

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: 055876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for four of four sampled residents (Resident 7, 90, 80, and 63) who were investigated for accidents, the facility failed to ensure adequate supervision and assistive device when: 1. Resident 7 fell out of bed when Certified Nursing Assistant (CNA) 3 looked away while changing Resident 7's brief. Resident 7 sustained multiple injuries that included, a hematoma (when blood collects outside a blood vessel) on the right cheek and around the right eye, intraparenchymal hemorrhage (bleeding that occurs within the brain tissue), and fractures of the left 10th and 11th ribs (when one of the bones in the rib cage cracks, usually as a result of a fall or an accident). Resident 7 was transferred to the hospital for further treatment. 2. Resident 90 fell out of bed while CNA 4 assisted with toileting hygiene. Resident 90 was taken to the hospital via 911 with injuries that included frontal scalp hematoma, displaced fracture (when broken bone fragments move out of alignment, resulting in a gap or misalignment between the bone ends) through the left anterior arch of C1 (front side of the topmost bone in the neck spine), and non-displaced bilateral posterior arch C1 (curved bony arch on the back of the neck spine) fracture (also called [NAME] fracture, a burst fracture of the first bone in the cervical spine, usually results from falls from heights onto the top of the head). 3. Resident 80 fell out of bed while CNA 4 provided personal hygiene. This failure had the potential to result in major injuries that included fractures, head trauma or death. 4. Resident 63 left the facility unaccompanied and unsupervised and was found missing for several hours. This failure placed Resident 63's safety at risk and could potentially result in harm. Findings: 1. During a review of Resident 7's admission Record (AR) dated 9/30/25, the AR indicated Resident 7 was admitted to the facility in April 2015 with multiple diagnoses that included contracture (type of scarring in your soft tissues that causes them to tighten and stiffen) of the right upper arm, muscle spasm, and cerebral infarction (when the blood flow to the brain is disrupted leading to brain tissue death, main reason for disability among people). During a review of Resident 7's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 3/27/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive (the mental processes involved in gaining knowledge and comprehension) status regarding attention, orientation, and ability to register and recall information) score of zero. A BIMS score of zero is an indication of severe cognitive impact. The MDS also indicated Resident 7 required substantial/maximal assistance when rolling left and right in bed (helper does more than half the effort, helper lifts and holds trunk or limbs and provides more than half the effort). During a review of Resident 7's Fall Risk Evaluation dated 3/27/25, the Fall Risk Evaluation indicated (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 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 7's score as six (a score of 10 or higher indicates a resident is a HIGH risk for falls). During a review of Resident 7's fall care plan last revised 5/21/21, the care plan indicated to anticipate Resident 7's needs, and to provide prompt response to request for assistance. During a review of Resident 7's Situation, Background, Assessment, Recommendation (SBAR, a written communication tool to simplify and effectively share patient status updates among healthcare providers) dated 5/30/25, the SBAR indicated, on 5/30/25 at 6 p.m., Resident 7 was found on the floor and was assisted back to bed. During a review of Resident 7's Post-Fall Evaluation dated 5/30/25, the Post-Fall Evaluation indicated the reason for Resident 7's fall was due to poor positioning and the bed being at an improper height. During a telephone interview on 10/2/25 at 11:22 a.m., with CNA 4, CNA 4 stated, on 5/30/25, Resident 7 had just finished dinner when CNA 4 lowered the bed's head. CNA 4 stated Resident 7 had no bed rails. CNA 4 stated using the bathroom and returning to the hallway when the charge nurse said Resident 7 was on the floor, next to the bed, inside Resident 7's room. During a review of Interdisciplinary Team (IDT, a group composed of individuals from different departments of the facility) Progress Notes dated 6/2/25, the IDT Progress Notes indicated recommendations to prevent future falls that included keeping the bed in the lowest position, and for staff to monitor Resident 7's position and reposition as needed. During a review of Resident 7's Progress Notes dated 6/4/25, the Progress Notes indicated, five days after the fall incident on 5/30/25, CNA 3 was caring for Resident 7 when CNA 3 turned his back to respond to Resident 7's roommate's call. Resident 7 Fell out of .bed to the floor, that resulted in swelling on the right eye and forehead. Resident 7 was taken to the hospital. During a telephone interview on 9/30/25 at 10:29 a.m. with CNA 3, CNA 3 stated, on the evening shift of 6/4/25, after cleaning Resident 7's perineal area (the area between the anus and the scrotum), CNA 3 turned Resident 7 to the right side of their body, facing away from CNA 3, without ensuring Resident 7 was positioned safely in the center of the bed. CNA 3 stated that while changing Resident 7's brief, CNA 3 got distracted by Resident 7's roommate. CNA 3 stated, while Resident 7 was on the right-side lying position, CNA 3 looked away from Resident 7 to face Resident 7's roommate, that was when Resident 7 fell out of bed, landing on the floor headfirst, followed by the right side of their body. CNA 3 stated there were no bed rails attached to the bed. Following the fall incident, CNA 3 stated receiving training on providing distraction-free care and prioritizing the residents being attended to. During a joint interview on 9/30/25 at 3:50 p.m. with Director of Nursing (DON) and Registered Nurse Consultant (RNC), DON stated, during resident care, such as changing briefs or performing perineal care, staff should turn residents towards them, not away. RNC stated there was no policy for this as it is a basic skill learned in school. During an interview on 9/30/25 at 10:17 a.m. with CNA 7, CNA 7 stated, when changing a resident, the resident should be pulled towards the CNA to face them. CNA 7 stated, the resident should be turned while ensuring enough space on the opposite side of the bed to prevent the resident from rolling off. CNA 7 also stated to never divert attention from the residents and the task to ensure safety. CNA 7 also stated Resident 7 was able to stay