STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055876	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Manor Healthcare Center, LLC	2124 57th Avenue Oakland, CA 94621

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect three of three sampled residents (Resident 1, Resident 2, Resident 3) from aggressive and inappropriate sexual behaviors exhibited by Resident 4. Resident 4 inappropriately touched Residents 1, 2, and 3 on their thighs, scrotum and buttocks areas without their consent. Resident 4 threw hot coffee at Resident 2.This failure resulted in feelings of emotional distress, embarrassment, anger and a loss of personal security on Resident 1, 2 and 3.Findings:During a record review of Resident 4's admission Record printed on 2/10/26, the record indicated, Resident 4 was admitted to the facility in 2020. The record indicated she was a [AGE] year-old female with history of mental and behavioral disorders.During a record review of Resident 4's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care), dated 2/3/26, the MDS indicated, Resident 4's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was seven (7) out of 15, indicating cognitive (mental) impairment.During a record review of Resident 1's admission Record printed on 2/10/26, the record showed Resident 1 was admitted to the facility in 2019. The record indicated Resident 1 was a [AGE] year-old male with diagnosis of limitations of activities due to disability.During a record review of Resident 1's MDS assessment dated [DATE], the assessment indicated Resident 1 was able to make himself understood and understood others.During an observation and interview on 2/10/26 at 10:00 a.m., in Resident 1's room, Resident 1 was sitting in a wheelchair. Resident 1 stated, a few weeks ago while he was in the Activity Room, Resident 4 wheeled herself to Resident 1, licking her lips at him, sticking her tongue out and rubbing his thighs without his consent. Resident 1 stated Resident 4 then grabbed his balls and made sexual comments at him. Resident 1 stated as a man, he was embarrassed to say the comments that Resident 4 made. Resident 1 stated it made him feel embarrassed, angry and unsafe.During an interview on 2/10/26 at 10:30 a.m. with Activity Director (AD 1), AD1 stated he did not witness the specific incident that occurred between Resident 1 and Resident 4. AD 1 stated however, he was aware that over time, the interactions between Resident 1 and Resident 4 became more explicit where Resident 4 would physically touch Resident 1. AD 1 stated he did not recall the dates for such incidents; however, he recalled that he had to keep both residents separated in the activity room. AD 1 also stated that when Resident 4's needs were not met immediately, Resident 4 would start yelling and getting aggressive. AD 1 stated on one occasion, Resident 4 threw coffee at Activity Assistant 1 (AA 1) and Resident 2 in the activity room. AD 1 stated he has reported Resident 4's inappropriate and aggressive behavior to facility management but he was told to continue to just separate her from other residents, when those behaviors are observed.During an observation and interview on 2/10/26 at 11:40 a.m. Resident 4 was up in her wheelchair and scooting herself to the activity room. Resident 4 refused to participate in the investigation.During a record review of Resident 2's MDS assessment dated [DATE], the MDS indicated Resident 2 was usually able to (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand others and able to make himself understood.During an observation and interview on 2/10/26 at 11:05 a.m., with Resident 2 in his room, Resident 2 was sitting in a wheelchair. Resident 2 stated Resident 4 was always causing problems with staff and other residents in the facility. Resident 2 stated Resident 4 tried to touch and grab his genitals. Resident 2 stated Resident 4 was a violent person when she did not get what she wanted. Resident 2 stated on one occasion, he witnessed that Resident 4 got so angry, that she hit AA 1, pulled her hair, threw hot coffee at AA 1 and him (at Resident 2). Resident 2 stated it made him upset and angry.During a record review of Resident 3's MDS assessment dated [DATE], the MDS indicated Resident 3's BIMS score was 14 out of 15, indicating Resident 3 was cognitively intact/coherent.During an interview on 2/10/26 at 11:20 a.m. Resident 3 stated he recalled an incident when Resident 4 grabbed his butt while his back was towards her. Resident 3 stated he got startled. Resident 3 stated he has seen Resident 4 getting very angry, yelling at others in the hallways of the facility or in the activities area. Resident 3 stated he felt uncomfortable when Resident 4 was near him.During a phone interview on 2/12/26 at 2:15 p.m. Registered Nurse (RN 1), RN 1 stated Resident 4 was known for having a hot temper. RN 1 stated she recalled an incident where Resident 4 was wheeling herself in the hallway, telling other resident to move out of her way. RN 1 stated when another resident did not move right away, Resident 4 got up from wheelchair and started screaming at them. RN 1 stated Resident 4 yelled I will beat the cowboy shit out of you and call my brothers to beat your ass. RN 1 stated she did not recall which resident got yelled at that time.During an interview on 2/10/26 12:01 p.m. with Director of Nursing (DON), the DON stated he was aware that Resident 4 exhibited hyper-sexualized behaviors towards male staff and residents. The DON stated on an occasion, Resident 4 grabbed him ‘on the butt' and made explicit sexual comments. The DON stated Resident 4 could get very aggressive with the residents, often tried to touch them inappropriately and get mad easily if they try to stop her. The DON stated he had witnessed Resident 4 touching residents inappropriately but was unable to name the residents.During a review of facility's Policy and Procedure (P&P) titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated, .Verbal abuse is defined as any use of oral , written , gestured communication, or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, regardless