

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Princeton Manor Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on observation, interview and record review, the facility failed to involve the resident representative in the development of the discharge plan for one of two residents (Resident 1) when Resident 1's Family Member (FM) 1, who was the healthcare decision maker, did not receive a written notice of the proposed discharge. This failure resulted in Resident 1's FM 1 to be uninvolved with the discharge planning process and was unable to appeal the Resident 1's discharge from the facility. Findings: During a review of Resident 1's Face Sheet, dated 7/15/26, the Face Sheet indicated Resident 1 was admitted in the facility on 1/26/23 with a diagnosis of unspecified dementia (a diagnosis given when a patient clearly exhibits cognitive decline or memory loss that impacts daily functioning, but the exact underlying cause cannot be definitively determined or requires further testing). The Face Sheet indicated Resident 1's FM 1 contact type was Responsible Party (RP, Healthcare Decision Maker), Emergency Contact # 1 and Durable Power of Attorney (DPOA, a document by which one person authorizes another to take actions on his/her behalf). During a record review of Resident 1's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 2/3/26, the MDS indicated Resident 1'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) score was 7 out of 15, indicating severe cognitive impairment. The MDS indicated there was no active discharge planning for Resident 1 to return to the community. During a review of Resident 1's Order Summary Report dated 11/11/25, the Order Summary Report indicated, Resident 1 was incapable of making healthcare decisions. During a review of Resident 1's Care Plan Report, undated, the Care Plan Report indicated Resident 1 had cognitive loss/dementia related to impaired decision making with one of the interventions was to communicate with family regarding resident's needs. During a review of Resident 1's Health Status Note, dated 3/3/26, the Health Status Note indicated Resident 1 was discharged from the facility. During an interview on 7/10/26 at 1:00 p.m. with the Director of Nursing (DON), the DON stated Resident's capacity to make healthcare decisions were identified through the BIMS or were documented in the Medical Doctor's Progress Notes. During a review of Resident 1's Progress Note dated 3/1/26, the Progress Note indicated Resident 1's POA was FM 1. During a concurrent interview and record review on 7/15/26 at 1:21 p.m. with Social Services Director (SSD), Resident 1's Notice of Proposed Transfer and Discharge, dated 3/2/26, was reviewed. The Notice of Proposed Transfer and Discharge indicated, the notification of proposed discharge was through a telephone call to FM 1. The Notice of Proposed Transfer and Discharge indicated, the process on how to appeal the proposed discharge. The SSD stated Resident 1's RP was the FM 1. The SSD stated Resident 1's Notice of Proposed Transfer and Discharge did not indicate a copy was given or was sent to FM 1. The SSD stated the purpose of notifying FM 1 was to involve FM 1 to get the process of discharge started. The SSD (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated RP should be involved with discharge planning anytime the resident is not self-responsible. The SSD stated Resident 1 should not have been discharged because she was not self responsible. During a concurrent interview and record review on 7/15/26 at 3:32 p.m. with SSD, Resident 1's Social Services Note, dated 3/2/26, was reviewed. The Social Services Note indicated, the Social Worker (SW) spoke to Resident 1 about discharging to community and agreed. The Social Services Notes indicated FM 1 did not return the SW phone call. The SSD stated the SW no longer works in the facility. During an observation and interview on 7/15/26 at 3:35 p.m., the SSD was observed reading Resident 1's Social Services Notes in the Electronic Health Record (EHR). The SSD stated there was no documentation of the SW attempting to call FM 1 again. The SSD stated the best practice was to call three times or to call until getting a response because ultimately FM 1 was Resident 1's the decision maker. During a telephone interview on 7/20/26 at 10:39 a.m. with FM 1, the FM 1 stated not knowing that the facility discharged Resident 1. The FM 1 stated not receiving paper works regarding the proposed discharge and not being able to appeal the discharge. The FM 1 stated she was not involved in selecting the Resident 1's new discharge location. The FM 1 stated the discharge did not align with her goals and treatment preferences for Resident 1. During a review of facility's policy & procedure (P&P) titled, Discharge and Transfer Residents, dated 2/27/25, indicated 5. Prior to discharge, the facility will provide the resident representative with the Notice of Proposed Transfer and Discharge document.