STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056170	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excell Health Care Center	3025 High Street Oakland, CA 94619

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 one of three sampled residents (Resident 1), the facility failed to ensure Resident 1, identified as a high risk for falls, was provided consistently close monitoring/supervision to minimize complications and prevent multiple falls.This resulted in Resident 1 sustaining fall injuries from a third unwitnessed fall. Resident 1 was transferred to the emergency department (ED) for evaluation and was found with multiple facial fractures (breaks in the facial bones such as the jaw, nose, or eye sockets, typically caused by accidents, falls, or assaults, and often required prompt medical attention).A review of Resident 1's admission Record, printed on 4/15/26, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a decline in memory or thinking skills severe enough to reduce a person's ability to perform activities of daily living [ADL, the basic self-care tasks an individual does on a day-to-day basis]), abnormalities of gait and mobility, muscle weakness, and adult failure-to-thrive (AFTT, a rapid, progressive decline in physical, functional, or cognitive health in older adults). A review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 9/12/25, indicated, Resident 1's primary language was Vietnamese, and had severely impaired cognition. Resident 1 required substantial/maximal assistance (helper does more than half the effort) to dependent (helper does all the effort) or the assistance of two or more helpers was required for the resident to complete the activity. Resident 1 required substantial/maximal assistance from sitting to lying position, lying to sitting on side of bed, sitting to standing, and chair/bed-to-chair transfer. A review of Resident 1's Care Plans, initiated date of 9/9/25, indicated Resident 1 had impaired cognitive function/dementia or impaired thought processes related to dementia. A Care Plan, with initiated date of 10/13/25, indicated Resident 1 had actual or suspected history of personal trauma, associated behaviors include trying to get out of bed, involuntary movements, and calling out related to dementia. Further review of Resident 1's Care Plans, initiated date of 10/10/25, indicated Resident 1 with episodes of behavior, crawling from bed to mattress and floor, episode of slapping her face, and tapping her left arm constantly. Review of the Care Plan also indicated when sitting in the wheelchair (w/c), Resident 1 observed with behavior of putting her feet up when staff passing by. Interventions included: Bring the resident to dining room to enjoy activities, implement head-to-toe assessments with each behavior of crawling and tapping and, ensure no skin issue injuries all the time. Keep resident in visual sight, monitor behavior frequently, observe what triggered behavior and notify Medical Doctor (MD). Offer frequently ADLs and mobility, place bed in lowest position all the time, and ensure mattress next to bed. A review of Resident 1's Care Plan, initiated date 11/12/25, indicated Resident 1 with an unwitnessed fall. Assist in ADLs and anticipate needs promptly, assist in transfers, toileting, and mobility functioning. Frequent visual check and assist the resident in the front or dining area, implement head-to-toe assessment and range of motion (ROM, a measure of joint functionality and flexibility), notify MD for any skin issues or injuries if noted. Monitor vital signs for any changes and notify MD, neurological check per protocol, monitor level of consciousness (LOC) closely, and notify MD promptly for any changes. On 11/13/25, Resident 1's existing care plan, (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	initiated on 11/12/25, was updated related to another unwitnessed fall incident. Resident 1 was found on the floor beside the wheelchair (w/c) on her right side, noted with skin cut below the eyebrow area with scant amount of bleeding, and with purplish skin discoloration around the right eye, more to the inner right eye area with swelling. Added interventions included: Transfer resident to emergency department for possible computed tomography (CT, uses special x-ray equipment to help assess head injuries, severe headaches, dizziness and other symptoms) scan of the head. A review of Resident 1's initial Fall Risk Observation/Assessment, dated 9/9/25, indicated Resident 1 had no falls in the past three months, was chair-bound and required assist in elimination, required use of an assistive device (example: w/c). A review of Resident 1's Fall Risk Observation/Assessment, dated 10/1/25, indicated resident had intermittent confusion, one to two falls in the past three months, chair-bound which required assistance in elimination, with balance problem while standing and walking, and required use of an assistive device. A Review of Resident 1's Fall Risk Observation/Assessment, dated 11/12/25, indicated Resident 1 had one to two falls in the past three months, chair-bound which required assist in elimination, and required use of an assistive device. Further review of Resident 1's Fall Risk Observation/Assessment, dated 11/19/25, indicated Resident 1 had three or more falls in the past three months, chair-bound which required assist in elimination, and required use of assistive device. A review of Resident 1's Situation Background Appearance Review and Notify (SBAR, a communication tool used to transfer critical patient information between members of the team) Communication Form, dated 10/1/25, at 3:15 p.m., indicated Resident 1 had an unwitnessed fall (first fall since admitted to the facility) in the hallway, was seen lying on the floor next to her w/c, alert and verbally responsive with confusion. Resident 1 pointed to her upper lip, upon assessment no injuries noted, no change in