

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Oakland Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3030 Webster Street Oakland, CA 94609	
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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide preventive treatment and services to maintain and improve range of motion (ROM is one aspect of exercise important for increasing or maintaining joint function) for three of four sampled residents (Residents 6, 75, and 26). This failure had the potential to result in further decline in Residents 6, 75, and 26's ROM. 1.A review of Resident 6's admission record (AR), undated, indicated Resident 6 was admitted on [DATE] with diagnoses that included hemiplegia (paralysis affecting one side of the body, often the face arm, leg, usually from brain or spinal cord injury), diabetes, and repeated falls. A review of Resident 6's Minimum Data Set (MDS - an assessment screening tool used to guide care) dated 11/7/25 indicated Resident 6 with functional limitations in range of motion on one side of the upper extremity (shoulder, elbow, wrist, hand) and one side of the lower extremity (hip, knee, ankle, foot). A review of the record of the last Physical Therapy (PT) Evaluation and Plan of Treatment (Evaluation only) dated 7/2/23 indicated date of service 6/23/23 - 6/23/23. There was no documented PT eval after that and no OT (Occupational Therapy) evaluation (eval) record were provided. During an interview on 1/13/26 at 11:25 a.m. with RNA (Restorative Nursing Assistant, a person trained to provide specific treatment to residents to restore and maintain strength, coordination, and skills to perform functional activities of daily living) 2, RNA 2 stated Resident 6 was not on the list of the residents on RNA program (RNA program - exercises or activities designed to maintain or improve residents' abilities to the highest practicable level such as range of motion exercises, splint or brace assistance, training and skills practice in bed mobility, transfers, walking, dressing, grooming, eating, communication) as there was no order. During a concurrent record review and interview on 1/14/26 at 9:47 a.m. with MDS Nurse (MDSN) 1, MDSN 1 stated Resident 6 had contractures and was bed bound. During an interview on 1/14/26 at 9:20 a.m. with Treatment Nurse (TN), TN stated Resident 6 was contracted and had wounds on and off on the lower extremities as they heal and then come back. During an observation and concurrent interview on 1/14/26 at around 1:42 p.m. in Resident 6's room, TN had just completed dressing changes of Resident 6's multiple wounds including stage 3 right thigh pressure ulcer and unstageable left palm pressure ulcer. Resident 6's lower extremities appeared very stiff and contracted. TN stated Resident 6 was not able to move his legs and his left arm/hand was (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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also contracted. During a review of Resident 6's care plan dated 11/19/23 indicated Resident 6 is on pain medication therapy related to (r/t) current medical condition (contracture at left arm). There was no evidence that the care plan was updated to address Resident 6's mobility and contractures. 2. A review of Resident 75's AR, undated, indicated Resident 75 was admitted on [DATE] with diagnoses that included chronic kidney disease dependent on renal dialysis and muscle weakness. A review of Resident 75's MDS indicated Resident 75 with functional limitations in range of motion on both sides of the lower extremity (hip, knee, ankle, foot). During a concurrent observation and interview on 1/12/26 at 10:30 a.m. Resident 75 was lying in bed, awake, alert. Resident 75 stated she was not getting therapy anymore because of insurance authorization. She stated she felt she needed more therapy exercises. Resident 75 stated they used the Hoyer lift to get her onto the wheelchair to go to dialysis every other day. During an interview on 1/13/26 at 11:25 a.m. with RNA 2, RNA 2 stated Resident 75 was not on the list of the residents on RNA program as there was no order. A review of the OT (Occupational Therapy) Evaluation Discharge summary dated [DATE] indicated Resident 75 had OT services on 10/23/24 & 12/9/24 with discharge recommendations: To request new authorization. During a review of Resident 75's care plan (CP) dated 2/16/23, revised on 10/8/25, the CP indicated Resident 75 had an ADL self-care performance deficit r/t impaired balance, limited mobility. 