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident was free from unnecessary medications (medications used in the presence of unwanted, unintended, or dangerous effects which indicate the dose should be reduced or discontinued) for one of three sampled residents (Resident 2). Resident 2 was administered Norco (also known as hydrocodone-acetaminophen) a controlled substance pain medication that causes dizziness and drowsiness), Lorazepam (also known as Ativan, a controlled substance medication that depresses the central nervous system [CNS] causing drowsiness, dizziness, weakness, and unsteadiness), and gabapentin (a medication used to treat nerve pain that causes extreme sleepiness, dizziness, and unsteadiness) in (one medication given along with either of the others) during the period of 12/11/23 to 12/15/23. Following Resident 2's return from the acute care hospital (ACH) on 12/18/23, the facility continued to administer lorazepam and Norco, despite ACH discontinuing these medications and identifying them as contributing to Resident 2's somnolence (a strong, persistent state of drowsiness, heavy sleepiness, or a desire to sleep during the day). This failure resulted in Resident 2 experiencing somnolence and placed Resident 2 at increased risk for excessive sedation and other adverse effects associated with CNS depression (brain and nervous system are slowed down). During a review of Resident 2's Face Sheet, dated 7/16/26, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of spastic hemiplegia affecting left dominant side (damage to the right hemisphere of the brain, leading to severe muscle stiffness, paralysis, and impaired fine motor control on the left side of the body). The Face Sheet indicated one of Resident 2's emergency contact was Family Member (FM) 2. During a review of Resident 2's Medication Administration Record (MAR) dated 12/1/23 through 12/31/23, the MAR indicated Resident 2 had physician orders for gabapentin (medication to treat nerve pain; causes extreme sleepiness, dizziness, and unsteadiness) 600 milligrams (mg) one tablet by mouth three times a day, Norco 5-325 mg one tablet by mouth every 8 hours as needed for moderate to severe pain, and lorazepam oral tablet 0.5 mg one tablet by mouth every 6 hours as needed for anxiety. The MAR further showed these medications were administered to Resident 2 in combination on the following dates and times: 12/11/23 at 5:00 p.m. - gabapentin 12/11/23 at 5:00 p.m. - lorazepam 12/13/23 at 4:03 a.m. - lorazepam 12/13/23 at 5:00 a.m. - Norco 12/14/23 at 5:00 p.m. - gabapentin 12/14/23 at 5:00 p.m. - lorazepam 12/15/23 at 11:49 a.m. - Norco 12/15/23 at 12:00 p.m. - gabapentin 12/15/23 at 1:17 p.m. - lorazepam During a review of Resident 2's Health Status Note, dated 12/16/23, the Health Status Note indicated Resident 2's FM 2 came by to visit and requested Resident 2 to be sent to the hospital and 911 was called. The Health Status Note indicated Resident 2 was transferred to Acute Care Hospital (ACH). During a phone interview on 7/14/26 at 2:50 p.m. with FM 2, FM 2 stated Resident 2 was overly medicated. FM 2 stated on 12/16/23 Resident 2 was unresponsive and an Emergency Medical Technician (EMT, a trained health professional who provides emergency first aid, basic life support, and safe transport to a hospital for people who are sick or hurt) was called. FM 2 stated on 12/18/23 the doctor from the hospital discontinued Resident 2's Norco and the lorazepam. FM 2 stated facility staff continued to give Resident 2 Norco and lorazepam when Resident 2 returned to the facility. During a review of Resident 2's ACH Discharge Summary, dated 12/18/23, the ACH Discharge Summary indicated, Resident 2's date of admission to the ACH was 12/16/23 and the reason for ACH admission was somnolence. The ACH Discharge Summary indicated Resident 2 presented with somnolence after getting both Norco and Ativan (lorazepam) in addition to her usual gabapentin dose. The ACH Discharge Summary (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated both opioids (a class of drugs such as Norco) and benzodiazepine (a class of drug such as Ativan) can lead to altered mental status (AMS, sudden or significant change in a person's baseline awareness, cognition, or consciousness). The ACH Discharge Summary indicated Resident 2 had some improvement in somnolence after receiving Narcan (medication that rapidly reverses the effects of opioid overdose). The ACH Discharge Summary indicated Resident 2 should not receive Norco and Ativan and gabapentin at the same time as all have unintended consequences of somnolence/AMS. During a review of Resident 2's Order Summary Report, dated 12/19/23, the Order Summary Report indicated Resident 2 had an order for gabapentin 600 mg one tablet by mouth three times a day. During a review of Resident 2's Order Details, dated 12/19/23, the Order Details indicated Resident 2 had a prescriber written order for Norco 5-325 mg, give one to two tablets by mouth every 8 hours as needed for moderate to severe pain and Ativan 0.5 mg, give two tablets by mouth every 6 hours as needed for anxiety were entered by LVN (Licensed Vocational Nurse) 2. During a review of Resident 2's MAR, dated 12/22/23 and 12/24/23, the MAR indicated, gabapentin, Norco and lorazepam were administered to Resident 2. During an interview on 7/16/26 at 3:33 p.m. with Registered Nurse (RN) 1, RN 1 stated her role was to enter medication orders during readmission. RN 1 stated medications that were not listed in the discharged medications would not be entered in the orders. During an interview on 7/16/26 at 3:42 p.m. with LVN 2, LVN 2 stated not remembering why she entered Norco and lorazepam in Resident 2's orders. During an interview on 7/20/26 at 12:00 p.m. with the Director of Nursing (DON), the DON stated all of Resident 2's medical records were in the Electronic Health Record (EHR). During an interview on 7/20/26 at 1:07 p.m. with RN 2, RN 2 stated the paper physician order sheet were used by doctors for handwritten orders. RN 2 stated handwritten orders in the physician order sheet were entered as prescriber written orders in the EHR. During a concurrent interview and record review on 7/20/26 at 1:29 p.m. with the DON, Resident 2's ACH Discharge Summary, dated 12/18/26 was reviewed. The ACH Discharge Summary indicated Resident 2's discharge medication list included gabapentin. The ACH Discharge Summary indicated Norco and lorazepam were not included in the discharge medication list. The DON stated a triplicate (form used by doctors to prescribe high-risk controlled substances) could be a source of prescriber written order when the physician order for Resident 2's Norco and lorazepam were requested. The DON stated the facility did not have a copy of the Norco and lorazepam triplicates because triplicates were picked up by pharmacy. During a concurrent observation and interview on 7/20/26 at 2:31 p.m. with the DON, the DON was observed looking for the physician order sheet in the uploaded document section of Resident 2's EHR. The DON stated she could not find the physician order sheet for Norco and lorazepam in Resident 2's medical records. During a phone interview on 7/20/26 at 4:27 p.m. with the Pharmacy Technician (PT), the PT stated there was no triplicate prescription on 12/19/23 for Resident 2's Norco and lorazepam. During a follow up interview on 7/20/26 at 4:48 p.m. with the DON, the DON stated the purpose of having the physician order sheet was to validate the order for medication reconciliation. The DON stated resident's medical records should be available upon request. During a review of Food and Drug Administration (FDA, a federal agency of the United States government responsible for protecting and promoting public health ensuring the safety, efficacy, and security of human and veterinary drugs biological products and medical devices) for Neurontin (gabapentin) revised in 2025, the FDA indicated 7 DRUG INTERACTIONS 7.1 Opioids Respiratory depression and sedation, sometimes resulting in death, have been reported following coadministration of gabapentin with opioids (e.g hydrocodone [Norco]). Especially tell your healthcare provider if you take. any opioid pain medicine such as hydrocodone. any medicines for anxiety (such as lorazepam) . or any medicines that make you sleepy. You may have a higher chance for dizziness, sleepiness, or breathing problems if these medicines are taken with NEURONTIN (gabapentin).		