STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056280	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Marina Post Acute	2919 Fruitvale Ave Oakland, CA 94602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 32717 Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to ensure Resident 1 was free from abuse when Family Member (FM) slapped Resident 1 in the face and called Resident 1 derogatory names. This failure resulted in Resident 1's abrasion on the left eyelid. Resident 1 was sent to the Emergency Department (ED) after complaining of left eye pain. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included hypertension (high blood pressure) and epilepsy (neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/19/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status. During an interview on 5/13/25 at 10:45 a.m. with Resident 1, Resident 1 stated, FM, Resident 2's sister, entered the room and loudly accused facility staff of mistreating Resident 2. Resident 1 and Resident 2 were roommates. Resident 1 stated FM said she was going to teach them a lesson, and started yelling and throwing things around the room. Resident 1 also stated, FM was visibly upset, came near Resident 1 and slapped Resident 1 in the face. Registered Nurse (RN) 1 entered the room and tried to stop FM from hitting Resident 1 more, but FM refused to stop, continued to yell, until FM went to sit by Resident 2's bed. Resident 1 stated wondering why FM would hit him if FM was upset with the facility staff. During an interview on 5/13/25 at 10:50 a.m. with Infection Preventionist (IP), IP stated seeing FM coming down the hallway, upset and fussing about something. IP stated FM said You all don't know me, you will hear from my lawyer, you don't know what I am capable of! . IP stated she entered Resident 1's room to find out what was going on. IP stated Resident 1 told her that FM had accused Resident 1 of stealing Resident 2's TV remote. IP stated Resident 1 alleged FM was very upset, came up to Resident 1 and slapped him across the face couple times. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/13/25 at 12:06 p.m. with RN 1, RN 1 stated, on 4/27/25, FM, who appeared visibly upset, walked past RN 1 in the hallway to Resident 1's room. RN 1 stated following FM to the room after FM did not acknowledge RN 1. As RN 1 walked towards the room, RN 1 heard Certified Nursing Assistant (CNA) 1's voice that said, Come! come!. RN 1 stated, upon entering the room, saw FM standing between the two residents, who were in their respective beds, facing Resident 1. FM held Resident 1's arms while Resident 1 defended himself by holding FM's hair. RN 1 stated he went closer by Resident 1's bed and told FM to get out of the room but FM refused to stop, went in and out of the room, and continued to yell loudly at Resident 1 and RN 1. RN 1 stated FM kept going at Resident 1, trying to agitate Resident 1 even more, calling Resident 1 derogatory names. RN 1 stated, when IP entered the room, FM calmed down and stayed at Resident 2's bedside. RN 1 stated moving Resident 1 to another room, where further skin assessment was done. RN 1 stated Resident 1 had a scratch on the left eyelid. During an interview on 5/13/25 at 12:27 p.m. with CNA 1, CNA 1 stated, as she entered Resident 1's room, FM stood between the two beds, closer to Resident 1, upset and yelled at Resident 1, Why are you grabbing my hair?. CNA 1 stated calling RN 1 for help. CNA 1 stated FM accused Resident 1 of stealing Resident 2's TV remote but Resident 1 denied taking it. CNA 1 stated looking through the entire room but did not find the TV remote. During a follow-up telephone interview on 5/22/25 at 11:34 a.m. with RN 1, RN 1 stated, FM called Resident 1 Fucker who stole my brother's TV remote!. RN 1 also stated there was so much tension in the room from FM yelling loudly, attacking [Resident 1] further with derogatory words. RN 1 also stated Resident 1 appeared afraid of FM and told FM to go away. During a review of Resident 1's eINTERACT Change in Condition Evaluation (eCiC) dated 4/27/25 and signed by RN 1, the eCiC indicated, Licensed nurse observed that a visitor to [Resident 2] had physically attacked [Resident 1] while he was in bed .