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	03/16/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and records review, the facility failed to ensure appropriate monitoring and interventions were provided for one of one sampled resident (Resident 1) after Resident 1 bit his tongue on 12/3/25 at 9:40 p.m.This failure could result in potential harm to Resident 1 due to delay of treatment. Resident 1 was transferred to the hospital on [DATE] and treated for tongue laceration (a tear or cut) requiring stitches. During a review of Resident 1's admission Record, dated 12/16/25, the admission Record indicated Resident 1 was admitted in the facility on 4/22/25 with an admission diagnosis of metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body), morbid obesity (individuals having a calculated measure of weight relative to height of 40 or greater or weighing in excess of 100 pounds of one's ideal weight), and paroxysmal atrial fibrillation (occasional episodes of a fast, chaotic heart rhythm).During a record review of Resident 1's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 10/29/25, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 15 out of 15, indicating intact cognitive response.During a record review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation, a structured, four-component communication framework designed to improve patient safety and efficiency, particularly in critical healthcare situations) Communication Form, dated 12/3/25, the SBAR Communication Form indicated, Licensed Vocational Nurse (LVN) 1 noted blood in Resident 1's mouth at 9:40 p.m. and Resident 1 stated he bit his tongue. The SBAR Communication Form indicated, Resident 1 refused to go to the hospital and the recommendation of the medical doctor (MD) was to continue to monitor.During a review of facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, revision dated 3/2018, the P&P indicated, Monitoring and Follow-Up: 1. The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. During a phone interview on 3/12/26 at 1:07 p.m. with LVN 1, the evening shift (3:00 p.m. to 11:30 p.m.) nurse for Resident 1 on 12/3/25, LVN 1 stated Resident 1 was monitored every 15 minutes after the bleeding. LVN 1 stated not remembering Resident 1's condition after every 15 minutes of monitoring. LVN 1 stated not remembering documenting Resident 1's condition after monitoring. During a phone interview on 3/12/26 at 1:29 p.m. with Registered Nurse (RN) 1, the night shift nurse on 12/3/25 at 11:00 p.m. up to 12/4/25 at 7:30 a.m. for Resident 1, RN 1 stated Resident 1's tongue continued to bleed towards the night. RN 1 stated not knowing how much bleeding was noted. RN 1 stated applying pressure to Resident 1's tongue when it continued to bleed. RN 1 stated being unsure if he had documented after monitoring Resident 1 and the interventions he provided. During a follow up phone interview on 3/16/26 at 1:20 p.m. with RN 1, RN 1 stated routinely monitoring Resident 1 during the night shift. RN 1 stated the purpose of documenting monitoring and intervention was to provide evidence during audit or review when questioned why there was no documented evidence of Resident 1's monitoring and interventions in the Progress Note.During a concurrent interview and record review on 3/12/26 at 2:10 p.m. with the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), Resident 1's Progress Notes, dated 12/3/25 to 12/4/25 was reviewed. The Progress Notes showed no documented evidence that LVN 1 and RN 1 monitored Resident 1 and provided intervention on 12/3/25 after 9:40 p.m. up to 12/4/25 at 6:21 a.m. During a record review of Resident 1's SBAR Communication Form, dated 12/4/25, the SBAR Communication Form indicated, Resident 1 continued to bleed through the night and RN 1 informed the MD of Resident 1's prolonged bleeding at 6:21 a.m. The SBAR Communication Form indicated RN 1 called emergency services (EMS) and Resident 1 was sent to the hospital.During a record review of Resident 1's Acute Care Hospital (ACH) After Visit Summary, dated 12/4/25 at 11:42 a.m., the Acute Care Hospital (ACH) After Visit Summary indicated, Resident 1 was treated for tongue laceration (a tear or cut). The Acute Care Hospital (ACH) After Visit Summary indicated, the bleeding was significant due to Resident 1's use of blood thinner medication. The Acute Care Hospital (ACH) After Visit Summary indicated, several methods were used to stop the bleeding, including applying pressure, using special glue, and stitching the cut.