

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Bay Marina Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, for one of two sampled residents (Resident 1) who were discharged , the facility failed to develop and implement an effective discharge planning process for transition to post-discharge care. This failure resulted in Resident 1 suffering homelessness and had the potential to result in unnecessary re-admission to the hospital. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility in June 2025 with diagnoses that included cognitive communication deficit (impaired memory and attention affecting communication), personal history of traumatic brain injury (temporary issues with thinking, understanding, movement, and behavior due to an external force), ataxia (poor muscle control affecting movement and balance), and repeated falls. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 12/23/25, 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 12 (a BIMS score of 8-12 is indication of moderate impairment in cognitive status). During a review of Resident 1's Discharge Summary (DS) dated 12/23/25, the DS indicated Resident 1 was discharged that evening with medications and a medication list. The facility sent Resident 1 to an Assisted Living Facility via Uber. During a review of Resident 1's Discharge Planning Review Form (DPRF) dated and signed 12/24/25, one day after discharge, the DPRF indicated, under section Medication Reconciliation (MR), the MR indicated medication list was provided to the subsequent provider, but not to Resident 1. The DPRF did not have any signature by Resident 1 or Resident 1's family member. During a telephone interview on 1/23/26 at 12:18 p.m. the Home Health Registered Nurse (HHRN) stated she assessed Resident 1 for admission to Home Health Services on 12/25/25. Resident 1 lacked a medication list and discharge medications. HHRN had to request the home health office to call the facility for the medication list. Additionally, Resident 1 did not have a primary care physician or information about a local pharmacy for refills. During a telephone interview on 1/23/26 at 12:26 p.m. with Assisted Living Staff (ALS), ALS stated Resident 1 said he could take his own medications but did not show which ones. Resident 1 walked without a walker in an unusual way, with his trunk leaning backward. ALS also stated Resident 1 often wandered off to an unknown shelter. During a telephone interview on 1/27/26 at 4:45 p.m. with Assisted Living Owner (ALO), ALO stated Resident 1 occasionally left the home, requiring ALO had to send an Uber for pickup. ALO stated there was an instance where the Uber refused to pick up Resident 1 because he was dirty after being homeless for a few days. ALO stated Resident 1 received financial benefits, but they did not know who the payee was or who was receiving the money. During a review of Resident 1's clinical record, the IDT note dated 11/26/25 indicated Resident 1's Family Member (FM) had called about discharge plans. The IDT notes indicated FM tried to apply for financial benefits on behalf of Resident 1 and would call the facility to coordinate discharge plan once the application was finished. However, the clinical record did not indicate any further</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056280
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>coordination or follow-up with FM by the facility staff regarding these plans. During a concurrent interview and record review on 1/23/25 at 12:44 p.m. with Director of Nursing (DON), DON stated Resident 1's clinical record did not indicate any discharge planning before the actual discharge date , and there was no discharge care plan developed. During a review of the facility's policy and procedure (P&P) titled Transfer and Discharge last revised 7/2/2020, the P&P indicated discharge planning begins upon a resident's admission. A Social Services Staff or designee will complete an initial discharge assessment within seven days. Referrals to local contact agencies and assistance with discharge planning will be recorded in the medical record. Social Services will document discharge planning, preparation, and post-discharge needs. The Social Services Staff will also develop a Discharge Care Plan with the IDT.</p>