

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/08/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services and procedures to six of six sampled residents (Residents 58, 93, 24, 121, 29, and 69) that ensured acquiring, dispensing, administration, and maintaining accurate controlled drug records when: Resident 93 and Resident 58's routine medications were not available during medication administration. The Controlled Drug Records (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) for four out of four sampled residents (Residents 29, 121, 69, and 24) did not reconcile with the Medication Administration Records (MAR). This failure had the potential to result in inaccurate accountability and the potential for abuse and diversion (when medication is taken for use by someone other than whom it is prescribed) of controlled medications and Resident 93 and Resident 58 not receiving appropriate treatments as per physician orders. 1. During a record review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility in September 2023 with multiple medical diagnosis including schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms). During a record review of Resident 58's MAR, dated 8/1/25 to 8/30/25, the MAR indicated Resident 58 had a physician order dated 12/10/24 for chlorpromazine hydrochloride (medication used to manage and treat mental conditions) tablet 25 mg, give two tablets by mouth one time a day for schizoaffective disorder manifested by delusions. The MAR also indicated Resident 58 did not receive chlorpromazine on 8/6/25. During a medication pass observation on 8/6/25 at 8:49 p.m. with Registered Nurse (RN) 1, RN 1 prepared Resident 58's morning routine medications. RN 1 stated Resident 58's chlorpromazine tablets were not available for administration. RN 1 proceeded to administer Resident 58's routine morning medication without the chlorpromazine. During a record review of Resident 93's admission Record, the admission Record indicated Resident 93 was admitted to the facility in June 2023 with multiple medical diagnosis including hypertension (High blood pressure). During a record review of Resident 93's MAR, dated 8/1/25 to 8/30/25, the MAR indicated Resident 93 had a physician order dated 8/2/24 for Eliquis (an anticoagulant or blood thinner to reduce risk of stroke and blood clots) oral tablet 2.5 mg, give 2.5 mg by mouth two times a day for atrial fibrillation (an irregular and often very rapid heart rhythm). The MAR also indicated Resident 93 did not receive Eliquis on the following dates and times: - 8/5/25 at 9:00 a.m. - 8/5/25 at 6:00 p.m. - 8/6/25 at 9:00 a.m. During a record review of Resident 93's Progress Notes, dated 8/5/25, the Progress Notes indicated the Eliquis was on order at 9:13 a.m. and medication unavailable. at 6:49 p.m. During a record review of Resident 93's Progress Notes, dated 8/6/25, the Progress Notes indicated the Eliquis was on order at 10:00 a.m. During a record review of Resident 93's Progress Notes, dated 8/6/25 at 3:26 p.m., the Progress Notes indicated Eliquis medication not administered because ran out. During medication pass observation on 8/6/25 at 9:42 a.m. with RN 1, RN 1 stated Resident 93's Eliquis was not available. RN 1 informed the Assistant Director of Nursing (ADON) about the missing Eliquis. ADON was observed searching for the Eliquis in the medication but did not find it. RN 1 then proceeded to administer the rest of Resident 98's routine morning medications without the Eliquis. During an interview on 8/6/25 at 10:04 a.m. with (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1, RN 1 stated he was new to the medication cart and was not sure why there were some medications that were unavailable for residents to use. RN 1 stated if a medication was not available, they should have checked the emergency kit (or e-kit, a limited supply of medication for urgent use) if the medication was available, inform the physician, and call the pharmacy to reorder the medication. RN 1 stated Resident 58 had the risk of mental instability if the chlorpromazine was not given as ordered by the physician. RN 1 further stated without the Eliquis, Resident 93 could have had complications of atrial fibrillation such as stroke. During a phone interview on 8/7/25 at 1:22 p.m. with Consultant Pharmacist (CP), CP stated the facility should have reordered from the pharmacy if the medications were running low. CP stated the medications in the bubble packs (a card that packaged doses of medication within plastic bubbles or blisters) contained a reminder label indicating the date to place a reorder. CP stated the facility had eight days to refill before the medications ran out. CP further stated Eliquis should have been available in e-kit for Resident 93 to use. CP stated it was important for residents to receive their routine medications in a timely manner because missed doses could have caused consequences. 2. During a record review of Resident 24's Medication Administration Record (MAR), dated 7/1/25 to 8/31/25, the MAR indicated Resident 24 had a physician order, dated 7/4/25, 7/18/25, and 7/21/25 for lorazepam (a controlled substance used for anti-anxiety) 2 milligrams (mg, unit of volume), give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days. During a record review of Resident 24's CDR, dated between 7/15/25 to 8/2/25, the CDR indicated licensed nursing staff signed out one tablet on the following dates and times but did not document the medication administration on the July and August 2025 MAR (total of seven doses):- 7/18/25 at 10:30 a.m.- 7/19/25 at 6:00 a.m.- 7/19/25 at 10:10 a.m.- 7/21/25 at 6:00 a.m.- 7/21/25 at 9:30 p.m.- 8/2/25 at 5:30 a.m.- 8/2/25 at 5:00 a.m. During a record review of Resident 121's MAR, dated 7/1/25 to 7/31/25, the MAR indicated Resident 121 had a physician order, dated 7/23/25 for lorazepam 2mg, give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days, hold for sedation. During a record review of Resident 121's CDR, dated between 7/24/25 to 8/4/25, the CDR indicated licensed nursing staff signed out one tablet on the following dates and times but did not document the medication administration on the July 2025 MAR (total of three doses):- 7/27/25 at 6:00 p.m.- 7/28/25 at 8:00 a.m.