and hold position when turned on the side and did not have (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/25 at 12:09 p.m. with Minimum Data Set Coordinator (MDSC), Resident 90's MDS dated [DATE] was reviewed. MDSC stated Resident 90's MDS indicated total dependence to roll from lying on back to left and right side and vice versa. MDSC stated Resident 90 was coded as totally dependent, which meant Resident 90 required two-person assistance. During a review of Resident 90's Emergency Department Note (EDN) dated 5/10/25 at 4:39 a.m., the EDN indicated Resident 90 arrived at the ED with a cervical collar (neck collar designed to prevent one's head or neck from moving after an injury) in place and a hematoma on top of the head. The EDN also indicated diagnoses that included a large right frontal scalp hematoma and nondisplaced fractures of bilateral posterior C1 arch and a slightly displaced fracture of left anterior C1 arch. During a review of Resident 90's CT (computerized tomography) of cervical spine dated 5/10/25, the CT indicated Resident 90 had a displaced fracture through the left anterior arch of C1 and bilateral posterior C1 arch fractures. During a review of Resident 90's Internal Medicine Discharge Summary (IMDS) dated 5/14/25, the IMDS indicated Resident 90 should wear a cervical collar for three months around the clock. 3. During a review of Resident 80's AR, the AR indicated Resident 80 was admitted to the facility in December 2011 with diagnoses that included dementia (decline in mental ability, including memory, thinking, and problem-solving skills, severe enough to interfere with daily life) weakness, parkinsonism (slow movements and tremors) and glaucoma (buildup of fluid in the eye, which increases the pressure and damages the nerve leading to vision loss). During a review of Resident 80's HSN, dated 9/25/25, the Progress Notes indicated, on 9/25/25 at 9:30 p.m., Resident 80 fell out of bed while CNA 4 changed Resident 80's brief. Resident 80 was found on the floor lying on the left side. During a telephone interview on 10/2/25 at 11:22 a.m. with CNA 4, CNA 4 stated Resident 80 was turned on the left side while CNA 4 cleaned Resident 80's back. CNA 4 stated he cleaned Resident 80 with his left hand while his right hand was on Resident 80's shoulder. CNA 4 stated releasing his hold to grab a brief, causing Resident 80 to fall from the bed and land on the opposite side. During an interview on 10/1/25 at 12:03 p.m. with Director of Staff Development (DSD), DSD stated CNA 4 had experienced missteps while providing care for three residents. DSD stated all three residents (Resident 7, 80 and 90) fell out of bed during CNA 4's care and that CNA 4's employment was terminated as of 10/1/25. 4. During a review of Resident 63's Face Sheet (FS), the FS indicated Resident 63 was admitted on [DATE] with multiple diagnoses that included dementia, chronic kidney disease stage (a condition where the kidneys gradually lose its ability to filter waste products from the blood, leading to buildup of toxins and other substances in the body), cirrhosis of the liver (a liver disease characterized by the irreversible destruction of liver cells and the formation of scar tissue), and alcohol dependence (the state of relying on alcohol for support). During a review of Resident 63's Elopement Evaluation (EE), dated 6/13/25, the EE score indicated the resident is at risk for elopement (unsupervised departure of a patient). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool) dated 9/18/25, Resident 63 indicated a score of 8 on his Brief Interview for Mental Status (BIMS, an assessment to detect cognitive impairment) indicating moderate cognitive impairment. During an interview on 9/29/25 with the administrator (ADM) on 9/29/25 at 10:35 a.m., ADM stated the elopement of Resident 63 was an unusual occurrence and was a mystery how the resident left the facility. ADM stated Resident 63 had a wanderguard (a discreet wearable device that tracks movement and triggers automated security responses when a resident nears a restricted area). ADM stated he did not know how the resident was able to leave without triggering the alarm, because they checked the wanderguard and it was functioning when he was found in the morning and assisted back to the facility. During a review of the progress note (PN) for Resident 63, dated 9/10/25 02:57 a.m., the PN indicated Certified Nursing Assistant (CNA) 5 made round few minutes to 2 a.m., and did not find Resident 63 and informed the nurse. Staff searched for Resident 63 but the resident was not found, and the police was called. During a review of the PN dated 9/10/25 at 9:32 a.m., the PN indicated Resident 63 was found wandering on the street of facility and three staff walked the resident back to the facility. During a review of the IDT (Interdisciplinary team) note dated 9/10/25, the IDT note indicated Resident 63 was missing at approximately 2 a.m. The IDT note indicated Resident 63 was found at approximately 8:30 a.m. During a review of Acute Care note dated 9/12/25, the note indicated Resident eloped last night and was found in the morning of 9/10/25 two blocks from the facility, sweeping floors outside a nearby store. During a concurrent interview and record review on 10/1/25 at 4:15 p.m., with the Director of Staff Development (DSD), DSD stated the elopement for Resident 63 was on 9/10/25 night and Licensed Vocational Nurse (LVN) 8 was the charge nurse that night and came on duty at 11 p.m. DSD stated they were supposed to check on the resident every two hour maximum. DSD stated if everything happened in between, they should be checking. When asked if they had documentation for checking rounds for Resident 63 every two hours, DSD looked at Resident 63's electronic record and stated there was nothing and printed out the bowel incontinence flowsheet, indicated the record for task: B&B &ndash; Bowel elimination. There was no documentation of the staff rounding every two hours on Resident 63 and no evidence of it being done. During a telephone interview on 10/1/25 at 5:58 p.m., with LVN 8, LVN 8 stated on the day Resident 63 eloped, she had asked CNA 5 to do rounds, and CNA 5 did not find Resident 63 in his room. LVN 8 stated they searched for Resident 63 and went outside but could not find him. LVN 8 stated she last saw Resident 63 sleeping at 11 p.m. and CNA 5 last saw Resident 63 at 11:30 p.m. LVN 8 stated she asked CNA 5 to take a wandering resident back to their room, around 1:30 a.m. LVN 8 stated she was in the front nursing station standing there and also went to station 2 to sign her assignment sheet. LVN 8 stated while at station 2, she was in the hallway, and she could see the front from