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	04/09/2026

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an interview and record review, the facility failed to ensure the Minimum Data Set (MDS, standardized assessment used in nursing homes to evaluate a resident's physical, psychological, and functional status) assessments were transmitted (electronically submitted to the national database) within the required 14 day timeframe for four of 19 sampled residents (Resident 12, 29, 46, and 64). This failure resulted in the delayed reporting of the residents' condition, which may negatively impact care planning, oversight, and delivery of appropriate services to meet the residents' needs. Findings:During a review of Resident 12's MDS, dated [DATE], the MDS indicated a completion date of 3/13/26.During a review of Resident 29's MDS, dated [DATE], the MDS indicated a completion date of 3/13/26.During a review of Resident 46's MDS, dated [DATE], the MDS indicated a completion date of 3/12/26.During a review of Resident 64's MDS, dated [DATE], the MDS indicated a completion date of 3/13/26.During a concurrent interview and record review on 4/9/26 at 8:26 a.m. with the MDS Registered Nurse (MDSRN), the facility provided document titled, MDS Final Validation Report, dated 4/1/26 was reviewed. The document indicated the MDS assessments for Residents 12, 29, 46, and 64 were submitted on 4/1/26 with a message of Record Submitted Late. The MDSRN stated the facility followed the Resident Assessment Instrument (RAI, standardized CMS-required system used in nursing homes to assess residents and guide their care) and confirmed the MDS assessments for Residents 12, 29, and 64 should have been submitted before 3/27/26 and Resident 46's should have been submitted by 3/26/26. The MDSRN further stated the facility waited to submit Residents 12, 29, 46, and 64's MDS assessments so they could be transmitted in a batch with other residents' MDS assessments on 4/1/26. During an interview on 4/9/26 at 12:23 p.m. with the Director of Nursing (DON), the DON confirmed the facility was responsible for ensuring the MDS assessment were submitted within the required 14 days of completion. During a review of the RAI Manual, dated October 2025, the manual indicated, MDS assessments must be submitted within 14 days of the MDS Completion Date.

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Quarterly Minimum Data Set (MDS, standardized assessment used in nursing homes to evaluate a resident's physical, psychological, and functional status) assessments were completed in a timely manner for two of 19 sampled residents (Resident 40 and 46) when: 1.Resident 40's Quarterly MDS was not completed within the required timeframe of 14 days from the Assessment Reference Date (ARD, specific date selected for an MDS assessment that determines the end of the observation) 2. Resident 46's Quarterly MDS was not within the required timeframe of 92 days from the prior MDS assessment. These failures resulted in the facility's inability to ensure timely and accurate assessments of Resident 40 and 46's condition and had the potential to negatively impact the residents' care planning and delivery of services to meet the residents' needs.Findings:1.During a review of Resident 40's Face Sheet (demographics), dated 4/9/26, the Face Sheet indicated Resident 40 was admitted with diagnoses including schizophrenia (serious mental health condition that affects how a person thinks, feels, and understands reality).During a concurrent interview and record review on 4/9/26 at 8:26 a.m. with the MDS Registered Nurse (MDSRN), the facility provided document titled, MDS Final Validation Report, dated 4/6/2026 was reviewed. The document indicated, Assessment Complete Late because the assessment completion date is more than 14 days after the assessment reference date for Resident 40. The MDSRN stated the facility followed the Resident Assessment Instrument (RAI, standardized CMS-required system used in nursing homes to assess residents and guide their care) Manual and the quarterly MDS should be completed within 14 days of the ARD. The MDSRN further stated Resident 40's most recent MDS has an ARD of 2/23/26, but was completed on 4/1/26, making it 23 days late.During a review of Resident 40's MDS, dated [DATE], the MDS indicated an ARD of 2/23/26 and completion date of 4/1/26.During an interview on 4/9/26 at 12:23 p.m. with the Director of Nursing (DON), the DON confirmed the facility was responsible for ensuring the completion date was within 14 days after the ARD. During a review of the RAI Manual, dated October 2025, the manual indicated, The MDS completion date . must be no later than 14 days after the ARD .2.During a review of Resident 46's Face Sheet (demographics), dated 4/9/26, the Face Sheet indicated Resident 46 was admitted with diagnoses including anxiety and hypertension (high blood pressure).During a concurrent interview and record review on 4/9/26 at 8:26 a.m. with the MDS Registered Nurse (MDSRN), the facility provided document titled, MDS Final Validation Report, dated 4/1/2026 was reviewed. The document indicated, Assessment Completed Late for Resident 