- 8/1/25 at 10:13 a.m. During a record review of Resident 29's MAR, dated 8/1/25 to 8/30/25, the MAR indicated Resident 29 had a physician order, dated 6/18/25, for oxycodone hydrochloride (a controlled substance used to relieve severe pain)) oral capsule 5 mg, give one capsule by mouth every four hours as needed for moderate to severe pain. During a record review of Resident 29's CDR, dated between 8/2/25 to 8/5/25, the CDR indicated licensed nursing staff signed out one capsule on the following dates and times but did not document the medication administration on the August 2025 MAR (total of two doses):- 8/3/25 at 4:30 a.m.- 8/3/25 at 5:05 p.m. During a record review of Resident 69's MAR, dated 8/1/25 to 8/30/25, the MAR indicated Resident 69 had a physician order, dated 7/29/25, for Roxicodone (an opioid analgesic used to treat moderate to severe pain) oral tablet 5mg, give two tablets by mouth every four hours as needed for severe pain. During a record review of Resident 69's CDR, dated between 8/1/25 to 8/5/25, the CDR indicated licensed nursing staff signed out two tablets on the following dates and times but did not document the medication administration on the August 2025 MAR (total of two doses):- 8/1/25 at 5:00 a.m.- 8/2/25 at 3:00 a.m. During a phone interview on 8/7/25 at 1:07 p.m. with the CP, CP stated when pulling out a controlled substance, licensed nursing staff were expected to document on both the CDR and MAR. CP stated MAR was an assurance that the controlled substance medications were received by residents. CP stated if CDR did not match the MAR, it would have been considered a discrepancy. CP stated not documenting accurately on the MAR, it would have been difficult to identify if the controlled substances were actually given to the residents. During an interview on 8/8/25 at 9:22 a.m. with Medical Record Director (MRD) 1, MRD 1 stated the CDR should have reflected the MAR for accurate recording of controlled drugs. MRD 1 stated she did not know how to answer when asked (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how they verified that the controlled medications were given to Residents 24, 121, 29, and 69 when licensed nursing staff did not document the controlled drugs given on CDR and MAR concurrently. MRD 1 stated not accurately documenting the administration of the controlled drugs had the risk for drug diversion where nurses could have used the controlled drugs for their own use. During a record review of the facility's policy and procedures (P&P), titled, Medication Administration, dated January 2023, the P&P indicated, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. During a record review of the facility's P&P, titled, Controlled Substances, dated November 2022, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of Comprehensive Drug Abuse Prevention and Control Act of 1976).The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following.a. Records of personnel access and usage.b. Medication administration records.During a record review of the facility's P&P, titled, Pharmacy Services Overview, dated April 2024, the P&P indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist.1. Pharmaceutical services consist of.a. process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling.dispensing.distributing, administering.c. the process of identifying evaluating and addressing medication-related issues including prevention and reporting of medication errors.3. Pharmacy services are available to residents 24 hours a day, seven days a week.8. The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to).a. acquisition and availability of medications.reconciliations of medications.f. documentation of processes, as applicable.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 safe medication storage and labeling practices with census of 119 when: 1) A box of Resident 59's discontinued and unlabeled oral prescribed medication was stored in an active storage area in medication cart #3.2) Resident 65's discontinued as needed prescription medication was stored in medication cart #2.3) Multiple medications with different routes of administration (a way by which a drug is taken into the body) were stored together in medication carts #2 and #3.4) An unopened insulin vial with pharmacy label of refrigerate until opened was stored at room temperature in medication cart #2. These failed practices could contribute to unsafe use of medications and potential for medication error. Findings: During a record review of Resident 59's Order Summary Report dated 8/7/25, the Orders Summary Report indicated Resident 59 had a physician order of cholestyramine light oral packet 4 grams - give 1 packet by mouth two times a day. that was discontinued since 8/30/24. During a concurrent observation and interview on 8/4/25 at 12:54 p.m. with Director of Staff Development (DSD) and Licensed Vocational Nurse (LVN) 3, in the medication cart #3, a box of medication with multiple cholestyramine light oral packet 4 grams (a prescription-only medication used to treat high cholesterol) did not have a label and the top lid of the container was missing. LVN 3 and DSD stated they did not know who the medication belonged to. After checking the electronic health records (EHR), LVN 3 stated the medication belonged to Resident 59. LVN 3 stated he was not sure if Resident 59's cholestyramine was discontinued or not. DSD stated all prescription medications should have had labels to prevent mistakes or errors. DSD stated medications without labels had potential to be given to other residents. During a concurrent observation and interview on 8/4/25 at 1:05 p.m. with DSD, two inhalers called Advair and Albuterol (handheld device used to deliver medication that helps breathing directly into the lungs), one haloperidol (antipsychotic medication that treats schizophrenia, a chronic mental disorder that affects how a person thinks) oral solution, one box nicotine lozenge (helps quit smoking), and one Proventil nebulizer solution (a liquid solution that is transformed into a fine mist by a nebulizer device and inhaled to lungs to help with breathing) were stored in one compartment in an active storage area of medication cart #3. DSD stated the medications should have been separated by route of administration to prevent contamination between the medications. During a record review of Resident 65's Order Summary Report dated 8/5/25, the Order Summary Report indicated Resident 65 had a physician order