STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 - Immediate jeopardy to resident health or safety 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 keep one resident, Resident 47, free from sexual abuse when Certified Nursing Assistant (CNA) 1 witnessed Resident 47 being sexually abused by Resident 2 and then closed the door without intervening, leaving Resident 47 at risk for further abuse by Resident 2.This failure resulted in Resident 47 being sexually abused and had the potential for psychosocial harm. Furthermore, this failure had the potential to result in further sexual abuse towards Resident 47 and/or other vulnerable residents in the facility.An Immediate Jeopardy situation (IJ, a situation in which a facility's actions places one or more residents in jeopardy of being significantly harmed up to the point of possible death if not immediately corrected) was identified and called due to the failure of the facility to protect Resident 47 and all other vulnerable residents from sexual abuse. The Administrator (ADM) and Director of Nursing (DON) were verbally notified of the IJ situation on 7/30/25 at 8:21 p.m. During a visit to the facility on 8/1/25, the facility provided an acceptable plan of action and the IJ was removed at 3:57 p.m. During a review of Resident 47's admission Record dated 7/29/25, the admission Record showed Resident 47 was admitted to the facility in December 2018.During a review of Resident 47's Quarterly Minimum Data Set (MDS - an assessment tool used to guide care), dated 6/5/25, MDS showed Resident 47 had multiple diagnoses that included Huntington's Disease (brain disorder that causes involuntary movements cognitive decline, and behavioral changes), non-Alzheimer's dementia (a condition that causes decline in cognitive abilities such as thinking), and depression.During a review of Resident 47's Care Plan dated 12/14/18, the Care Plan indicated, Resident 47 had a diagnosis of Huntington's Disease and required dependent assist with two or more staff due to choreic (involuntary, jerking) movements. The Care Plan also indicated, Resident 47 was at risk for victimization (any unwanted or forced sexual activity, ranging from unwanted physical contact to rape) and one of Resident 47's goals was to maintain dignity and self-esteem. Resident 47's Care Plan did not show an active intervention that addressed risk for victimizationDuring a review of Resident 47's Post Event Assessment Form, dated 7/26/25, under B. Situation 1. Description of the event/Why the doctor is being called indicated, CNA 1 reported that he saw [Resident 47's] room door shut. He checked and saw Resident 2 with his pants down and had Resident 47's private area in his [Resident 2's] mouth.During a review of Resident 47's Nursing Progress Notes, dated 7/26/25, the Nursing Progress Notes indicated .staff reported that he saw [Resident 47's] room door shut. He checked and saw Resident 2 with his pants down and had Resident 47's private area in his [Resident 2's] mouth.During a review of Resident 2's admission Record, dated 7/29/25, the admission Record indicated Resident 2 was originally admitted to the facility in December 2020 and was readmitted in August 2022. During a review of Resident 2's Annual MDS, dated [DATE], the MDS showed Resident 2 had multiple diagnoses that included impaired cognitive functions and awareness.During a review of Resident 2's Care Plan dated 8/9/22, the Care Plan indicated Resident 2 was at risk for physical altercations, property destruction and inappropriate sexual behavior. The Care Plan also indicated, Resident 2 made comments of a sexual nature and masturbated in front of staff.During a review of Resident 2's Post Event Assessment Form, dated (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	7/26/25, under B. Situation 1. Description of the event/Why the doctor is being called indicated, Staff reported that he saw peer [Resident 47] room door shut. He checked and saw Resident 2 with his pants down and had peer's [Resident 47's] private area in his mouth.During a review of Resident 2's Nursing Progress Notes, dated 7/26/25, the Nursing Progress Notes indicated .Staff reported that he saw peer [Resident 47's] room door shut. He checked and saw Resident 2 with his pants down and had peer's [Resident 47] private area in his mouth.During an interview on 7/29/25 at 1:15 p.m. with CNA1, CNA 1 stated, when he opened the door to Resident 47's room, he saw Resident 2 with his pants pulled down to his legs. CNA 1 stated, Resident 2 had his head on Resident 47's private part. CNA 1 also stated, he left Resident 47's room to get help.During a concurrent observation and follow-up interview on 7/29/25 at 1:35 p.m. in Resident 47's room with CNA 1, CNA 1 demonstrated the incident. CNA 1 opened the door to Resident 47's room. CNA1 stated he saw Resident 2 with his pants pulled down to his legs. CNA 1 then walked towards Resident 47's bedside and stated he saw Resident 2 with his head over Resident 47's private area. CNA 1 added, he saw Resident 47's penis showing. CNA 1 further stated, he left Resident 2 in Resident 47's room because he was scared. During a concurrent observation and interview on 7/29/25 at 1:50 p.m., with Clinical Director (CD), in the security room, the video footage from 7/26/25 was reviewed. The video footage showed the following:14:24:42 Resident 2 appeared at the bottom of the screen walking in the hallway.14:24:48 Resident 2 looked towards Resident 47's room.14:24:50 Resident 2 entered Resident 47's room.14:24:56 Resident 47's door closed. 