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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056350	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Merritt Healthcare Center LLC	309 MacArthur Boulevard Oakland, CA 94610

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect one of five sampled residents, (Resident 1), from physical abuse when Resident 2 hit Resident 1 in the head with a chair. This failure resulted in Resident 1 having a laceration (deep cut in the skin), on Resident 1's left forehead requiring transfer to an acute care hospital.During a review of Resident 1's admission Record printed on 1/6/26, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, (a brain disorder that slowly destroys memory and thinking skills.), Parkinson's Disease, (a chronic, progressive brain disorder affecting movement, and can contribute to memory loss) and agitation, (behavior marked by verbal outbursts and physical aggression).During a 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 12/8/25, the MDS indicated Resident 1's Brief Interview for Mental Status Score, (BIMS, a scoring system used to determine the residents cognitive status in regard to attention, orientation, and ability to register and recall information), of four out of fifteen, indicating severe cognitive impairment, (significant problems with thinking, memory and orientation).During a review of Resident 2's admission Record printed on 1/6/26, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy, (brain dysfunction coming from chemical imbalances leading to memory loss and personality changes), anxiety, (when feelings of fear, worry or unease are excessive, persistent and interferes with daily life), and adjustment disorder with mixed disturbance of emotions and conduct, (stress-related condition where a person experiences both emotional symptoms and behavioral problems). During a review of Resident 2's MDS assessment dated [DATE], Section B, (Hearing and Speech), indicated Resident 2 sometimes makes himself understood and sometimes was able to understand others.During a concurrent observation and interview on 1/6/26 at 2:45 p.m. with Resident 1 in Resident 1's room, Resident 1 was sitting on his bed with his wife at his bedside, Resident 1 stated Resident 1 could not recall going to the Emergency Department of how resident 1's head was injured.During a concurrent observation and interview on 1/6/26 at 10:20 a.m. with Resident 2 in Resident 2's room, Resident 2 stated he hit Resident 1 in the head with a chair because Resident 2 was angry that Resident 1 woke Resident 2 up because Resident 1 wanted to talk to Resident 2. During a telephone interview on 1/9/26 at 8:41 a.m., Registered Nurse 1, (RN1), stated RN1 was on duty on 11/1/25. RN1 stated at 5:50 a.m. RN1 heard a sound and went to investigate. RN1 stated when RN1 arrived at the location of the sound, (room [ROOM NUMBER] belonging to Resident 2), RN1 observed Resident 1 sitting on the floor in the doorway of room [ROOM NUMBER] with blood coming from the left side of Resident 1's forehead. RN1 stated RN1 observed Resident 2 standing in his room, holding a chair and screaming. During a review of Resident 1's Progress Notes dated 11/1/25, the Progress Notes indicated Resident 1 was assessed by RN1 to have a laceration, (a deep cut in the skin), (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the left side of Resident 1's forehead, resulting in resident 1 being transferred to the hospital by ambulance.During a review of Encounter Summary, (from the acute care hospital), dated 11/1/25 the Encounter Summary indicated Resident 1 sustained a 4 centimeter, (unit of measure), requiring stiches, (medical threads used to sew skin together to close wounds).During a review of Resident 2's care plan, (CP), dated 11/1/25, the CP indicated Resident 2 exhibits .physical and verbal aggression related to hitting, pushing, threatening and throwing objects as evidenced by observed aggressive behavior toward staff and residents . During a review of the facility's policy and procedure titled, Resident Rights, dated 02/21, indicated residents have the right to .be free from abuse, neglect, misappropriation of property and exploitation.