of hydroxyzine (medication used to treat anxiety) hydrochloride oral tablet 25 milligrams (mg, unit of volume) - give one tablet by mouth every 6 hours as needed for anxiety manifested by overconcern with anything for 14 days that was completed since 4/9/25. During an observation and interview, on 8/5/25 at 11:48 a.m. with LVN 4, the medication cart #4 contained Resident 65's discontinued hydroxyzine oral tablet 25 mg was stored in medication cart #4. LVN 4 stated Resident 65's hydroxyzine should have been discarded and destroyed by two licensed nurses because it had the risk of being given to the wrong residents. During an observation and interview on 8/5/25 at 12:10 p.m. with Assistant Director of Nursing (ADON), Resident 70's eyedrops called cyclosporine ophthalmic emulsion 0.05% (a prescription medication used to treat chronic dry eye disease) was stored together with Resident 29's diclofenac sodium 1% gel (a topical gel medication that treats arthritis of the knee). ADON stated she needed to verify what their policy was for storing medications. During an observation and interview on 8/5/25 at 12:29 p.m. with LVN 1, Resident 86's unopened insulin vial with a pharmacy label of refrigerate until opened was stored at room temperature inside the medication cart #2. LVN 1 stated Resident 86's unopened insulin should have been refrigerated and not stored at room temperature. LVN 1 stated storing unopened insulin incorrectly could have decreased its effectiveness. During an interview on 8/7/25 at 1:07 p.m. with Consultant Pharmacist (CP), CP stated discontinued medications should have been pulled out and (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded from the medication carts. CP stated storing discontinued medications could have caused confusion from the nurses that could potentially have caused medications errors. CP stated all residents' medications should have had proper labeling. CP further stated without proper labeling, nurses could have had a hard time identifying the difference between a prescription and over the counter medications. CP further stated without a label; the medication had a risk of being given to the wrong resident. CP stated nurses had a risk of giving the medications continually to the residents. CP stated the medications should have been stored by route of administration to prevent medication errors. CP stated it was best practice to keep unopened insulin vials in the refrigerator if not ready for use. CP stated once the unopened insulin vial was stored at room temperature, then the 28-day count for the expiration date should have been started even without opening the vial. During a record review of the facility's policy and procedure (P&P), titled, Medication Storage dated January 2023, the P&P indicated, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support a safe effective drug administration.1. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements. This may include such containers as medication carts medication rooms.4. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, suppositories.6. Eye medications are stored separately from ear medications and inhalers, etc.12. Insulin products should be stored in the refrigerator until opened.14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure accuracy of medical record for four of four sampled residents (Residents 24, 121, 29, and 69) when:1. Resident 24 had a physician's order to give an as needed lorazepam (a controlled substance used by calming the nervous system and reducing feelings of anxiety, fear, and worry) was created on 8/5/25 with a start date of 8/1/25, resulting in a four-day backdate (put an earlier date to a document than the actual one) without verification.2. Residents 24, 121, 29, and 69's controlled drug records (CDR) and medication administration record (MAR) did not match, and licensed nursing staff subsequently created late entry and back dated notes.This failure resulted in inaccurate reflection of physician orders for Resident 24, as well as inaccurate accountability for Resident 24, 121, 29, and 69's controlled medications that had the potential for abuse and drug diversion (when medication is taken for use by someone other than whom it is prescribed). 1. During a record review of Resident 24's admission Record (AR), dated 8/5/25, the AR indicated Resident 24 was admitted in the facility in August 2025 with diagnosis of schizoaffective disorder (a mental health condition characterized by a combination of schizophrenia symptoms like hallucinations and delusions and mood disorder symptoms like depression or mania) and anxiety disorders (a group of mental health conditions characterized by excessive worry, fear, or unease that can interfere with daily life. During a record review of Resident 24's Physician Order, dated 8/1/25, the Physician Order indicated an order for Lorazepam oral tablet two milligrams (mg, unit of volume) .Controlled drug.Give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days. The Physician Order also indicated the order for lorazepam was created on 8/5/25, resulting in a four-day backdate.During a concurrent interview and record review on 8/6/25 at 11:26 a.m. with Assistant Director of Nursing (ADON), Resident 24's order for lorazepam was reviewed. ADON stated on 8/1/25, she received a verbal order from the physician authorizing the administration of lorazepam to Resident 24. ADON stated she could not recall why she did not enter the physician's order right away into Resident 24's record. ADON further stated they have 30 days to correct documentation including medication administration. ADON stated she informed the charge nurse on 8/1/25 that it was okay to administer lorazepam to Resident 24. During a follow up interview and record review on 8/7/25 at 12:08 p.m. with ADON, Resident 24's medical records were reviewed. ADON stated she could not recall if she created a physician order sheet after she received the verbal order from the physician as part of their policy and procedure. ADON stated she did not find any documentation from the physician that indicated the rationale for Resident 24 to continue the as needed lorazepam. ADON stated late entry of physician's order had a risk of administering the wrong medication and may have had prevented the medications from being given on time.During a phone interview on 8/7/25 at 1:07 