14:25:19 CNA 1 appeared on (bottom) screen and looked towards Resident 47's closed door.14:25:47 CNA 1 opened Resident 47's door, partially stepped in. CNA 1 then stepped outside Resident 47's room. 14:25:57 CNA 1 closed Resident 47's door, walked towards Nursing station 3, then disappeared from the screen.CD confirmed CNA 1 closed the door and left Resident 2 inside Resident 47's room. CD stated, CNA 1 was afraid.14:26:12 Resident 2 exited Resident 47's room. 14:30:16 Registered Nurse (RN) 1 looked into Resident 47's room from the hallway.14:30:23 RN 4 looked into Resident 47's room from the hallway.14:36:40 CNA 1, CNA 2, CNA 3, CNA 4 followed by RN 4, Licensed Vocational Nurse (LVN) 2, RN 1 all entered Resident 47's room.During a follow-up interview on 7/29/25 at 3:14 p.m. with CNA 1, CNA 1 stated, he closed the [Resident 47's] door because he was very scared of Resident 2 following him after he had witnessed Resident 2 sexually abusing Resident 47. During a telephone interview on 7/29/25 at 3:47 p.m. with RN 4, RN 4 stated, RN 1 reported to her that Resident 2 had his mouth in Resident 47's private area. RN 4 stated, she walked by Resident 47's room but did not go inside to assess Resident 47.During a concurrent interview and record review interview on 7/30/25 at 2:38 p.m., with CD, the SOC 341 form (form used in California to report suspected abuse of a dependent adult or elder person) completed by CNA1 and dated 7/26/25 was reviewed. CD confirmed CNA 1's statement under C. REPORTERS'S OBSERVATIONS, BELIEFS, AND STATEMENTS. indicated, I put a resident in the shower and saw Resident 47's door shut. I opened the door and stepped in and saw Resident 2 with his pants down and had Resident 47's private area in his mouth.During a telephone interview on 7/31/25 at 10:11 a.m., with Resident 47's Conservator (CSV), CSV stated, the facility notified her that another resident was giving Resident 47 oral sex. CSV added, she was afraid for the safety and well-being of Resident 47 because this was not the first time Resident 47 was sexually abused in the facility. CSV further added, the facility was not doing enough to keep Resident 47 safe otherwise the abuse would not have happened again. CSV also stated, Resident 47 was vulnerable and was not able to scream or ask for help due to his condition.During a concurrent interview and record review on 7/31/25 at 4:09 p.m. with DON, DON stated Resident 47 was a high risk for victimization due to past incident of being abused by a former staff member at the facility. DON stated, there was no care plan to address risk of victimization, therefore no proper intervention was put in place to ensure Resident 47's safety and well-being. DON also stated, CNA 1 was not supposed to leave Resident 47 when he witnessed abuse happening. DON added, CNA 1 was expected to stay with Resident 47 and initiate a code green to alert other staff of the incident.During a telephone interview on 7/31/25 at 4:40 p.m., with CNA 2, CNA 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	stated on 7/26/25 at around 2:25 p.m., CNA 1 approached her in the hallway near nursing station 1. CNA 2 stated, she followed CNA 1 inside room [ROOM NUMBER] where she was told by CNA 1 he saw Resident 2 with his pants down, bent over sucking Resident 47's penis. CNA 2 added, she and CNA 1 did not immediately check on Resident 47's well-being. CNA 2 stated the expectation was to not leave Resident 47 alone, especially when CNA 1 saw Resident 47 being abused. CNA 2 added, we were supposed to stay with Resident 47 and call code green to alert other staff of the situation. During an interview on 8/1/25 at 9:18 a.m., with RN 1, RN 1 stated, CNA 1 should not have left Resident 47's room when abuse was happening because this placed the resident [Resident 47] at risk for further abuse. RN 1 further added, she did not check on Resident 47 right away after learning Resident 47 was sexually abused. During a review of facility's policy and procedure (P&P) titled, Abuse Prevention and Reporting, undated, revealed under definitions: .3. Sexual abuse - means non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to: *Unwanted intimate touching of any kind especially of breast or perineal area. *All types of sexual assault or battery, such as rape, sodomy, and coerced nudity. *Sexual contact is nonconsensual if the resident either: .lacks the cognitive ability to consent;.6. Resident to Resident Abuse - Aggressive or inappropriate behavior by one resident towards another comprises resident-to-resident abuse.C. Sexual aggression -examples of sexually aggressive behavior include, but not limited to, saying sexual things, inappropriate touching/grabbing. The P&P also indicated under prevention: .F. Staff is required to intervene, identify, and correct the situations where any type of abuse or suspected crimes may occur .