STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555067	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McClure Post Acute	2910 McClure Street Oakland, CA 94609

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, for two of two residents (Resident 2 and Resident 3) who were discharged , the facility failed to develop and implement an effective discharge planning process for their transition to post-discharge care when:1.For Resident 2, the facility failed to assist in obtaining a government ID and bank card before discharge. The facility did not arrange primary care or pharmacy services for medication follow-up. This had the potential to result in Resident 2 lacking funds for his ILF (Independent Living Facility) stay and potentially facing homelessness.2.For Resident 3, the facility failed to establish a primary care provider and pharmacy for medication refills after discharge. This failure had the potential to result in unnecessary re-admissions.1.During a review of Resident 2's admission Record (AR) printed 1/15/26, the AR indicated Resident 2 was admitted to the facility in February 2024 with multiple diagnoses that included cognitive communication deficit (impairment in communication such as speaking, listening, reading, or writing caused by impaired memory and attention), depression (persistent sadness, loss of interest in activities) and stage 3 chronic kidney disease (the kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood). The AR also indicated Resident 2 was discharged from the facility on 12/9/25.During a telephone interview on 1/15/26 at 1:06 p.m. with Family Friend (FF), FF stated Resident 2 was discharged from the facility to an ILF without any means to pay rent, as he had lost his ID and debit card. FF stated, consequently, Resident 2 left the ILF, became homeless, and was eventually taken to the hospital ER for a medical issue.During a review of Resident 2's Social Service Note (SSN), late entry, dated 12/9/25, the SSN indicated Resident 2 was discharged to an ILF. The SSN indicated discharge instructions were reviewed with Resident 2 as provided by the Interdisciplinary Team (IDT, a group composed of individuals representing different departments of the facility) that included follow-up appointments and a medication plan. During an interview on 1/21/26 at 10:38 a.m. with Social Services Director (SSD), SSD stated Resident 2 did not have his ID and debit card. SSD stated that once Resident 2 obtained them, Resident 2 could pay rent at his new residence (ILF). SSD stated she did not assist Resident 2 in acquiring these items before discharge, but Resident 2 received post-discharge instructions on the day of discharge.During a review of Resident 2's Physician's Order dated 12/9/25, the physician's order indicated home health services and a primary care physician appointment after discharge.During a review of Resident 2's Discharge Summary and Post-Care Instructions (DCPCI) dated 12/9/25, the DCPCI indicated the section Post-Discharge Plan of Care Services, Referrals, and Equipment lacked complete information. Specifically, the fields for primary care physician name and appointment details, phone number, address, and pharmacy information were left blank. A copy of the DCPCI was provided to Resident 2 at the time of discharge.During a telephone interview on 1/21/26 at 10:52 a.m. with Independent Living Facility Owner (ILFO), ILFO stated she was unaware Resident 2 lacked an ID or debit card. ILFO stated Resident 2 said he was going to the bank with a friend but did not return. A few days later, a local hospital informed (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ILFO that Resident 2 had visited the Emergency Department (ED) for medication. ILFO confirmed Resident 2 has not returned to the ILF.During a telephone interview on 1/21/26 at 12:04 p.m. with Home Health Registered Nurse (HHRN) 1, HHRN 1 stated Resident 2 did not have a medication list during visit at the ILF. HHRN also stated there was no established pharmacy or primary care physician.During a concurrent interview and record review on 1/21/26 at 12:30 p.m. with Case Manager (CM), CM stated Resident 2's medical record lacked documentation of the pharmacy for medication pick-up and did not indicate if a primary care physician was established for follow-up. CM also stated there was no discharge planning documented until the actual day of discharge.2. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility in September 2025 with diagnoses that included myopathy (diseases that affect skeletal muscles or the muscles that connect to your bones), chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs, results in swelling and irritation inside the airways), epilepsy (a brain condition that causes recurring seizures), anxiety disorder (repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak, panic attacks, within minutes), and spinal stenosis (narrowing of the space inside the back bone putting pressure on the spinal cord and nerves). Resident 3 was discharged from the facility on 12/12/25.During a review of Resident 3's Discharge Summary (DC) dated 12/12/25, the DC indicated while it recorded Resident 3's discharge date , it lacked information on the discharge location and transportation method.During an interview on 1/21/26 at 2:02 p.m. with SSD, SSD stated Resident 3 was discharged to ILF.During a review of Resident 3's DCPCI dated 12/12/25, the DCPCI indicated the incomplete information in the Post-Discharge Plan of Care Services, Referrals, and Equipment section. Specifically, the fields for primary care physician name and appointment details, phone number, address, and pharmacy information were left blank. The DCPCI indicated a copy of the document was given to Resident 3 at the time of discharge.During a review of the facility's policy and procedure (P&P) titled Discharge Summary and Plan last revised March 2025, the P&P indicated if the resident has no primary care provider (PCP), staff will assist in finding one and document their efforts. Discharge planning should specify the discharge destination and include the final discharge plan detailing where the resident will live, follow-up care from other providers, and contact information for those providers, as well as instructions on when and how to contact the continuing care provider.