

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 11/20/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review the facility failed to ensure necessary treatment and care services were provided for one (Resident1) of three sampled residents in accordance with professional standards of practice and care plan when: 1.Facility did not reevaluate Resident 1's routine administered of Acetaminophen (Tylenol) medication twice a day for pain management when Resident 1's pain symptoms had resolved. (Tylenol - medication used to relieve mild to moderate pain and reduce fever). 2. Facility did not carry out diagnostic laboratory tests dated 8/30/24 for Resident 1 as ordered by the physician. 3. Facility did not monitor Resident 1's fluid intake and output record as indicated on care plan. 4. LVN 1 did not notify physician and document failed attempts to obtain STAT UA specimen via straight catheterization for Resident 1. STAT lab order means immediately. It is a medical instruction that indicates that a laboratory test should be performed, and the results should be provided as soon as possible.Straight catheterization is a medical procedure that uses a straight, hollow tube to drain urine from the bladder These failures had the potential to cause delay to receive the necessary care and services, suffer from unnecessary medication and dehydration for Resident 1.1.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 11/30/24, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, 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.) score was 01 and indicated severe cognitive impairment. The MDS indicated Resident 1 was not able to recall the correct year, month, and day of the week, had clear speech, and had difficulty communicating some words or finish her thoughts but able if prompted or given time. The MDS indicated Resident 1 needed supervision with eating food and/or liquid to mouth and swallow. The MDS indicated Resident 1 received a scheduled pain medication regimen. The MDS indicated Resident 1 had had no complaint of pain when interviewed. The MDS indicated Resident 1 had diagnoses to include non-Alzheimer's dementia (a progressive disease that destroys memory and other important mental functions) and malnutrition (lack of sufficient nutrients in the body). During a review of Resident 1's Progress Notes, dated 8/13/22, the Progress Notes indicated the physician ordered Resident 1 to receive acetaminophen tablets 325 mg give two tablets by mouth every 6 hours as needed for pain and give two tablets by mouth two times a day for pain management for complain of generalized pain. Further review of the Progress notes indicated Resident 1 had no complaint of pain and discomfort at the time and no change in level of consciousness. During a review of Resident 1's Medication Review Report (MRR), dated 12/3/24, the MRR indicated on 8/13/22 the physician verbally prescribed Resident 1 to receive Acetaminophen tablet 325 mg give two tablets by mouth two times a day for pain management. During a review of Resident 1's Medication Administration Record (MAR), dated July, August, September, October, November, December 2024 and January 2025, the MARs indicated Resident 1 was administered acetaminophen tablet 325 mg two tablets by mouth two times a day for pain management. Further review of Resident 1's MARs dated July, August, September, October, November, December 2024, and January 2025, the MARs indicated Resident 1 was assessed for pain every shift. MARs indicated Resident 1 had no pain. During an interview on 9/29/25 at 2:10 p.m. with Registered Nurse (RN1), RN 1 stated Resident 1 had generalized chronic pain. RN 1 stated reevaluation may not apply to Resident 1's administration of routine Tylenol medication because Resident 1 had chronic pain. RN 1 stated Resident 1 was assessed every shift for pain and had no pain. During a review of Resident 1's Pain/discomfort Care Plan, initiated 5/24/22, the Pain/discomfort Care Plan indicated Resident 1 had risk for pain/discomfort, interventions included medicate for pain and assess for effectiveness. During an interview on 9/29/25 at 3:05 p.m. with Director of Nursing (DON), DON stated licensed nurses are expected to reevaluate Resident 1's need for pain medication and assess for effectiveness. 2. During a review of Resident 1's Physician's Orders (PO), dated 8/30/24, the PO indicated, Resident 1's physician ordered laboratory testing to include CBC, A1C, TSH/T4, Lipid profile and CMP (blood work) During a concurrent interview and record review on 9/29/25 at 3:05 p.m. with Director of Nursing (DON), Resident 1's PO, dated 8/30/24, was reviewed. The PO indicated on 8/30/24, Resident 1's physician ordered laboratory tests for blood work for Resident 1. DON stated the lab test ordered by the physician for Resident 1 was not carried out. 3. During a review of Resident 1's Nutritional Assessment, dated 12/09/24, the Nutritional Assessment indicated Resident 1's nutritional goal was for oral intake to meet adequate hydration and estimated fluid</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to ensure one (Resident 1) of three sampled residents' medical records was accurately documented and systematically organized when Licensed Vocational Nurse (LVN1) did not document in Resident 1's medical records, the physician order to obtain STAT laboratory test for urinalysis (UA) and straight catheterization to include the date and time the order was received in accordance with accepted professional standards and practices. This failure had the potential to cause inaccurate documentation and confusion of care and treatment provided for Resident 1. During an interview on 9/29/25 at 3:25 p.m. with LVN 1, LVN 1 stated an order for a STAT lab test for UA, blood work and straight catheter to obtain UA specimen were received for Resident 1 a day before Resident 1 was transferred to the hospital. LVN 1 stated she attempted to obtain urine specimen by straight catheterizing Resident 1 twice but there was no urine. LVN 1 stated she endorsed the STAT order for UA to the night shift nurse. LVN 1 stated her mistake was that she did not notify the physician of failed attempts to obtain UA specimen. LVN 1 stated Resident 1 complained of pain after receiving routine Tylenol. LVN 1 stated she did not inform the physician that attempts to obtain urine specimen failed. LVN 1 stated she did not inform physician that Resident 1 continued to complain of pain. LVN 1 said she did not document order for straight catheter. LVN 1 stated when she returned the next day, Resident 1 had low grade fever and low oxygen saturation. LVN 1 stated she called the doctor and received an order to transfer Resident 1 to hospital. During a concurrent interview and record review on 9/29/25 at 4:20 p.m. with DON, LVN 1 and Administrator (Admin), Resident 1's Progress Notes, dated 1/10/25 through 1/17/25 and laboratory reports dated 1/16/25, were reviewed. Lab report for STAT UA specimen was received 1/16/25 at 10:15 a.m. Resident 1 Progress Notes, dated 1/16/25 at 00:20 indicated that LVN1 received orders from the physician the previous day. DON stated she was not aware that Resident 1's STAT lab order for UA was endorsed from shift to shift. DON stated she did not know that Resident 1's STAT lab orders was received a day before Resident 1 was transferred to the hospital. DON stated the progress notes did not reflect the time upon which physician order for STAT labs was received.</p>		