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a medication error rate of 5% (%: percent, a unit of measure) or less when two medication errors were observed out of 36 opportunities: Resident 44 did not receive two drops of Systane Eye Solution in each eye, per physicians order.Resident 30 did not receive Vitamin B12 Oral Tablet Extended Release 1000mcg (Cyanocobalamin), per physicians order. This failure resulted in a medication error rate of 5.56% and placed Resident 44 and Resident 30 at risk for receiving a subtherapeutic dose and compromised effects of the medications.1.A record review of Resident 44's physician orders dated 12/17/2024, indicated to instill 2 drops of Systane Ophthalmic (Eye) Solution 0.4-0.3 % (PolyethyleneGlycol-Propylene Glycol) in both eyes two times a day for chronic dry eyes (when tears are unable to lubricate eyes).During and observation on 07/29/2025 at 09:07 AM Registered Nurse (RN) 1 donned gloves and placed one drop of Systane Eye Solution in Resident 5's right eye, held right inner canthus, changed gloves, placed one drop in Resident 5's left eye, held left inner canthus, removed gloves and performed hand hygiene. During an interview on 07/29/2025 at 09:52 AM with RN 1 confirmed Resident 5's physician order for Systane Ophthalmic (Eye) Solution 0.4-0.3 % (PolyethyleneGlycol-Propylene Glycol; eye drop protectant against further irritation or to relieve dryness of the eye) in both eyes. RN 1 stated, I thought I gave two. RN stated it is important to give medications per physician orders for patient safety. 2. A record review of Resident 30's physician orders dated 03/01/2024, indicated Vitamin B12 Oral Tablet Extended Release 1000 mcg (Cyanocobalamin/B12; is a nutrient that helps keep your body's blood and nerve cells healthy) give 1 tablet by mouth one time a day for as supplement. During an observation on 07/29/2025 at 09:18 AM RN 1 gave Vitamin B12 Oral Tablet Extended Release 500 mcg. During an interview and record review on 07/29/2025 at 09:52 AM with RN 1 she stated she was supposed to give Resident 30 two tabs of Vitamin B12 compared to the one tablet that was given. RN 1 stated she was not confused on physician order but assumed the Vitamin B12 tablets were 1000mcg each, versus the 500mcg that was available in the bottle. RN 1 stated she should have given two tablets of Vitamin B12 to administer 1000mcg ordered dose. During a record review of facility's Policy and Procedure (P&P), dated 01/23, titled 'Medication Administration' the P&P indicated read the medication label three (3) times before preparing/pouring medication; when pulling the medication, when dose is prepared and before dose is administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure adequate storage and labeling of medications when the following occurred:Medication refrigerator in Station 3 medication room did not have a working thermometer to allow for accurate temperature monitoring.Mutli-use over the counter (OTC) Artificial Tears (Lubricating Eye Drops; for relief of dry eyes) was opened and unlabeled without Resident identifier, and undated with first use/open date in Station 2 medication cart. Two expired Antipsychotic medication bubble packaging cards found were in Station 2 medication cart. An Apple Juice box was found in Station 3 medication freezer where other medications were stored. Mutli-use, over the counter (OTC) Bisacodyl Suppositories (medication to treat constipation) was opened, unlabeled without Resident identifier, and undated with first use/open date in Station 3 medication refrigerator. This failure had the potential to result in a medication error, negative Resident side effects related to expired medication, and inadequate stored refrigeration temperature.During an observation and interview on 07/30/2025 at12:45 PM an unlabeled, opened, Artificial Tears (Lubricating Eye Drops) were located in top drawer of Station 2 medication cart. Licensed Vocational Nurse (LVN 1) stated she opened eye drops today and it is important to label medications to prevent medication errors.During an observation and interview on 07/30/2025 at 12:52 PM two expired Antipsychotic medication bubble packaging cards (simplifies the process of organizing medications by neatly arranging each dose in individual compartments, often sealed with protective bubbles), dated 02/25/25, of Quetiapine 50mg (medication used to treat bipolar disorder (depressive and manic episodes) and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) were