STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555254	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Hill Healthcare Center	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)
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. (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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(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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three sampled residents for closed record review (Resident 132), the facility failed to ensure an effective discharge process when caregiver training and discharge notice were not provided in a timely manner. This failure had the potential to result in avoidable accidents and unsafe discharge. During a review of Resident 132's admission Record (AR), the AR indicated Resident 132 was admitted to the facility on [DATE] with diagnoses that included dislocation of the left knee, difficulty walking, dislocation of left hip prosthesis and the need for assistance with personal care. During a review of Resident 132's Order Summary Report (OSR) as of 8/7/25, the OSR indicated a physician's order dated 7/8/25 to discharge Resident 132 to home with hospital bed and Hoyer lift (also known as a patient lift or hydraulic lift, is a medical device designed to assist in the transfer of patients with limited mobility. It is commonly used in hospitals, nursing homes, and private residences to move patients safely from one location to another, such as from a bed to a wheelchair or from a wheelchair to a toilet). During a review of Resident 132's care plans, dated 5/19/25, the care plans indicated the following: - Discharge/Transfer Referral, interventions included to arrange for necessary home modifications as indicated, and to coordinate in-home support services. - Discharge/Transfer Planning Preference interventions included addressing availability, capability, and training needs of caregiver/support person as needed and to coordinate in-home support services. - The resident wishes to return home. interventions included to make arrangement with required community resources to support independence after discharge. During an interview on 8/7/25 at 12:37 p.m. with Director of Nursing (DON), DON stated that Resident 132 was scheduled for discharge on [DATE]. DON stated, on the day of discharge, Resident 132 complained of stroke-like symptoms and was sent to the hospital. DON stated, discharge plans had already begun while Resident 132 was at the facility. During discharge planning, Resident 132 mentioned having a caregiver, a friend, to assist. DON stated she did not know if the caregiver received training and would check with the Rehabilitation Department. During an interview on 8/7/25 at 1:30 p.m. with Assistant Director of Rehabilitation (ADOR), ADOR stated Resident 132 would not improve with activities of daily living despite treatments. ADOR stated the facility's social services indicated Resident 132 would be discharged home. ADOR stated Resident 132 would need assistance will all ADLS at home, if a caregiver was present, the caregiver would need training for care transfers and Hoyer lift transfers. ADOR stated no caregiver training was provided for Resident 132. During a telephone interview on 8/7/25 at 2:15 p. m. with Ombudsman (OMB), OMB stated Resident 132 was wheelchair-bound and appeared absent-minded during a visit. OMB stated Resident 132 did not have a caregiver, had no power in the apartment, and that property manager had left it unlocked. OMB stated the hospital case manager communicated that Resident 132's insurance and approved an additional week at the facility to complete discharge arrangements. During an interview on 8/7/25 at 2:54 p.m. with Case Manager (CM) 1, CM 1 stated that on 7/1/25, she and DON asked Resident 132 if she wanted to be discharged , and Resident 132 agreed. CM 1 stated discharge planning began, and the necessary Durable Medical Equipment (hospital bed and Hoyer lift) was delivered before the 7/9/25 discharge date . CM 1 stated that Resident 132 had a Community Case Manager (CCM) who arranged for a caregiver but did not verify this herself with CCM. CM 1 stated although Resident 132 had a brother and a sister, they were not involved in the discharge planning. CM 1 stated, on 7/9/25, the day Resident 132 was to be discharged home, CM 1 missed several calls from CCM and could not return them. During a telephone interview on 8/7/25 at 3:48 p.m. with CCM, CCM stated, on 7/1/25, Resident 132 had called to say the facility planned to discharge her on 7/9/25. CCM stated she called CM 1 regarding Resident 132's discharge plan, but CM 1 indicated no knowledge of the discharge plan or date. CCM stated, on 7/9/25, Resident 132 called again to inform CCM that she was being discharged that day. CCM 1 stated she attempted multiple times to reach CM 1 to prevent the discharge, but none of her calls were answered or returned. CCM stated the facility did not contact her to coordinate Resident 132's discharge, had they called her, CCM stated she would have informed them that Resident 132 did not have a caregiver and did not have resources at home. CCM stated only becoming aware that Resident 132 had been taken to the hospital when Resident 132 called CCM the following day, distressed, stating that she had been left on the couch by the transport service and had not moved because Resident 132 was wheelchair-bound. CCM stated the office called 911 to have Resident 132 transported back to the hospital. During a review of Resident 132's ED (Emergency Department) Notes dated 7/9/25, the ED notes indicated, Was being discharged today from