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	06/12/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 1 and Resident 2) and/or their individual Resident Representatives (RRs) were notified of the mixed gender room arrangement when male resident, Resident 1's unexpected return to facility following less than a 24-hour hospitalization stay, was placed together in a room with newly admitted female resident (Resident 2). This failure resulted in Resident 1 and Resident 2's inappropriate room accommodation, roomed in with the person not of their choice, and without individual consent or advanced written notifications in place.A review of Resident 1's Face Sheet, printed on 6/11/26, indicated Resident 1 was admitted to the facility in 2025 with multiple diagnoses that included Diabetes Mellitus (a long-term [chronic] disease in which the body cannot regulate the amount of sugar in the blood), bipolar disorder (a mental condition in which a person has wide or extreme swings in their mood. Periods of feeling sad and depressed may alternate with periods of intense excitement and activity or being cross or irritable), and schizophrenia (a mental condition which makes it difficult to think clearly, have normal emotional responses, act normally in social situations, and tell the difference between what is real and what is not real). A review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 4/17/26, indicated Resident 1 had a Brief Interview of Mental Status (BIMS, an assessment tool for a resident's orientation to time, and capacity to remember. The BIMS score ranges from 0-15, with 15 as an indication of intact skills) score of 8, a moderately impaired cognition. A review of Resident 2's Face Sheet, printed on 6/11/26, indicated Resident 2 was admitted to the facility on [DATE], with multiple diagnoses that included metabolic encephalopathy (a brain dysfunction which can affect one's mood, thinking, and memory caused by an underlying condition) and muscle weakness. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had impairment on both lower extremities (hip, knee, ankle, and foot) and was bedbound. A review of the Facility Census, dated Tuesday, June 2, 2026, indicated Resident 2 (a female resident) was admitted on [DATE], at 6:10 p.m. in A bed, to a room already designated for a male resident (Resident 1) in B bed, who was on bed hold as of 6/2/26. A review of the Facility Census, dated Wednesday, June 3, 2026, indicated Resident 1 was readmitted on [DATE], at 3:20 a.m. in B bed, with female resident, Resident 2 in A bed. A review of Resident 1's Progress Notes, dated 6/3/26, at 3:15 a.m., indicated Resident 1 was readmitted to the facility following return from the hospital on 6/3/26 around 3:20 a.m. Progress Notes further indicated Resident 1 was placed in a room and the curtains were drawn to maintain privacy between the two residents. The Progress Notes, however, did not indicate that male resident, Resident 1 was placed in the resident room's A bed, with B bed already occupied by female resident, Resident 2. During an interview on 6/11/26, at 1:11 a.m., with the Administrator (ADM), ADM stated resident admission room assignments were generally the responsibility of either Admissions Department, Department Managers, or nursing staff on the floor but normally fell under the ADM for the overall decision making. During a follow-up interview on 6/11/26, at 3:13 p.m., with the ADM, ADM stated both Resident 1 and Resident 2 did not have the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	capacity to make medical decisions and no informed consents were requested from or approved by each residents' RRs. ADM stated neither Resident 1 nor Resident 2, nor the residents' RRs were notified of the mixed gender room arrangement. During a telephone interview on 6/11/25, at 3:56 p.m., with Resident 1's RR (RR 1), RR 1 stated she was not aware Resident 1, after being transferred and returned from the hospital to the facility in less than 24 hours, was placed in a newly assigned room with a newly admitted female resident (Resident 2). RR 1 stated she was shocked and disappointed and was unaware of the facility's anomaly (something that deviates from the normal or expected standard). RR 1 stated had she been notified by the facility in a timely manner, RR 1 would have requested Resident 1's immediate transfer to a different room with strictly male only residents. During an interview on 6/12/25, at 12:10 p.m., with the Director of Nursing (DON), DON claimed responsibility for Resident 1 and Resident 2's inappropriate mixed-gender room accommodation. DON stated the room changes were necessary, however, the decisions on resident room designations were not addressed appropriately. A review of the facility's policy and procedure (P&P) titled, Room or Roommate Change, dated 6/9/26, indicated, .Purpose: To enable residents to exercise their right to change rooms or roommates. A review of the facility's P&P titled, Resident Rights, 1/1/12, indicated, To promote and protect the rights of all resident at the facility.Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.The resident is encouraged to make choices about aspects of his or her life in the Facility including: A. Rooming with the person of his or her choice, providing both individuals consent to the choice.

