STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555851	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Area Healthcare Center	1833 10th Avenue Oakland, CA 94606

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45645 Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #6) of 1 resident reviewed for self-administration of medications was assessed to determine if they were clinically appropriate and safe to administer their own topical medications. Findings included: A facility policy titled, Self- Administration by Resident, dated 2007, revealed, Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration. The policy also indicated, 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. 2. The interdisciplinary team determines the resident's ability to self-administer medication by means of a skill assessment conducted as part of the care plan process. The policy specified, 3. The results of the interdisciplinary team assessment are recorded on the Medication Self Administration Assessment, which is placed in the resident's medical record. An Admission Record indicated the facility admitted Resident #6 on 05/09/2016. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/12/2025, revealed Resident # 6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #6's Care Plan Report included a focus area, initiated on 04/21/2021 and revised on 01/15/2025, that indicated the resident self-administered supplements. The focus area included a goal that the resident would be able to perform proper procedures for medication administration. Interventions dated 01/15/2025 directed staff to assess the resident with a self-medication assessment form and to inform and update the resident's physician with the results of the assessment. The focus area did not indicate which supplements or medications staff were to assess the resident's ability to self-administer. Resident #6's Order Summary Report contained the following orders: - an order dated 07/19/2021 for hydrocortisone cream 1%, apply to itchy body areas topically every 12 hours as needed for itchiness; (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order dated 10/04/2024 for lidocaine external cream 4%, apply to toes topically every shift for pain management; - an order dated 08/01/2024 for nystatin external cream 100000 units per gram, apply to right plantar foot topically every 12 hours as needed for fungal rash; and - an order dated 08/01/2024 for nystatin powder, apply to right foot between toes every 24 hours at night as needed for fungal rash. The Order Summary Report also reflected orders for various dietary supplements with instructions that specified the resident may self administer & [and] keep at bedside; however, the above topical treatment orders contained no such instructions. A concurrent interview and observation on 02/24/2025 at 9:52 AM revealed a medication cup containing an ointment at Resident #6's bedside. Resident #6 stated the ointment was for eczema, and the nurse left it in their room. An observation on 02/25/2025 at 9:15 AM revealed three medication cups containing topical medications on Resident #6's bedside table. One of the medication cups contained an ointment and was labeled with the word toe, one contained an ointment and was labeled with the words inner thigh, and one contained a powder but was not labeled. Two additional medication cups containing ointment were observed on another table in the resident's room, one of which was labeled with the word rash. Resident #6 and a staff member were in the bathroom at the time of the observation. On 02/25/2025 at 9:22 AM, Certified Nursing Assistant (CNA) #6 emerged from the bathroom in Resident #6's room. CNA #6 stated it was the resident's assigned shower day, and the nurse left the cups of medications at the resident's bedside earlier that morning. CNA #6 further stated Resident #6 kept some of their medications with them and was able to apply the medications themselves. During an interview on 02/25/2025 at 9:27 AM, Licensed Vocational Nurse (LVN) #3 stated she was Resident #6's assigned nurse and admitted she left three prescribed ointments and a prescribed powder at the resident's bedside. LVN #3 identified the medications as triamcinolone ointment, lidocaine ointment, and nystatin powder. LVN #3 described the resident as alert and said she did not think it was a big issue; however, LVN #3 further stated the resident did not have an order to self-administer the topical medications and said perhaps the resident needed one. During an interview on 02/25/2025 at 11:01 AM, Resident #6 stated they requested the nurses leave their prescribed topical mediations with them so the resident could apply them when needed. During an interview on 02/25/2025 at 2:56 PM, LVN #1 stated that if a resident requested to self-administer a medication, staff initiated the process of assessing the resident to ensure they could safely administer the medication in question. LVN #1 reviewed Resident #6's medical record and confirmed the resident did not have a self-administration of medication assessment or an order to self-administer their topical medications. LVN #1 stated the resident had been administering their own typical medications, so an assessment should be completed and an order obtained from the physician. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2025 at 10:37 AM, the Director of Nursing (DON) stated if a resident asked to self-administer a medication, nursing staff should know to complete an assessment or notify a supervisor or the DON. The DON stated that Resident #6 was self-administering their topical mediations, but the facility did not have a self-administration assessment or an order for the resident to do so. The DON stated she expected nurses to follow the facility's policies regarding safety and also expected them to have completed an assessment for self-administration as soon as it was known the ointments were left at the resident's bedside. During an interview on 02/26/2025 at 10:51 AM, the Administrator stated Resident #6 was managing prescribed ointments without an assessment or an order to do so. The Administrator stated she expected the nurses to follow the facility's policy regarding self-administration of medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 22445 Based on observation, interview, record review, and facility document and policy review, the facility failed to dispose of expired medications that were stored on 1 of 5 medication carts. Findings included: A facility policy titled, Storage of Medications, dated 2007, revealed, 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. An undated facility document titled, Following Meds [medications] Expired After Opening revealed latanoprost eye drops expired 42 days after opening. A concurrent interview and observation of the Station 2 medication cart with Licensed Vocational Nurse (LVN) #7 on 02/26/2025 at 11:18 AM revealed two bottles of latanoprost eye drops. One bottle was labeled for Resident #16 and had an open date of 01/01/2025, and the other bottle was labeled for Resident #1 and had an open date of 01/08/2025. LVN #7 confirmed the bottles of latanoprost for Resident #16 and Resident #1 were expired and should have been discarded 42 days after they were opened. The Director of Nursing (DON) was interviewed on 02/26/2025 at 12:11 PM. The DON stated if a medication was expired, she expected the nurses to remove the medication from the medication cart. The DON confirmed the two bottles of latanoprost for Resident #16 and Resident #1 were expired, because the medication was only good for 42 days once it was opened.