located in the second drawer of Station 2 medication cart. LVN 1 stated second drawer is for extra medications, not active medications. LVN 1 stated it is all of the nurses job to go through medication carts and double check expiration dates before administration. LVN 1 stated the risk of storing expired medication is medication errors and potential side effects.During an observation and interview on 07/30/2025 at 01:08 PM the thermometer in Station 3 Medication refrigerator appeared broken and unable to read. Registered Nurse (RN) 5 stated thermometer is working, use the silver thermometer holder to read thermometer, which was placed over the 40 degrees Fahrenheit (F), or 0 degrees Celsius (C) mark at that time. RN 5 stated the Station 3 medication refrigerator temperature was 40 degrees F at that time. During an observation and interview on 07/30/2025 at 01:11 PM a boxed apple juice was found in Station 3 medication refrigerator in the freezer compartment in upper right corner. RN 5 stated that apple juice had been there for years and staff have been unable to remove from freezer compartment.During an observation and interview on 7/30/2025 at 1:44 PM Station 3 medication refrigerator thermometer appeared broken. Facility Manager (FM) stated the thermometer in Station 3 medication refrigerator was broken. RN 5 stated it is important to have a working thermometer in medication refrigerator to make sure all medications are controlled at the right temperature. During record review of facility's policy and procedure (P&P) titled, Medication Storage, dated 1/2023, the P&P indicated, .Medications requiring ?refrigeration' or ?temperatures between 2 degrees C (36 degrees F) and 8 degrees C (46 F) are kept in the refrigerator with a thermometer to allow temperature monitoring .During record review of facility's P&P titled, Medication Storage, dated 1/2023, the P&P indicated, .Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock.During record review of facility's P&P titled, Medication Storage, dated 1/2023, the P&P indicated, .Refrigerated medications should be kept in closed and labeled containers, with internal medications separated from external medications and all medications segregated from fruit juices, applesauce, and other foods used in administering medications .During (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review of facility's P&P titled, Medication Administration, dated 1/2023, the P&P indicated, .The nurse shall place a ?date opened' sticker on medication if one is not provided by the dispensing pharmacy and enter the date opened .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions when:a. A mounted can opener was dirtyb. A toaster oven was dirtyc. A knife rack was dirtyd. Multiple food items were stored beyond the use by date. e. Food items stored in the freezer were unlabeled There failures placed the facility's 56 residents, who received food from the kitchen, at risk for foodborne illnesses. During the initial kitchen observation on 7/28/25 at 9:30 a.m. with Food Service Manager (FSM), the following was observed: (a) mounted can opener was dirty with yellow/orange and black residue build up and the blade coating was peeling off(b) countertop toaster oven was dirty with white/brown/black debris inside the compartment and the conveyor. (c) stainless steel wall mounted knife rack was dirty with sticky white residue on the surface where clean knives were stored(d) One opened 1-Quart sized container of Half and half received 7/7/25, had no open or use by date, an opened 1-Gallon (G, unit of measurement) container of milk had no open or use by date, an opened container of tofu had a prepared date of 7/22/25 and use by date of 7/25/25, an opened 1/2 gallon carton of half and half creamer had no open or use by date, an 18-ounce (oz -unit of measurement) container of ground white pepper had a use by date of 6/6/25, a 16-oz container of cumin seed had use by date of 2/13/25, a 16-oz container of ground turmeric had a use by date of 6/13/25, an opened bag of waffle fries did not have open and /or use by date , an opened bag of French toast did not have open and /or use by date and an egg frittata did not have open and /or use by date.During an interview on 7/28/25 at 9:36 a.m., with the FSM, FSM stated the mounted can opener needed to be replaced because rust on the blade can get residents sick. FSM also stated, the toaster has not been cleaned, and debris can contaminate the food that resident consume. FSM further stated, the dirty mounted knife rack can contaminate the clean knives used for food preparation. During an interview on 7/28/25 at 9:59 a.m., with FSM, FSM stated, food items that are labeled with beyond use by should not be stored as there was potential to use them in cooking food being served to residents. FSM added, all food items should be labeled so that staff know when it should be discarded.During a review of the facility's policy and procedure (P&P) titled, SANITATION