3. A review of Resident 26's AR undated, indicated he was initially admitted [DATE] and readmitted on [DATE]. A review of Resident 26's MDS dated [DATE] indicated Resident 26's Basic Interview of mental status (BIMS) score was 10 (indicating moderate cognitive impairment). The MDS of Resident 26 indicated limited ROM and impairment on one side of the upper extremity (shoulder, elbow, wrist, hand) and one side of the lower extremity (hip, knee, ankle, foot) The diagnoses included generalized muscle weakness, right (R) hand primary osteoarthritis, left hand primary osteoarthritis. During an interview on 1/13/26 at 11:25 a.m. with RNA 2, RNA 2 stated Resident 26 was not on the list of the residents on RNA program as there was no order. A review of Resident 26's OT Discharge summary dated [DATE] indicated Resident had an OT evaluation/ treatment and was recommended for Restorative ROM, Restorative Splint and Brace program & BUE (both upper extremities) AROM (Active ROM) and R (right) resting hand splint. A review of the Physician order report indicated a PT/OT order dated 6/28/25, the physician ordered PT, OT or ST evaluation and treatment as indicated and an order dated 12/8/21 indicated, Right hand therapy due to contracture. During a review of the CP dated 10/22/21, revised 11/10/25 indicated Resident 26 required extensive to total assistance to turn and reposition in bed as necessary. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/26 at 2 p.m. with Rehab Consultant (RC), RC stated when transitioning from skilled to long term care, every resident has opportunity to have an RNA and residents are given an option. She stated they make sure residents are on regular annual evaluation and quarterly for residents with contractures. During an interview on 1/14/25 at 2:51 p.m. with RC, RC stated she was filling in today and for a week. She stated the Assistant Director of Rehab (ADOR) resigned on Friday. RC acknowledged Residents 6, 26, and 75 were supposed to be on the RNA program (exercises or activities designed to maintain or improve residents' abilities to the highest practicable level such as range of motion exercises, splint or brace assistance, training and skills practice in bed mobility, transfers, walking, dressing, grooming, eating, communication) and confirmed evals (evaluations) were not done. RC stated they have now scheduled evals for the patients and would be doing evals now. RC stated the RNA program is important to prevent contractures, decline, also to make sure to maintain skin integrity, minimize hospitalization and for quality of life. During an interview on 1/15/26 at 9:02 a.m. with Resident 26 about his right hand/digits' contracture, Resident 26 stated they used to put a splint on his right hand but they stopped. He stated he could not remember what month they stopped. During an interview on 1/15/25 at 10 a.m. with RNA 1, RNA 1 stated he had not seen Resident 26 with a splint, and they did not have an order. During an interview on 1/15/26 at 1:40 p.m. with Director of Nursing (DON), DON stated Resident 26's PT/OT order was a standing order and not supposed to be active, and they would clarify the order with the physician today. During an interview on 1/15/26 at 2 p.m. with Assistant DON (ADON) stated for the residents (Resident 6, 75, 26) who have limited range of motion, RNA program is important to prevent contractures and declines. ADON stated that the residents, after they graduate from PT/OT, are supposed to be referred to RNA Program and then after 90 days, are reassessed to see if they are cleared from the RNA program or have to renew if needed. During a record review of the facility's policy and procedure (P&P) titled Restorative Nursing Program Guidelines dated September 19, 2019, the P&P indicated, The Restorative Nursing Program provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently and as safely as possible. During a record review of the facility's P&P titled, Range of Motion Exercise Guidelines dated January 1, 2012, indicated, Purpose - To maintain/increase Range of Motion (ROM) of joint, to prevent deformity/reduce deformity (prevent/decrease contractures) . During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning, revised 8/24/23, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety . needs of residents in order to obtain and maintain the highest physical. well-being.