis of congestive heart failure (chronic condition where the heart muscle is weakened and cannot pump blood efficiently throughout the body).</p> <p>During a record review of Resident 37's Medication Administration Record (MAR), dated 2/1/2025-2/28/2025, the MAR indicated Resident 37 had an order to administer pantoprazole (medication for heart burn or acid reflux) 1 tablet 40 milligrams (mg) by mouth two times for gastro-esophageal reflux (GERD, stomach acid leaks backward from stomach into the food pipe) to be given 30 minutes before breakfast and dinner.</p> <p>During a medication pass observation and interview on 2/11/25 at 8:26 a.m., Licensed Vocational Nurse (LVN) 2 prepared one tablet of pantoprazole 40mg, together with the rest of Resident 37's 9:00 a.m. medications. Resident 37 had the breakfast tray on the table. Resident 37 stated she already ate and had cereal, cup of fruit and yogurt for breakfast. LVN 2 administered the medication to Resident 37 even after Resident 37 had the consumed breakfast.</p> <p>During a follow up interview on 2/11/25 at 9:10 a.m. with LVN 2, LVN 2 stated Resident 37's pantoprazole medication was scheduled on her shift at 9:00 a.m. LVN 2 stated she should have given Resident 37's pantoprazole before breakfast. LVN 2 stated when she gave Resident 37 the pantoprazole after Resident 37 had eaten breakfast, LVN 2 stated the medication could have been least effective.</p> <p>During an interview on 2/12/25 at 11:28 a.m. with the Director of Nursing (DON), the DON stated LVN 2 should have given the pantoprazole to Resident 37 before breakfast. The DON stated it was important to give pantoprazole on an empty stomach because it coats the stomach lining to prevent acid reflux.</p> <p>2. During a record review of Resident 108's Admission Records, printed on 2/11/25, the Admission Record indicated Resident 108 was admitted to the facility in January 2025 with diagnosis of chronic kidney disease (long-term condition where the kidneys are damaged and could not properly filter blood).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 108's Brief Interview for Mental Status (BIMS, is 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.), dated 2/2/25, the record indicated Resident 108's BIMS score was 14.</p> <p>During a record review of Resident 108's MAR, dated 2/1/2025-2/28/2025, the MAR indicated Resident 108 had an order to administer Lidoderm patch 5% (skin patch that helps relieve pain) apply on skin in the morning at 9:00 a.m. for pain and remove within 12 hours or as directed by doctor Resident 108's Lidoderm 5% patch had a order start date of 2/3/25.</p> <p>During a medication pass observation on 2/11/25 at 8:45 a.m. LVN 2 prepared and administered Resident 108's oral medication. LVN2 did not apply Resident 108's Lidoderm patch during the medication administration.</p> <p>During a follow up interview on 2/11/25 at 2:17 p.m. with LVN 2, LVN 2 stated she did not give Resident 108's Lidoderm 5% patch because it was not available on hand. LVN 2 stated she did not contact the pharmacy to inquire about the missing medication. LVN 2 further stated the pharmacy did not deliver Resident 108's Lidoderm's patch because it was not approved by the insurance.</p> <p>During a record review of Resident 108's MAR, dated 2/1/25 to 2/28/25, the MAR indicated LVN 2 documented Resident 108 refused the Lidoderm 5% patch on 2/11/25 during the 9:00 a.m. scheduled administration.</p> <p>During an interview on 2/12/25 at 9:24 a.m. with Resident 108, Resident 108 stated she did not refuse the Lidoderm patch from LVN 2. Resident 108 stated she had not received the Lidoderm 5% patch at all from the facility. Resident 108 stated she wanted to have the Lidoderm 5% patch applied to her because she had lower back and left hip pain.</p> <p>During a concurrent record and interview on 2/12/25 at 11:36 a.m. with the DON, Resident 108's MAR was reviewed. The DON stated LVN 2 did not document the reason why Resident 108 refused the Lidoderm 5% patch. The DON stated LVN 2 should have also notified the doctor if Lidoderm 5% was not available on hand and requested for an alternative. The DON stated Lidoderm 5% patch could have helped Resident 108 ease discomfort and pain.</p> <p>During a record review of the facility's policy and procedure, titled, Medication Administration Policy, revised on 4/11/24, the P&P indicated, Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .Administer medication as ordered in accordance with manufacturer specifications.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>50474</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices with census of 49 when:</p> <ol style="list-style-type: none"> 1. A box of opened thickened lemon-flavored water did not have an open date and time and was stored in room temperature. 2. The medication cart#2 had oral, eye drops, injectable solution (administered into the body using a needle and syringe), and suppositories (a medication that is inserted into the rectum, vagina, or urethra) medications were stored together. <p>These failed practices could contribute to unsafe use of biologicals and medications and had the potential for medication error.