AND INFECTION CONTROL, dated 2018, indicated under subject: CLEANING SMALL APPLIANCES/EQUIPMENT showed, Equipment will be cleaned and sanitized to prevent food borne illness. Under procedures: .2. Can Openers will be cleaned after each use and sanitized daily.4. Toaster will be cleaned after each use. 5. Knives will be cleaned and sanitized after each use.During a review of the facility's (P&P) titled, SANITATION AND INFECTION CONTROL, dated 2018, indicated under subject: FREEZER STORAGE, showed, .6. Frozen food should be labeled with the date it was placed in the freezer. During a review of the facility's CANNED AND DRY GOODS STORAGE Guidelines, dated 2018, indicated, the recommended maximum storage period if unopen for seasonings/spices was 6-12 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were implemented when the following was observed:Registered nurse (RN) 1 did not sanitize (disinfect; removal of bacteria, etc.) a blood pressure cuff between use for Resident 27 and Resident 37. RN 1 did not sanitize a medication tray between uses during morning medication pass between each Residents observed (Resident 36, Resident 27, Resident 37, Resident 44, Resident 30, and Resident 5).This failure placed facility residents at risk for contracting community infections. During an observation on 07/29/2025 at 08:31 AM RN1 did not sanitize a blood pressure cuff or medication tray after use for Resident 27 and before use for Resident 37.During an observation on 07/29/2025 at 08:43 AM, RN 1 used a blood pressure cuff and medication tray for Resident 37 without sanitizing first after use by Resident 27. During an interview on 07/29/2025 at 09:52 AM with RN 1, RN 1 stated shared equipment such as a vital sign machine, blood pressure cuff and medication tray should be sanitized between each resident. RN 1 stated the facility's policy stated shared equipment should be wiped down with a germicidal wipe and allowed to air dry for three minutes. RN 1 stated it is important to sanitize shared equipment in between each resident use for infection control and prevention. During record review of facility's undated policy and procedure (P&P) titled, Cleaning and Non-Critical, Reusable Equipment Used by Persons Served (SNF), the P&P indicated, .Reusable equipment and medical devices are devices that health care providers can reprocess and reuse on multiple individuals served. These devices are designed for multiple uses and are reprocessed through cleaning followed by disinfection between individuals served .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their abuse policy and procedure was implemented for one of one sampled Residents (Resident 47).This failure resulted in Resident 47 being sexually abused and had the potential for other residents to be unprotected against abuse.During a review of Resident 47's admission Record dated 7/29/25, the admission record showed Resident 47 was admitted to the facility on [DATE].During a review of Resident 47's Quarterly Minimum Data Set (MDS - an assessment tool used to guide care), dated 6/5/25, MDS showed resident 47 had multiple diagnoses that included Huntington's Disease (brain disorder that causes involuntary movements cognitive decline, and behavioral changes), non-Alzheimer's dementia (a condition that causes decline in cognitive abilities such as thinking), and depression.During an interview on 7/29/25 at 1:15 p.m. with CNA1, CNA 1 stated, when he opened the door to Resident 47's room, CNA 1 saw Resident 2 with his pants pulled down to his legs. CNA 1 added, Resident 2 had his head on Resident 47's private part. CNA 1 further added, he left Resident 47's room to get help.During a concurrent observation and interview on 7/29/25 at 1:35 p.m. in Resident 47's room with CNA 1, CNA 1 demonstrated the incident. CNA 1 opened the door to Resident 47's room, stated he saw Resident 2 with pants pulled down to his legs. CNA 1 then walked towards Resident 47's bedside and stated he saw Resident 2 with his head over Resident 47's private area. CNA 1 added, he saw Resident 47's penis showing. CNA 1 further stated, he left Resident 2 in Resident 47's room because he was scared. During a concurrent observation and interview on 729/25 at 1:50 p.m., with Clinical Director (CL), in the security room, the video footage showed the following timeline:14:24-42 Resident 2 appeared on bottom screen walking in the hallway.14:24-48 Resident 2 looked towards Resident 47's room.14:24-50 Resident 2 entered Resident 47's room.14:24-56 Resident 47's door closed. 