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility failed to store food in accordance with professional standards for safety when: Kitchen staff had uncovered facial hair while in the kitchen. Beyond use by date food items were stored in the kitchen refrigerator. Unlabeled, undated and expired food items were stored in the resident refrigerator. These failures had the potential for contamination of food resulting in food borne illness for the 97 residents who lived at the facility. During an observation on 1/12/26, at 9:24 a.m., the Dietary Supervisor (DS) had uncovered facial hair while in the facility kitchen. During an observation on 1/12/26, at 9:42 a.m., the kitchen refrigerator had cranberry sauce with a use by date of 12/27/25 and salad dressing with a use by date of 12/30/25. During an observation on 1/12/26, at 10:18 a.m., the resident refrigerator had a smoothie with an expiration date of 1/5/26, one pack of ready to eat chicken not labeled with resident name or date, one unknown food item not labeled with date, and one unknown food item not labeled with resident name or date. During an interview on 1/13/25, at 3:16 p.m., with the Registered Dietician (RD), RD stated kitchen staff with facial hair should have worn a beard guard while in kitchen because hair could have got in the food. RD stated the facility should not have kept food that was beyond their use by date or expired because it was not appropriate for human consumption and should have been thrown out. RD stated staff should have labeled food in the resident refrigerator with the date it was opened or brought in, the use by date, and resident name for food safety and to prevent food borne illnesses. During a review of the facility's policy and procedure (P&P) titled, Dietary Department - Infection Control, revised 2/29/24, the P&P indicated, Cover hair, beard, and mustache, with an effective hair restraint, such as hats, hair coverings, or nets while in the kitchen and food storage areas. During a review of the facility's policy and procedure (P&P) titled, Foods Brought by Family/Visitors, revised 4/24/25, the P&P indicated, Place the food in a food container that is clearly labeled with the resident's name and date received. When refrigerated, it will be labeled, dated and discarded after 48 hours if not consumed. Unopened/ sealed foods must be discarded by the manufacture's printed best by or used by date.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure two of 25 sampled residents (Residents 30 and 95) received nail care and shaved in accordance with their preferences. This failure had the potential to cause Residents 30 and 95 to feel embarrassed and undignified. During a review of Resident 30's admission Record, printed 1/15/26, the Record indicated Resident 30 was admitted to the facility in December 2025 with a diagnosis of need for assistance with personal care. During a review of Resident 30's Brief Interview for Mental Status (BIMS, is 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 eight to twelve is an indication of moderate impairment.), dated 12/9/25, the record indicated Resident 30's BIMS score was 12. During a concurrent observation and interview on 1/12/26, at 11:41 a.m., with Resident 30, Resident 30 was observed with facial hair and long dirty finger nails. Resident 30 stated staff did not offer to shave or cut and clean their finger nails. Resident 30 stated their facial hair, and long dirty nails made them feel embarrassed. During a review of Resident 30's Care Plan, revised 12/9/25, the Care Plan indicated, The Resident has a decreased ability to perform self care related to impaired activity intolerance, impaired balance/safety, impaired coordination, pain limiting function, weakness. During a review of Resident 95's admission Record (AR), printed on 1/13/25, the AR indicated Resident 95 was admitted to the facility in October 2025 with diagnoses of cerebral infarction (brain tissue dies because it doesn't get enough blood), depression (a serious mood disorder causing persistent sadness, loss of interest in enjoyable activities, and impacts daily life) and atherosclerosis (thickening or hardening of the arteries) of extremities with gangrene (death of tissue) on bilateral legs. During a review of Resident 95's Care Plan, revised 12/3/25, the Care Plan indicated, The resident has a decreased ability to perform self care related to decreased range of motion (how far a joint can move in different directions) impaired activity intolerance, impaired balance/safety, impaired coordination, weakness. During an observation and interview on 1/14/26 at 10:07 a.m. with Resident 95, Resident 95's fingernails were long, and facial hair was present around the chin and jaw area. Resident 95 stated the nursing staff had not offered assistance with trimming facial hair or fingernails. Resident 95 stated a preference for facial hair to be trimmed due to discomfort of looking like a man and for fingernails to be kept short to prevent scratching the skin, particularly the lower legs with existing wound. Resident 95 further stated a desire to feel clean and look well-groomed. During an observation and interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 95's fingernails were overgrown and needed to clipping. CNA 1 stated the CNAs were responsible for assisting the residents in maintaining their grooming. CNA 1 stated residents' fingernails and facial hair should have been offered to Resident 95. CNA 1 stated unwanted facial hair grooming and nail care should have been offered to residents who needed assistance to promote comfort and self-esteem. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/26 at 12:57 p.m. with the Assistant Director of Nursing (ADON), ADON stated unwanted facial hair could negatively affect a female residents' physical appearance and at risk for low self-confidence and could affect their dignity. ADON further stated long finger nails were prone to skin irritation and skin infection. During review of the facility's policy and procedure (P&P), titled, Resident Rights, revised on 1/1/12, the P&P indicated, II. The Facility makes every effort to assist each resident in exercising his/her rights by providing the following services: .A. The Facility's staff encourages residents to participate in planning their daily care routines (including ADLs [Activities of Daily Living]) .III. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, assessments and plans of care, including: B. Personal care needs, such as bathing methods, grooming styles . During review of the facility's P&P, titled, Grooming, revised on 1/1/12, the P&P indicated, The facility will work with residents to improve their ability to groom him/herself to promote independence, hygiene, comfort, self-esteem and dignity by teaching the resident to groom him/herself with use of assistive device and with appropriate types and amount of assistance .		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observation, interview, and record review, the facility failed to ensure timely assessment and intervention to one of two sampled residents (Resident 95) when Resident 95 had a significant change in condition related to weight loss. This failure placed Resident 95 at risk for malnutrition (body does not receive enough nutrients), dehydration (insufficient body fluid), decline in functional status, and emotional discomfort. During a review of Resident 95's admission Record (AR), printed on 1/13/25, the AR indicated Resident 95 was admitted to the facility in October 2025 with diagnoses of cerebral infarction (brain tissue dies because it doesn't get enough blood) and depression (a serious mood disorder causing persistent sadness, loss of interest in enjoyable activities, and impacts daily life). During a review of Resident 95's Care Plan, revised on 10/27/25, the Care Plan indicated Resident 95 had potential nutritional problems related to diagnoses and body weight of 264 pounds (lbs.). The Care Plan further indicated a goal for Resident 95 to remain within 5% of 264 lbs. and required physician notification if significant weight loss of -5% of body weight in 30 days, -7.5% in 90 days, or -10% in 180 days occurred. During a review of Resident 95's record, titled, Nutritional Risk Assessment, dated 10/27/26, completed by a Registered Dietician (RD), the Nutritional Risk Assessment indicated the RD had a recommendation for Resident 95 to gradually lose 0.5 lbs. to 4 lbs. of weight per month. During a review of Resident 95's Order Summary Report, dated 1/14/26, the Order Summary Report indicated Resident 95 had a physician order to monitor weights monthly that started on 10/24/25. During an observation and interview on 1/12/26 at 3:26 p.m. with Resident 95, Resident 95 stated experiencing difficulty chewing and swallowing food related to an ongoing ear infection. Resident 95 further stated recently experiencing a weight loss of more than 20 lbs. within one week. Resident 95 was observed rubbing the left jaw and stated it was too painful to talk, bite down on food, and swallow. Resident 95 stated the appetite had been affected for some time and expressed feeling helpless about the situation. During a record review and interview on 1/14/26 at 11:38 a.m. with Licensed Vocational Nurse (LVN) 2, facility's record, titled, Monthly Weights, dated 1/1/26 was reviewed. LVN 2 stated Resident 95's last documented weight in the Electronic Health Record (EHR) prior to January 2026 was recorded on 12/1/25 as 254.8 lbs. LVN 2 further stated the Monthly Weights record, dated 1/1/26 for Resident 95 reflected a weight of 228.0 lbs. indicating Resident 95 experienced a weight loss of 26.8 lbs. (-10.91%). within one month. LVN 2 stated the weighing scale may have been inaccurate at the time Resident 95's weight was obtained that's why it was not recorded in Resident 95's EHR. LVN 2 further stated the physician order for monthly weight