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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. Based on interview and record review, for one of eleven sampled residents (Resident 1), the facility did not provide Resident 1 and Resident Representative 1 (RR 1) a written seven (7) day Bed Hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave [absences for purposes other than required hospitalization] or hospitalization) Agreement when Resident 1 was transferred to the hospital and sent back to the facility the same day, in less than 24 hours. This failure resulted in Resident 1 and/or RR1 not having a written notification of the facility's Bed Hold Agreement prior to hospitalization and led Resident 1 not to be able to return to his previous room following an unexpected less than 24-hour stay at the hospital.A review of Resident 1's Face Sheet, printed on 6/11/26, indicated Resident 1 was admitted to the facility in 2025. A review of Resident 1's Order Summary, dated 6/2/26, indicated transfer resident to hospital for nasogastric (NG, a flexible tube passed through the nose, down the esophagus, and into the stomach for feeding and medication administration) tube placement due to failure to thrive (a syndrome of global physical, cognitive, and functional decline characterized by unexplained weight loss, poor nutrition, decreased appetite, inactivity, and social isolation). Order Summary further indicated, Bed hold for 7 days if admitted . During an interview on 6/11/26, at 12:05 p.m., with Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their residents) Member 1 (IDT M1), IDT M1 stated it was the facility's policy that all residents and/or RRs signed a written 7-day Bed Hold Agreement upon admission and before every resident therapeutic leave or hospitalization. During a telephone interview on 6/11/25, at 3:56 p.m., with Resident 1's RR, RR 1 stated she was not aware of the 7-day bed hold but aware that the facility had to keep a bed and not refuse to take Resident 1 back. RR 1 confirmed she did not receive a written 7-day Bed Hold Agreement before Resident 1 was transferred to the hospital on 6/2/26. During a concurrent interview and record review on 6/12/26, at 9:30 a.m., with Medical Records (MR), MR presented Resident 1's admission 7-day Bed Hold Agreement, dated 10/9/25, but was unable to provide Resident 1's Bed Hold Agreement from Resident 1's recent transfer to the hospital on 6/2/26. MR stated DON confirmed with MR there was no written Bed Hold Agreement provided to Resident 1 and/or to RR 1 before the transfer to hospital took place on 6/2/26. A review of the facility's policy and procedure (P&P) titled, Bed Hold, revised on July 2017, indicated, To ensure that the resident and/or his/her representative is aware of the Facility's bed-hold policy, and that such policy complies with state and federal law regulations.Transfer to an Acute Care Hospital/Therapeutic Leave: A. the facility notifies the resident and/or representative, in writing, of the bed hold, option, any time the resident is transferred to an acute care hospital or request therapeutic leave.C. When the resident or his/her representative provides notice within 24 hours of transfer that the resident elects his/her right to hold the bed, the Facility keeps that bed available for seven (7) days.Bed Hold Agreement will be kept in the resident's medical record. The completed form will remain in the medical record with a copy placed in the resident's financial folder in the Business Office.