14:25-19 CNA 1 appeared on (bottom) screen looked towards Resident 47's closed door.14:25-47 CNA 1 opened Resident 47's door, partially stepped in. CNA 1 then stepped outside Resident 47's room. 14:25-57 CNA 1 Closed Resident 47's door, walked towards Nursing station 3, then disappeared from the screen.CD confirmed CNA 1 closed the door and left Resident 2 inside Resident 47's room and stated, CNA 1 was afraid.14:26-12 Resident 2 exited Resident 47's room. 14:30-16 Registered Nurse (RN) 1 looked into Resident 47's room from the hallway.14:30-23 RN 4 looked into Resident 47's room from the hallway.14:36:40 CNA 1 , CNA 2, CNA 3, CNA 4 followed by RN 4, Licensed Vocational Nurse (LVN) 2, RN 1 all entered Resident 47's room.During an interview on 7/29/25 at 3:14 p.m. with CNA 1, CNA 1 stated, he closed the door because he was very scared of Resident 2 following him after he had witnessed Resident 47 sexually abusing Resident 47. During a concurrent interview and record review on 7/31/25 at 4:09 p.m. with Director Of Nursing (DON), DON stated, CNA 1 was not supposed to leave Resident 47 when he witnessed an abuse happening. DON added, CNA 1 was expected to stay with Resident 47 and initiate code green to alert other staff of incident.During a review of facility's policy and procedure (P&P) titled, Abuse Prevention and Reporting, undated, revealed under definitions: .3. Sexual abuse - means non-consensual contact of ay type with a resident. Sexual abuse includes, but is not limited to: *Unwanted intimate touching of any kind especially of breast or perineal area. *All types of sexual assault or battery, such as rape, sodomy, and coerced nudity. *Sexual contact is nonconsensual if the resident either: .lacks the cognitive ability to consent;.6. Resident to Resident Abuse - Aggressive or inappropriate behavior by one resident towards another comprises resident-to-resident abuse.C. Sexual aggression -examples of sexually aggressive behavior include, but not limited to, saying sexual things, inappropriate touching/grabbing. The P&P also indicated under prevention: .F. Staff is required to intervene, identify, and correct the situations where any type of abuse or suspected crimes may occur. During a review of facility's P&P titled, Change in Resident Status (SNF) undated, indicated under procedure B. Process: .2. In the event of suspected physical abuse, a licensed nurse will assess involved individuals without delay (Immediately).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its abuse Policy and Procedure (P&P) when the facility did not report an incident of sexual abuse to law enforcement for two of two Residents (Residents 47 and 2) within two hours of the incident occurring. This failure had the potential to put other residents at risk of further abuse.During a review of Resident 47's admission Record dated 7/29/25, the admission record showed Resident 47 was admitted to the facility on [DATE].During a review of Resident 47's Quarterly Minimum Data Set (MDS - an assessment tool used to guide care), dated 6/5/25, MDS showed resident 47 had multiple diagnoses that included Huntington's Disease (brain disorder that causes involuntary movements cognitive decline, and behavioral changes), non-Alzheimer's dementia (a condition that causes decline in cognitive abilities such as thinking), and depression.During a review of Resident 47's nursing progress notes, dated 7/26/25, indicated staff reported that he saw (Resident 47's) room door shut. He checked and saw Resident 2 with his pants down and had Resident 47's private area in Resident 2's mouth.During a review of Resident 2's admission Record, dated 7/29/25, the admission Record showed Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. During a review of Resident 2's Annual MDS, dated [DATE], the MDS showed Resident 2 had multiple diagnoses that included unspecified symptoms and signs with cognitive functions and awareness.During a review of Resident 2's nursing progress notes, dated 7/26/25, indicated Staff reported that he saw peer room door shut. He checked and saw Resident 2 with his pants down and had peer's private area in his mouth. During an interview on 7/29/25 at 1:35 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, he saw Resident 2 with his pants pulled down to his legs. CNA 1 added, Resident 2 had his head on Resident 47's private part. CNA 1 further added, he left Resident 47's room and reported right away.During an interview on 7/29/25 at 2:38 p.m. with Clinical Director (CD), CD stated, as far as I know, there's a three hour time frame for reporting any abuse allegation. CD added, that she initiated the investigation for the sexual abuse but did not notify the law enforcement right away. CD added, the abuse incident occurred on 2:25 p.m. but she did not call law enforcement until 6:25 p.m. When asked why law enforcement was not called immediately, CD stated, .it was a lot going.During a concurrent follow-up interview and record review on 7/30/25 at 3:42 p.m. with CD, the Incident Timeline dated 7/26/25 was reviewed. CD indicated, she called the law enforcement at 6:25 p.m., four hours after the sexual abuse occurred as reported by CNA 1. During an interview on 7/30/25 at 12:33 p.m. with the Director Of Nursing (DON), DON was asked about the facility process of reporting alleged abuse. DON stated, she was aware of the two hour reporting requirement if there was significant injury. DON