monitoring should have been obtained and followed. During an observation on 1/14/26 at 11:51 a.m. with Resident 95, Resident 95 was assisted onto a weighing scale by a Restorative Nurse Assistant (RNA) 2. While Resident 95 was standing on the scale, the displayed weight was 227.0 lbs., confirming the weight loss. During a follow-up interview on 1/14/26 at 11:55 a.m. with LVN 2, LVN 2 stated an assessment should have been completed, and the physician and RD should have been notified regarding the weight loss that was noted on 1/1/26. LVN 2 stated she was also the case manager for Resident 95 and she was not aware that Resident 95 had a significant weight loss. LVN 2 further stated Resident 95's current weight represented a significant weight loss and placed Resident 95 at risk for severe malnutrition (inadequate nutrition) and dehydration (inadequate total body water). During an interview on 1/15/26 at 2:30 p.m. with the Assistant Director of Nursing (ADON), ADON stated Resident 95's significant weight loss should have been addressed immediately upon identification of weight loss on 1/1/26. ADON stated if there were significant change in weight was identified, the facility should have completed an assessment of Resident 95 and the physician, RD, and responsible party should have been notified. ADON stated the cause of weight loss should have been identified and interventions should have been implemented. ADON stated failure to identify and address the weight loss in a timely manner could place Resident 95 at risk for complications like dehydration and delayed wound healing, as Resident 95 had wounds on the lower extremities. During a review of the facility's (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure (P&P), titled, Re-hospitalization, revised in January 2019, the P&P indicated, The facility will utilize process to aide early identification of a change in condition and a method of providing the healthcare provider with resident specific information about that change. The notification process will facilitate appropriate care interventions to avoid the need for unplanned hospitalization. During a review of the facility's P&P, titled, Evaluation of Weight and Nutritional Status, effective on 2/20/25, the P&P indicated, The facility will maintain an acceptable nutritional status for residents per professional standards .b. Analyzing the assessment information to identify the medical conditions, causes and/or problems related to resident's condition and needs .c. Implementing interventions for maintaining or improving nutritional statis that are consistent with resident's needs, goals, and standards of practice .d. Developing interventions involving resident and/or the resident representative to ensure resident's needs, preferences and goals are accommodated .		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to identify significant weight loss and implement interventions for two out of four sampled residents (Resident 28 and 95). These failures had the potential to result in continuous, unplanned weight loss for Residents 28 and 95.1. During a review of Resident 28's admission Record, dated 1/15/26, the admission Record indicated Resident 1 was admitted in the facility on 12/25/25 with an admission diagnosis of nontraumatic chronic subdural hemorrhage (bleeding under the brain's outer covering, occurring without significant head injury). During an interview on 1/12/26 at 11:46 a.m. with Resident 28, Resident 28 stated having difficulty chewing food and losing weight. During a concurrent interview and record review on 1/15/26 at 9:19 a.m. with Restorative Nursing Assistant (RNA) 1, Resident 28's Weekly Weights, dated 12/29/25 and 1/5/26 were reviewed. The Weekly Weights indicated, Resident 28's weight the week of 12/29/25 was 134.4 pounds (lbs.), and the week of 1/5/26 was 123.2 lbs. RNA 1 stated giving a copy of the Weekly Weights to the charge nurse. RNA 1 stated could not recall the nurse who received the copy of the Weekly Weights. During a concurrent interview and record review on 1/15/26 at 9:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 28's Weekly Weights, dated 12/29/25 and 1/5/26 was reviewed. The Weekly Weights indicated, Resident 28's weight the week of 12/29 was 134.4 pounds (lbs.), and the week of 1/5/26 was 123.2 lbs. LVN 1 stated Resident 28 lost 11.2 lbs. in a week and was considered a significant weight loss. LVN 1 stated a change of condition assessment should be performed for a resident with significant weight loss. During a follow-up concurrent interview and record review on 1/15/26 at 9:50 a.m. with LVN 1, Resident 28's Electronic Health Record (EHR), dated 1/5/26 to 1/15/26 was reviewed. Resident 28's EHR