p.m. with Consultant Pharmacist (CP), CP stated any psychotropic (a class of drugs that affect the brain and influence mental processes and behaviors) medication including lorazepam could not be renewed or reordered verbally unless it was written and signed by the physician. CP stated only a pharmacist may receive verbal orders for controlled drugs from the physician, and only in emergency situations.2. During a record review of Resident 24's Medication Administration Record (MAR), dated 7/1/25 to 8/31/25, the MAR indicated Resident 24 had a physician order, dated 7/4/25, 7/18/25, and 7/21/25 for lorazepam (a controlled substance used for anti-anxiety) 2 milligrams (mg, unit of volume), give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days.During a record review of Resident 24's CDR, dated between 7/15/25 to 8/2/25, the CDR indicated licensed nursing staff signed out one tablet on the following dates and times but did not document the medication administration on the July and August 2025 MAR (total of eight doses):- 7/18/25 at 10:30 a.m.- 7/18/25 at 6:12 p.m.- 7/19/25 at 6:00 a.m.- 7/19/25 at 10:10 a.m.- 7/21/25 at 6:00 a.m.- 7/21/25 at 9:30 p.m.- 8/2/25 at 5:30 a.m.- 8/2/25 at 5:00 a.m.During record review of Resident 24's (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Notes with an effective date on 7/18/25 at 10:30 a.m., was created on 8/5/25 at 5:51 p.m., resulting in an 18-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 7/18/25 at 6:12 p.m. was created on 8/5/25 at 6:11 p.m., resulting in an 18-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 7/19/25 at 6:00 a.m. was created on 8/5/25 at 5:58 p.m., resulting in a 17-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 7/19/25 at 10:00 a.m. was created on 8/5/25 at 5:52 p.m., resulting in a 17-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 7/21/25 at 6:00 a.m. was created on 8/5/25 at 6:06 p.m., resulting in a 14-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 7/21/25 at 9:14 p.m. was created on 8/5/25 at 6:15 p.m., resulting in a 14-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 24's Progress Notes with an effective date on 8/2/25 at 5:30 a.m. was created on 8/5/25 at 4:43 p.m., resulting in a 4-day backdate. The Progress Notes indicated the lorazepam was administered. During a record review of Resident 121's admission Record (AR), dated 8/5/25, the AR indicated Resident 121 was admitted in the facility in April 2025 with diagnosis of schizoaffective disorder. During a record review of Resident 121's MAR, dated 7/1/25 to 7/31/25, the MAR indicated Resident 121 had a physician order, dated 7/23/25 for lorazepam 2mg, give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days, hold for sedation. During a record review of Resident 121's CDR, dated between 7/24/25 to 8/4/25, the CDR indicated licensed nursing staff signed out one tablet on the following dates and times but did not document the medication administration on the July 2025 MAR (total of three doses):- 7/27/25 at 6:00 p.m.- 7/28/25 at 8:00 a.m.- 8/1/25 at 10:13 a.m. During record review of Resident 121's Progress Notes with an effective date on 7/27/25 at 6:00 p.m. was created on 8/5/25 at 4:42 p.m., resulting in a 9-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 121's Progress Notes with an effective date on 7/28/25 at 8:00 a.m. was created on 8/5/25 at 5:17 p.m., resulting in an 8-day backdate. The Progress Notes indicated the lorazepam was administered. During record review of Resident 121's Progress Notes with an effective date on 8/1/25 at 10:13 a.m. was created on 8/5/25 at 5:27 p.m., resulting in a 4-day backdate. The Progress Notes indicated the lorazepam was administered. During a record review of Resident 29's admission Record (AR), dated 8/5/25, the AR indicated Resident 29 was admitted in the facility in May 2024 with diagnoses of polyneuropathy (happens when the nerves that are located outside of the brain and spinal cord are damaged) and chronic pain (persistent or recurrent pain lasting longer than three to six months). During a record review of Resident 29's MAR, dated 8/1/25 to 8/30/25, the MAR indicated Resident 29 had a physician order, dated 6/18/25, for oxycodone hydrochloride (a controlled substance used to relieve severe pain) oral capsule 5 mg, give one capsule by mouth every four hours as needed for moderate to severe pain. During a record review of Resident 29's CDR, dated between 8/2/25 to 8/5/25, the CDR indicated licensed nursing staff signed out one capsule on the following dates and times but did not document the medication administration on the August 2025 MAR (total of two doses):- 8/3/25 at 4:30 a.m.- 8/3/25 at 5:05 p.m. During record review of Resident 29's Progress Notes with an effective date on 8/3/25 at 4:30 a.m. was created on 8/5/25 at 5:02 p.m., resulting in a 2-day backdate. The Progress Notes indicated the oxycodone was administered. During record review of Resident 29's Progress Notes with an effective date on 8/3/25 at 5:05 p.m. was created on 8/5/25 at 5:41 p.m., resulting in a 2-day backdate. The Progress Notes indicated the oxycodone was administered. During a record review of Resident 69's admission Record (AR), dated 8/5/25, the AR indicated Resident 69 was admitted in the facility in May 2025 with diagnosis of right clavicle fracture (broken collarbone). During a record review of Resident 69's MAR, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 8/1/25 to 8/30/25, the MAR indicated Resident 69 had a physician order, dated 7/29/25, for Roxicodone (an opioid analgesic used to treat moderate to severe pain) oral tablet 5mg, give two tablets by mouth every four hours as needed for severe pain. During a record review of Resident 69's CDR, dated between 8/1/25 to 8/5/25, the CDR indicated licensed nursing staff signed out two tablets on the following dates and times but did not document the medication administration on the August 2025 MAR (total of two doses):- 8/1/25 at 5:00 a.m.