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	03/18/2026

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 Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for two of three sampled residents (Resident 1 and 2), the facility failed to provide required discharge notice in a timely manner when notice of proposed discharge were provided on the day of discharge. This failure had the potential to prevent residents from understanding their rights or available appeal options.During a review of Resident 1's admission Record(AR) dated 3/17/26, the AR indicated Resident 1 was admitted to the facility 11/12/25 with diagnoses that included peripheral vertigo (severe sensation of spinning), chronic kidney disease (long-term, progressive loss of kidney function), muscle weakness, difficulty walking and other symptoms and signs involving cognitive functions and awareness. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/26/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status as regards to attention, orientation, and ability to register and recall information) score of 15. A BIMS score of 13-15 is an indication of intact cognitive status. During a review of the Notice of Proposed Transfer/Discharge-V4.0 dated and signed 1/26/26, the notice indicated appeal rights and contact information, that if Resident 1 believed the proposed discharge is inappropriate, Resident 1 had the right to appeal to the appropriate state long-term agency. During a review of Resident 1's Progress Notes dated 1/26/26 and Discharge Summary and Post-Care Instructions dated 1/26/26, both documents indicated Resident 1 was discharged from the facility on 1/26/26. During a review of Resident 2's AR, dated 3/17/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included necrosis of the right femur, depression, toe cellulitis, and mild cognitive impairment. During a review of Resident 2's Notice of Proposed Transfer/Discharge dated 2/13/26 indicated the notice was provided to Resident 2 and signed by facility staff on 2/14/26. During a review of Social Service Note (SSN) dated 2/13/26, the SSN indicated Resident 2 was discharged on 2/14/26. During an interview on 3/17/26 at 3:04 p.m. with Social Services Director (SSD), SSD stated, when discharged from the facility, residents receive several documents that included a Discharge Summary and Post-Care Instructions, Inventory of Personal Items, a Medications list, and a Notice of Proposed Transfer/Discharge, which provides the proposed discharge date but is only given to residents on the actual day of discharge. SSD stated that the 30-day Discharge Notice is a recent development, and the facility does not have any established policy and procedure for it yet.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for two of three sampled residents (Resident 1 and 3), the facility failed to maintain complete and accurate medical records in accordance with professional standards when:1.a.Resident 3 left the faciity on 3/9/26 without staff knowledge or permission (elopement, when a resident leaves the facility without staff knowledge or permission), and this was documented in the medical record as leaving Against Medical Advice (AMA, a situation in which a resident chooses to leave a healthcare facility or discontinue recommended care despite the facility's clinical advice to remain).1.b. Resident 3's request for room changes, as well as the facility's corresponding response, were not documented in the clinical record. 2. For Resident 1, the clinical record lacked documentation of communication between the Social Services Director (SSD) and Case Manager (CM) 2 regarding discharge plans. This failure had the potential to result in a lack of continuity of care and the inability to provide safe and effective services.1.a. During a review of Resident 3's admission Record (AR) dated 3/17/26, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included severe sepsis (a life-threatening complication of infection, requiring immediate aggressive treatment), pneumonia (lung infection), anxiety disorder (excessive, persistent fear or worry that interferes with daily life), depression (a serious, common mood disorder causing persistent sadness, loss of interest) and heart failure (a chronic, serious condition where the heart cannot pump blood efficiently). During a review of Resident 3's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 2/1/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status as regards to attention, orientation, and ability to register and recall information) score of 12. A BIMS score of eight to 12 is an indication of moderate impairment in cognitive status. During a telephone interview on 3/17/26 at 3:46 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that on 3/9/26 at 8:10 p.m., while passing medications, she saw Resident 3 in the room doorway and confirmed no medication was needed. Later, while passing medications at a different section of the unit, LVN 1 noticed Resident 3 leaving his room toward the hallway. Between 8:30-8:45 p.m., LVN 