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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:1. For three of three sampled residents (Resident 9, Resident 10, and Resident 11) the facility failed to ensure accurate representations of change in condition (COC, any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual) had documented entries that were signed by licensed nurses (LNs) in real time. 2. The facility failed to provide complete, accurate, and prompt recordings of clinical services and documentation on Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their residents) Meeting Notes as the events of clinical discussion occurred in real time during IDT meetings. These failures resulted in incomplete and inaccurate reflections of the medical care and services provided to each residents' actual date and time of COCs, as well as IDT notes and recommendations.1. A review of Resident 9's Face Sheet, printed on 6/12/26, indicated Resident 9 was admitted to the facility in 2026 with multiple diagnoses that included dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) with agitation and metabolic encephalopathy (a brain dysfunction which can affect one's mood, thinking, and memory caused by an underlying condition). A review of Resident 9's medical record titled, Change in Condition Evaluation, indicated, Effective Date: 5/20/2026 21:27, showed, Resident 9 noted with agitation, irritability, and impulsive behavior. Noted to continue with loud vocalizations and calling out behaviors unresolved with current medication regimen. Nurse Practitioner 1 (NP 1) assessed resident today and provided new orders. COC Evaluation indicated Resident 9's Resident Representative (RR 9, whose name was not listed as one of Resident 9's contacts) was notified on 5/20/26, at 12 midnight. Resident 9's medical record further indicated the COC Evaluation was electronically signed (e-signed) by the Director of Nursing (DON) on 5/21/26. A review of Resident 10's Face Sheet, printed on 6/12/26, indicated Resident 10 was admitted to the facility in 2026 with multiple diagnoses that included schizophrenia (a mental condition which makes it difficult to think clearly, have normal emotional responses, act normally in social situations, and tell the difference between what is real and what is not real), major depressive disorder (a serious mental health condition characterized by persistent low mood and loss of interest in activities), and quadriplegia (paralysis of both upper and lower extremities). A review of Resident 10's medical record titled, COC Evaluation, indicated, Effective Date: 5/20/2026 20:52, showed, Resident 10 noted to have itchy, flaky skin noted on scalp with dandruff. NP 1 assessed Resident 10 today.New orders in place. The COC Evaluation indicated Resident 10 was responsible for himself and aware of the situation on 5/20/26, at 12 midnight. Resident 10's medical record further indicated the COC Evaluation was e-signed by the DON on 5/21/26. A review of Resident 11's Face Sheet, printed on 6/12/26, indicated Resident 11 was admitted to the facility in 2026 with multiple diagnoses that included metabolic encephalopathy, dementia, major depressive disorder, and post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life threatening, or deeply shocking event). A review of Resident 11's medical record titled, COC Evaluation, indicated, Effective Date: 5/20/2026 19:56, showed, Resident 11 continues to experience nightmares and sleep disturbances. The COC Evaluation indicated Resident 11's RR, RR 11 was notified on 5/20/26, at 7p.m. Resident 11's medical record further indicated the COC Evaluation was e-signed by Registered Nurse 2 (RN 2) on 5/21/26. During an interview on 6/12/26, at 11 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated COCs were created by assigned LNs on the floor, when resident COC occurred. LVN 2 stated best practice on resident documentation/charting was to create an electronic COC, saved, then locked in real time. LVN 2 stated saved and unlocked electronic records (e-Record, any information captured, created, or stored in a digital format) can always be unlocked for editing by another person. LVN 2 stated Director of Nursing (DON) had instructed LNs to keep e-Records (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlocked so DON can edit the e-Records as needed. During an interview on 6/12/26, at 11:25 a.m., with LVN 1, LVN 1 stated DON had instructed the LNs not to lock the e-Records so that DON can check documentation of resident COCs were completed according to DON's standards. During an interview on 6/12/26, at 12:10 p.m., with DON, DON stated saving and signing COC documentation was what was required of the LNs unless the LNs needed education in real time. DON emphasized that a few of the facility's LNs were new graduates who currently needed guidance and education on situations so that documentations were not locked to ensure resident COCs were completed thoroughly. DON stated entries should be recorded promptly as the events of observation occur. A review of the facility's policy and procedure (P&P) titled Change of Condition, revised date 11/18/21, indicated, .The Facility will ensure Residents, family, legal representatives and physicians are informed of changes in the resident's condition in a timely manner.Documentation.Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and subsequent assessment in the Resident's chart.vi. Complete an incident report. 