

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Fruitvale Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain management was provided, consistent with the comprehensive resident-centered plan of care and professional standards of practice for one of two sampled residents (Resident 2) when a scheduled pain medication was not administered according to the physician's order. This failure had the potential to result in ineffective pain management. During a review of Resident 2's Resident Face Sheet (RFS), the RFS indicated Resident 2 was admitted to the facility in August 2025 with diagnoses that included systemic lupus erythematosus (a chronic autoimmune disease, causing inflammation and tissue damage, with symptoms like joint and muscle pain) and chronic pain syndrome. During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care) assessment dated [DATE], the MDS indicated Resident 2 received scheduled and prn (given as needed) pain medication daily, and occasionally experienced pain rated at four out of 10 (zero as no pain and 10 being the worst pain). During a review of the facility's policy and procedure (P&P), undated, titled Pain Management, the P&P indicated that a pain rating scale of four to six represented moderate pain. The P&P also indicated for the licensed nurse to administer therapeutic interventions, non-drug treatments, or pain medication as ordered by the physician. During a review of Resident 2's pain care plan dated 8/30/25, the care plan indicated approaches to manage pain that included acknowledging Resident 2's pain and administering pain medication as ordered. During a review of the Physician Order Report (POR) dated 8/30/25-9/10/25, the POR indicated a physician order dated 8/30/25 for acetaminophen (Tylenol) 500 milligrams (mg) two tablets by mouth for chronic pain, to be administered three times daily at 6 a.m., 2 p.m., and 10 p.m. During a concurrent interview and record review on 9/18/25 at 10:43 a.m. with Registered Nurse Supervisor (RNS), the Medication Administration Record (MAR) and POR for September 2025 were reviewed. RNS stated, Resident 2 requested two tramadol (opioid/narcotic pain medication) tablets during the night shift, but the physician's order was for only one tablet. RNS stated there was a misunderstanding between the licensed nurse and Resident 2 regarding the pain medication order. The POR indicated Tylenol was to be administered at 10 p.m. but the MAR indicated administration at 2 pm. RNS confirmed that Resident 2 did not receive the scheduled Tylenol dose at 10 pm, before asking for prn medication. Further review of the MAR indicated Resident 2 did not receive Tylenol 1000 mg dose scheduled for 10 p.m. from 9/1/25 to 9/7/25. During a concurrent interview and record review on 9/18/25 at 11:10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she administered Tylenol 1000 mg to Resident 2 twice each day shift, at 10 a.m. and 2 p.m. During a follow-up interview on 9/18/25 at 1:25 p.m. with RNS, RNS stated a computer glitch that was overlooked by the admitting nurse. RNS stated the correct administration times were 6 a.m., 2 p.m., and 10 p.m., but this was not transcribed in the MAR. RNS stated that improper administration could result in Resident 2's pain not being properly managed.</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
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