1 did not see Resident 3 in the room, but this was not unusual as Resident 3 often walked around the facility even in late evenings. After checking the resident's room and common areas without success, LVN 1 attempted to call Resident 3's cellphone several times with no answer. LVN 1 stated she searched nearby streets but did not go further due to safety concerns of being out in the dark by herself. LVN 1 informed the DON, Resident 3's physician, and the incoming NOC shift nurse about Resident 3's elopement before leaving for the day. During a review of Resident 3's Progress Notes PN, the PN indicated the following:i. On 3/9/26 at 11:24 p.m., the Nurse's note indicated, [Resident 3] left the facility without informing the staff and has not returned yet. MD and DON notified.ii. On 3/10/26 at 1:30 p.m., the Nurse's note indicated Resident 3 returned to the facility from the hospital, on a gurney with a closed nondisplaced clavicle (collar bone) fracture, swollen eye and a sling on the left arm.iii. On 3/10/26 at 1:56 p.m., the IDT (Interdisciplinary Team, a group composed of individuals representing different departments of the facility) Note indicated, the IDT met to discuss Resident 3's departure from the facility Against Medical Advice (AMA) and subsequent hospitalization. The IDT determined that after Resident 3 left the facility premises, the facility was no longer responsible for Resident 3's supervision or care, and that the fall and injury happened outside the facility's oversight.The PN did not indicate whether the Night nurse continued searching for Resident 3 or checked on Resident 3's location, and the Night shift nurse did not provide any documentation.During a concurrent interview and record review on 3/19/26 at 11:28 a.m. with Case Manager (CM) 1, IDT Notes dated 3/10/26 and the facility's policy and procedure (P&P) titled Discharging a Resident Against Medical Advice, copyrighted 2001 were reviewed. CM 1 stated the NOC shift documentation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	by LVN 1 lacked details about Resident 3's departure and whether risks of leaving the facility AMA were explained. CM 1 stated, although the IDT Notes the next day addressed the lack of documentation, no IDT members were present when Resident 3 left unnoticed. CM 1 also stated, since Resident 3 was alert and able to make healthcare decisions, it was considered AMA, even if staff were unaware of Resident 3 leaving the facility. The P&P indicated the facility's discharge policy requires documentation of the reason for requesting discontinuation of care, clinical risk of discontinuing care information provided to the resident and why it is in the best interest of the resident to stay at the facility, resident's consent for discharge and any information provided by the resident regarding the setting and care-giving arrangements made for the resident after discharge. CM 1 stated Resident 3's clinical record did not include this required information.1.b. During an interview on 3/17/26 at 11:44 a.m. with Resident 3, Resident 3 stated requesting a room change due to a bathroom issue with a roommate, but the facility has not responded to this request.During a concurrent interview and record review on 3/17/26 at 11:14 a.m. with CM 1, CM 1 stated Resident 3 had complained about a bathroom issue with a roommate and was offered a room change, which Resident 3 declined. However, CM 1 stated there was no documentation regarding the room change or offer. 2. During a review of Resident 1's AR dated 3/17/26, the AR indicated Resident 1 was admitted to the facility 11/12/25 with diagnoses that included peripheral vertigo (severe sensation of spinning), chronic kidney disease (long-term, progressive loss of kidney function), muscle weakness, difficulty walking and other symptoms and signs involving cognitive functions and awareness.During an interview on 3/17/26 at 3:04 p.m. with Social Services Director (SSD), SSD stated Resident 1 had a case manager (CM 2) for community resources. SSD stated calling CM 2 about finding an Independent Living Facility (ILF) for Resident 1's discharge but could not recall the exact date of the telephone call, she believed it was 1/19/26.During a review of Resident 1's discharge care plan dated 11/12/25, the care plan indicated Resident 1 needed placement assistance, with interventions that included coordinating referral to outside resources.During a telephone interview on 3/17/26 at 3:32 p.m. with CM 2, CM 2 stated SSD contacted her on 1/26/26, to inform her that the facility found an ILF for Resident 1. CM 2 stated requesting SSD to provide the name and address of the ILF so she could arrange a tour; SSD responded that the information would be sent via a text message. CM 2 stated waiting throughout the day for this information but later found out that Resident 1 had been discharged that afternoon.During a review of Resident 1's Discharge Summary and Post-Care Instructions V2 (DSPCI) dated 1/26/26, the DSPCI indicated Resident 1 was discharged to an ILF on 1/26/26.