- 8/2/25 at 3:00 a.m. During record review of Resident 69's Progress Notes with an effective date on 8/1/25 at 5:00 a.m. was created on 8/5/25 at 5:11 p.m., resulting in a 4-day backdate. The Progress Notes indicated the Roxicodone was administered. During record review of Resident 69's Progress Notes with an effective date on 8/2/25 at 3:00 a.m. was created on 8/5/25 at 5:24 p.m., resulting in a 3-day backdate. The Progress Notes indicated the Roxicodone was administered. During a phone interview on 8/7/25 at 1:07 p.m. with the CP, CP stated when pulling out a controlled substance, licensed nursing staff were expected to document on both the CDR and MAR. CP stated MAR was an assurance that the controlled substance medications were received by residents. CP stated if CDR did not match the MAR, it would have been considered a discrepancy. CP stated not documenting accurately on the MAR, it would have been difficult to identify if the controlled substances were actually given to the residents and it had the risk for drug diversion. MDR 1 stated inaccurate recording of the controlled substance had the potential for abuse and nurses using the controlled substances for their own good. During an interview on 8/8/25 at 9:22 a.m. with Medical Record Director (MRD) 1, MRD 1 stated the CDR should have reflected the MAR for accurate recording of controlled drugs. MRD 1 stated she did not know how to answer when asked how they verified that the controlled medications were given to Residents 24, 121, 29, and 69 when licensed nursing staff did not document the controlled drugs given on CDR and MAR concurrently. MRD 1 stated not accurately documenting the administration of the controlled drugs had the risk for drug diversion where nurses could have used the controlled drugs for their own use. During an interview on 8/8/25 at 9:30 a.m. with MRD 2, MRD 2 stated residents' charts and records should have been done in a timely manner to make sure they were compliant. MRD 2 stated documenting a medication administration should have been done as soon as the medication was given. MRD 2 stated a resident's chart should have had complete and accurate documentation, including progress notes and MAR because they were all part of a resident's records. During a record review of the facility's policy and procedures (P&P), titled, Controlled Substance Medication Orders, dated January 2023, the P&P indicated, Before a controlled substance medication can be dispensed, the pharmacy must be in receipt of a clear, complete, valid prescription from a person lawfully authorized to prescribe them. The pharmacy can dispense a Schedule III-V (Schedules I-V are classification of controlled drugs based on their potential for abuse including lorazepam) controlled substance medication after a receipt of practitioner signed a valid Schedule III-V prescription (original, fax, or electronically prescribed). or the practitioner (or his agent) speaks directly to the pharmacist providing verbal authorized controlled substance prescription. Incomplete prescriptions and verbal order for controlled substances may not be edited or changed by the facility nursing staff. During a record review of the facility's P&P, titled, Controlled Substances, dated November 2022, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of Comprehensive Drug Abuse Prevention and Control Act of 1976). The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following. a. Records of personnel access and usage. b. Medication administration records. During a record review of the facility's P&P, titled, Medication Administration, dated January 2023, the P&P indicated, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. During a record review of the facility's P&P, titled, Charting and Documentation, dated July 2017, the P&P (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, All services provided to the resident.shall be documented in the resident ?s medical record.Documentation in the medical record will be objective.complete, and accurate.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for two of 27 sampled residents (Resident 40 and Resident 94), the facility failed to ensure their call lights were within reach. This failure had the potential to result in their inability to call for help. During a review of Resident 40's admission Record (AR), the AR indicated Resident 40 was admitted to the facility in September 2003 with diagnoses that included paraplegia (paralysis of the lower half of the body) and epilepsy (characterized by unprovoked seizures, loss of consciousness and sensory disturbances). During a review of Resident 40's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 7/9/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine a resident's cognitive status regarding attention, orientation, and inability to register and recall information) score of 5. A BIMS score of 0-7 indicates severe cognitive impairment). The MDS also indicated Resident 40 required staff assistance with turning and repositioning in bed. During a review of Resident 94's AR, the AR indicated Resident 94 was admitted to the facility in October 2019 with diagnoses that included anxiety disorder (mental health condition characterized by excessive and persistent worry and fear about everyday situations), major depressive disorder (persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in daily activities) and morbid obesity (extreme obesity). During a review of Resident 94's MDS dated [DATE], the MDS indicated Resident 94 had a BIMS score of 12. A BIMS score of 12 indicates moderate cognitive impairment. The MDS also indicated Resident 94 required staff assistance with turning and repositioning while in bed. During a concurrent observation and interview on 8/4/25 at 12:47 p.m. with Resident 94, Resident 94 stated not feeling well and had no way to call the nurse. Resident 94 stated she could not find the call light or knew its location. Resident 94 and Resident 40 were roommates. During a concurrent observation and interview on 8/4/25 at 12:56 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 entered the room and found Resident 94's call light tucked away in the nightstand drawer. Resident 94 stated being unable to see it due to limited neck movement. LVN 1 went over to Resident 40's bedside and found Resident 40's call light wrapped around the bed's left side rails. LVN 1 stated Resident 40 had limited range of motion on upper extremities and would not be able to unwrap the call light from the side rails. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light last revised September 2022, the P&P indicated that to ensure timely response to the resident's needs and requests, staff must Ensure that the call light is nearby to the resident.		