added, the incident was not reported within two hours because Resident 47 did not have significant injury. During an interview on 8/1/25 at 3:02 p.m. with DON, DON stated, on 7/26/25 at 2:29 p.m. staff called her to report that Resident 2 sexually abused Resident 47. DON added, she contacted CD at 2:51 p.m. to start the investigation and reporting process. DON stated, she instructed CD to call law enforcement after 4:00 p.m.During a review of facility's Communication Result Report, dated 7/26/25, the Communication Result Report indicated the SOC 341 (document used to report suspected abuse), was submitted to the State Agency at 6:19 p.m.During a review of facility's Communication Result Report, dated 7/26/25, the Communication Result Report indicated the SOC 341 was submitted to the Long Term Care Ombudsman at 6:20 p.m. During a review of facility's Communication Result Report, dated 7/26/25, the Communication Result Report indicated the SOC 341 was submitted to the local law enforcement agency at 6:23 p.m. A review of facility's P&P titled, Abuse Prevention and Reporting undated, the P&P indicated under .PROCEDURE: .4. IDENTIFICATION A. Where the incident reasonably appears to be exploitation, physical, mental, sexual, verbal abuse, abandonment, isolation, financial abuse, or neglect, or the employee has been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told by a resident that he/she experienced such behavior or there is a reasonable suspicion of a crime against a resident, the employee must comply with the mandated reported requirements.7. REPORTING GUIDELINES AND TIMEFRAMES; Per California Assembly [NAME] 1417, in all situations with one exception, the reported must a) Verbally report to local law enforcement as soon as practically possible and in no event later than 2 hours after observing, obtaining knowledge of, or suspecting abuse or neglect. The P&P also indicated, pursuant to 42 CFR 483.12 (c) 1) All alleged violations of abuse, neglect, exploitation, or mistreatment. The facility was required to, in accordance with the State law, including to the State Agency and the adult protective services where state law provides for jurisdiction in long-term care facilities (e.g., Ombudsman), All alleged violations: Immediately but not later than 2 hours after forming the suspicion with written report. A review of CDPH All Facilities Letter (AFL) 21-26 Mandated Reporting Requirements of Potential Abuse, Neglect, Exploitation, or Mistreatment of Elders or Dependent Adults dated 7/26/21, the AFL indicated, Pursuant to Title 42 CFR section 483.12(c)(1) for incidents that involve abuse or result in serious bodily injury, facilities must: Call local law enforcement immediately, but no later than two hours after the allegation is made. File a written or electronic report to the LTC ombudsman, local law enforcement, and DO within two hours. Pursuant to Title 42 CFR section 483.12(c)(1) for any other reasonable suspicion that does not result in abuse or serious bodily injury, facilities must: Call local law enforcement as soon as possible, but no later than 24 hours after the allegation is made. File a written or electronic report to the LTC ombudsman, local law enforcement and DO (District Office) within 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive epistaxis (nosebleed) care plan for Resident 5 to address medical needs. This failure placed Resident 5 at risk for potential harm from bleeding. During record review of admission record, printed on 8/01/25, Resident 5 was admitted on [DATE].During record review of Resident 5's Minimum Data Set (MDS, an assessment used to guide care) dated 7/17/25, indicated Resident 5's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 09 out of 15, indicated Resident was mildly impaired. During record review on 07/29/2025 at 4:30 PM of Resident 5's 'Post Assessment Form Part 1,' dated 4/11/25 at 02:38 AM indicated in the hallway, Resident noted blood dripping on his nose and took 5 mins to stop the bleeding, denies he pick his nose. No change in LOC. Denies pain or discomfort. Resident on Eliquis 2.5mg BID. Informed MD and ordered to hold Eliquis for 3 days. Ordered carried out.During record review of Resident 5's 'Post Assessment Form Part 1,' dated 4/27/25 at 02:11 AM indicated in Station 1, Resident noted blood dripping on his nose and took 15 mins to stop the bleeding, denies he pick his nose. No change in LOC. Denies pain or discomfort. Resident on Eliquis 2.5mg qd. Informed MD and ordered to hold Eliquis for 3 days. Ordered carried out. hold eliquis, apply pressure to stop the bleeding and give ice chips.During record review of Resident 5's 'Post Assessment Form Part 1,' dated 5/01/25 at 15:11 PM indicated in Station 1, Resident came to station and c/o he has nosebleed and noted blood dripping on his nose, denies he pick his nose, able to stop the bleeding. No change in LOC. Denies pain or discomfort. Resident just start Eliquis 2.5mg qd this am. Informed