[Resident 1] says he was hit in the eye. started risk management, change of condition, 72 hour charting . The eCiC indicated Resident 1 sustained a left eye discoloration with small abrasion on eye lid that measured 0.5 c.m. x 0.5 c.m. During a review of System Note signed by RN 1 and dated 4/27/25, the System Note indicated Resident 1 complained of pain on the left eye. During a review of the Interdisciplinary Note (IDT, a team composed of individuals from different departments of the facility) dated 4/28/25 and signed by Director of Nursing (DON), the the IDT Note indicated, on 4/27/25, FM allegedly slapped Resident 1 on the left side of the face, leaving a scratch over the left eyelid. The IDT Note indicated Resident 1 was sent to the Emergency Department (ED) for further evaluation. Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to ensure Resident 1 was free from abuse when Family Member (FM) slapped Resident 1 in the face and called Resident 1 derogatory names. This failure resulted in Resident 1's abrasion on the left eyelid. Resident 1 was sent to the Emergency Department (ED) after complaining of left eye pain. Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included hypertension (high blood pressure) and epilepsy (neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/19/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status. During an interview on 5/13/25 at 10:45 a.m. with Resident 1, Resident 1 stated, FM, Resident 2's sister, entered the room and loudly accused facility staff of mistreating Resident 2. Resident 1 and Resident 2 were roommates. Resident 1 stated FM said she was going to teach them a lesson, and started yelling and throwing things around the room. Resident 1 also stated, FM was visibly upset, came near Resident 1 and slapped Resident 1 in the face. Registered Nurse (RN) 1 entered the room and tried to stop FM from hitting Resident 1 more, but FM refused to stop, continued to yell, until FM went to sit by Resident 2's bed. Resident 1 stated wondering why FM would hit him if FM was upset with the facility staff. During an interview on 5/13/25 at 10:50 a.m. with Infection Preventionist (IP), IP stated seeing FM coming down the hallway, upset and fussing about something. IP stated FM said You all don't know me, you will hear from my lawyer, you don't know what I am capable of! . IP stated she entered Resident 1's room to find out what was going on. IP stated Resident 1 told her that FM had accused Resident 1 of stealing Resident 2's TV remote. IP stated Resident 1 alleged FM was very upset, came up to Resident 1 and slapped him across the face couple times. During a telephone interview on 5/13/25 at 12:06 p.m. with RN 1, RN 1 stated, on 4/27/25, FM, who appeared visibly upset, walked past RN 1 in the hallway to Resident 1's room. RN 1 stated following FM to the room after FM did not acknowledge RN 1. As RN 1 walked towards the room, RN 1 heard Certified Nursing Assistant (CNA) 1's voice that said, Come! come!. RN 1 stated, upon entering the room, saw FM standing between the two residents, who were in their respective beds, facing Resident 1. FM held Resident 1's arms while Resident 1 defended himself by holding FM's hair. RN 1 stated he went closer by Resident 1's bed and told FM to get out of the room but FM refused to stop, went in and out of the room, and continued to yell loudly at Resident 1 and RN 1. RN 1 stated FM kept going at Resident 1, trying to agitate Resident 1 even more, calling Resident 1 derogatory names. RN 1 stated, when IP entered the room, FM calmed down and stayed at Resident 2's bedside. RN 1 stated moving Resident 1 to another room, where further skin assessment was done. RN 1 stated Resident 1 had a scratch on the left eyelid. During an interview on 5/13/25 at 12:27 p.m. with CNA 1, CNA 1 stated, as she entered Resident 1's room, FM stood between the two beds, closer to Resident 1, upset and yelled at Resident 1, Why are you grabbing my hair?. CNA 1 stated calling RN 1 for help. CNA 1 stated FM accused Resident 1 of stealing Resident 2's TV remote but Resident 1 denied taking it. CNA 1 stated looking through the entire room but did not find the TV remote. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up telephone interview on 5/22/25 at 11:34 a.m. with RN 1, RN 1 stated, FM called Resident 1 Fucker who stole my brother's TV remote!. RN 1 also stated there was so much tension in the room from FM yelling loudly, attacking [Resident 1] further with derogatory words. RN 1 also stated Resident 1 appeared afraid of FM and told FM to go away. During a review of Resident 1's eINTERACT Change in Condition Evaluation (eCiC) dated 4/27/25 and signed by RN 1, the eCiC indicated, Licensed nurse observed that a visitor to [Resident 2] had physically attacked [Resident 1] while he was in bed .