there. When asked if she checked the wanderguard for functioning, LVN 8 stated, I can't remember, I can't be remembering because it was three weeks ago. LVN 8 stated normally she rounds on the residents every two hours, and CNA 5 also does his own rounds. LVN 8 was asked if they checked Resident 63 at two hours interval that night after they saw him last at 11:30 p.m. LVN 8 stated CNA 5 had to (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	redirect the patient that was wandering back to his room. When asked if it took CNA 5 half an hour to redirect the wandering resident and if there was an assigned CNA to the resident. LVN 8 stated she did not know whether the CNA for the wandering patient was busy. LVN 8 stated she did not hear any alarm sound that night. When asked further questions about checking Resident 63's wanderguard that night if functioning, LVN 8 stated, I really don't know, I can't say right now. During a telephone interview on 10/2/24 at 5:43 p.m. with CNA 5, CNA 5 stated he saw Resident 63 at 11:30 p.m. on the bed with his cap on. CNA 5 stated he then went to his position in the hallway. CNA 5 stated there was a resident from the back location walking around. CNA 5 stated LVN 8 asked him to take the resident back to his room around 1:30 p.m. &ndash; 2 a.m. CNA 5 stated it took him maybe 20 minutes or less than 30 minutes to take that patient to his room. CNA 5 stated he came back around 2 a.m., and it occurred to him to check his residents. CNA 5 stated Resident 63 used to get up and wander around from 2 a.m. to 4 a.m. CNA 5 stated he looked in Resident 63's room and did not find him. He made LVN 8 aware, and they checked the bathroom and patio. He stated the other CNAs also searched for Resident 63. CNA 5 stated he did not know if Resident 63 had a wanderguard, and there was no sound of alarm during the night. He stated staff do not use the side door and the side door is always locked. CNA 5 stated resident 63 had history of elopement but not in the facility and this was his first time. CNA 5 stated the interventions the facility had in place for Resident 63 to prevent elopement were to just to be alert and to check on Resident 63 at least every two hours. CNA 5 stated only CNAs checked the residents, and the charge nurse sometimes reminded them about doing rounds. CNA 5 acknowledged they were supposed to check the resident at least every two hours, and he should have checked Resident 63 at 1:30 a.m. and anything could have happened within the 30 minutes of not checking Resident 63. During a telephone interview on 10/2/25 at 6:55 p.m. CNA 5 (who was assigned to Resident 63 the night he eloped) stated that rounding every two hours was important to ensure the residents are okay, on their beds sleeping, and safe. During the facility's Policy and Procedure (P&P) titled, Policy and Procedure Implementation Form &ndash; Person-Centered Care Planning, dated August 2017, the P&P indicated The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives, and timeframes to meet a resident' s medical, nursing, mental, and psychological needs that are identified in the comprehensive assessment. During a review of the care plan initiated on 6/13/25, Resident 63's care plan indicated, Risk for wandering/elopement identified, use of wanderguard with goals: The resident will not leave facility unattended, the resident's safety will be maintained, and the facility will not leave the facility unaccompanied. The care plan indicated the wanderguard on the right wrist. Resident 63's care plan did not include checking on the resident every 2 hours by facility staff. During review of the facility's policy and procedure (P&P) titled, Wandering and Elopement revised 1/31/23, the P&P indicated, The licensed nurse, in collaboration with the .(IDT), will assess residents.and upon identification of significant change in condition according to the to determine their risk of elopement.The resident's risk for elopement and preventative interventions will be documented.and will be reviewed and re-evaluated by the IDT.and upon change in condition.The IDT will develop a plan of care considering the individual risk factors for the resident.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect belongings for one sampled resident (Resident 63), when his clothes and personal items were missing and were not accounted for. This failure had compromised the right of Resident 63 to retain personal possessions. Findings:A review of the admission record for Resident 63 indicated, Resident 63 was admitted on [DATE] with diagnoses that included chronic kidney disease (progressive loss of kidney function). Resident 63 was discharged on 9/18/25.During a telephone interview on 10/2/25 at 9:45 a.m., with Resident 63's Responsible Party (RP), RP stated Resident 63 was missing clothes and personal items while he was in the facility and that the facility were not returning his clothes. RP stated she had noted other residents were wearing Resident 63's clothes during Resident 63's stay in the facility and had notified staff. RP stated she was not given Resident 63's inventory of personal items upon the resident's discharge and that no one went over the resident's personal item inventory list with her.During a concurrent interview and record review of the theft and loss log on 10/2/25 at 11:15 a.m., with the Social Services Director (SSD), SSD stated she did not have the old logs because she was new in the facility. SSD stated she only had the logs for August and September 2025. SSD stated the missing personal property for Resident 63 was not in the August and September theft and loss log. Further review of the facility's grievance log for August and September 2025, revealed no report of Resident 63's missing items in the log. During an interview on 10/2/25 at 11:43 a.m., with the SSD, SSD stated Resident 63's RP reported to her that Resident 63 were missing clothes and gave SSD a list. SSD stated she did not put the missing items in the log because the list of items that RP claimed were missing were not in the inventory list.During an interview on 10/2/25 at 1:40 p.m., with CNA 9, CNA 9 confirmed that sometimes residents do have other residents' clothes on, especially when residents were moved to different rooms. CNA 9 stated when residents' clothes were laundered, laundered clothes were returned to the same rooms from where they came from, and residents may have moved to different rooms. CNA 9 stated sometimes residents would put someone else's clothes on, and CNAs made an effort to get them back to the resident. During a review of a copy of Resident 63's inventory titled, Personal Effects Inventory form, signed 8/28/25, the form had a list of clothes and