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	12/11/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 2) received adequate supervision and assistance device to prevent falls when Certified Nursing Assistant (CNA) 1 transferred Resident 2, who was totally dependent on staff for activities of daily living, from wheelchair to bed without another staff present and without using a Hoyer lift (interchangeably used with mechanical lift, uniquely designed electronically operated patient lift to transfer patients between two surfaces, for example from their bed to another surface such as a wheelchair or couch). This failure resulted in Resident 2's fall and transfer to the hospital for a four-day hospitalization for closed displaced subtrochanteric fracture of the right femur (broken bone specifically in the area just below the hip joint, where the fractured pieces are significantly out of alignment, but the skin over the fracture site remains intact, making it a non-open wound). Findings: During a review of Resident 2's Resident Face Sheet, the Resident Face Sheet indicated Resident 2 was admitted to the facility in February 2023 with diagnoses that included polyneuropathy (a disease that damages the peripheral nerves, causing weakness, numbness, and burning pain), chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months and does not respond to conventional treatments), abnormalities of gait and mobility and osteoarthritis (a degenerative joint disease that occurs when the cartilage and bone in a joint break down over time). During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 11/10/24, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's mental status in regard to attention, orientation, and ability to register and recall information) score of 13 (A BIMS score of 13-15 is an indication of intact cognitive status). The MDS also indicated Resident 2's functional ability with everyday activities was impaired on both sides of the upper and lower extremities. The MDS indicated, Resident 2 was dependent (helper does all of the effort, or the assistance of two or more helpers is required for the resident to complete the activity) on staff with everyday activities that included; rolling from left and right side while in bed, sitting on the side of the bed to lying flat, lying on the back to sitting on the side of the bed, transferring to and from a bed to a chair or wheelchair. The MDS indicated, Resident 2's ability to come to a standing position from sitting in a chair was not attempted during the assessment due to medical condition or safety concern. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review on 12/11/24 at 1:02 p.m. with Director of Nursing (DON), Resident 2's ADL (activities of daily living) care plan dated 2/22/23 was reviewed. The ADL care plan indicated for staff to provide Resident 2 with needed assistance in ADL to maintain comfort and dignity, multiple approaches that included Establish patient's physical function and capabilities and provide approaches to assist patient but did not indicate a specific approach to transfer Resident 2. DON stated Resident 2 needed a Hoyer lift for transfers. During a review of the facility's undated policy and procedure (P&P) titled Resident Transfers, the P&P indicated for staff to assess resident's functional ability and type of assist needed, and to document the type of transfer and assistance device needed on the resident's comprehensive care plan, in the electronic health record system and progress notes. During an interview on 12/11/24 at 1:08 p.m., Resident 2 stated while she was up in a wheelchair, CNA 1 picked her up and dropped her. During an interview on 12/11/24 at 1:12 p.m. CNA 2, who was Resident 2's regular CNA for almost six months, stated, Resident 2 needed a Hoyer lift and help of another CNA, to transfer Resident 2 to and from the wheelchair to bed. During an interview on 12/11/24 at 1:16 p.m. with Nurse Supervisor (NS), NS stated Resident 2 was not able to move both legs and not able to stand up even with help from staff. NS stated Resident 2 always required Hoyer lift, with two staff assisting, for transfers. During an interview and concurrent record review on 12/11/24 at 1:28 p.m. with Director of Nursing (DON) Resident 2's Care Plan Essentials (a communication tool with specific details about the resident's care needs) initiated 3/4/24 was reviewed. The Care Plan Essentials indicated Resident 2 needed Hoyer lift with assistance of two staff for transfers to and from a bed to a wheelchair. During a telephone interview on 12/11/24 at 1:59 p.m. with CNA 1, CNA 1 stated working her first shift at the facility on 11/19/24. CNA 1 stated she received report from a regular staff that Resident 2, who was in a wheelchair at the start of the shift, would not go back to bed around 8:00 