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a medication pass observation on 2/11/25 at 8:09 a.m., an opened box of thickened lemon-flavored water with a handwritten date of 2/6/25 was stored in room temperature on top of the medication cart#1. The box of thickened water was not cold when touched. <p>During a review of the manufacturer's instructions written on the box of the thickened lemon-flavored water, the instructions indicated, Refrigerate prior to serving .After opening, may be kept up to 7 days under refrigeration .Storage and Handling .Serve chilled.</p> <p>During an interview on 2/11/25 at 9:10 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she did not know how long the box of thickened water was stored on top of the medication cart and in room temperature. LVN 2 stated when she took over the medication cart at the start of her shift, the box of thickened water was already there. LVN 2 stated the date 2/6/25 that was handwritten on the box was the open date. LVN 2 stated she would have discarded or returned the box of thickened water in the refrigerator after she was done using it.</p> <p>During an interview on 2/12/25 at 11:32 a.m. with the Director of Nursing (DON), the DON stated the date 2/6/25 on the box of the thickened water was the date it was received date from the kitchen. The DON stated the licensed nurse who opened the box of thickened water should have dated it on the day it was opened.</p> <p>During an interview on 2/12/25 at 12:45 p.m. with the Registered Dietician (RD), the RD stated the box of thickened water should have been refrigerated after opening or placed in a container with ice to maintain the temperature and prevent growth of bacteria.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of the facility's policy and procedure (P&P), titled, Food Storage, revised on 4/11/24, the P&P indicated, Ensure all food are stored appropriately according to the state and federal food code to prevent foodborne illness in the community .Cold foods shall be stored at the proper temperatures necessary to prevent the growth of bacteria .</p> <p>2. During an observation on 2/11/25 at 12:32 p.m. with LVN 1, multiple medications stored together in a bin were found inside the medication cart#2 as followed:</p> <p>a. Resident 2's lubricant eye drops.</p> <p>b. Resident 19's oral medications called senna (drug used for constipation) 8.6 milligrams (mg) and Zofran 4mg (drugs used to prevent nausea and vomiting).</p> <p>c. Resident 21 and Resident 39's oral medication called nitroglycerin (drug that can treat and prevent chest pain) 0.4 mg.</p> <p>d. Resident 19's suppositories called acetaminophen (treats pain or fever) 650 mg and bisacodyl (treats constipation) 10mg to be given rectally.</p> <p>e. Resident 202's vial of injectable solution medication called heparin (an anticoagulant) 5,000 unit/milliliter.</p> <p>During an interview on 2/12/25 at 12:40 p.m. with LVN 1, LVN 1 stated the medications should have been stored separately for organization and neatness of the cart.</p> <p>During an interview on 2/12/25 at 11:42 a.m. with the DON, the DON stated the medications in medication cart#2 should have been stored separately by administration route not only for organization but mostly because it was the standard of practice. The DON stated storing oral, solution, eyedrops and suppositories medications together could have confused the licensed nurses which may have led to medication errors.</p> <p>During a record review of the facility's P&P, titled, Storage of Medication, dated January 2023, the P&P indicated, Medications and biologicals are stored properly, following the manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration .Internally administered medications are stored separately from the medications used externally such as lotions, creams, ointments, and suppositories .Eye medications are stored separately from ear medications, inhalers, etc .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32717</p> <p>Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards of food service safety when:</p> <ol style="list-style-type: none"> 1. An opened tub of ice cream was stored in the freezer without a lid. 2. Multiple food items, stored in walk-in refrigerators # 1, were either not labeled or not dated. 3. Multiple food items, stored in walk-in refrigerators # 2, were either not labeled or not dated. <p>These failures had the potential to result in cross-contamination and food borne illnesses.</p> <p>Findings:</p> <p>During an observation and concurrent interviews on 2/10/25 at 9:21 a.m. with Registered Dietician (RD) and Kitchen Staff (KS) 1, in the main kitchen, the following were observed:</p> <ol style="list-style-type: none"> 1) In the ice cream freezer, there was an opened tub of ice cream that was loosely covered with a brown parchment paper, the tub did not have a lid. KS stated the lid was being washed, then later stated, it will be temporarily covered with paper because they could not find the lid. 2) Inside walk-in refrigerator #1; there was a small pan of brown colored puree food item loosely covered with cling wrap that did not have a label and was not dated, an opened box of sausage patties without an opened-on date, an opened box of diced dark and white chicken with opened-on date 2/3/25 with Keep Frozen written on the side of box. RD stated she did not know what was in the pan and would check the facility's policy on how long opened food items would be safely stored inside the refrigerator. 