

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER McClure Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45091 Based on observation, interview, and record review, the facility failed to allow one out of 15 Residents (Resident 42) to exercise their right to self-determination when Resident 42 was not provided nutrition in accordance with their preferences. This failure had the potential to result in Residents 42 feeling upset and disrespected. Findings: During a review of Resident 42's Admission Record, printed 3/13/25, the record indicated Resident 42 was admitted to the facility in December 2024 with a diagnosis of protein-calorie malnutrition and depression. During a concurrent observation and interview on 3/10/25, at 12:36 p.m. with Resident 42, Resident 42's lunch tray was observed with one regular serving of vegetables. Resident 42 stated they were supposed to get an additional large portion of vegetables with their regular vegetables. Resident 42 stated they felt upset and disrespected that staff did not follow their food preferences. During a concurrent observation and interview on 3/11/25, at 12:45 p.m. with Registered Dietician (RD), Resident 42's lunch tray was observed with one regular serving of vegetables. RD stated Resident 42 should have got an additional large portion of vegetables and added a large portion of vegetables. RD stated it was important to honor resident preferences. During a review of Resident 42's Lunch Tray Ticket, dated 3/10/25, the ticket indicated, Notes: Add: Large portion vegetable. During a review of Resident 42's Lunch Tray Ticket, dated 3/11/25, the ticket indicated Notes: Add: Large portion vegetable. During a review of Resident 42's Dietary Interview/Pre-Screen, dated December 2024, the interview indicated Special Preferences . Lunch . add: vegetable. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, dated 2001, the P&P indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Rights, dated 2001, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . self - determination.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31403 Based on interview and record review, licensed nursing staff did not notify the doctor for changes in condition for one of 15 sampled residents (Resident 49). Staff did not report continued low food intake, pain, and low blood pressures. This failure resulted in Resident 49 becoming unresponsive with a low blood sugar and sent to the hospital emergency department where she experienced a cardiac arrest (condition when heart suddenly and unexpectedly stops beating) and died . Findings: During a review of Resident 49's clinical document, titled Admission Record, the Admission Record showed the facility admitted Resident 49 on [DATE] with diagnoses including Crohn's Disease (chronic inflammatory bowel disease). During a record review of Resident 49's clinical document Weights and Vitals Summary, dated [DATE], the document indicated Resident 49's blood pressure was ,d+[DATE] on [DATE]. There was no documentation in the clinical record which showed the doctor had been notified. During an interview on [DATE] at 9:45 a.m. with the Director of Nursing (DON), DON stated staff should have retaken the blood pressure and notified the doctor if it was still low. In a concurrent record review, the DON confirmed there was no documentation in the clinical record which showed the doctor had been notified. During a record review of the Resident 49's Nutritional Risk Assessment, dated [DATE], the document showed Resident 49 was At high risk for malnutrition . During a record review of Resident 49's clinical document titled, Documentation Survey Report v2, dated [DATE], the document showed Resident 49's percentage of food intake on multiple meals between [DATE] to [DATE] was zero to 26% intake. There was no documentation in the clinical record which showed the doctor had been notified. During a record review of Resident 49's Nutritional Risk Assessment (Admission/Annual) - V 5.0, dated [DATE], the document showed Resident 49 was Not feeling well and her roommate reported to the Registered Dietitian (RD) Resident 49 was in a lot of pain, hadn't eaten breakfast that morning and was Zoning in and out. There was no documentation which showed the RD reported this information to the licensed nursing staff or the doctor had been notified. The RD was not available to be interviewed. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:45 p.m. with DON, DON confirmed there was no documentation in the clinical record which showed the doctor or nurse had been notified regarding the low food intake, pain, or mental status change. The DON stated when someone is at risk for malnutrition, she expected staff to monitor the intake, observe for dehydration, and skin breakdown. The DON also stated staff should have been monitoring Resident 49's blood sugar since hypoglycemia (low blood sugar) was a potential outcome for low food intake. The DON stated signs of low blood sugar included becoming pale, sweaty, and a potential altered level of consciousness. During a record review of Resident 49's Progress Notes *New*, dated [DATE] to [DATE], the Progress Notes showed on [DATE] at 7:04 a.m., licensed nursing staff reported Resident 49 had gotten Little to no sleep due to pain which had not been relieved by medication. There was no documentation in the clinical record which showed the doctor had been notified. During an interview on [DATE] at 2:26 p.m. with DON, DON confirmed the staff had not notified the doctor regarding the unrelieved pain. Further review of document Progress Notes *New*, dated [DATE] to [DATE], the notes showed later that morning on [DATE] at 10:50 a.m., staff found Resident 49 unresponsive with a blood sugar level of 56. (normal range: ,d+[DATE]). Staff called 911 and Patient 49 was sent to the hospital emergency department (ED). During a record review of Resident 49's ED to Hosp-Admission (discharged) , dated [DATE], the record showed Resident 49 arrived at the ED with a blood pressure of ,d+[DATE] and hemoglobin of 6.5. (Hemoglobin: protein in red blood cells that is responsible for delivering oxygen to the tissues. Normal range: ,d+[DATE]). Resident 49's diagnoses included septic shock and a GI bleed (septic shock: life-threatening condition caused by a severe localized or system-wide infection) (GI: gastrointestinal). Resident 49 was transferred to the hospital Intensive Care Unit where she went into cardiac arrest and died . During an interview on [DATE] at 10:57 a.m. with the facility's physician (MD 1), MD1 stated he could not recall if anyone had notified him regarding Patient 49's low blood pressure readings. He stated he was aware of the pain and poor appetite but that the GI team never stabilized her (GI: gastrointestinal) and that maybe a feeding tube (Feeding Tube: tube placed directly into the stomach to deliver liquid food) would have helped. MD 1 stated Resident 49 was A mess. During an interview on [DATE] at 11 a.m. with the Emergency Doctor (MD 2), MD 2 stated it would have been useful to have a physician assess Patient 49 and check her blood sugar when she was described as Zoning in and out. MD 2 stated Patient 49's blood cultures from the ED showed Enterobacter (intestinal bacteria) which meant that the bacteria source for her sepsis came from the GI track. MD 2 stated, not having a proper diet can contribute to the development of a GI bleed and having a feeding tube placed would have helped. During a record review of the Resident 49's clinical document titled, Care Plan Report dated [DATE], the care plan showed Resident 49 was at risk for malnutrition. Goals included Will identify physical symptoms or conditions that could lead to a decreased appetite or ability to eat. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's Policy and Procedures (P and P) titled, Nutritional assessment dated 2001, the P & P showed As part of the comprehensive assessment, the nutritional assessment will be a systemic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. On multivariate analysis, there was a significant increase in mortality in patients with malnutrition. Patients with malnutrition had greater rates of sepsis events, perforation and GI bleed. On multivariate analysis, malnutrition appeared to significantly increase mortality. [Malnutrition Imparts Worse Outcomes in Patients with Diverticulitis: A Nationwide Inpatient Sample Database Study: [NAME], Ayham Khrais, [NAME] Le, Sushil Ahlawat. NIH National Library of Medicine:pubmed.ncbi.[NAME].nih.gov/35989747/]		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, for one of one sampled resident (Resident 20) reviewed for vision impairment, the facility did not assist Resident 20 in making appointments for cataract evaluation. This failure had the potential to result in worsening of visual function without treatment. Definition: Cataract, a clouding of the normally clear lens of the eye, leading to blurry and hazy vision. Cataract Evaluation, a comprehensive eye exam to assess the presence, severity, and potential impact of cataracts, as well as overall eye health, to determine the best course of treatment, which may include surgery. Ophthalmology, the branch of medicine focused on the eyes and vision, encompassing the diagnosis, treatment, and prevention of eye diseases and disorders, including surgical procedures and vision correction. Findings: During a review of Resident 20's clinical record, the Admission Record indicated Resident 20 was admitted to the facility in July 2021 with diagnoses that included major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and hypertension (high blood pressure). Resident 20's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 12/21/24 indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 15. A score of 13-15 is an indication of intact cognitive status. During a review of Resident 20's MDS dated [DATE], the MDS indicated, under Section F-Preferences for Customary Routine and Activities (an interview for activity preferences), for Resident 20, it was very important to have books, newspapers, and magazines to read and to keep up with news while in the facility. During an observation and concurrent interview on 3/10/25 at 10:51 a.m. with Resident 20, while Resident 20 watched television in the room, Resident 20 stated she could not see what was shown on the screen as it was blurry. Resident 20 stated being diagnosed with cataract by an eye doctor in the last year and was told by Social Services Director (SSD) that facility would look for a surgeon to perform surgery on her eye. Resident 20 stated she has not heard back from SSD since. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 1:23 p.m. with SSD, SSD stated Resident 20 was seen by the facility's ophthalmologist (eye doctor) in December 2024. Review of Ophthalmology Consultation dated 12/11/24 indicated Resident 20 complained of blurry vision and inability to read or see TV, and with a diagnosis of having cataract on the left eye. The ophthalmologist recommendations included referral to a specialist for cataract extraction (a surgical procedure to remove a cloudy lens [cataract] lens of the eye and, in most cases, replace it with an artificial lens) evaluation. During a review of Resident 20's Order Summary Report dated 3/12/25, the Order Summary Report indicated a physician's order dated 12/11/24 for eye consult for eye health with follow-up as indicated. During a follow-up interview on 3/11/25 at 1:39 p.m. with SSD, SSD stated she did not see the recommendation for Resident 20's referral for cataract extraction. SSD stated all the residents at the facility were seen by the facility's ophthalmologist every six months and she only looked at the six-month follow-up for Resident 20. SSD stated she has not referred Resident 20 to an eye surgeon. During a review of the facility's policy and procedure (P&P) titled Eye Care Services, undated, the P&P indicated Eye care services will be made available to residents upon request, referral, or when a clinical need is identified. Residents will receive eye care services in accordance with physician's orders .may include but are not limited to: eye exams .provision of corrective lenses, treatment for eye disease and follow-up care . Follow-up visits will be scheduled and coordinated as needed based on the results of the eye examination.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 32717 Based on interview and record review, for one of two sampled residents (Resident 24) reviewed for pain management, the facility failed to ensure pain management was provided consistent with professional standards of practice when facility did not administer pain medication to address Resident 24's severe pain. This failure had the potential to result in severe discomfort. Findings: During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was admitted to the facility in April 2024 with diagnoses that included complete traumatic amputation (a surgical procedure where a limb or part of a limb is removed) at level between knee and ankle and osteomyelitis (a bone infection). During a review of Resident 24's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 2/2/25 indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine resident's cognitive status in regards to attention, orientation, and ability to register and recall information) score of 14. A score of 13-15 is an indication of intact cognitive status. During an interview on 3/10/25 at 10:49 a.m. with Resident 24, Resident 24 stated having headaches and severe pain on the left amputated leg. Resident 24 described pain intensity as 10 out of 10 (on a scale of 1-10, one as the absence of pain and 10 being the worst pain). Resident 24 also stated being given pain medication that does not help much with pain relief. During a concurrent interview and record review on 3/12/25 at 12:39 p.m. with Director of Nursing (DON), Resident 24's Medication Administration Records (MARs) and Order Summary Report (OSR) were reviewed. The OSR indicated a physician's order dated 12/27/24 to give oxycodone-acetaminophen (a narcotic pain medication) 5-325 milligram (mg) 1 tablet every 4 hours as needed for moderate pain (4-6). Resident 24's January 2025 MAR indicated a physician's order to give oxycodone-acetaminophen (Percocet, a narcotic pain medication) 5-325 mg 1 tablet by mouth every 4 hours for moderate pain (4-6). The MAR for January 2025 indicated Resident 24 had severe pain (7-10) but was given pain medication indicated for moderate pain (4-6) on the following dates; 1/20/25, 1/21/25, 1/22/25, 1/23/25, 1/24/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, and 1/29/25. The MAR for February 2025 indicated Resident 24 had severe pain (7-10) but was given pain medication indicated for moderate pain (4-6) on the following dates; 2/5/25, 2/24/25 and 2/26/25. The MAR for March 2025 indicated Resident had severe pain (7-10) but was given pain medication indicated for moderate pain (4-6) on the following dates; 3/4/25, 3/9/25 and 3/10/25. DON stated the MARs did not indicate a pain medication order for when Resident 24 had severe pain. DON also stated the licensed staff should have called Resident 24's physician to request for pain medication indicated for severe pain. During a review of the Consultant Pharmacist's Medication Regimen Review (CPMRR) dated 1/20/25, the CPMRR indicated Percocet (oxycodone-acetaminophen) was administered outside of parameters (refer to the specific aspects of pain that are evaluated during assessment, including intensity and quality). The recommendation was for staff to review and reinforce proper procedure with staff. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25 at 12:46 p.m. with Assistant Director of Nursing (ADON), ADON stated she had followed up on the medication regimen recommendation by giving in-service education to the licensed staff but did not call the doctor to request pain medication. During a concurrent interview and record review on 3/12/25 at 1:25 p.m. with DON, DON stated a new physician's order for severe pain was obtained from the physician. The OSR dated 3/12/25 indicated a new order dated 3/12/25 for oxycodone-acetaminophen 5-325 mg 2 tablets every 4 hours as needed for severe pain (7-10). During a review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, undated, the P&P indicated pain management is a multidisciplinary process that includes interventions that are consistent with the resident's goals for treatment which are defined and documented in the care plan. It also indicated pain management interventions should reflect the sources, type and severity of pain. During a review of Resident 24's pain care plan last revised 4/18/24, the care plan indicated for staff to administer medications as ordered and allow time to participate in activities of daily living to minimize discomfort.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation, staff interview, and record review, the facility failed to store and prepare food in accordance with professional standards for safety when: 1. Unlabeled, undated food items were stored in the kitchen refrigerator. 2. [NAME] (CK) 1 did not wear a beard restraint while preparing resident food. 3. Expired and moldy food items were stored in the resident refrigerator. These failures had the potential for contamination of food resulting in food borne illness for the 55 residents who received food from the kitchen and used the resident refrigerator. Findings: During an observation on [DATE], at 9:47 a.m. the kitchen refrigerator was observed with one covered container of unlabeled and undated onions, one covered container of unlabeled and undated peas, and one pack of undated turkey burgers. During an observation on [DATE], at 10:49 a.m. the resident refrigerator was observed with one opened bottle of milk with an expiration date of [DATE], one pack of garlic with an expiration date of [DATE] and one container of blueberries and strawberries dated [DATE] that had mold. During an observation on [DATE], at 12:05 p.m., in the kitchen, CK 1 was observed wearing a surgical mask that did not cover CK 1's entire beard, while preparing resident salads for lunch. During an interview on [DATE], at 2:55 p.m., with Registered Dietician (RD), RD stated it was important to label and date food so they could have known when they were expired. RD stated staff should have discarded food in the kitchen and resident refrigerators that were unlabeled, undated, expired and moldy to prevent cross contamination and food borne illness. RD stated CK 1 should have worn a beard restraint when CK 1 prepared resident food to prevent food borne illness. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated 2001, the P&P indicated, Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. During a review of the facility's P&P titled, Sanitation and Infection Control, dated 2023, the P&P indicated, Subject: Food Brought in From Outside Sources . Food that does not have a manufacturer's printed dated must be thrown out 3 days from the time it was brought in. During a review of the facility's P&P titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated 2001, the P&P indicated, Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens.		

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation and record review, the facility failed to ensure that resident bedrooms were limited to a maximum of four residents for one out of 24 rooms. This failure had the potential to result in a lack of sufficient space for the provision of care by facility staff, affect resident's right to privacy, dignity and lack of sufficient space for storage of resident belongings. Findings: During an observation on 3/11/25, room [ROOM NUMBER] was occupied by five residents. During a review of the Facility's Daily Census, dated 3/10/25, the census indicated room [ROOM NUMBER] was occupied by five residents. According to the Code of Federal Regulations, Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. Bedrooms must . Accommodate no more than four residents.		