STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555358	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fruitvale Healthcare Center	3020 East 15th Street 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 32717 Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being when psychiatric and mental health services were not provided to treat mental and substance use disorders. This failure had the potential to result in significant distress from unresolved psychosocial and mental health issues. Findings: During a review of Resident 1's Resident Face Sheet, the Resident Face Sheet indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included schizophrenia (serious mental health condition that affects how people think, feel and behave), auditory hallucinations (sensory perceptions of hearing in the absence of an external stimulus) and psychoactive substance abuse (strong desire or sense of compulsion to take psychoactive substance, various natural or synthetic compounds that cause changes in thoughts, emotions and behavior). During a review of Resident 1's Hospitalists SNF/Rehab Discharge Summary (Hospital DC Summary), dated 1/10/24, the Hospital DC Summary indicated Resident 1 admitted to using methamphetamine (a powerful, highly addictive stimulant that affects the central nervous system) earlier on 1/7/24. The summary also indicated urine toxicology was done and Resident 1 tested positive for methamphetamine and cocaine (also a highly addictive stimulant, a stimulant speeds up the messages traveling between the brain and the rest of the body). During a review of Resident 1's Minimum Data Set (MDS, , a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 1/17/24, the MDS indicated Resident 1 had the following active diagnoses: schizophrenia, other psychoactive substance abuse, and auditory hallucinations. During a review of Resident 1's Physician Order Report, dated 1/10/24 - 7/7/24, the Physician Order Report indicated the following: 1. A physician's order, dated 1/10/24, to refer Resident 1 to Mental Health. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Behavioral care plan, to address diagnosis of substance abuse, dated 1/10/24. Interventions included encouraging resident to attend activities of choice, encouraging resident to verbalize feelings and offer understanding and empathy, identify situations causing behavioral problem and assist resident in resolving identified issues, monitor behavior not easily altered and refer to attending physician, observe for pain or discomfort that might trigger negative behavior, psychiatric consult if needed, and psychosocial management as ordered. All interventions were dated 1/11/24. The care plan indicated two more problems were identified when, on 4/28/24, Resident 1 dropped a used drug paraphernalia on the floor, and on 5/12/24, when Resident 1 was caught stealing other resident's belongings. The care plan did not indicate any revisions or added interventions after the two incidents were identified. During a review of Resident 1's Monthly IDT (a group composed of individuals from different departments in the facility) Pain/Psychotropic (any drug that affects brain activities associated with mental processes and behavior; psychotropic drugs include, but are not limited to the following categories: anti-psychotics, anti-depressants, anti-anxiety, and hypnotics) Review, dated 5/29/24, the Monthly IDT Pain/Psychotropic Review indicated to continue current acetaminophen order for pain and olanzapine (an antipsychotic) for management of schizophrenia. The review indicated the current care plan was not reviewed. During a review of Resident 1's Care Conference Notes, dated 4/18/24, the Care Conference Notes indicated current care plans were appropriate. The clinical record indicated there were no care conferences/meetings done to address Resident 1's behavior on 4/28/24, 5/12/24 and 5/26/24. During an interview on 7/26/24 at 12:02 p.m. with DON, DON stated he did not have knowledge of the type of drug paraphernalia found in Resident 1's possession on 4/28/24. During a review of Resident 1's Social Services (SS) Progress Notes, dated 1/12/24, the SS Progress Notes indicated an initial interview with Resident 1 about Resident 1's prior living arrangement and previous drug use. Another SS Progress Notes, dated 7/10/24, indicated efforts to reach Resident 1's family members after Resident 1 was transferred out to the hospital and passed. The clinical record did not indicate any other SS Progress Notes to address incidents on 4/28/24, 5/12/24 and 5/26/24. The clinical record did not indicate any interventions or Social Service visits with Resident 1 after 1/12/24, despite multiple behavior issues identified on 4/28/24, 5/12/24 and 5/26/24. During an interview on 7/26/24 at 1:52 p.m. with Administrator (Adm), Adm stated there were only two SS Progress Notes found in Resident 1's clinical record. Adm stated keeping a Social Services Director (SSD) and having complete documentation of Social Services Notes have been challenging. During an interview on 7/26/24 at 2:20 p.m. with Social Services Assistant (SSA), SSA stated meeting with Resident 1 to discuss financial issues and on how to get Resident 1 Social Security Income benefits. SSA stated she did not give Resident 1 counseling after the incidents on 4/28/24, 5/12/24 and 5/26/24. During a review of the facility's Facility Assessment, last revised 7/16/24, the Facility Assessment indicated the facility's current residents included those with psychiatric/mood disorder (psychosis [hallucinations, delusions], schizophrenia, and opioid dependence) which is the fifth most prevalent in the facility. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 12:38 p.m. with Adm, Adm stated the facility's policy and procedure (P&P) to address Substance Use Disorder and Opioid Overdose Response were not in place at the time Resident 1 was a resident at the facility. During a telephone interview on 8/5/24 at 8:34 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, on 7/7/24, Resident 1 was found unresponsive with no pulse and no spontaneous breathing and was foaming at the mouth. During a review of Resident 1's Resident Progress Notes, dated 7/7/24, the Resident Progress Notes indicated, on 7/7/24 at 8:00 a.m., Resident 1 was found unresponsive, was taken to the hospital by paramedics who responded to the emergency call. During a review of Resident 1's ED (Emergency Department) Provider Notes, dated 7/7/24, the ED Provider Notes indicated Resident 1 presented to the ED in cardiac arrest, Resident 1 passed at 9:04 a.m