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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. **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 with 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 (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the facility and upon being given. papers [Resident 132] started to complain of abdominal pain.also states left shoulder was painful.anxious about her living situation as she has nowhere to go. During a follow-up interview on 8/8/25 at 9:28 a.m. with CM 1, CM 1 stated, discharge notice for Resident 132 was to be given on the day of discharge. CM 1 stated she did not keep a copy of the discharge notice or document it in the clinical record. CM 1 added being unsure of the discharge process due to the sudden departure of the social services staff responsible. During an interview on 8/8/25 at 9:51 a.m. with Director of Staff Development (DSD), DSD stated that residents receive a notice of discharge on e week prior to the actual discharge date . During a joint interview on 8/8/25 at 9:53 a.m. with CM 2 and DON, CM 2 stated the notice of discharge is signed by the resident on the day of discharge, the same copy would be sent to the Ombudsman's office the same day. DON stated Resident 132 stayed at the facility for over 30 days. During a review of the facility's policy and procedure (P&P) titled Discharge Summary and Plan last revised March 2025, the P&P indicated every resident has an individualized discharge plan, developed by the interdisciplinary team (a group composed of individuals from different departments of the facility) to meet the resident's discharge needs. A resident's discharge needs must be addressed before the resident can be safely discharged (e.g. caregiver support and education, rehabilitation, etc.).		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the skilled nursing facility's licensed nursing staff did not perform a complete assessment of 2 of 17 sampled residents (Residents 81 and 129) when:Assigned nursing staff were unable to explain why Resident 81 was grinding her teeth. Assigned nursing staff could not explain the necessity for a 1:1 sitter (aide with a resident around-the-clock) for Resident 129. This deficient practice had the potential to result in residents receiving inappropriate care or being unable to achieve established health care goals. Record review of the document admission Record showed the facility admitted Resident 81 on 12/8/2010. Diagnoses included Major Depressive Disorder.Record review of the document MDS 3.0 Section C-Cognitive Patterns (Resident Assessment) dated 5/8/2025 indicated Resident 81 could not identify the correct day of week, current month or year. On 8/4/2025 at 11:30 a.m. Resident 81 was observed sitting in a wheelchair in the hallway. She was moving her jaw side to side which produced an audible grinding/clicking sound. In a concurrent interview, Licensed Vocational Nurse 6 (LVN 6) stated he did not know why Resident 81 was producing the noise and asked, Maybe it's her behavior? LVN 6 stated he was Unsure how having that information would impact the care he provided for Resident 81.During an interview on 8/5/2025 at 9:15 a.m. Registered Nurse 1 (RN 1) stated he was not sure why Resident 81 was making the oral grinding/clicking sounds. RN 1 stated he should have that information as More knowledge means better care.Record review of the document NBU Behavioral & Psychiatric Interdisciplinary Rounds dated 7/30/2025 indicated Resident 81 had Bruxism (teeth grinding) which she had reported to staff was due to her getting food out of her teeth. Plan was to increase Lorazepam (anti-anxiety medication)During a record review of the document PACS-Medication Administration Record dated 7/1/2025 - 7/31/2025 showed Resident 81 was to be administered Lorazepam 1 mg 2 times per day for anxiety, increase muscle mouth rigidity, sweateness, bruxism, muscle tension, racing heart. During an interview on 8/6/2025 at 10 a.m. the facility's Director of Nursing (DON) was asked why Resident 81 was grinding her teeth. The DON stated she not sure and would need to Investigate. Record review of the document admission Record showed the facility admitted Resident 129 on 5/23/2025. Diagnoses included schizophrenia. (mental health condition with symptoms that include hallucinations, delusions, depression, mania)Record review of the document MDS 3.0 Section C - Cognitive Patterns dated 5/30/2025 indicated Resident 81 could not identify the correct current day, year or month.Record review of the document Care Plan Report dated 5/23/2025 indicated Resident 81 had a history of a suicide attempt and interventions included 1:1 supervision.During an observation on on 8/4/2025 at 11:13 a.m. Resident 129 was observed in his room with a 1:1 sitter.During an interview on 8/4/2025 at 11:13 a.m. LVN 6 stated he did not know why Resident 129 had a 1:1 sitter. LVN 6 stated it would be good for him to know so he could Care for him appropriately.During an interview on 8/6/2025 at 10:20 a.m., the DON stated she would expect staff to understand why a resident was with a 1:1 sitter or why someone may be grinding their teeth as knowing this information Is helpful in caring for the resident. Record review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 2001 indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		