MD and ordered to hold Eliquis for 3 days and ENT consult for frequent nose bleed. Ordered carried out. hold eliquis, apply pressure to stop the bleeding and give ice chips.During record review of Resident 5's 'Post Assessment Form Part 1,' dated 7/20/25 at 07:20 AM indicated in dining room, Resident noted blood dripping on his nose and took 5 mins to stop the bleeding, denies he pick his nose. No change in LOC. Denies pain or discomfort. Resident on Eliquis 5mg BID. Informed MD and ordered to hold Eliquis for 2 days. Ordered carried out. hold eliquis, apply pressure to stop the bleeding and give ice chips.During record review of Resident 5's progress notes dated 6/3/25 indicated, Noted resident was bleeding from the right nostril. Apply pressure, cold compress, nasal spray. it took 30 minutes before the blood stop. MD will be notified.During record review of Resident 5's progress notes dated 7/1/25 indicated Resident 5 had an appointment with Ear Nose and Throat (ENT) with Dr. [NAME] related to a deviated septum (when the cartilage and bone that divides your nose down the middle is not straight). During record review of Resident 5's physicians orders it indicated, Monitor S/S of Bleeding and notify MD if any occur. Bruising, nosebleeds, bleeding gums, prolonged bleeding from wound or IV or surgical sites, blood in urine or feces or vomit, coughing up blood, abrupt onset hypotension or low platelet count. three times a day.During record review of Resident 5's comprehensive care plan there was no active epistaxis/nosebleed care plan initiated. During a record review of Resident 5's ENT After Visit Summary Notes dated 7/1/25 it indicated Resident #5 had chronic nose bleeds over the past year .noted that bleeds seem to come from both sides .Discussed nasal precautions/epistaxis precautions, Vaseline .return at any time if bleeding continues.During record review of Treatment Team Conference Form (IDT meeting; group of people who have a role in Resident's care) dated 7/17/25 at 14:37 PM indicated Resident 5 was recently seen by local ENT outpatient facility related to scab (a hard, dried blood clot that can form over a cut or broken skin) near nasal septum. During an interview on 08/01/2025 at 3:42 PM with Registered Nurse (RN 3) stated Resident 5 is on monitoring for nosebleeds. In the event Resident 5 were to have a nosebleed RN 3 stated his Eliquis 5mg tablet (blood thinner; a medication used to prevent and treat blood clots) should be held for 24 hours and if the Resident does not have a nosebleed within 24 hours, medication can be resumed as ordered. RN 3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A396	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield Neurobehavioral Center	1451 28th Avenue Oakland, CA 94601

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated nosebleed time should be monitored, stop bleeding with a nose clamp, check vital signs, call physician, document event, and endorse to next shift. RN 3 stated Resident 5 does not have a nosebleed care plan at this time in the electronic health record (an electronic version of a patients medical history), but may have a short term care plan with Director of Nursing (DON) or Minimum Data Set (MDS) Coordinator. RN 3 stated a short term care plan is for issues that are short term or the issues have been resolved. RN 3 stated Resident 5 should have a nose bleed care plan initiated because it import to serve as a guide and or plan of Residents' care. RN 3 stated without a care plan Residents may receive disorganized, poor planned care. During an interview and record review on 08/01/2025 at 4:02 PM with the Director of Nursing (DON) and MDS, they stated Resident 5 had a nose bleed care plan initiated on 4/27/25 but it was resolved by MDS on 7/4/25. MDS stated nosebleed care plan was resolved because he checked the progress notes and last nosebleed was 4/12/25. MDS and DON stated Resident 5 does not have an active nose bleed care plan at this time. MDS and DON stated they were not aware Resident 5 had a nose bleed on 7/29/25. DON stated Resident 5 should have an active nosebleed care plan because the issue is ongoing. MDS stated the active potential impairment skin care plan does not specifically identify nosebleed interventions nor goals. DON stated Resident 5 should have a long term care plan related to nosebleeds to identify ongoing issues, interventions and goals. DON and MDS stated unable to give definition for long term and short term care plans, stated use short term care plans for short term issues. MDS stated the important of care planning is to establish Resident centered goals around specific issues. DON stated importance of care planning is collaboration of team as care plan should reflect the totality of resident, identify problem and find solutions to optimize care of the Resident. During record review of facility's undated policy and procedure (P&P) titled, Change in Resident Status indicated, update care plans as indicated.