personal items that included: one black easy rider SS Tee shirt, one burgundy, blue grey stripes Tee shirt SS polo, One sleeveless burgundy T-shirt - Game time label, 10 white hangars, one blue, whitegrey- mixed jacket, one fleece Azter blue, greywhite jacket, two baseball caps - blue, grey solid, one grey and white quilt, one white sleeveless undershirt, one green, elastic bottom North pole sweat pants, one grey/black Game time sweats.During an interview with SSD on 10/3/25 at 1 p.m., SSD confirmed the inventory form provided for Resident 63 was for admission. SSD stated she could not find Resident 63's inventory form for discharge. SSD stated she did not know if Resident 63's property was given upon discharge. SSD stated she was not present when Resident 63 was discharged .During an interview on 10/3/25 at around 1:20 p.m., with the Director of Staff Development (DSD), DSD stated she looked and could not find the discharge copy of Resident 63's inventory form. DSD stated she did not know if clothing and/or personal items were given back to Resident 63 and/or the RP.During an interview on 10/3/25 with Director of Nursing (DON), DON stated staff should be getting an inventory sheet, go over the property with the RP and sign it off and upload upon admission and discharge.During the facility's policy and procedure (P&P) titled, Personal Property revised 7/14/17, the P&P indicated, To ensure the facility takes reasonable steps to protect resident's personal property.the facility will return inventoried personal items to residents or their representative upon discharge in a timely manner, and take reasonable steps to safeguard the belongings in the interim.Upon discharge home, the resident/resident representative will review the Resident inventory to ensure all personal items are taken. The resident/ resident representative will (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sign the inventory indicating that all personal property is released to them.During a review of the facility's P&P titled, Theft and Loss, revised 7/11/17, the P&P indicated, To assist residents in safeguarding their personal property. The facility is committed .maintains documentation of all reports of lost and stolen property.At time of admission and discharge, Facility staff complete a Resident inventory. When personal property is reported missing.A Theft and Loss report is to be initiated.Social Services staff documents reports of lost and stolen resident property.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure residents were free from physical abuse when two of five sampled residents (Resident 3 and Resident 26) were involved in a physical altercation. This failure resulted in Resident 3 sustaining a skin tear on the left arm. Findings: During a record review of Resident 3's admission Record (AR), printed on 9/19/25, the AR indicated that Resident 3 was admitted to the facility on [DATE]. During a record of Resident 26's AR, printed 9/18/25, the AR indicated that Resident 26 was admitted to the facility on [DATE]. During a record of review of Resident 3's Minimum Data Set (MDS, resident assessment instrument used to identify resident problems to be addressed in an individualized care plan), dated 8/8/25, the MDS indicated, Resident 26 had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12. A BIMS score of 8 to 12 is an indication of moderate cognitive impairment. During a record review of Resident 26's MDS, dated 8/29/25, the MDS indicated, Resident 26 had a BIMS score of 11. During a concurrent observation and interview on 10/1/25, at 1:04 p.m., Resident 3 was observed to have a healed skin tear on the left arm. Resident 3 stated Resident 26 grabbed him on the left arm and hit him on the left shoulder during an argument over television use. Resident 3 stated that he wanted to watch television (TV), but Resident 26 wanted him to go to the TV room. During an interview on 10/1/25, at 1:32p.m., Resident 26 stated Resident 3 had just moved into the room the previous day. Resident 26 stated that Resident 3 turned on the TV and kept walking in and out of the room. Resident 26 stated he asked Resident 3 to either sit down and watch TV, turn it off, or go to the TV room. Resident 26 stated Resident 3 then came over and hit him on the right arm. Resident 26 stated he hit Resident 3 back, and Resident 3 swung his arm, hit the furniture and started bleeding on the left arm. During a concurrent interview and record review of Resident 3's Change in Condition Evaluation, dated 9/18/25, on 10/3/25 at 10:07 a.m., with the Administrator (ADM), the Change in Condition Evaluation indicated that Resident 3 sustained a skin tear on the left arm during the altercation. ADM stated that staff was expected to monitor Resident 3 closely to prevent resident altercations since Resident 3 had been involved in another incident prior to this altercation. During a record review of Resident 26's Progress Notes (PN), Summary, dated 9/18/25, and Interdisciplinary Team (IDT, a group composed of individuals from different department of the facility) Note, dated 9/19/25, the PN Summary and IDT note indicated that Resident 26 had no injuries. During an interview on 10/3/25, at 2:59 p.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated, on 9/18/25, she was in the hallway and heard loud argument coming from Resident 3 and Resident 26's shared room. Upon entering the room, CNA 8 observed Resident 26 standing at the foot of the bed, and Resident 3 was in the restroom using a paper towel to wipe blood from his left arm. During a review of facility's Policy and Procedure (P&P) titled, Abused Prevention and Management, revision date 5/30/24, the P&P Indicated, The Facility does not condone and form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based interview and record review, for one of five sampled residents (Resident 2) reviewed for unnecessary medication use, the facility failed to ensure Resident 2 did not receive unnecessary psychotropic (also referred to as psychoactive medications, including antianxiety medications) medications when:-Lorazepam (antianxiety) was given for PRN (as needed) beyond 14 days.-Monitoring for behavioral manifestation for lorazepam use did not coincide with physician-ordered lorazepam PRN use. This failure had the potential to result in increased risk of adverse drug effects, such as dependence, sedation, confusion, and falls. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility in December 2023 with diagnoses that included anxiety disorder (repeated episodes of sudden feelings of intense fear or worry) depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and insomnia (difficulty falling or staying asleep). During a concurrent joint interview and record review on 10/2/25 at 1:48 p.m. with Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 7, Resident 2's Order Summary Report (OSR) and Medication Administration Record (MAR) for September 2025 were reviewed. RN 1 stated the OSR indicated lorazepam was ordered every 8 hours as needed for anxiety manifested by restlessness. LVN 7 stated Resident 2 received lorazepam daily around 12 noon to 1 p.m. for verbalization of anxiety. During a review of the MAR for September 2025, the MAR indicated lorazepam PRN was administered once daily between 12 noon to 1 p.m. for anxiety manifested by restlessness. The MAR also indicated staff monitored for episodes of intense anger as the behavioral indication for the use of lorazepam PRN. The MAR did not indicate behavior monitoring for restlessness. During a review of Consultant Pharmacist's Medication Regimen Review (CPMRR) dated 7/1/25, 8/1/25, 9/5/25, the CPMRR indicated, episodes of intense anger (lorazepam PRN behavior) do not coincide with lorazepam PRN usage. Lorazepam PRN should be given in response to a specific behavior, so behavior charting should coincide with PRN medication usage. The CPMRR dated 8/1/25 also indicated a recommendation to change lorazepam from one tablet by mouth every 8 hours PRN to one tablet by mouth daily at 12 noon for anxiety. None of these recommendations have been implemented. During a review of the facility's policy and procedure (P&P) titled Behavior/Psychoactive Drug Management last revised November 2018, the P&P indicated, any psychoactive medication ordered on a prn basis must be ordered not to exceed 14 days. The physician must document the need to continue the medication, and the order should not exceed the 14-day limit.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two sampled residents (Resident 6) who were reviewed for PASRR (Pre-admission Screening and Resident Review, required to determine if the resident needs specialized services for serious mental illness or mental retardation before admission to a Medicaid certified nursing facility) evaluation, the facility failed to coordinate PASRR Level II (a more in-depth evaluation for individuals identified by the Level I screen) determination after a positive PASRR I evaluation. This failure had the potential to result in Resident 6 receiving care that is not appropriate for their needs. Findings: During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility in July 2025 with diagnoses that included schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia such as disorganized thinking, false beliefs, hallucinations, and bouts of mania and depression). During an initial observation and interview on 9/29/25 at 11:38 a.m., with Resident 6, Resident 6 stated being the second Son of God and claimed past sexual immorality. The conversation shifted to devils, demons, seeing angels, and wanting to go home. During a concurrent interview and record review on 10/2/25 at 10:59 a.m., with the Director of Staff Development (DSD), Resident 6's PASARR I screening dated 7/24/25 was reviewed. The PASARR I screening indicated positive results for PASARR II evaluation. DSD confirmed there was no PASARR II evaluation in the clinical record. During a review of Resident 6's Medication Administration Record (MAR) for September 2025, the MAR indicated several behaviors that included paranoid delusional thinking (persistent, irrational, and unfounded beliefs that others are trying to harm, deceive, or persecute you, often leading to deep distrust, suspicion, and a hostile attitude) that staff are working with the CIA and claims of being Jesus. During a concurrent interview and record review on 10/2/25 at 12:20 p.m., with the MDS Coordinator (MDSC), MDSC stated the PASARR I screening done at the hospital did not have PASARR II evaluation. The facility did not verify if a PASARR II evaluation was performed before Resident 6's admission. MDSC stated a new PASARR I screening was completed today, 10/2/25, to initiate a PASARR II evaluation. During a review of Resident 6's After-Visit Summary (AFS) dated 7/29/25, the AFS indicated Resident 6 was hospitalized from [DATE] to 7/29/25 for disorganized behavior and emotional lability (sudden, dramatic mood changes).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat skin rash for one of five sampled residents (Resident 42) when nursing staff was not aware of Resident 42's skin rash. This failure resulted in Resident 42 having an untreated skin rash for unknown of length of time. Findings: During a review of Resident 42's admission Record AR, printed on 10/1/25, the AR indicated that Resident 42 was admitted to the facility on [DATE]. During a review of Resident 42's Minimum Data Set (MDS, resident assessment instrument used to identify resident problems to be addressed in an individualized care plan) dated 9/26/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12. A BIMS score of 8 to 12 is an indication of moderately impaired cognitive status. During an interview on 9/29/25, at 12:30 p.m., with Resident 42, Resident 42 stated that she had rashes in the groin area which were itchy and burning. During an observation on 10/2/25, at 8:55 a.m., Resident 42 was observed to have bright red rashes on both inner thighs and extended to bilateral buttocks. Resident 42 stated that area itched and burned after urination. Resident 42 stated that she had told multiple Certified Nursing Assistants (CNAs) about the rashes and the CNA's responses were I don't have cream. or I already told the nurse. Resident 42 stated that the rashes had been present for approximately two months. Resident 42 stated the CNAs only changed her diapers but did not apply any (barrier) cream (a topical product applied to the skin to protect it from irritation or moisture). During an interview on 10/2/25, at 8:55 a.m., with CNA 1 in Resident 42's room, CNA 1 stated that she had applied A and D ointment (a topical skin protectant that contains vitamins A and D) on Resident 42, and stated she should have informed the nurse about the rashes. During a concurrent interview and observation on 10/2/25, at 9:13 a.m., with the Nurse Practitioner (NP) and Licensed Vocational Nurse (LVN) 5, NP evaluated Resident 42's skin rash and prescribed topical medication for Resident 42. NP stated incontinent skin care was a basic nursing measurement when asked if the facility should have a routine incontinent skin care program. NP further stated Resident 42 was prone to have urinary traction infections and that could lead to the skin rash. During an interview on 10/2/25, at 9:31 a.m., with LVN 5, LVN 5 stated she was not aware of Resident 42's skin rash. LVN 5 stated it should be identified and