STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056280	A. BUILDING _____ B. WING _____	**03/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HEALTHCARE CENTER OF OAKLAND	**2919 FRUITVALE AVE OAKLAND, CA 94602**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the skilled nursing facility did not develop a patient-centered care plan for one of three sampled residents (Resident 1) in a timely manner. Resident 1 suffered from a disorder which caused him to believe bugs were crawling over his body. The disorder was not identified on the plan of care until seven days after admission to the facility. This failure resulted in Resident 1 experiencing unnecessary agitation and leaving the facility without notifying staff. Findings: A review of the document Hospitalist Discharge Summary dated 8/2/19 showed Resident 1 was discharged from the hospital and had [DIAGNOSES REDACTED]. A record review of the document, Facesheet showed the facility admitted Resident 1 on 8/3/19. The [DIAGNOSES REDACTED]. A record review of theNurse's Notes dated 8/4/19, 8/7/19, 8/8/19, and 8/12/19 reflected Resident 1 had persistent delusions that bugs/lice were on his skin. The nurse's notes dated 8/12/19 indicated, Resident 1 continued to complain of bugs and left the facility without signing out. A review of the document Interdisciplinary Team Conference Review dated 8/10/19 and 8/12/19, indicated Resident 1's continued belief that he had bugs crawling over his body when he had none, and he had scratch marks from picking at his skin. A review of Resident 1's care plan showed the Delusional Parasitosis was identified as a concern on 8/10/19, seven days following admission. In an interview and concurrent record review on 8/22/19 at 2:33 p.m., the Director of Nursing (DON) confirmed the delusions were not care planned until seven days following his admission. A review of the document Comprehensive Person-Centered Care Planning, dated November 2018 showed the purpose was to Ensure that a comprehensive person centered care plan is developed for each resident. It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environment needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.
F 0742 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the skilled nursing facility (SNF) failed to ensure appropriate and timely treatment for [REDACTED]. Resident 1 suffered from a disorder which caused him to believe bugs were crawling over his body. The facility did not refer Resident 1 to a psychologist for further evaluation. This failure resulted in Resident 1 experiencing unnecessary anxiety. Resident 1 left the facility without telling the staff and against medical advice. Findings: A review of the document titled, Hospitalist Discharge Summary showed Resident 1 was discharged from the hospital on [DATE]. The [DIAGNOSES REDACTED]. A record review of the Facesheet showed the facility admitted Resident 1 on 8/3/19. The [DIAGNOSES REDACTED]. A review of the Nurse's Notes showed the following entries: 8/4/19: Resident 1 had multiple scabs noted on all extremities. 8/7/19: Patient claimed there are bugs/lice on his skin. There is no evidence of bugs/lice. He showed me little black particles in a cup - But they are not bugs/lice. Patient has a history of hallucinations of bugs, see history and physical. 8/8/19: Resident 1 claimed he had bugs running over his body. 8/12/19: Resident 1 continued to complain of bugs and left the facility without signing out. There was no documentation in the clinical record which showed Resident 1 had been referred for a psychological evaluation and assessment. A review of the document Social Service Progress Notes showed the following: 8/5/19: Resident has complaints of bugs all over his body which has been noted in the hospital records. 8/7/19: Resident came into office requesting to go buy lice spray for his room. Resident is convinced that lice are all over his body and on the walls in his room. Resident then became upset when advised to see the nurse if the spray was appropriate and stormed away. 8/12/19: .resident was threatening to leave on his own anyway and had his items packed. A review of the document Interdisciplinary Team Conference Review showed the following: 8/10/19: Resident believes he has bugs crawling over his body - non-visualized by staff on multiple exams .no change in treatment. 8/12/19: Resident stated he had lice all over his body. None were visualized by staff. Resident stated It's falling from the ceiling. Resident 1 noted to have scratch marks and picks at his skin. In an interview on 8/21/19 at 9:30 a.m., the facility's administrator (ADM) stated Resident 1 had complained of bugs since admission, and there was no psychological consultation requested because Resident 1 had not been at the facility for a long enough period of time. A review of the care plan showed the Delusional Parasitosis was documented as a concern for Resident 1 on 8/10/19 which was seven days following his admission. In an interview and concurrent record review on 8/22/19 at 2:33 p.m., the Director of Nursing (DON) stated the facility's social worker had requested a psychological consultation on the day Resident 1 left the faciity on [DATE]. She stated Patient 1 had gone to the hospital emergency department (ED) on 8/8/19 and returned the same day on 8/8/19 and visited the ED again on 8/10/19. The DON stated Resident 1 complained of bugs crawling on his body during both ED visits. The DON confirmed there was no psychological referral or interventions implemented during Patient 1's stay at the facility. A record review of the care plan titled,Anti-Anxietydated 8/4/19 reflected interventions that included to refer for psychological or psychiatric services if needed, and provide support and understanding. A review of the document Patient Referral Form (request for a psychological evaluation) showed Resident 1 had been experiencing Hallucinations/Delusions, Depression/Mood Swings, Isolation/Withdrawal, and Confusion/Disorientation. The referral form indicated the request had been sent on 8/12/19, nine days following Resident 1's admission to the facility without any follow-up. A review of the document Comprehensive Person-Centered Care Planning, dated November 2018 showed it was the policy of the facility to, Provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environment needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.

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

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.