STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555313	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Oakland	210 40th Street Way Oakland, CA 94611

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 52135 Based on interview and record review, the facility failed to protect one of five sampled residents (Resident 4) from physical abuse, when Resident 5, with a known of history of aggressive behavior, hit Resident 4 with a bed power cord (a thick electrical cord that connects the hospital bed with a power outlet). The failure resulted in Resident 4 suffering from a bleeding facial/scalp wound and received and hospitalization for further care. Findings: During a review of Resident 4's Admission Record (a document that records a patient's information when they are admitted to a hospital or other healthcare facility), printed on 2/6/25, the record indicated Resident 4 was admitted to the facility in November 2023 with vascular dementia (a loss of brain function, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior). During a review of Resident 4's Minimum Data Set (MDS, an assessment used to guide care), dated 9/5/24, the MDS indicated Resident 4's Brief Interview of Mental Status (BIMS, is a scoring system used to determine the resident ' s cognitive status) score of eight (8) out of 15, indicating Resident 4 was moderately cognitively impaired. During a review of Resident 5's Admission Record, printed on 2/6/25, the record indicated Resident 5 was admitted to the facility in November 2022 with diagnoses of unspecific dementia, unspecific psychosis (a mental health condition characterized by a loss of contact with reality that can cause significant distress and impairment in daily functioning) and anxiety (feeling of unease, worry, fear, and apprehension) During a review of Resident 5's MDS assessment, dated 10/5/24, the MDS indicated Resident 5's BIMS score was14 out of 15, indicating Resident 5 was cognitively intact. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/6/24 at 11:30 a.m. with MDS Coordinator (MDSC), Resident 4's Nursing Progress Notes, dated 9/24/24, were reviewed. Licensed Vocation Nurse (LVN) 4 documented, at 0015, [LVN] [heard] a shout from the room, help rushed in to see [Resident 4] bleeding profusely from the head .[Resident 5] hit [Resident 4] with bed control cord on her head .called 911 immediately, and she was transferred to [Acute care Hospital] by paramedic for further evaluation . MDSC stated Resident 4 did not come back to the facility after this hospitalization . During a concurrent interview and record review on 2/6/25 at 11:40 a.m. with MDSC, Resident 5's Nursing Progress Notes, dated 9/24/24 and Behavior Care Plans, dated 8/26/24, were reviewed. LVN 4 documented [Resident 5] hit [Resident 4] with her bed control cord on her head, to the face . MDSC stated Behavior Care Plan indicated Resident 5 is/has potential to be physically aggressive, threatening to hit roommate with a hanger, related to anger. The MDSC stated Resident 5 had a few room-changes in the past because of conflict with prior roommates. During an interview on 2/6/25 at 12:30 p.m. with Director of Nursing (DON), DON stated she was aware of the incident between Resident 4 and Resident 5. The DON stated the staff involved in the incident did not work at the facility anymore. The DON stated the involved staff told her, on 9/24/24 when they rushed to Resident 4 and 5's shared room, they saw Resident 5 was sitting on the floor, swinging the bed power cord in her hand, and Resident 4 was bleeding heavily. During a phone interview on 2/6/25 at 4:57 p.m. with LVN 4, LVN 4 stated she heard one of the staff members was shouting that Resident 4 was bleeding, and she rushed to Resident 4's room. LVN 4 stated Oh, my gosh, there was a lot of blood on [Resident 4's] face and head. LVN 4 stated she had to put pressure on Resident 4's head to stop the bleeding and called 911 for further care. During a review of the facility's policy and procedure (P&P) titled Abuse-Prevention, Screening, and Training Program, revised 7/2018, the P&P indicated the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment and develops facility policies, procedures, training programs, and screening and prevention system to promote an environment free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 52233 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 2 did not have access to facility residents and their personal care, after one of five sampled residents (Resident 3) alleged that CNA 2 hit him. CNA 2 continued to provide care to Resident 3 and at least 18 other residents for 12 more hours after the allegation was made. This failure placed Resident 3 and other residents at the facility at risk for abuse and further complications. Findings: During a record review of Resident 3's undated Admission Record (a document with patient's basic personal information), the record indicated Resident 3 was admitted to the facility in April 