treated. During an interview on 10/3/25, at 9:03 a.m., with CAN 2, CNA 2 stated that she had reported Resident 42's skin rash to a nurse on 9/30/25, prior to her two days off, and was instructed to apply barrier cream to the affected area. CNA 2 stated she was not sure which nurse she had reported the information to and was unsure what cream she had applied to Resident 42's bilateral inner thigh and buttocks. During an interview on 10/3/25, at 9:30 a.m., with Director of Staff Development (DSD), DSD stated that CNA should report skin issues to the charge nurse so the nurse could assess resident and request appropriate treatment. DSD stated that she was not sure whether the facility had other process to identify resident's skin issues. During an interview on 10/3/25, at 9:51 a.m., with LNV 4, the designated treatment nurse, LVN 4 stated that they were not aware of Resident 42's skin rash until 10/2/25. During a record review on 10/3/25, at 11:30 a.m., Resident 42's September 2025 (weekly) N Adv-Skin Check records were reviewed and indicated that skin check was not performed on 9/19/25. During a review of facility's Policy and Procedure (P&P) titled, Skin Integrity Management, revision date 6/27/24, the P&P indicated, As Licensed Nurse will complete the skin evaluation weekly.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility failed to provide the prescribed Bi-level positive airway pressure (BiPAP is a non-invasive ventilation machine that automatically adjusts the air pressure according to patient's requirement at a particular time) therapy as ordered for one of five sampled residents (Resident 8). This failure placed Resident 8 at risk for poor sleep quality, respiratory compromise and worsening chronic conditions. Findings: During a review of Resident 8's admission Record (AR), printed on 10/2/25, the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure (lungs are not working well to get enough oxygen into blood or to remove enough carbon dioxide from the body) with hypoxia (low oxygen in the blood), Chronic Obstructive Pulmonary Disease (COPD, a long-term lung condition that makes it hard to breathe because the airway become narrowed or blocked), and obstructive sleep apnea (OSA, breathing stops for short periods while sleeping because the airway gets blocked). During a review of Resident 8's Minimum Data Set (MDS, an assessment tool used to direct patient care), dated 8/21/25, the MDS indicated, Resident 8 had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information score of 14. A BIMS score of 13 to 15 is an indication of intact cognitive status. During a concurrent interview and observation on 9/29/25, at 11:47a.m., Resident 8 was observed lying in bed with head of bed elevated. Resident 8 stated that the oxygen tank and BiPAP machine with mask had been missing since they moved to this room at the end of July of 2025. Resident 8 stated needing oxygen and BiPAP at times because of shortness of breath. No oxygen tank or BiPAP machine was observed in Resident 8's room at the time of the observation. During a concurrent interview and record review of Resident 8's MDS, dated 2/26/25 and 8/21/25, on 10/2/25, at 9:00 a.m., the MDS Coordinator (MDSC) confirmed that Resident 8 used BiPAP and had diagnoses of COPD, Respiratory failure, and OSA. During an interview on 10/2/25, at 9:11a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated they had never seen a BiPAP machine in Resident 8's room. LVN 5 stated that Resident 8 had episode of shortness of breath and anxiety which was related to pain and those episodes were resolved after administering pain medication. During an interview on 10/3/25, at 8:30 a.m., with the Infection Preventionist (IP), IP stated that if a resident had a physician order for BiPAP, they should have one with them. IP stated the resident could stop breathing during sleep without using BiPAP. During a concurrent interview and record review on 10/3/25, at 9:21 a.m., with Registered Nurse (RN) 1, Resident 8's Order Summary Report (OSR) and September Respiratory/Medication/Treatment Administration Record (a document where nurses record all medication, treatment given to a resident) were reviewed. The OSR indicated a physician's order for BiPAP Mask type: Full Face Mask, Frequency: when sleeping at bedtime for COPD and Oxygen at two liter per minute via nasal canula to keep oxygen saturation as needed for COPD. RN 1 stated the BiPAP order was not completed and should include (equipment) settings. During a record review of Resident 8's September 2025 Medication Administration Record (MAR), on 10/3/25, at 9:25 a.m., with RN 1, the MAR indicated, BiPAP treatments were not administered on multiple dates, including 9/5, 9/6, 9/10, 9/11, 9/12, 9/13, 9/17, 9/18, 9/23, 9/29 and 9/30. RN 1 stated that the BiPAP treatment should have been administered according to the physician's order. During an interview on 10/3/25, at 9:40 a.m., with Director of Staff Development (DSD) and Administrator (ADM), DSD stated that she saw the BiPAP machine when Resident 8 was admitted to the facility. DSD went to Resident 8's previous room to locate the BiPAP machine but was unable to find it. ADM stated that the BiPAP may have been returned to the rental company. During a concurrent phone interview and record review on 10/3/25, at 11:05 a.m., with LVN 2, Resident 8's September 2025 MAR was reviewed. LVN 2 stated that there was no BiPAP machine in Resident 8's room and she had mistakenly signed the BiPAP treatments on the MAR for 9/1, 9/2, 9/3, 9/4, 9/7, 9/8, 9/9, 9/14, 9/15, (continued on next page)		

Department of Health & Human Services
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/16, 9/19, 9/21, 9/22, 9/25, 9/26, 9/27 and 9/28. During a record review of Resident 8's History & Physical (H&P), dated 2/21/25, the H&P indicated, Resident (8) was found to have OSA which caused them to have the AV block. During a review of Resident 8's active care plan, the care plan indicated, interventions for BiPAP via Full Mask when sleeping; Encourage Resident's use of BiPAP; Educate Resident on the importance of BiPAP therapy. During a review of facility's Policy and Procedure (P&P) titled, Physician Order, revision date 11/16/22, the P&P indicated orders will include a clear and complete description to provide clarity on the physician's plan of care.