LOC. Resident 1 tried to stand by herself, denied head strike, skin intact, able to move all extremities without difficulty, vital signs stable. A review of Resident 1's SBAR Communication Form, dated 11/12/25, at 9:30 p.m., indicated Resident 1 had another unwitnessed fall (second fall) in the hallway, found seated on the floor beside her w/c, with both knees flexed near to chest, and both hands on the floor. No noted bump, no skin discoloration, no bleeding, skin intact, no signs of grimacing, or moaning. Able to move all extremities with no difficulty, noted no change in LOC. A review of Resident 1's SBAR Communication Form, dated 11/13/25, at 6:00 a.m., indicated Resident 1 had another unwitnessed fall (third fall), in resident's room, seated on the floor beside her w/c. Resident 1 was noted with a small cut on her right eyebrow, with scant bleeding, and discoloration (from previous fall on 11/12/25) noted. Able to move all extremities with no change in LOC. ROM to upper and lower extremities with no complaint of pain. A review of Resident 1's Skin and Wound Evaluation, dated 11/13/25, indicated Resident 1 sustained a laceration (a jagged, deep tear) to the right corner of eyebrow, 7.2 centimeters (cm) length by 5.2 cm width, with scant amount of bleeding, with black/blue skin discoloration, and swelling. A review of Resident 1's Neurological Flowsheet, dated 11/13/25, at 6:00 a.m., indicated a head-to-toe assessment was started, and at 10:00 a.m. Resident 1 was transferred to the hospital for evaluation. A review of Resident 1's Investigation Summary, dated 11/13/25, indicated Resident 1 had taken a fall on 11/13/25, at approximately 6:00 a.m., and was sent out to the hospital for further evaluation. A review of Resident 1's Hospital Emergency Department (ED) visit, dated 11/13/25, indicated an admission diagnosis of unspecified injury of head. Resident 1 was discharged from the hospital on [DATE], with final discharge diagnoses that included: Traumatic (an injury that causes severe and lasting physical damage) subarachnoid hemorrhage (bleeding into the space around the brain caused by head trauma) without loss of consciousness, initial encounter. Maxillary fracture (a break in the upper jawbone), right side, initial encounter for closed fracture (a broken bone that does not break through the skin). Fracture of orbital floor (bottom of the eye socket), right side, initial encounter for closed fracture. Zygomatic (cheekbone) fracture, right side, initial encounter for closed fracture. Laceration without foreign body of right eyelid and periocular (surrounding the eye) area, initial encounter and pain in the left elbow. Resident 1 also received a discharge order for follow up appointment on 11/20/25, at Oral (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and Maxillofacial Surgery (OMFS, a specialized dental surgical specialty focused on treating conditions, injuries, and defects of the mouth, teeth, jaws, face, head, and neck). During a telephone interview on 4/16/26, at 10:45 a.m., with Resident 1's Resident Representative (RR), RR stated although Resident 1's behavior remained the same at home, Resident 1 had not had any falls in the last four months since discharged from the facility on 12/19/25. During a telephone interview on 4/17/26, at 8:30 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 denied knowledge of Resident 1's fall and stated he was unable to recall the incident but remembered Resident 1 as frequently restless, unsettled, and fidgety, with frequent episodes of attempting to get out of bed. CNA 1 stated Resident 1 did not have a permanent 1:1 sitter (a healthcare worker who provides continuous, dedicated, one-on-one observation for a single patient to ensure their safety and prevent injuries), instead, whoever was the CNA assigned to that room assignment watched the resident. During a telephone interview on 4/23/26, at 6:45 a.m., with CNA 2, CNA 2 stated she did not take care of Resident 1 directly but knew the resident moved around a lot in bed when awake and was at a high risk for fall. CNA 2 stated Resident 1 did not have a dedicated 1:1 sitter, any of the nursing staff not currently busy shared in watching the resident. During a telephone interview on 4/23/26, at 6:55 a.m., with Registered Nurse 1 (RN 1), RN 1 stated on 11/13/25, at approximately 6:00 a.m., CNA 1 reported Resident 1 had an unwitnessed fall while CNA 1 assisted Resident 2 (Resident 1's roommate) with incontinent care (help provided to someone who cannot control their bladder or bowel), while Resident 1 was asleep in bed right inside the same room with privacy curtain pulled. RN 1 stated CNA 1 found Resident 1 seated on the floor mattress next to the resident?s bed and w/c. Resident 1 was noted with a skin cut below the right eyebrow area, with scant amount of bleeding, and had a purplish skin discoloration with swelling around the right eye. During an interview on 5/13/26, at 11 a.m., with the Director of Nursing (DON), DON stated Resident 1 was a high risk for falls, had no safety awareness, and had no capacity to make medical decisions. Interventions to prevent further falls included putting the bed in the lowest position, mattress on floor, monitored and watched closely by staff, and/or taken to the Nurses' Station, Rehab Therapy, or Activities. DON stated Resident 1 did not have a dedicated 1:1 sitter who had no other responsibilities but to stay and keep the resident safe. A review of the facility's policy and procedure (P&P) titled, Fall Prevention Program, date reviewed/revised 9/2/22, indicated, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.A fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level.The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.Provide additional interventions as directed by the resident's assessment, including but not limited to.Sitter, if indicated.interventions will be monitored for effectiveness.