2022. During a review of Resident 3's Minimum Data Set (MDS, an assessment tool used to guide care), dated 10/11/24, showed Resident 3's short-term memory was intact. A record review of Resident 3's Nursing Progress Notes, dated 9/14/24, the notes indicated Licensed Vocational Nurse (LVN) 3 documented, on 9/14/24 around 7:30 pm resident called 911. Paramedic is here to [check] him. Resident stated he is physically hurt by CNA [with CNA 2's full name] .they recommended to us to keep monitoring him . During a concurrent phone interview and record review with Director of Nursing (DON) on 2/7/25 at 4:10 p.m. , the facility's documents titled Nursing Staffing Assignment and Sign- in Sheet, dated 9/14/25, were reviewed. The DON stated the Sign- In Sheet indicated CNA 2 worked Shift 2 and Shift 3. The Sign- in Sheet indicated CNA 2 started working on 9/14/24 at 3:40 p.m. and did not leave the facility until 7:37 a.m. on 9/15/24. The DON stated she was under the impression that CNA 2 was sent home after Resident 3 made an allegation of abuse against CNA 2 but was unable to state why Sign-in Sheet indicated that CNA 2 continued to work for 12 more hours in the resident care areas even after the abuse allegation was still under investigation. During a phone interview on 2/7/25 at 8:45 a.m. with CNA 2, he stated he recalled Resident 3 becoming upset at him, and then police came to the facility on the evening of 9/14/24. CNA 2 stated police talked to him about Resident 3. CNA 3 stated however, nobody, including facility staff told him that Resident 3 had alleged that he had abused Resident 3. CNA 3 stated he did not hit Resident 3, but he kept his distance from Resident 3 after the police left the facility and continued working for rest of the evening and night shift, until the morning of 9/15/24. CNA 3 stated he continued to provide care to all his assigned residents. During a phone interview on 2/7/25 at 12:42 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was the nurse assigned to Resident 3 on 9/14/24. LVN 3 stated she had started one week prior to incident. LVN 3 stated Resident 3 alleged CNA 2 kicked him, but it was an unwitnessed event. LVN 3 stated Resident 3 called the police by himself. LVN 3 stated she interviewed CNA 2, he denied the allegation and indicated nothing happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone Interview with LVN 3 on 2/7/25 at 1:46 p.m. LVN 3 stated she was not aware of the incident until the police arrived at the building. LVN 3 stated she was not sure if CNA 2 was removed from resident care areas and or sent home. During a phone interview on 2/11/25 at 1:39 p.m. with DON, DON stated CNA 2 provided direct personal care to at least 11-12 residents during evening shift and up to 18 residents during the night shift on 9/14/24. DON stated CNA 2 worked for at least 12 more hours after Resident 3 had alleged that CNA 2 hit him around 7:30 p.m. on 9/14/24. During a review of facility's Policy and Procedure (P&P) titled Abuse & Neglect- Reporting and Investigations, dated 1/1/24, the P&P indicated, 2. Immediate Action a. The Administrator or designated representative will provide for a safe environment for the resident as indicated by the situation . ii. If the suspected perpetrator is an employee, remove the employee immediately from the care of the resident (s) and immediately suspend the employee pending the outcome of the investigation in accordance with facility policies.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51692 Based on observation, interview and record review, the facility failed to assist one of five sampled residents (Resident 1) to push the wheelchair safely, while she was sitting in her unlocked wheelchair, sliding down the slope of the ramp (ramp is a slope or an incline, a surface that tilts from one level to another) to enter the smoking patio on the left side of the facility. This failure resulted in Resident 1 falling out of wheelchair facing downwards, sustaining a contusion (bruise caused by direct blow to the body that can cause damage to the surface of the skin and to deeper tissues as well) of nose, closed fracture (broken bone) of nasal bone and feeling embarrassed. Findings: During a record review of Resident 1's Admission Record (record with residents' basic personal information), the record indicated Resident 1 was admitted to the facility in January 2023. A review of Resident 1's Minimum Data Set (MDS, an assessment used to guide care), dated 11/19/24, indicated Resident 1 was usually able to make herself understood and was usually able to understand others. The MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 11 out of 15, indicated moderately cognitive (mental) impairment. The assessment indicated Resident 1 used Manual wheelchair for mobility. The assessment also indicated Resident 1 had diagnoses of cervical spinal stenosis (space in back bone in the neck area becomes small pressing the nerves going through the spinal cord), gout (a