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to schedule a registered nurse (RN) for eight consecutive hours a day, seven days a week for three days in January 2025. This failure had the potential to put residents at risk and not receive sufficient care. During a concurrent interview and record review on 10/3/25 at 9:20 a.m., with the Payroll Account Payable Coordinator (PAPC), PBJ (Payroll - Based Journal) Staffing Data Report [NAME] Report 171705D FY (Fiscal Year) Quarter 2 2025 (a method of staffing data from nursing facilities) January 1- March 31, dated 9/22/25 was reviewed. PAPC stated she was not aware that there were days in January with no RN on duty for 8 hours a day. During a concurrent interview and record review on 10/3/25 at around 12:18 p.m., with the PAPC, the Payroll document titled, DHPPH (Direct Care Service Hours Per patient Day - form to accurately capture the direct care service hours provided to patients in skilled nursing facilities) Worksheet - Totals was reviewed. PAPC confirmed that there were three days in January 2025 namely 1/19/25, 1/25/25, 1/30/25, wherein the facility did not have an RN on duty for 8 hours a day. During an interview on 10/3/25 at 12:26 p.m., with the Staff Scheduler (SS), SS acknowledged they were short-staffed in January 2025. SS stated it was important to have an RN on duty 8 hours a day so that RNs can assess the patients, give IVs (intravenous such as IV antibiotics) and manage the care of the patients with IVs. During an interview on 10/3/25 at 12:48 p.m., with the SS, SS stated there were three days with no RN on duty on 1/19/25, 1/25/25, and 1/30/25.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications were available and provided to residents when: 1. Resident 78 did not receive Xarelto (a blood thinner) medication as ordered by the physician. 2. Two medication E-kits (Emergency kits) were opened and not replaced within 72 hours. These failures had the potential to put patients at risk for harm due to missed doses of medications including delayed treatment during emergency situations when medications are not available for use. Findings:1. During a medication pass observation on 9/30/25 at 8:04 a.m., Licensed Vocational Nurse (LVN) 9 prepared five oral medications for Resident 78. LVN 9 stated Xarelto medication was supposed to be given at this time but was not available. LVN 9 stated it was requested from pharmacy. During record review of Resident 78's admission Record (AR), undated, the AR indicated Resident 78 was admitted in October 2025, with diagnoses that included pain in the lower leg, and current use of anticoagulants (blood thinners). During a review of Resident 78's Minimum Data Set (MDS, an assessment tool used to guide care), dated 7/14/25, the MDS indicated a Brief Interview Mental Status (BIMS, a brief scanner to help detect cognitive impairment) score of 14 indicating no cognitive impairment. During a follow up interview on 9/30/25 at 5 p.m., with LVN 9, LVN 9 confirmed that Resident 78 did not get her Xarelto because it was not yet delivered by pharmacy. During a record review of physician order (PO), dated as of 10/1/25, the PO indicated, Xarelto oral tablet 10 mg (Rivaroxaban) Give 1 tablet by mouth one time a day for DVT (Deep Vein Thrombosis- a blood clot in a deep vein, usually in the legs) prevention. During a record review on 10/1/25 of the Medication Administration Record (MAR), the MAR dated September 2025 indicated a code, 9 entered for 9/30/25 indicating the medication was not given due to the reason on the chart code with 9 indicating, Other/See progress notes. During a record review of the Orders - Administration Note dated 9/30/25, the note indicated Xarelto oral tablet 10 mg one time a day for DVT prevention, med on progress, pharmacy will deliver today, and will be given today, MD is aware. During an interview on 10/2/25 at 12:21 p.m. with Resident 78, Resident 78 stated she did not receive Xarelto medication on Tuesday 9/30/25 because pharmacy did not deliver it. During a telephone interview on 10/2/25 at 2:56 p.m., with the Consultant Pharmacist (CP), CP stated if it is a medication refill, the facility can request a refill. CP stated that if a medication is requested, the facility should request five days before the medication runs out. CP acknowledged that it was not okay for Resident 78 to miss a dose. CP stated he did not have access to the dispensing information in order to know when it was requested. During a review of the facility's Policy and Procedure (P&P), titled Organizational Aspects - Provider Pharmacy Requirements dated April 2008, the P&P indicated, .The provider pharmacy agrees to perform the following pharmaceuticals services, including but not limited to: Providing routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week. Providing, maintaining, and replenishing emergency medication supply.in a timely manner. 2. During a concurrent observation and interview on 9/30/25 at 1:50 p.m., in the medication room, with Licensed Vocational Nurse (LVN) 7, two E-kits were opened, with a yellow log form on top of the contents inside each E-kit, indicating documentation of the medications removed. LVN 7 stated the first E-kit, (medium size), labeled Oral Emergency Kit that contained 38 medications had been opened and sealed with yellow plastic ties and was last used on 9/10/25. LVN 7 stated the second E-kit (small), labeled Narcotic Emergency Ekit that contained 10 medications was also opened, had the yellow ties, and last used on 9/17/25. LVN 7 explained that the process on E-kit use and provided the originals of the pharmacy logs for each opened E-kit. The Oral E-kit pharmacy log indicated the E-kit was opened on 9/10/25 at 6:50 p.m. and 2 tablets of cephalexin antibiotics were taken out. The Narcotic E-kit pharmacy log indicated the E-kit was opened on 9/17/25 at 8 p.m. and 1 tablet of oxycodone for pain was taken out. LVN 7 was unable to show evidence that the staff requested a replacement for the opened E-kits. During a telephone (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 10/2/25 at 3:15 p.m. with the CP, CP stated the facility was supposed to request a replacement for opened E-kits within 72 hours by phone or fax. During an interview on 10/3/25 at 8:35 a.m., with Director of Nursing (DON), DON stated they needed a code, needed to fill out the form, and fax the form to pharmacy to renew the E-kits. DON acknowledged opened E-kit requests were not being faxed to the pharmacy. DON stated it was important to replace E-kits to decrease drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purpose). During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, revised January 2025, the P&P indicated, .When an emergency or stat dose of a medication is needed, the nurse unlocks the container.After removing.complete the emergency e-kit slip and re-seal the emergency supply.As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply by faxing a request utilizing the prescription refill sticker.the used sealed kits are replaced with the new sealed kits within 72 hours of opening.		