did not indicate a change of condition assessment was performed and an intervention was documented for Resident 28's significant weight loss. LVN 1 stated not being aware of Resident 28's significant weight loss. LVN 1 stated the purpose of change of condition assessment for a significant weight loss was to make sure residents would receive the proper diet if a diet change was needed, to evaluate resident's meal consumption, to identify what was causing the weight loss and to provide intervention to prevent further weight loss. During a review of the facility's policy and procedure (P&P) titled, Evaluation of Weight and Nutritional Status, dated 1/25, indicated, 1. Definitions. b. Weight loss. Significant weight loss 5% &/or 5 lbs. in one month. 2. Clinical Evaluation. b. Any resident weight that varies from the previous reporting period by 5% in 30 days. will be evaluated by the interdisciplinary team (IDT) to determine the cause of weight loss and the intervention(s) required. 2. During a review of Resident 95's admission Record (AR), printed on 1/13/25, the AR indicated Resident 95 was admitted to the facility in October 2025 with diagnoses of cerebral infarction (brain tissue dies because it does not get enough blood) and depression (a serious mood disorder causing persistent sadness, loss of interest in enjoyable activities, and impacts daily life). During a review of Resident 95's record, titled, Nutritional Risk Assessment, dated 10/27/26, completed by Registered Dietician (RD), the assessment indicated a recommendation for gradual weight loss of 0.5 to 4 pounds (lbs.) per month. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 95's Care Plan, revised on 10/27/25, the Care Plan indicated Resident 95 had potential nutritional problems related to diagnoses and body weight of 264 lbs. The Care Plan further indicated a goal for Resident 95 to remain within 5% of 264 lbs. and required physician notification if significant weight loss of 5% of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days occurred. During an observation and interview on 1/12/26 at 3:26 p.m. with Resident 95, Resident 95 stated experiencing difficulty chewing and swallowing food related to an ongoing ear infection and further stated experiencing a weight loss of more than 20 lbs. within one week. During a record review and interview on 1/13/26 at 3:26 p.m. with Registered Dietician (RD), Resident 95's Nutritional Risk Assessment and Weights and Vital Summary were reviewed. RD stated there was a physician order for monthly weight monitoring; however, the January 2026 weight had not been completed. RD 1 further stated Resident 95 was only assessed by a dietician upon admission and RD 1 was not aware of reported weight changes or chewing and swallowing difficulties. RD stated if issues with chewing and swallowing had been identified, the RD should have been notified to assess Resident 95 and determine the need for a Speech Therapist evaluation. RD further stated monthly weight monitoring should have been completed to track weight changes and allow for a timely evaluation and intervention. During a record review and interview on 1/14/26 at 11:38 a.m. with Licensed Vocational Nurse (LVN) 2, facility's record, titled, Monthly Weights, dated 1/1/26 was reviewed. LVN 2 stated Resident 95's last documented weight in the Electronic Health Record (EHR) prior to January 2026 was recorded on 12/1/25 as 254.8 lbs. LVN 2 further stated the Monthly Weights record, dated 1/1/26 for Resident 95, reflected a weight of 228.0 lbs., with a re-weigh on the same date of 226.6 lbs. LVN 2 stated the weighing scale may have been inaccurate at the time Resident 95's weight was obtained. During an observation on 1/14/26 at 11:51 a.m. with Resident 95, Resident 95 was assisted onto a weighing scale by a Restorative Nurse Assistant (RNA) 2. While Resident 95 was standing on the scale, the displayed weight was 227.0 lbs., confirming the weight loss. During a follow-up interview on 1/14/26 at 11:55 a.m. with LVN 2, LVN 2 stated an assessment should have been completed, and the physician and RD should have been notified regarding the weight loss. LVN 2 further stated Resident 95's current weight represented a significant weight loss and placed Resident 95 at risk for severe malnutrition (inadequate nutrition) and dehydration (inadequate total body water). During a review of Resident 95's Weights and Vitals Summary, printed on 1/14/26, Weights and Vital Summary showed the following recorded weight for Resident 95: 1/14/26: 227 lbs. 12/1/25: 254.8 lbs. 11/1/25: 256.4 10/24/25: 264 lbs. The Weights and Vitals Summary record showed Resident 95 experienced a total weight loss of 37 