

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER San Leandro Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 368 Juana Avenue San Leandro, CA 94577	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of three sample selected residents (Resident 1) was treated with respect and dignity, when the facility's staff talked to Resident 1 disrespectfully on two separate occasions as a reaction towards Resident 1's difficult behaviors towards direct care staff. This deficient practice resulted in Resident 1 feeling bad, disrespected and threatened. Findings: During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility in October 2021. During a review of Resident 1's Minimum Data Set (MDS, an assessment to plan and guide care) assessment dated [DATE], Section C - Cognitive Patterns indicated Resident 1's Brief Interview for Mental Status (BIMS, screening tool used by healthcare professionals to evaluate a person's memory, attention, and orientation) score was 15 of 15 (cognitive response and short-term memory are entirely intact). During an interview on 6/8/26 at 10:08 am., with Resident 1, Resident 1 stated on 04/2026, LVN 1 told him Don't act like a Devil because Resident 1 told her why LVN 1 did not answer the phone. Resident 1 stated it made him feel bad when Licensed Vocational Nurse (LVN) 1 called him devil and still feels bad every time seeing LVN 1. During an interview on 6/8/26 at 10:46 a.m., Resident 1 stated on another occasional in 01/2026, Certified Nursing Assistant (CNA) 1 was cleaning him up and the water was cold. Resident 1 asked CNA 1 to change the water and called him boy because he did not remember CNA 1's name, CNA 1 got upset and called him nigger a few times. Resident 1 stated he felt threatened by CNA1, still feels bad and disrespected. During a review of Resident 1's Progress notes dated 4/29/26, indicated Resident 1 reported to staff on 4/25/26 around 6:30 p.m., Resident 1 attempted to get help to replace his low oxygen tank, but was unable to reach staff by phone and staff (Licensed Vocational Nurse - LVN 1) disrespected him by calling him Devil. During an interview on 6/9/26 at 12:17 p.m., with LVN 1, LVN 1 stated she was the assigned nurse supervisor on 4/25/26 and saw Certified Nursing Assistant (CNA) 2 was crying in the hallway. CNA 2 told LVN 1 that Resident 1 told CNA 2 bad words, and hence LVN 1 told Resident 1 don't act like a Devil on that day. LVN 1 stated Resident 1 was very mean to staff, yelled at them and used bad words all the time and she was trying to stop Resident 1 from abusing staff. During an interview on 6/9/26 at 12:50 p.m., with CNA 2, CNA 2 stated on 4/25/26, she was taking lunch break, when Resident 1 started yelling at her and wanted to go to his bed. CNA 2 told Resident 1 that she still had 5 minutes, when CNA 2 went back to Resident 1's room, Resident 1 started to yell at her and told her, crybaby and fat. CNA 2 left the room and started crying, LVN 2 saw CNA 2 and told Resident 1 don't act like a devil. During a review of Resident 1's IDT Progress Notes dated 1/27/26 indicated, Resident 1 reported to the Administrator (ADM) on 1/26/26 that Certified Nurse Assistant (CNA)1 called him Nigger during care, CNA 1 was interviewed and stated Resident 1 repeatedly called him Boy, and in responding, asked how Resident1 would feel if he was called him Nigger. During an interview on 6/9/26 at 10:42 a.m., with CNA1, CNA1 stated he was cleaning Resident 1 and Resident 1 called him Boy and CNA 1 told Resident 1 if I call you Nigger you like it? and Resident 1 start yelling. CNA 1 stated he knew that he was not supposed to have an argument with Resident 1, but Resident 1 insulted him and CNA1 responded like that. During an (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 6/9/26 at 09:30 a.m., with the Registered Nurse (RN)1, RN1 stated, on 1/26/26 at around 5 a.m., heard Resident 1 was calling CNA 1 Boy and started yelling, Resident 1 called RN1, and told CNA 1 called him Nigger, RN1 asked CNA 1 to leave the room. During a review of the facility's undated policy and procedure (P&P) titled Resident Rights indicated .Employees shall treat all residents with kindness, respect, and dignity.		