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

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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 10/20/2025
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based interview and record review, for one of five (Resident 2) sampled residents reviewed for unnecessary medication use, the facility failed to act on the Consultant Pharmacist's (CP) recommendations for monthly Medication Regimen Review (MRR, in-depth evaluation of a patient's complete list of medications by a pharmacist to ensure safety and effectiveness) for three consecutive months. This failure had the potential to result in unnecessary medication use. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility in December 2023 with diagnoses that included anxiety disorder (repeated episodes of sudden feelings of intense fear or worry) depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and insomnia (difficulty falling or staying asleep). During a concurrent joint interview and record review on 10/2/25 at 1:48 p.m., with Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 7, Resident 2's Order Summary Report (OSR) and Medication Administration Record (MAR) for September 2025 were reviewed. RN 1 stated the OSR indicated lorazepam was ordered every 8 hours as needed. LVN 7 stated Resident 2 received lorazepam daily around 12 noon to 1 p.m. for verbalization of anxiety. During a review of the MAR for September 2025, the MAR indicated lorazepam PRN was administered once daily between 12 noon to 1 p.m. for anxiety manifested by restlessness. The MAR also indicated staff monitored for episodes of intense anger as the behavioral indication for the use of lorazepam PRN. During a review of the OSR, the OSR indicated, lorazepam oral tablet 0.5 milligram (mg) one tablet by mouth every 8 hours as needed for anxiety manifested by restlessness, was ordered 5/14/25. The OSR also indicated an order dated 1/4/25 to monitor for target behavior related to the use of lorazepam manifested by intense anger. During a review of Consultant Pharmacist's Medication Regimen Review (CPMRR) dated 7/1/25, 8/1/25, 9/5/25, the CPMRR indicated, episodes of intense anger (lorazepam PRN behavioral) do not coincide with lorazepam PRN usage. Lorazepam PRN should be given in response to a specific behavior, so behavior charting should coincide with PRN medication usage. The CPMRR dated 8/1/25 also indicated a recommendation to change lorazepam from one tablet by mouth every 8 hours PRN to one tablet by mouth daily at 12 noon for anxiety. None of these recommendations have been implemented. During an interview on 10/2/25 at 1:55 p.m. with Director of Nursing (DON), DON stated CP conducted the MRR, which along with recommendations, was sent to the facility. DON stated the Nursing Department was responsible for communicating recommendations to the physician and ensuring any new orders were transcribed. DON stated there was no clear process for conducting MRR at the facility. During a review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports effective June 2021, the P&P indicated, the consultant pharmacist reviews each resident's medication regimen monthly. Any irregularities or clinically significant risks are reported to the Director of Nursing and/or prescriber. Recommendations are implemented and documented by the staff or prescriber. Physicians must respond to recommendations and explain any disagreements by the next visit.		

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NAME OF PROVIDER OR SUPPLIER Princeton Manor Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2124 57th Avenue Oakland, CA 94621	
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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 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. Based on observation, interview, and record review, the facility failed to ensure the safe storage and labeling of medications when:1. Three medications - Adult Gummies C, Extra strength D 3, and Magnesium Extra strength were observed at Resident 71's bedside.2. One over the counter (OTC) eye drop in the medication (med) cart 1 was not labeled with name.These failures had the potential for medication errors and unsafe use of medications and biologicals.Findings:1.During a concurrent observation and interview during an initial tour on 9/29/25 at 10:45 a.m., in Resident 71's room, there were three medication bottles containing vitamin supplements - Kirkland Adult Gummies C 250 mg, Kirkland extra strength D3 50 mcg, and Nature made magnesium extra strength 400mg inside a basin that contained other stuff on top of Resident 71's bedside table. Resident 71 stated they were his vitamins but did not elaborate.During an observation on 10/1/25 at 12:24 p.m. in Resident 71's room, the three medication bottles containing vitamin supplements - Kirkland Adult Gummies C 250 mg, Kirkland extra strength D3 50 mcg and Nature made magnesium extra strength 400 mg were still inside the basin on Resident 71's bedside table. Resident 71 was agitated at this time and declined to talk about it.During a concurrent observation and interview on 10/1/25 at 12:26 p.m. with Licensed Vocational Nurse (LVN) 6, the supplements were observed at Resident 71's bedside, LVN 6 stated she had just seen the medications by Resident 71's bedside and was not aware Resident 71 had those medications there. LVN 6 stated Resident 71 did not have an order for medication self-administration and no resident in the facility was on medication self-administration. LVN 6, then removed the medications and put them in a plastic bag.During an interview on 10/2/25 at 1:12 p.m. with the Certified Nursing Assistant (CNA) 6, CNA 6 stated she was Resident 71's regular CNA. CNA 6 stated the medication supplements on Resident 71's bedside table had been there for a while now, for 2- 3 months. CNA 6 stated she did not know who it belonged to and did not ask Resident 71 because he would start cursing.During an interview on 10/3/25 at 8:40 a.m. with the Director of Nursing (DON), DON stated that at no time should medications be left at the resident's bedside because of safety. DON stated somebody could come and take the medications and it was not a safe practice.During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the facility, dated April 2008, the P&P indicated, .medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized.2. During an observation on 9/29/25 at around 4:25 p.m., of medication cart 1, there was an over the counter (OTC) artificial tears (used for eye dryness) with an opened date but no identifying label on the carton and the bottle. LVN 3 stated it had an opened date and was being used. LVN 3 stated he did not know who they were using it for. LVN 3 stated they were supposed to be identified with a resident's name.During an interview on 10/3/25 at 9:02 a.m. with DON, DON stated the eye drops should have a label and to be used for one patient. DON stated the eye drops was not supposed to be in the med. cart and discarded if they could not identify who it was for.During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy undated, the P&P indicated, .Nonprescription medications not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information is not covered.		