painful form of inflammation of joints), bilateral osteoarthritis (when tissues in the joint break down) of knees and left shoulder. During a record review of Resident 1's untitled Care Plan, dated 11/28/23, the care plan indicated Resident 1 had impaired physical mobility, she was at risk for decline in Activities of Daily Living (ADLs) and functional mobility. The Care plan indicated to assist Resident 1 in performing movements/tasks and monitor for environmental barriers to mobility. Review of an untitled care plan, dated 12/11/24, indicated Resident 1 had decreased functional mobility with wheelchair, had poor seating and positioning and there was a need for assistance with personal care. During a concurrent observation and interview on 2/6/25 at 10:38 a.m. with Director of Environment (DOE), facility's smoking patio area on the left side of building was observed. There was a ramp on the left side of the facility guarded by a gate going into smoking area. The ramp was made of brown plastic board slacks, and the first two slacks were uneven with cracks in the cement. The ramp had twelve pieces of black nonskid straps spaced out and taped on it. The DOE stated the first two boards created a divot (small hole) and became uneven at times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/25 at 10:48 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had previous falls in the past and was at high risk for falls. LVN 1 stated Resident 1 was a smoker, and she was the charge nurse for Resident 1 on 12/13/24. LVN 1 stated on 12/13/24 around 10:00 a.m., Resident 1 was going outside to smoke with a Certified Nurse Assistant (CNA 1). LVN 1 stated Resident 1 slipped and fell on her left side and succumbed an injury to nose and left arm. LVN 1 stated after injury Resident 1 was alert and responsive but was bleeding heavily from nose. LVN 1 stated 911 was called, Resident 1 went to the emergency room and returned the same day in the evening. During an interview on 2/6/25 at 10:55 a.m. LVN 1 stated she recalled that on 12/13/24, CNA 1 tried to wheel two residents (Resident 1 and Resident 2) at the same time. LVN 1 stated it was not safe for one staff member to push two wheelchair bound residents at the same time because staff needed two hands to push one wheelchair safely. During an observation and interview on 2/6/25 at 11:26 a.m. Resident 1 was sitting upright in a wheelchair in Activity Room. Resident 1 stated staff usually wheeled her whenever she needed to go through the ramp to go the smoking area; Resident 1 stated on 12/13/24, she was under the impression that CNA 1 was pushing and controlling her wheelchair from the behind, but she was unaware CNA 1 was pushing Resident 2's wheelchair at that time. Resident 1 stated she went down the ramp too fast and fell out of wheelchair. Resident 1 stated she felt embarrassed after falling out of wheelchair as that had never happened before. Resident 1 stated she was bleeding from nose and was taken to the emergency room after the fall. During an interview on 2/6/25 at 12:08 p.m. Director of Nursing (DON) stated facility had designated staff monitoring the smoking residents all the time. The DON stated, on 12/13/24 CNA 1 was the assigned staff to monitor the smoking area at the time of incident. The DON stated CNA 1 was behind Resident 1 but was pushing Resident 2 down the ramp. The DON stated Resident 1 fell down ramp and out of wheelchair. The DON stated the incident was avoidable, if CNA 1 communicated with Resident 1 that she was not pushing Resident 1 wheelchair at the time, she was pushing Resident 2. The DON stated facility installed twelve pieces of black reflector nonskid tape on the ramp after Resident 1's fall. The DON also stated CNA 1 did not work at the facility anymore. During an interview on 2/6/25 at 12:25 p.m. Resident 2 stated she remembered the incident when Resident 1 fell out of wheelchair on 12/13/24. Resident 2 stated she was in her wheelchair, behind Resident 1 when they were going down the slope of the ramp, to the smoking area. Resident 2 stated she witnessed Resident 1 wheeled herself, without any assistance from the staff, fell out of her wheelchair, got bloody nose and was taken by ambulance. During a review of Resident 1's Nursing Progress Notes, dated 12/13/24, the notes indicated [Resident 1] fell outside of the building from the wheelchair when going out for smoke at 11:30 am, fell on the cemented floor and she was bleeding the left side of the nose. Per [staff] she fell on her left arm. Kept resident flat on the floor with sheet underneath and covered with blanket, gave pressure on the left nose with gauge. Applied ice top of the nose. 911 called [a way to get immediate help from ambulance service] .sent out to [Acute Care Hospital- ACH]. During a review of Resident 1's After Visit Summary (AVS) from the post fall hospitalization at ACH, dated 12/13/24, the AVS indicated Resident 1 sustained contusion of nose and closed fracture of nasal bone.