46. The MDSRN stated the facility follows the Resident Assessment Instrument (RAI, standardized CMS-required system used in nursing homes to assess residents and guide their care) Manual and the quarterly MDS should be done within 92 days of the last MDS assessment. The MDSRN stated Resident 46's admission MDS was on 12/1/25 but the next MDS was not done until 3/5/26 so it was late. During an interview on 4/9/26 at 12:23 p.m. with the Director of Nursing (DON), the DON confirmed the facility was responsible for ensuring Resident 46's next MDS was completed within 92 days after the previous MDS.During a review of Resident 46's Clinical Record on 4/9/26, the clinical record indicated the comprehensive MDS assessment completed at admission had an Assessment Reference Date (ARD, date that establishes the timeframe for capturing the resident's condition and services provided for the MDS assessment) of 12/1/25 and the following MDS assessment had an ARD of 3/5/26, making it 94 days after the admission MDS.During a review of the RAI Manual, dated October 2025, the manual indicated, The Quarterly assessment is .non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous .assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored .The ARD (A2300) must be not more than 92 days after the ARD of the most recent . assessment of any type.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure supervision was provided during dining per physician's orders for one of 19 sampled residents (Resident 23). This failure resulted in an increased risk of choking, aspiration (entry of food or liquid into the airway or lungs), and potential respiratory complications such as death for Resident 23. During a review of Resident 23's Face Sheet (FS, demographics), dated 4/9/26, the FS indicated Resident 23 was originally admitted to the facility on [DATE] and then was readmitted after a change of condition on 2/16/26. The FS further indicated Resident 23's diagnosis was a stroke (blood flow blocked to the brain) with difficulty swallowing and speaking.During a concurrent observation and interview on 4/9/26 at 8:16 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 23's room, Resident 23 was in bed, sitting up, head tilted to left, chin resting on her neck sleeping. Resident 23's right hand was on the bedside table with her fingers in a bowl of cooked breakfast cereal with a full glass of red colored liquid next to the bowl. LVN 1 stated Resident 23 required direct one-on-one supervision during dining due to a recent stroke, history of pocketing food, and difficulty swallowing. LVN 1 confirmed Resident 23 needed one-on-one supervision during dining. During a concurrent observation and interview on 4/9/26 at 8:16 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 23's room, CNA 1 entered the room and attempted to arouse Resident 23 but was unsuccessful. CNA 1 indicated that Resident 23 required one-on-one supervision during meals and needed prompting to take small bites, swallow, and clear her mouth while eating. CNA 1 stated she had taken away Resident 23's tray after observing her eat some of her breakfast and left the full bowl of uneaten cooked breakfast cereal and juice on the bedside table for Resident 23 to finish alone while she picked up other resident's trays. During a concurrent interview and record review on 4/9/26 at 9:15 a.m. with Speech Language Pathologist (SLP), Resident 23's Electronic Medical Record (EMR) was reviewed. The EMR indicated Resident 23 experienced a stroke in February 2026 and was readmitted to the facility on [DATE]. SLP stated that due to Resident 23's difficulty eating and swallowing, the physician ordered that Resident 23 receive one-to-one supervision during dining. SLP stated the reason for supervision was to monitor Resident 23's swallow, prompt the resident to clear her mouth between bites, and maintain safety while eating and drinking. SLP reported that Resident 23 had a history of pocketing food, failing to complete swallowing, and hiding food in her room. SLP verified that Resident 23 had an episode of choking on 3/8/26. SLP emphasized that if food was left in Resident 23's room without supervision, there was a significant risk of choking, which could lead to respiratory distress or aspiration. During a concurrent observation and interview on 4/9/26 at 10:05 a.m. with SLP, SLP was wiping Resident23's face which had thick secretions from her mouth, down her chin, to her chest. Resident 23's eyes were closed, head was tilted to the left, and her gown appeared moist. There was a full glass of red liquid on the overbed table. SLP stated, food should not have been left in the resident's room unobserved. The resident needs to be observed to prevent choking and aspiration. During a review of Resident 23's Physician Order (PO), dated 2/16/26, the PO indicated, Resident 23 had a 1 to 1 eating every shift.During a review of Resident 23's PO dated 3/9/26, the PO indicated, 1:1 assistance when eating. During a review of Resident 23's, Speech Therapy Encounter Note (STN), dated 3/9/26, the STN indicated Resident 23, needs cues to double swallow to clear residue.frequent cues to swallow . and not hold food in her mouth. During a review of Resident 23's, Care Plan Report (CPR), dated 4/9/26, the CPR indicated a focus was on issues of Coughing while eating and Resident requires assistance while eating.During a review of the facility's policy and procedure (P&P) titled, Assistance with Meal/Mealtime Policy, dated December 2025, the P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.During a review of the facility's P&P titled, Activities of Daily Living (ADL) supporting, dated April 2025, the P&P indicated, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents are provided with care.as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently receive the services necessary .