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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. Based on observation, interview and record review, the facility failed to ensure an environment free of accident hazards when one of three (Resident 67) sampled residents, Resident 67, who was on pureed diet, did not receive adequate supervision during meals. Resident 67 received and ate regular consistency food. This failure had the potential to result in choking and aspiration. During a review of Resident 67's admission Record (AR), the AR indicated Resident 67 was admitted to the facility in March 2025 with diagnoses that included dementia (decline in cognitive function, impaired memory, thinking and decision-making abilities severe enough to interfere with daily life) and dysphagia (difficulty swallowing). During a review of Resident 67's Order Summary Report (OSR) as of 8/7/25, the OSR indicated an order dated 6/3/25 for Resident 67 to have pureed texture with honey thick liquid, 1:1 assist with meals as needed. During an observation on 8/4/25 at 1:36 p.m. in the front dining room, Resident 67 was seated at a dining table with Resident 2 and Resident 72. Resident 67 pointed towards the tray of noodles and orange chicken brought by Resident 2's family for lunch. The family offered some noodles and three pieces of cut-up chicken, which Resident 67 eagerly accepted. Resident 67 proceeded to eat the noodles with a fork, though some fell from her mouth. Resident 2's family expressed uncertainty about whether Resident 67 was allowed to consume noodles and chicken, and apologized by saying, I'm sorry. There were no staff members present in the dining room at that time. During an interview on 8/4/25 at 1:39 p.m., Registered Nurse (RN) 1 was asked about Resident 67's diet. RN 1 responded that Resident 67 was not his patient and did not go to the dining room to check on Resident 67. During an interview on 8/4/25 from 1:41 p.m. to 1:43 p.m. with Director of Staff Development (DSD), DSD stated Certified Nursing Assistant (CNA) 1 was assigned to monitor the dining room. However, DSD later found CNA 1 in another resident's room and instructed CNA 1 to check on Resident 67. CNA 1 went to the dining room to attend to Resident 67. DSD stated Resident 67 was on pureed diet. During an interview on 8/4/25 at 1:43 p.m. with CNA 1, CNA 1 stated being in the dining room but had to step out of the dining room to give the food to another resident who was not in the resident's room. CNA 1 stated because Resident 67's tray was pureed, was the last tray to come out as all the other regular trays have all been served. CNA 1 stated Resident 67 needed assistance with meals. During an interview on 8/4/25 at 2:49 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 67's nurse, LVN 1 stated Resident 67 was on pureed diet and honey thick liquids. LVN 1 stated, during mealtimes, it was very important for staff to supervise Resident 67 to prevent aspiration or choking accidents. During a joint interview on 8/4/25 at 3:05 p.m. neither LVN 1 nor Assistant Director of Nursing (ADON) knew the number of staff assigned to monitor the dining room during mealtimes or could explain the facility's dining protocol. During a review of the facility's policy and procedure (P&P) titled Dining Room last revised October 2024, the P&P indicated the dietician, and/or the dietary supervisor will make scheduled daily meal rounds to every dining room at all mealtimes to assess whether adequate staff are available to assist with passing trays, meal set-up and feeding.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sample resident (Resident 24) was free from significant medication error when Resident 24 was given a psychotropic (any drug that affects brain activities associated with mental processes and behavior) medication called lorazepam (drugs that helps calm the brain and reduce symptoms of anxiety) without a physician's order. This failure had the potential to result in unnecessary use of psychotropic medication, placing Resident 24 at risk for adverse consequences such as impairment or decline in Resident 24's mental or physical condition. During a record review of Resident 24's admission Record (AR), dated 8/5/25, the AR indicated Resident 24 was admitted in the facility in August 2025 with diagnosis of schizoaffective disorder (a mental health condition characterized by a combination of schizophrenia symptoms like hallucinations and delusions and mood disorder symptoms like depression or mania) and anxiety disorders (a group of mental health conditions characterized by excessive worry, fear, or unease that can interfere with daily life. During a record review of Resident 24's Physician Order, dated 8/1/25, the Physician Order indicated an order for Lorazepam oral tablet two milligrams (mg, unit of volume) .Controlled drug.Give one tablet by mouth every four hours as needed for anxiety manifested by over concern with anything for 14 days. The Physician Order also indicated the order for lorazepam was created on 8/5/25, resulting in a four-day backdate (writing a date on document or record that is earlier than the actual date it was completed or signed).During a record review of Resident 24's Medication Administration Record (MAR) dated 8/1/25 to 8/30/25, the MAR indicated Resident 24 received the lorazepam on 8/2/25 at 5:30 a.m. and 8/3/25 at 5:00 a.m.During record review of Resident 24's Progress Notes with an effective date on 8/2/25 at 5:30 a.m. was created on 8/5/25 at 4:43 p.m., resulting in a 4-day backdate. The Progress Notes indicated the lorazepam was administered.During a concurrent interview and record review on 8/6/25 at 11:26 a.m. with Assistant Director of Nursing (ADON), Resident 24's order for lorazepam was reviewed. ADON stated on 8/1/25 around past 10:00 p.m., she received a verbal order from the physician authorizing the administration of lorazepam to Resident 24. ADON stated she could not recall why she did not enter the physician's order right away into Resident 24's record. ADON further stated they have 30 days to correct documentation including medication administration. ADON stated she informed the charge nurse on 8/1/25 that it was okay to administer lorazepam to Resident 24. ADON stated she believed the informed consent was also obtained by the physician prior to administering the lorazepam to Resident 24.During a phone interview on 8/6/25 at 3:44 p.m. with Resident 24's Responsible Party (RP) 3, RP 3 stated the facility did not contact him on 8/1/25 to obtain informed consent for the use of lorazepam for Resident 24. During a follow up interview and record review on 8/7/25 at 12:08 p.m. with ADON, Resident 24's medical records were reviewed. ADON stated she could not recall if she created a physician order sheet after she received the verbal order from the physician as part of their policy and procedure. ADON stated she did not find any documentation from the physician that indicated the rationale for Resident 24 to continue the as