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	07/10/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a safe discharge to one sampled resident (Resident 1) when Resident 1 who had a physician order to be discharged to an assisted living (a type of housing designed that offers caregiver support and assistance with activities of daily living/ADL, including dressing, grooming, showering, moving around, and managing medication) was placed to an independent living housing (designed for people who are still active and require little to no support with the activities of daily living) instead.This deficient practice placed Resident 1 at risk for an unsafe discharge and re-hospitalization.During a record review of Resident 1's admission Record (AR) printed on 7/10/25, the AR indicated Resident 1 was admitted in the facility in January 2025 with diagnoses of cerebral infarction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain) affecting left-dominant side, muscle weakness, need for assistance with personal care, and history of falling. The AR also showed Resident 1 was discharged in June 2025 to a Board and care (a small, licensed residential setting that provides housing and personal care services to a limited number of residents, typically six or fewer, who need assistance with ADLs)/assisted living/group home: Assisted Living. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/8/25, the MDS assessment Section G (Functional Abilities and Goal) indicated Resident 1 needed substantial assistance (helper lifts, holds, or support trunk or limbs and provide more than half the effort) transferring to and from a bed to a chair and dependent (helper does all the effort) during toilet transferring (ability to get on and off a toilet or commode). The MDS assessment section C indicated Resident 1's Brief Interview of Mental Status (BIMS- an assessment for cognition status) score was 15 out of 15 which indicated no cognitive impairment status. During a record review of Resident 1's Order Summary dated 6/19/25, the Order Summary indicated Resident1 had a physician order that showed Discharge resident to Assisted living with home health (medical care delivered in the patient's home) Registered Nurse/Physical Therapist/Occupational Therapist. During a phone interview on 7/10/25 at 11:04 a.m. with Resident 1, Resident 1 stated she was discharged to an independent living housing. Resident 1 stated she agreed with the facility-initiated discharge because the facility told her she was going to a board and care home or assisted living. Resident 1 stated she was not fully independent and needed a lot of help with her personal care. Resident 1 stated the place where the facility discharged her did not have the support she needed. Resident 1 further stated the lady that owned the house did not help her with her daily needs. During an interview on 7/10/25 at 12:20 p.m. with the Social Services Director (SSD), SSD stated Resident 1 was discharged back to her previous board and care home. SSD stated the board and care home provided Resident 1 the basic ADL care that also included transportation to and from Resident 1's appointments. During a follow-up phone interview on 7/11/25 at 11:10 a.m. with Resident 1, Resident 1 stated she never lived at the address where the facility discharged her. Resident 1 further stated the facility discharged her to a different address than the one that she signed and listed in her file. Resident 1 stated she expected to live in an environment that had caregiver support at all times because one side of her body had weakness from a stroke, and it was hard for her to do a lot of things on her own. Resident 1 stated she felt upset and helpless when the facility did not discharge her to an assisted living. Resident 1 further stated she did not want to experience this ever again.During a phone interview on 7/11/25 at 11:45 a.m. with the independent living owner (ILO), ILO confirmed her place offered room and board for independent living. ILO stated when she accepted residents from the facility, she expected them to be able to provide care for themselves. ILO stated it turned out that Resident 1 was unable to care for herself and needed a lot of assistance. ILO stated they also did not have in-house caregivers to provide support and assistance for residents.During a follow-up phone interview and record review on 7/11/25 at 12:08 p.m. with SSD, Resident 1's Progress Notes dated 6/18/25 was reviewed. SSD stated on 6/18/25, she documented that Resident 1 agreed to be discharged to a board and care home. SSD stated the address she documented as Resident 1's discharged place was wrong. SSD stated ILO owned two different locations and SSD did not know why ILO brought Resident 1 to another location different from what she documented. SSD stated she was very confused because ILO told her that she was able to provide care for Resident 1. SSD stated Resident 1 was self-responsible when asked how the facility made sure that Resident 1's discharge was safe.During a phone interview on 7/11/25 at 12:46 p.m. with the Administrator (ADM), ADM stated prior to discharging a resident, the facility should have planned a resident's discharge