STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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 - Some	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 two of four sampled residents (Resident 1 and Resident 3) when Resident 2 pushed Residentˆ1 to the floor; and Resident 4 punched Residentˆ3 in the face during an altercation. This failure resulted in Resident 1 falling to the floor and sustained a laceration (a cut in the skin) of left shin and right knee. Resident 3 sustained swelling under the right eye on his face. During a record review of Resident 1's admission Record on 3/5/26, the record showed Resident 1 was admitted to the facility on 10 /25/11. During a record review of Residentˆ1's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care) assessment dated [DATE], the assessment indicated Resident 1's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was 10 out of 15, indicating moderate cognitive impairment. During a record review of Resident 2's admission Record 03/5/26 the record showed Resident 2 was admitted to the facility on [DATE]. During a record review of Resident 2's Annual MDS assessment dated [DATE], the assessment indicated Resident 2's BIMS score was nine (9) out of 15, indicating moderate cognition. During an observation and interview on 3/5/26 at 2:05 p.m. Resident 1 was sitting in his wheelchair by the nursing station of the hallway. Resident 1 stated Resident 2 was angry and yelled at him. Resident 1 stated Resident 2 pushed him to the floor and pointed to his right shin and knee said cut. During an observation and interview with Resident 2 on 3/5/26 at 2:22 p.m. Resident 2 was lying in bed and refused the interview.During a phone interview on 3/6/26, at 10:40 a.m. with Registered Nurse (RN) 1, RN 1 stated on 12/20/25, while he was in the hallway, he heard yelling. RN 1 stated he went to the area of the yelling and saw Resident 1 and Resident 2 facing each other and were ready to pounce at each other. Resident 1 ended up on the floor after being pushed to the ground by Resident 2. Resident 1 acquired a laceration on the right knee and left shin. They were both very upset and it was hard to deescalate the situation. RN 1 stated he had to call the police for help. During a record review of Resident 1's clinical progress note dated 12/20/25, RN 1 documented observed [Residents 1 and 2] engaged in an escalating altercation. Both residents were holding chairs and positioned defensively, attempted to de-escalate the situation; however, the attempts were unsuccessful. [Resident 2] pushed [Resident 1], causing [Resident 1] to fall forward and off the wheelchair. Resident 1 sustained a laceration to the left shin and a laceration to the right knee.During a record review of Resident 3's admission Record dated 03/05/26 the record indicated Resident 3 was admitted to the facility on [DATE]. A record review of Residentˆ3's MDS assessment dated [DATE] indicated, Resident 3's BIMS score was four (4) out of 15, indicating severe cognitive impairment. During a record review of Resident 4's admission Record dated 03/05/26 the record indicated Resident 4 was admitted to the facility on [DATE]. During a record review of Resident 4's Annual MDS assessment dated [DATE], the assessment indicated Resident 4's BIMS score was 14 out of 15, indicating intact cognition. During an observation and interview with Resident 3 on 3/5/26 at 12:05 p.m., Resident 3 was sitting on his bed in his room. Resident 3 stated he was minding his own business, when Resident 4 started yelling about him making racist comments and then punched him on his face as he was leaving the room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 4 on 3/5/26 at 10:15 a.m., Resident 4 stated he punched Resident 3 on his face because he thought Resident 3 took his shirt.During a phone interview on 3/5/26, at 10:00 a.m., Certified Nursing Assistant (CNA) 1 stated she was the 1:1 sitter for Resident 4 on 12/10/25. CNA 1 stated [Resident 4] punched [Resident 3] on his face because he mistakenly thought [Resident 3] was wearing his shirt while he was being escorted to the activity room. I was not expecting for [resident 4] to charge at [resident 3] and punch him. During an interview on 03/09/2026 at 3:55p.m., CNA 2 stated Resident 4 had a history of punching people that is why he had a 1:1 sitter. [Resident 4] got up abruptly and charged at [resident 3] and punched him on the face. I was by resident 3's bedside setting up the food tray for lunch. [Resident 3] got up from seated position in a defensive posture and was visibly angry. I tried to calm [resident 3] down and a few minutes later, I notified LVN 1 of the incident and we relocated resident 3 to another room. During an interview on 3/6/26 at 12:55 p.m., Licensed Vocational Nurse (LVN) 1 stated Resident 3 suffered a swollen face when Resident 4 hit him on 12/10/25. During a record review of Resident 3's progress notes dated 12/10/25, LVN 1 documented, was called by [CNA 2] reported that resident was hit by his roommate below the right eye, the roommate was complaining he was wearing his shirt. He sustained a swelling below the right eye .Pain medication was administered, ice pack was applied. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Reporting and Investigation and Residents Rights dated 05/2025 the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' rights to a dignified existence, to be treated with respect, kindness and dignity

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an appropriate and residentˆcentered discharge planning process for one of five sampled residents (Resident 5). Resident 5, with a known history of suicidal ideation, was discharged to an acute care hospital for suicidal attempt at the facility and facility refused to accept her back at the facility. This failure resulted in Resident 5's extended acute care hospital stay, and placed at risk for an unsafe and unplanned transition.During a record review of Resident 5's admission Record printed on 3/5/26, the record indicated Resident 5 was admitted to the facility on [DATE].Resident 5 has a diagnosis of Cognitive communication deficit, Unspecified Dementia with Agitation. During a record review of Residentˆ5's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care) assessment dated [DATE], the assessment indicated Resident 5's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was four (4) out of 15, indicating severe cognitive impairment. During a record review of Resident 5 Care plan dated 08/11/25, the care plan indicated Resident 5 had a language problem due to primary language being Russian. the care plan dated 08/29/25 indicated Resident 5 had a behavior of suicidal ideation related to Dementia and the staff was to Maintain close monitoring and implement suicide precautions. During a record review of Resident 5's progress dated 12/2/25 Licensed Vocational Nurse (LVN) 1 documented around 9:30 am [Resident 5] noted with a string used to turn on/off room light around her neck. Resident was holding the string tightly around her neck, resident was immediately approached and removed the string away from the room .Notified MD [Medical doctor] and RP [Responsible Party] about resident behavior . During a record review of resident 5's progress notes dated 12/2/25, indicated at 4pm police came, the officer tried to calm her down, Resident 5's behavior was out of control, police called ambulance, at 4:20 pm [medical] ambulance and resident left from the facility to the [acute care] hospital. During a phone interview, on 3/9/26 at 3:45 p.m. LVN 1 stated she was the charge nurse for Resident 5 on 12/2/25. LVN 2 stated Resident 5 often spoke native language, and at times it was hard to understand Resident 5 but staff were able to meet [Resident 1], needs by using hand gestures or pointing to items so the resident could communicate what was wanted. LVN1 stated this was her first time seeing Resident 5's suicidal behavior. LVN 1 stated to her knowledge, Resident 5 never expressed that there was a desire to leave the facility. During a phone interview on 3/9/25 at 10:55 a.m., the Medical Social Worker (MSW) at the Acute Care Hospital stated Resident 5 was considered ready for transport back to the facility on [DATE]. The MSW stated when MSW reached out to the Director of Nursing (DON) at the facility on 12/3/25, the DON declined to accept Resident 5 back due to resident's high risk for selfˆharm and the facility's lack of trained staff to meet the resident's needs. The MSW further stated this was not the first time that facility had refused to readmit their residents back. During an interview with DON on 3/5/26 at 2:45 p.m. the DON stated the facility did not accept Resident 5 back to the facility in 12/2025 because facility did not have the staff to be able to communicate with Resident 5 due to the language barrier and she had never shown behaviors to self-harm prior to 12/02/25 (when Resident 5 was already identified with both issues in 8/2025). During a record review of Resident 5's acute care hospital progress note indicated, [acute care staff] call to facility's DON was made, the DON stated, facility will not be accepting her back citing high patient risk of self-harm.