

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2025
NAME OF PROVIDER OR SUPPLIER  Shields Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3230 Carlson Boulevard El Cerrito, CA 94530	

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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure Resident 1 ' s representative (RR) received copies of medical records within forty-eight hours from requested date.</p> <p>This failure resulted in RR not receiving requested documents for forty-two days.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE].</p> <p>During a review of the letter of request, dated 2/20/25, the letter was addressed to the facility ' s Custodian of Records. The letter indicated a request for Resident 1 ' s medical records.</p> <p>During a review of the documents, the authorization request was hand delivered and served to the facility on 2/27/25 and received by facility staff. On 3/17/25, Medical Records (MR) staff confirmed to RR the facility received the request. MR said he was still working on it and was not finished gathering the records.</p> <p>During an interview on 5/22/25, at 1:07 p.m., with MR, MR stated he did not see the request as the letter might have been in the Administrator ' s (ADM) office. Per MR, he was not sure when he knew about the request. MR stated the requested documents were placed in a USPS (United States Postal Service) parcel box and ADM mailed it at the post office. Per MR, medical records request must be completed in seventy-two hours.</p> <p>During a concurrent interview and record review on 5/22/25, at 1:07 p.m., with ADM, the USPS receipt was reviewed. The ADM stated he took the parcel box containing the requested documents and mailed it at the post office. The USPS receipt indicated the parcel box was mailed on 3/26/25 at 4:58 p.m Per receipt, the parcel box was mailed with certified mail and return receipt tracking numbers.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Release of Information, dated November 2009, the P&amp;P indicated, A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request.</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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview, and record review the facility failed to assess the coccyx (tailbone) pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence) wound for one (Resident 1) of three sampled residents.</p> <p>This failure had the potential for Resident 1 ' s wound to worsen, delay wound healing, have pain, infection and hospitalization.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s face sheet, the face sheet indicated Resident 1's admitting diagnoses included unspecified dementia (a progressive state of decline in mental abilities) and urinary tract infection (UTI - an infection in the bladder/urinary tract).</p> <p>During a review of facility document Skin Only Evaluation, the Skin Only Evaluation noted Resident 1 had bluish purplish skin discoloration in coccyx area and foam dressing placed. The facility document Clinical admission Evaluation, noted Resident 1 had a pain score of 1 (1 being the least and 10 being the worst).</p> <p>During a review of Resident 1 ' s face sheet, the face sheet indicated an additional diagnosis of pressure ulcer of sacral region, stage 3 (stage 1 as lowest wound severity and stage 4 as highest wound severity) with onset date twenty months after admission.</p> <p>During a review of the facility document Wound - Weekly Observation Tool, the Wound - Weekly Observation Tool, in 2024, was completed on 2/6, 3/15, 6/14, 6/21, 7/5, 7/26, 8/23, 10/18, and 11/8.</p> <p>During a review of the facility document Long Term Care Evaluation - Weekly Evaluation, the Long Term Care - Weekly Evaluation, in 2024, the Skin Section did not have any skin evaluation documented on 2/8, 3/17, 3/21, 4/4, 4/18, 5/2, 5/9, 5/23. In 2024, the Skin Section did not have wound description documented on 2/29, 3/14, 3/28, 4/25, 5/17, 6/13, 6/20, 6/27, 7/18, 11/7, 11/14, 11/21, and 12/5.</p> <p>During a review of facility document Braden Scale (assessment of a patient ' s risk of developing pressure ulcer) for Predicting Pressure Ulcer Risk, Resident 1 ' s Braden Score was 12 (12 or lower = very high risk).</p> <p>During an interview on 4/23/25, at 12:31 p.m., with the Director of Nursing (DON), the DON stated skin evaluation should be done on admission then on weekly assessments.</p> <p>During an interview on 5/22/25, at 10:25 a.m., with Licensed Vocational Nurse (LVN) 1, LVN1 stated wound description should be documented in progress notes and change of condition. Per LVN 1, wound documentation included description of wound, length, depth, and color. LVN 1 stated wound assessment documentation should be done weekly. Per LVN 1, when doing weekly evaluation charting, it was not expected to include wound assessment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/25, at 11:45 a.m., with the DON, the DON stated weekly wound evaluation should be done once a week. The DON added documentation on wound assessment should include staging. Per DON, if not done, nobody will know if there is infection and not know if wound is getting better.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Wound Care, dated October 2010, the P&amp;P indicated, The following information should be recorded in the resident ' s medical record .all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.</p>		