[Resident 1] says he was hit in the eye. started risk management, change of condition, 72 hour charting . The eCiC indicated Resident 1 sustained a left eye discoloration with small abrasion on eye lid that measured 0.5 c.m. x 0.5 c.m. During a review of System Note signed by RN 1 and dated 4/27/25, the System Note indicated Resident 1 complained of pain on the left eye. During a review of the Interdisciplinary Note (IDT, a team composed of individuals from different departments of the facility) dated 4/28/25 and signed by Director of Nursing (DON), the the IDT Note indicated, on 4/27/25, FM allegedly slapped Resident 1 on the left side of the face, leaving a scratch over the left eyelid. The IDT Note indicated Resident 1 was sent to the Emergency Department (ED) for further evaluation.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 32717 Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to have evidence that an alleged physical abuse was thoroughly investigated and failed to report the result of the investigation to the State Survey Agency within 5 working days of the incident. This failure had the potential to result in the inability to protect residents from further abuse. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included hypertension (high blood pressure) and epilepsy (neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/19/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status. During an interview on 5/13/25 at 10:45 a.m. with Resident 1, Resident 1 stated, FM, Resident 2's sister, entered the room and loudly accused facility staff of mistreating Resident 2. Resident 1 and Resident 2 were roommates. Resident 1 stated FM said she was going to teach them a lesson, and started yelling and throwing things around the room. Resident 1 also stated, FM was visibly upset, came near Resident 1 and slapped Resident 1 in the face. Registered Nurse (RN) 1 entered the room and tried to stop FM from hitting Resident 1 more, but FM refused to stop, continued to yell, until FM went to sit by Resident 2's bed. Resident 1 stated wondering why FM would hit him if FM was upset with the facility staff. During a telephone interview on 5/13/25 at 12:06 p.m. with RN 1, RN 1 stated, on 4/27/25, FM, who appeared visibly upset, walked past RN 1 in the hallway to Resident 1's room. RN 1 stated following FM to the room after FM did not acknowledge RN 1. As RN 1 walked towards the room, RN 1 heard Certified Nursing Assistant (CNA) 1's voice that said, Come! come!. RN 1 stated, upon entering the room, saw FM standing between the two residents, who were in their respective beds, facing Resident 1. FM held Resident 1's arms while Resident 1 defended himself by holding FM's hair. RN 1 stated he went closer to Resident 1's bed and told FM to get out of the room but FM refused to stop and continued to yell loudly at Resident 1 and RN 1. RN 1 stated FM kept going at Resident 1, trying to agitate Resident 1 even more, calling Resident 1 derogatory names. RN 1 stated Resident 1 had a scratch on the left eyelid. During a concurrent interview and record review on 5/13/25 at 12:26 p.m. with Administrator (ADM), ADM provided a handwritten note about the interview with FM but could not provide evidence that staff who witnessed the alleged abuse were interviewed. ADM stated the investigation summary (result of the investigation) was not completed as of 5/13/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up telephone interview on 5/22/25 at 11:34 a.m. with RN 1, RN 1 stated, FM called Resident 1 Fucker who stole my brother's TV remote!. RN 1 also stated there was so much tension in the room from FM yelling loudly, attacking [Resident 1] further with derogatory words. RN 1 also stated Resident 1 appeared afraid of FM and told FM to go away. During a review of Resident 1's eINTERACT Change in Condition Evaluation (eCiC) dated 4/27/25 and signed by RN 1, the eCiC indicated, Licensed nurse observed that a visitor to [Resident 2] had physically attacked [Resident 1] while he was in bed .[Resident 1] says he was hit in the eye. started risk management, change of condition, 72 hour charting . The eCiC indicated Resident 1 sustained a left eye discoloration with small abrasion on eye lid that measured 0.5 c.m. x 0.5 c.m. During a follow-up telephone interview and record review on 5/22/25 at 12:18 p.m. with ADM, investigation summary dated 5/6/25, sent by ADM on 5/14/25, was reviewed. ADM stated he interviewed FM who denied the allegation. When asked if ADM reviewed RN 1's notes, ADM stated, FM denied hitting Resident 1 but could not make RN 1 change the already written notes about the incident. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention and Management last revised 5/30/24, the P&P indicated The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification .within five (5) working days of the reported allegation. Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to have evidence that an alleged physical abuse was thoroughly investigated and failed to report the result of the investigation to the State Survey Agency within 5 working days of the incident. This failure had the potential to result in the inability to protect residents from further abuse. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility in January 2024 with diagnoses that included hypertension (high blood pressure) and epilepsy (neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/19/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status. During an interview on 5/13/25 at 10:45 a.m. with Resident 1, Resident 1 stated, FM, Resident 2's sister, entered the room and loudly accused facility staff of mistreating Resident 2. Resident 1 and Resident 2 were roommates. Resident 1 stated FM said she was going to teach them a lesson, and started yelling and throwing things around the room. Resident 1 also stated, FM was visibly upset, came near Resident 1 and slapped Resident 1 in the face. Registered Nurse (RN) 1 entered the room and tried to stop FM from hitting Resident 1 more, but FM refused to stop, continued to yell, until FM went to sit by Resident 2's bed. Resident 1 stated wondering why FM would hit him if FM was upset with the facility staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/13/25 at 12:06 p.m. with RN 1, RN 1 stated, on 4/27/25, FM, who appeared visibly upset, walked past RN 1 in the hallway to Resident 1's room. RN 1 stated following FM to the room after FM did not acknowledge RN 1. As RN 1 walked towards the room, RN 1 heard Certified Nursing Assistant (CNA) 1's voice that said, Come! come!. RN 1 stated, upon entering the room, saw FM standing between the two residents, who were in their respective beds, facing Resident 1. FM held Resident 1's arms while Resident 1 defended himself by holding FM's hair. RN 1 stated he went closer to Resident 1's bed and told FM to get out of the room but FM refused to stop and continued to yell loudly at Resident 1 and RN 1. RN 1 stated FM kept going at Resident 1, trying to agitate Resident 1 even more, calling Resident 1 derogatory names. RN 1 stated Resident 1 had a scratch on the left eyelid. During a concurrent interview and record review on 5/13/25 at 12:26 p.m. with Administrator (ADM), ADM provided a handwritten note about the interview with FM but could not provide evidence that staff who witnessed the alleged abuse were interviewed. ADM stated the investigation summary (result of the investigation) was not completed as of 5/13/25. During a follow-up telephone interview on 5/22/25 at 11:34 a.m. with RN 1, RN 1 stated, FM called Resident 1 Fucker who stole my brother's TV remote!. RN 1 also stated there was so much tension in the room from FM yelling loudly, attacking [Resident 1] further with derogatory words. RN 1 also stated Resident 1 appeared afraid of FM and told FM to go away. During a review of Resident 1's eINTERACT Change in Condition Evaluation (eCiC) dated 4/27/25 and signed by RN 1, the eCiC indicated, Licensed nurse observed that a visitor to [Resident 2] had physically attacked [Resident 1] while he was in bed .[Resident 1] says he was hit in the eye. started risk management, change of condition, 72 hour charting . The eCiC indicated Resident 1 sustained a left eye discoloration with small abrasion on eye lid that measured 0.5 c.m. x 0.5 c.m. During a follow-up telephone interview and record review on 5/22/25 at 12:18 p.m. with ADM, investigation summary dated 5/6/25, sent by ADM on 5/14/25, was reviewed. ADM stated he interviewed FM who denied the allegation. When asked if ADM reviewed RN 1's notes, ADM stated, FM denied hitting Resident 1 but could not make RN 1 change the already written notes about the incident. During a review of the facility's policy and procedure (P&P) titled Abuse Prevention and Management last revised 5/30/24, the P&P indicated The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the California Department of Public Health Licensing and Certification .within five (5) working days of the reported allegation.