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure nursing staff were adequately trained and competent regarding medication management of self-administered medications that were stored at bedside for one of 19 sampled residents (Resident 76). This failure resulted in Resident 76's medications being administered without appropriate oversight or documentation, placing the resident at risk for medication errors. Findings:During a review of Resident 76's Face Sheet (demographics), dated 4/9/26, the Face Sheet indicated Resident 76's diagnoses included acute and chronic respiratory failure with hypoxia (a short-term and ongoing breathing problem where the body is not getting enough oxygen).During a concurrent observation and interview on 4/9/26 at 11:30 a.m. with Resident 76 in his room, Resident 76 stated he kept his albuterol sulfate inhaler (medication inhaled into the lungs that helps make breathing easier) in a locked box in his room and self-administered the medication as needed. Resident 76 stated he last self-administered the albuterol on 4/7/26 at 7pm and recorded it on paper. Resident 76 stated staff did not ask him to notify them when he self-administers his medication.During an interview on 4/9/26 at 11:32 a.m. with Licensed Vocational Nurse (LVN) 2, LNV 2 was asked how staff would know when Resident 76 self-administered albuterol. LVN 2 was unaware of actions to be taken to determine when Resident 76 was self-administering his medication.During an interview on 4/9/26 at 11:35 a.m. with LVN 3, LVN 3 stated she was not sure about the process for self-administered medications kept at bedside.During an interview on 4/9/26 at 11:43 a.m. with the Director of Nursing (DON), the DON stated the facility had not provided education and training to nursing staff regarding the monitoring and documentation of self-administered medications kept at bedside. The DON further stated the expectation was at the end of every shift, staff should ask Resident 76 how many times he self-administered the medication, when it was administered, and document that information on the Medication Administration Record (MAR). The DON stated staff were not monitoring Resident 76's use of the albuterol inhaler or possible side effects of the medication. During a review of Resident 76's MAR, dated 4/9/26, the MAR did not indicate an administration of albuterol on 4/7/26. The MAR indicated the last administration of albuterol was on 3/22/26 at 2:47 p.m.During a review of the facility policy and procedure (P&P) titled, Self-Administration of Medication, dated February 2021, the P&P indicated, Nursing staff reviews the self-administered medication record for each nursing shift, and transfers pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 medications were stored in a safe and secure manner for one of 19 sampled residents (Resident 76) when his albuterol sulfate inhaler (medication inhaled into the lungs that helps make breathing easier) was found lying on his tray table. This failure had the potential to result in unsafe or unauthorized medication use, drug diversion, and accidental ingestion by Resident 76 or other medically vulnerable residents.Findings:During a review of Resident 76's Face Sheet (demographics), dated 4/9/26, the Face Sheet indicated Resident 76's diagnoses included acute and chronic respiratory failure with hypoxia (a short-term and ongoing breathing problem where the body is not getting enough oxygen).During a concurrent observation and interview on 4/6/26 at 4:33 p.m. with Resident 76 in his room, the albuterol inhaler was lying on Resident 76's tray table. Resident 76 stated, It was getting annoying asking the nurse when I need my puffer, so the medication was kept at his bedside. During a concurrent observation and interview on 4/6/26 at 4:55 p.m. with Licensed Vocational Nurse (LVN) 2 confirmed Resident 76's albuterol inhaler was left on his bedside table and stated medication shouldn't be left unsecured at bedside. During an interview on 4/9/26 at 11:43 a.m. with the Director of Nursing (DON), the DON confirmed the albuterol inhaler should not have been left unsecured at Resident 76's bedside. During a review of the facility's P&P titled, Storage of Medications, dated November 2020, the P&P indicated, The facility stores all drugs and biological in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments The nursing staff is responsible for maintaining medication stores and preparation areas in a clean, safe, and sanitary manner.