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Oakland Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3030 Webster Street Oakland, CA 94609	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lbs., representing approximately 14% body weight loss within less than three months, meeting criteria for a significant weight loss. During an interview on 1/15/26 at 9:30 a.m. with Resident 95, Resident 95 stated there were no plans or discussion regarding the weight loss program. Resident 95 stated the weight loss was unplanned, excessive, and bothersome. Resident 95 further stated the weight loss was drastic that bones felt increasingly prominent. During an interview on 1/15/26 at 2:00 p.m. with the Director of Nursing (DON), weight logs should have been reviewed by the nursing supervisor and entered into the resident's EHR. DON stated if there was a significant change in weight, there should have been an Interdisciplinary Team (IDT, a group of healthcare professionals who coordinate comprehensive resident care) to identify the cause and provide interventions to address the weight loss. During a review of Resident 95's record, titled, After Visit Summary, dated 1/13/26, the record showed Resident 95 was seen in the emergency department (ED) on 1/13/26 with diagnoses of periapical abscess (localized collection of pus at the tip of a tooth's root, usually caused by bacterial infection) with facial involvement, jaw swelling, and dehydration. The After Visit Summary further indicated Resident 95 received a bolus (given all at once) of Lactated Ringer's solution (an intravenous fluid, given through the veins, that's used to replace fluids and electrolytes when someone is dehydrated or needs volume support). During a review of the facility's policy and procedure titled, Evaluation of Weight and Nutritional Status, dated 1/25, indicated, 1. Definitions. b. Weight loss. Significant weight loss 5% &/or 5 lbs. in one month. 2. Clinical Evaluation. b. Any resident weight that varies from the previous reporting period by 5% in 30 days. will be evaluated by the interdisciplinary team (IDT) to determine the cause of weight loss and the intervention(s) required.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview and record review, the facility failed to report an unusual occurrence report within 24 hours to the California Department of Public Health (CDPH) when one of two sampled residents (Resident 4) had an unwitnessed fall and sustained lacerations (cuts) on the back of the head after being found and was sent to acute care hospital. This failure delayed regulatory oversight and placed Resident 4 at increased risk of repeated falls and additional injury, while also putting other residents at risk for similar harm. During a review of Resident 4's admission Record printed on 1/15/26, the admission Record indicated Resident 4 was admitted to the facility in November 2025 with diagnoses of right femur fracture (broken leg), abnormalities of gait and mobility and mild cognitive impairment. During an interview on 1/12/26 at 3:23 p.m. with Resident 4, Resident 4 stated experiencing a recent fall that resulted in a laceration to the back of the head requiring two staples (metal clips used to close the wound). Resident 4 stated the fall occurred in the shared bathroom when a family member from the other room suddenly opened the door while holding the doorknob, causing Resident 4 to lose balance and fall. During a record review and interview on 1/15/26 at 12:45 p.m. with the Assistant Director of Nursing (ADON), Resident 4's Electronic Health Record (EHR) was reviewed. ADON stated the incident was not reported because the fall was believed to be witnessed by a family member and therefore did not require reporting to CDPH. However, ADON acknowledged that the EHR documentation indicated Resident 4 sustained an unwitnessed fall resulting in injury. ADON further stated the facility considered Resident 4's head injury to be minor despite the injury requiring two staples to the back of the head. ADON stated if the fall had been identified as unwitnessed, the incident should have been reported as unusual occurrence to ensure thorough investigation from CDPH and to prevent recurrence. During a review of the facility's policy and procedure (P&P), titled, Unusual Occurrence Reporting revised on 5/30/24, the P&P indicated, The facility will follow all applicable state and federal laws and regulations regarding the reporting of unusual occurrence .The facility report the following events by phone and in writing to the appropriate State or Federal agencies: .c. Other Occurrences: ii. Major accidents .2. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and the confirmed in writing .		