

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Medical Hill Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 475 29th 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50474</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse were reported to officials that included the State Survey Agency, Office of the Long-Term Care Ombudsman and law enforcement officials within the required timeframe for one of one sampled resident (Resident 1).</p> <p>This failure had the potential to result in the lack of protection for residents alleging abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility in February 2025 with cerebral infarction (stroke) affecting left non-dominant side and need for assistance for personal care.</p> <p>During a record review of the Social Service Director ' s Progress Notes dated 3/7/25, the Progress Notes indicated Resident 1 ' s Responsible Party (RP) informed the facility that a female Certified Nurse Assistant (CNA) was very rough and rude during the care of Resident 1. The Progress Notes also indicated, Resident 1 said . a female CNA came to change her but just removed her blanket and told her to turn to her left side. According to the resident, the CNA was very rough .she got hurt and expressed ' ouch ' .and the CNA said, 'I'm just cleaning you, you want to stay on your shit?' .She also said that the same CNA is always rude to her and her roommate .</p> <p>During an interview on 5/30/25 at 11:40 a.m. with SSD, SSD stated she interviewed Resident 1 with the RP present on 3/7/25. SSD stated during her visit to Resident 1, Resident 1 was not able to recall the details of the incident involving a CNA. SSD stated because Resident 1 was very confused, and could not recall the details of the incident, the complaint was only filed as a grievance and not as an allegation of abuse. SSD stated the incident was reported to the Abuse Coordinator and it was decided that the incident was unfounded because Resdient 1 was confused. SSD stated she knew she was a mandated reporter and she should have considered Resident 1 ' s allegation as a suspected abuse. SSD stated she also did not interview the roommate to verify Resident 1's allegation of abuse. SSD further stated there was no follow up monitoring done for any psychosocial behavior changes on Resident 1.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview on 5/30/25 at 12:02 p.m. with the Director of Staff Development (DSD), SSD 's Progress Notes dated 3/7/25 was reviewed. DSD stated she considered Resident 1 ' s allegation as a suspected abuse and should have been reported and investigated appropriately. DSD stated it was very important to take the allegation of abuse seriously so that a thorough investigation could be conducted. DSD also stated when a staff was involved in an allegation of abuse, the staff should have been suspended while the investigation was ongoing.</p> <p>During an interview on 5/30/25 at 12:29 p.m. with the Director of Nursing (DON), the DON stated a suspected abuse should have included a thorough investigation, identification of the staff involved, staff suspension, and reporting to state and local agencies should be done immediately or within 23 hours. The DON further stated SSD did not consider the complaint as a suspected abuse because Resident 1 was confused.</p> <p>During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Mistreatment- Reporting and Investigating, copyrighted 2001, the P&P indicated, The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing certification agency responsible for surveying/licensing the facility; b. The local/stated ombudsman; .e. Law enforcement officials . 'Immediately' is defined as a. within two hours of an allegation involving abuse or result in serious bodily injury .</p>		