p.m. to 9:00 p.m. CNA 1 stated, around 9:00 p.m., CNA 1 went to the room to transfer Resident 2 back to bed. CNA 1 stated placing Resident 2's both arms around her while CNA 1 grabbed Resident 2's waistband on the back in a hugging position. CNA 1 stated, during the transfer, Resident 2 told CNA 1 Don't drop me. CNA 1 stated reassuring Resident 2 everything was going to be okay as the bed and the wheelchair had already been locked. CNA 1 stated attempting to lift Resident 2 to a standing position towards the bed when CNA 1 noticed Resident 2 was dead weight, did not have good function on both legs, and started to slide down. CNA 1 stated she asked Resident 3 (Resident 2's roommate) to lower the bed so CNA 1 could sit Resident 2 on the side of the bed. CNA 1 stated then she thought, Resident 3 was demented (one who has impaired memory and decision-making) and could not understand CNA 1's instruction, so CNA 1 eased Resident 2 down to the floor. CNA 1 stated she needed to be told at the start of the shift that a Hoyer lift and another CNA were needed to transfer Resident 2. CNA 1 stated she left the room to call Registered Nurse Supervisor (RNS) for help while Resident 2 sat on the floor. During a review of Resident 3's MDS dated [DATE], the MDS indicated a BIMS score of 14 (A score of 13-15 indicates intact cognitive status). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/11/24 at 1:42 p.m., Resident 3 stated CNA 1 came to the room to get Resident 2 back to bed. Resident 3 stated she offered help to CNA 1 to transfer Resident 2 from wheelchair to bed as she thought to herself how did she think she could pick [Resident 2] up by herself? Resident 3 stated CNA 1 just picked up Resident 2 then dropped her. During a telephone interview on 12/11/24 at 1:55 p.m. with Registered Nurse Supervisor (RNS), RNS stated CNA 1 came out of the room saying she needed help with Resident 2. RNS stated, upon entering the room, Resident 2 was sitting on the floor with back against the bed. During a follow-up telephone interview on 12/13/24 at 9:47 a.m. with RNS, RNS stated Resident 2 could not bear weight at all and had always used a Hoyer lift for transfers. RNS also stated Resident 2 was not a high risk for fall as Resident 2 had no history of attempting to get out of bed unassisted. During an interview on 12/11/24 at 3:05 p.m. with DON, DON stated, for residents who are dependent on staff with transfers, a Hoyer lift should be used. During a review of Resident 2's SBAR (Situation, Background, Assessment, Recommendation, written communication tool that helps provide essential, concise information, usually during crucial situations) dated 11/19/24, the SBAR indicated, Resident 2 had an assisted fall. The SBAR indicated, when Resident 2 slid off the bed, CNA 1 eased Resident 2 down to the floor. During a review of Resident 2's Risk Meeting Notes Initial Week One dated 11/25/24 created by DON, the Risk Meeting Notes Initial Week One indicated the following: - On 11/19/24, Resident 2 had a Guided (assisted) fall while transferring from wheelchair to bed. - On 11/22/24, Resident 2 complained of pain on the right thigh and right knee, a STAT (suggests a possible emergency condition, one where treatment must immediately be undertaken) x-ray was ordered by the Nurse Practitioner (NP). - On 11/23/24, STAT x-ray result came back. Resident 2 had a right proximal femur fracture .Resident 2 was transferred to the hospital for further evaluation and management per Nurse Practitioner's order. During a review of Resident 2's Radiology (imaging) Report dated 11/23/24, the Radiology Report indicated Resident 2 had a Proximal right femur fracture. as described. The findings are new compared to 23JUN2023. During a review of Resident 2's Physician's Order dated 11/23/24, the Physician's Order indicated an order to transfer Resident 2 to the hospital for management of fractured femur. During a review of Resident 2's hospital Internal Medicine Discharge Summary dated 11/27/24, the Internal Medicine Discharge Summary indicated Resident 2 was admitted to the hospital after a fall that resulted in right subtrochanteric femur fracture. Resident 2 was sent back to the facility after IMN (Intermedullary Nailing, a surgical procedure used to treat bone fractures by inserting a metal rod [nail] into the hollow center [medullary canal] of the bone) and an order to receive Lovenox (an injectable blood thinner that helps prevent the formation of blood clots) for 30 days. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's Progress Notes dated 11/27/24, the Progress Notes indicated Resident 2 returned to the facility from the hospital, on 11/27/24, with a 4 centimeter (cm) right upper hip incision with six staples, 5 cm right hip incision with seven staples, and 2 x 5 cm incision behind the right knee with six staples.