of age, ability to comprehend, or disability . Sexual abuse is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault.Prevention. The facility identifies, corrects, intervenes, in situations in which abuse, neglect, exploitation, misappropriation of resident property and/or mistreatment is more likely to occur.Immediate Actions. The administrator or designated representative will provide for a safe environment for the resident as indicated by the situation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a thorough investigation for an allegation of abuse involving two of four sampled residents (Resident 1, and Resident 4). Resident 1, a male resident alleged Resident 4 (female) touched him inappropriately and made sexual comments at him.This failure placed Resident 1 and other vulnerable residents at the facility to experience Resident 4's inappropriate sexual behaviors.Cross Reference F600.Findings:During a record review of Resident 1's admission Record printed on 2/10/26, the record showed Resident 1 was admitted to the facility in 2019. The record indicated Resident 1 was a [AGE] year-old male with diagnosis of limitations of activities due to disability.During a record review of Resident 1's MDS assessment dated [DATE], the assessment indicated Resident 1 was able to make himself understood and understood others.During an observation and interview on 2/10/26 at 10:00 a.m., in Resident 1's room, Resident 1 was sitting in a wheelchair. Resident 1 stated, a few weeks ago while he was in the Activity Room, Resident 4 wheeled herself to Resident 1, licking her lips at him, sticking her tongue out and rubbing his thighs without his consent. Resident 1 stated Resident 4 then grabbed his balls and made sexual comments at him. Resident 1 stated as a man, he was embarrassed to say the comments that Resident 4 made. Resident 1 stated it made him feel embarrassed, angry and unsafe.During a concurrent interview and record review on 2/10/26 at 1:35 p.m. with Social Worker (SW) 1, Resident 1's progress notes dated 11/14/25 were reviewed. The progress notes indicated, .yesterday morning .a female resident [Resident 4] inappropriately [touched] him on his private area in the activity room . SW 1 stated the facility was unaware of Resident 1's complaint against Resident 4, until they were notified by the Ombudsman (an advocate for long term care residents) on 11/14/25.During a record review of Resident 4's admission Record printed on 2/10/26, the record indicated Resident 4 was admitted to the facility in 2020. The record indicated she was a [AGE] year-old female with history of mental and behavioral disorders.During a record review of Resident 4's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care), dated 2/3/26 indicated Resident 4's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was seven (7) out of 15, indicating cognitive (mental) impairment.During an observation and interview on 2/10/26 at 11:40 a.m. Resident 4 was up in her wheelchair and scooting herself to the activity room. Resident 4 refused to participate in the investigation.During an observation and interview on 2/10/26 at 11:05 a.m., with Resident 2 in his room, Resident 2 was sitting in a wheelchair. Resident 2 stated Resident 4 had tried to touch and grab his genitals and it made him upset and angry.During an interview on 2/10/26 at 11:20 a.m. Resident 3 stated he recalled an incident when Resident 4 grabbed his butt while his back was towards her. Resident 3 stated he got startled. Resident 3 stated he has seen Resident 4 getting very angry, yelling at others in the hallways of the facility or in the activities area. Resident 3 stated he felt uncomfortable when Resident 4 was near him.During an interview on 2/10/26 12:01 p.m. with Director of Nursing (DON), the DON stated he was aware that Resident 4 exhibited hyper-sexualized behaviors towards male staff and residents. The DON stated on an occasion, Resident 4 grabbed him ‘on the butt' and made explicit sexual comments. The DON stated he had witnessed Resident 4 touching residents inappropriately but was unable to name the residents.During a concurrent interview and record review on 2/10/26 at 2:01 p.m. with Administrator (ADM) and Director of Nursing (DON), facility's investigation summary dated 11/21/25 was reviewed. The report indicated it was five (5)- day report for incident between Resident 1 and Resident 4 on 11/14/25. The report indicated, [Resident 1] reported to Ombudsman that [Resident 4] has been touching him inappropriately .in activities room. [Resident 1] and [Resident 4] kept apart, report given to the nursing (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team and activities team to ensure both residents are supervised and kept apart . [Activity Director-AD 1] interviewed by ADM, AD 1 states, I never seen that happen before. The investigation summary further indicated, allegations could not be proven factual. The ADM stated he was not the one who conducted above investigation, that is not how he would have conducted the investigation. The ADM stated he would have interviewed at least few more residents. ADM stated however, by the time he realized that facility did not complete a thorough investigation, it was too late and it was not re-done.During a record review of facility's policy and procedure (P&P) titled, Abuse Prevention and Management, dated J 6/12/2024 , the P&P indicated, .The facility identifies, corrects, and intervenes in which an abuse. is more likely to occur. Allegations of abuse.are to be reported to the Administrator or designated representative immediately.When the Administrator or designated representative receives a report of an allegation of resident abuse.the Administrator or designated representative, will initiate an investigation immediately.The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation .Witnesses includes but are not limited to the resident, witnesses to the incident, other residents under the care of the staff member involved, roommates, family, visitors, etc .