3) Inside walk-in refrigerator #2; an opened half block white cheese without an opened-on date, an opened bag of shredded parmesan cheese without opened-on date, an opened bag of shredded cheddar cheese without opened-on date, and an opened bag of mozzarella cheese without opened-on date. RD took out all the opened bags of cheese and stated they would be thrown out. <p>During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods last revised in 2023, the P&P indicated, newly opened food items need to be closed and labeled with an open date and use by date. P and P also indicated all prepared foods need to be covered, labeled and dated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50474</p> <p>3) During a subsequent medication pass observation o 2/11/25 at 8:36 a.m. with LVN 2, LVN 2 was observed administering Resident 14's oral medications with disposable gloves on. LVN 2 then touched Resident 14's tray table and picked up the cup of water with straw and assisted Resident 14 to drink. Using the same gloves, LVN 2 touched Resident 14's eyelids and administered the eye drops on both eyes. LVN 2 did not perform hand hygiene and did not change gloves before administering the eye drops to Resident 14.</p> <p>During a follow up interview on 2/11/25 at 9:10 a.m. with LVN 2, LVN 2 stated she forgot to change her gloves in between procedures. LVN 2 stated she should have removed her gloves and performed hand hygiene after she touched Resident 14's table and cup prior to administering the eye drops to Resident 14 because the gloves could have been contaminated.</p> <p>During an interview on 2/12/25 at 11:36 a.m. with the DON, the DON stated LVN 2 should have performed hand hygiene and changed gloves before she administered the eye drops to Resident 14. The DON stated not changing gloves had the risk for spread of bacterial infection to Resident 14.</p> <p>During a record review of the facility's policy and procedure (P&P), titled, Medication Administration, revised on 4/11/24, the P&P indicated, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>During a record review of the facility's policy and procedure (P&P), titled, Handwashing Policy, revised on 4/11/24, the P&P indicated, Hand hygiene is indicated .b. before performing an aseptic task (free of germs) . c. after contact with blood, body fluids, or contaminated surfaces .Single-use disposable gloves should be used .a. before aseptic procedures .The use of gloves does not replace hand washing/hand hygiene .</p> <p>32717</p> <p>Based on observation, interview and record review, the facility failed to follow infection prevention and control procedures when:</p> <p>1) Multiple staff did not wear Personal Protective Equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury and to prevent the transmission of infectious agents from one person to another, also known as cross-contamination) while inside Droplet Precaution (used to prevent the spread of infections that are spread through respiratory droplets. This includes infections like the flu and the common cold) rooms.</p> <p>2) Multiple staff did not perform hand hygiene before entering and after exiting Enhanced Barrier Precaution rooms.</p> <p>3)Licensed Nurse did not wash hands and change gloves in between procedures for multiple residents.</p> <p>These failures had the potential to result in spread of infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mercy Retirement & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3431 Foothill Blvd. 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings:</p> <p>1) During an observation and concurrent interviews on 2/10/25 at 11:41 a.m. with Licensed Vocational Nurse (LVN) 4 and Housekeeping Aide (HA)1, HA 1 was seen entering Resident 1's room, going to Resident 1's bathroom and Resident 1's bedside to clean, exited and re-entered the room multiple times wearing only a mask and without face shield or protective eyewear. Resident 1's room had a signage on the door that indicated, Stop Droplet Precautions EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. HA 1 stated he did not see the signage on the door. LVN 4 stated the resident in that room tested positive for flu and the HA 1 should have donned appropriate PPE while inside the room.</p> <p>2) During another observation and concurrent interview on 2/11/25 at 9:04 a.m. with Certified Nursing Assistant (CNA)1, CNA 1 was observed inside a Droplet Precaution room providing care to Resident 106 wearing only a mask that was pulled down to CNA 1's chin. CNA 1 did not wear a face shield or protective eyewear.</p> <p>During a follow-up observation and concurrent interview on 2/11/25 at 9:10 a.m. with Infection Preventionist (IP), in front of Resident 106's room, IP stated, both Resident 106 and Resident 38 shared a room, and both tested positive for flu, hence, the droplet precaution. During the interview, CNA 1 exited the room wearing only a mask. IP stated, CNA1 did not follow facility's infection control protocol for droplet precautions.</p>