needed lorazepam. ADON stated there was also no documentation explaining why the lorazepam was given and what behaviors Resident 24 exhibited on 8/2/25 and 8/3/25. ADON stated late entry of physician's order had a risk of administering the wrong medication and may have had prevented the medications from being given on time.During a phone interview on 8/7/25 at 1:07 p.m. with Consultant Pharmacist (CP), CP stated any psychotropic medication including lorazepam could not be renewed or reordered verbally unless it was written and signed by the physician. CP stated only a pharmacist may receive verbal orders for controlled drugs from the physician, and only in emergency situations. CP stated psychotropic medications could not be renewed unless the physician had re-evaluated a resident to determine the need to continued use. CP further stated administering psychotropic medication to a resident without a physician's order could be considered a medication error and could have affected a resident's mental stability.During a (continued on next page)		

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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 08/08/2025
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone interview on 8/7/25 at 1:58 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 Resident 24 was readmitted on [DATE] and she noticed that the lorazepam was not included in Resident 24's medication order from the hospital. LVN 5 stated she informed ADON about it and both of them called the physician to obtain an order for lorazepam. LVN 5 stated she could not recall if lorazepam order was listed on the MAR when she administered it to Resident 24 on 8/2/25 and 8/3/25. LVN 5 stated based on the verbal order she received from ADON, she gave the lorazepam to Resident 24 even though the order did not reflect on the MAR. LVN 5 stated Resident 24 had ongoing behaviors of anxiety. LVN 5 stated she could not remember if she documented the reasons why she administered lorazepam to Resident 24 on 8/2/25 and 8/3/25. During a record review of the facility's policy and procedures (P&P), titled, Medication Administration, dated January 2023, the P&P indicated, Medications are administered as prescribed. Prior to administration, review and confirm medication orders for each individual resident on the MAR. Medications are administered in accordance with written orders from prescriber. During a record review of the facility's P&P, titled, Controlled Substance Medication Orders, dated January 2023, the P&P indicated, Before a controlled substance medication can be dispensed, the pharmacy must be in receipt of a clear, complete, valid prescription from a person lawfully authorized to prescribe them. The pharmacy can dispense a Schedule III-V (Schedules I-V are classification of controlled drugs based on their potential for abuse including lorazepam) controlled substance medication after a receipt of practitioner signed a valid Schedule III-V prescription (original, fax, or electronically prescribed). or the practitioner (or his agent) speaks directly to the pharmacist providing verbal authorized controlled substance prescription. Incomplete prescriptions and verbal order for controlled substances may not be edited or changed by the facility nursing staff.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection control and prevention measures when Certified Nursing Assistant (CNA) 1 provided direct resident care inside an Enhanced Barrier Precaution room without adequate Personal Protective Equipment (PPE). This failure had the potential to spread infections. Definitions: Enhanced Barrier Precaution (EBP, refers to the use of gown and gloves during high-contact care activities that provide opportunities for transfer of Multi-Drug-Resistant Organisms/ MDRO.) MDROs are microorganisms, usually bacteria, that have developed resistance to one or more classes of antimicrobial agents (antibiotics and antifungals) to staff hands and clothing. Personal Protective Equipment (PPE, refers to various types of protective clothing, gloves, face shields, goggles, face masks and other equipment designed to protect the wearer from injury or infection. During a review of Resident 67's admission Record (AR), the AR indicated Resident 67 was admitted to the facility in March 2025 with diagnoses that included urinary retention and sepsis. During a concurrent observation and interview on 8/5/25 at 10:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 67's room was an Enhanced Barrier Precaution (employs targeted gown and glove use during high contact resident care activities) room. There was a sign Contact Precaution (require the use of gown and gloves on every entry into a resident's room) posted on the door. LVN 2 stated she would go ask Director of Nursing DON why the posted sign indicated Contact Precaution instead of Enhanced Barrier Precaution. CNA 1 was inside the room, at Resident 67's bedside, providing care. During an interview on 8/5/25 at 10:27 a.m. with DON, DON stated the sign should indicate Enhanced Barrier Precaution, DON removed the sign Contact Precaution and posted Enhanced Barrier Precaution sign. During a concurrent observation and interview on 8/5/25 at 10:31 a.m. with CNA 1, CNA 1 came out of the room with a plastic bag of used disposable brief. CNA 1 stated she was in the room and changed Resident 67's briefs. CNA 1 did not wear any PPE except facemask and gloves. CNA 1 stated she did not wear a gown because Resident 67 had the tendency to grab CNA 1 during care. During a review of Resident 67's Order Summary Report (OSR) as of date 8/7/25, the OSR indicated a physician's order dated 3/19/25 for Contact Precaution (may cohort) related to ESBL. The OSR indicated Resident 67 had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine). During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precaution last revised December 2024, the P&P indicated that contact precautions apply when: A resident is infected or colonized with any MDRO, has a wound or indwelling medical device. The P&P indicated other references such as the CDC Implementation of Personal Protective Equipment in Nursing Homes to Prevent Spread of MDRO.		