2. During an interview on 6/11/26, at 12:05 p.m., with the IDT M1, IDT M1 stated LNs on the floor documented the resident COCs and were overlooked by the IDT. IDT M1 stated COCs should be completed upon review by the IDT, however IDT M1 was unsure whether the COCs had been closed or locked before the IDT meetings took place. During an interview on 6/12/26, at 11:25 a.m., with the Infection Preventionist (IP), IP stated the IDT Members included LNs, IP, Minimum Data Set Coordinator (MDSC), Director of Staff Development (DSD), Case Manager (CM), Social Services Director (SSD), Director of Rehabilitation (DOR), Activity Director, Dietary Manager (DM), Registered Dietitian (RD), and Administrator (ADM). IP stated the DON documented on IDT Notes and the members signed a paper copy for attending the IDT meeting. During an interview on 6/12/26, at 1:45 p.m., with IDT M2, IDT M2 stated DON had LNs left resident COCs open and unlocked until DON had reviewed the COCs. IDT M2 stated DON routinely edited the COCs. IDT M2 further stated DON also did the IDT notes and had IDT members sign the IDT Notes and made it look like the members were present at the time of creation. During an interview on 6/12/26, at 2:15 p.m., with IDT M4, IDT M4 stated resident COCs were discussed during IDT meetings and at a separate time, the DON entered notes and recommendations and added the names of the IDT members, as if the team members were present during the time of creation. IDT M4 stated the IDT members signed their names on paper before the IDT Notes were completed. A review of the facility's P&P titled Completion & Correction, revised date 1/1/12, indicated, .To ensure that medical records are complete and accurate.The facility will work to complete and correct medical records in a standardized manner to provide the highest quality in accuracy in documentation.II. Entries will be recorded promptly as the events of observation occur. III. Entries will be complete, legible, descriptive and accurate. IV. Any person(s) making observations or rendering direct services to the resident will document in the record. V. Entries should be written in chronological sequence. If it is necessary to chart out of sequence during the appropriate date and time will be entered. A. When adding an entry at a later date, the entry is to be clearly identified as a late entry.XII. Documentation Content: XIII. No portion of the record is to be obliterated, erased, or destroyed. A. If an error needs to be corrected, draw one line through the entry, designate the entry as an error and initial next to the change. XIV. Facility staff may not sign or another person.XVII. An addendum provides additional information to address a specific situation or incident and should include the following: A. The current date and time B. Designate the information as addendum and state the reason for the addendum referring back to the original entry. XVIII. Clarification is a type of entry used to clarify a previous entry to avoid incorrect interpretation of information that has been previously documented and should include the following: A. The current date and time B. Designate the information as clarification and state the reason for the clarification referring back to the original entry.XIX. Computerized Records: A. Correcting an error in an electronic/computerized medical record system follows the same principles as correcting a paper record. B. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a Compliance and Ethics Program. Based on interview and record review the facility failed to maintain their compliance and ethics program when the facility did not promote honest and ethical behavior in all work-related activities. This failure resulted in false medical records and reports and placed the residents in the facility at risk of receiving unsafe care. 1. A review of the facility census, dated 6/2/26, indicated a mixed gender room arrangement between a male resident, Resident 1 who at this time was transferred to the hospital for a medical procedure and a female resident, Resident 2, newly admitted to the facility on this day, at 6:20 p.m. A review of the facility census, dated 6/3/26, indicated Resident 1 returned from the hospital at 3:20 a.m., and was placed in B bed, while Resident 2's A bed now showed as vacant when Resident 2 moved to an all-female room with two other female residents. The census manipulation reflected an attempt to obscure the overnight mixed gender room situation. A review of Resident 1's Progress Notes, dated 6/3/26, at 3:15 a.m., indicated curtains were drawn to maintain privacy between Resident 1 and Resident 2. From 3:20 a.m., up until the time Resident 1 and Resident 2 were both relocated to different rooms sometime during the day shift (7 a.m., -3:30 p.m.), the two residents, male Resident 1 in B bed and female Resident 2 in A bed, slept through the remainder of the NOC shift (11 p.m.-7:30 a.m.) in the same room simultaneously. During an interview on 6/11/26, at 1:03 p.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated CNA 2 was assigned to care for Resident 1 and Resident 2 who occupied the same room during the evening shift (3 p.m.-11:30 p.m.) on 6/2/26. CNA 2 stated it was a complicated resident room arrangement. During a telephone interview on 6/11/26, at 1:20 p.m., with CNA 1, CNA 1 stated CNA 1 provided care to Resident 1 and Resident 2 who occupied the same room during the NOC shift until 7:30 a.m. on 6/3/26. CNA 2 stated it was an abnormal resident room arrangement. 2. During a concurrent interview and record review on 6/11/26, at 12:37 p.m., with Registered Nurse Supervisor 1 (RNS 1), Resident 1's medical records were incomplete. RNS 1 stated it was practiced that charge nurses took care of the written 7-day bed hold notice during resident transfers to hospital, however, there was no 7-day Bed Hold Notice found for Resident 1. RNS 1 was also unable to present Resident 1's Room Change Notification from Resident 1's previous room to a new room designation upon return from the hospital in less than 24 hours on 6/3/26. RNS 1 only presented Resident 1's Room Change Notification from 6/4/26, after a second change of room relocation took place since Resident 1 returned from the hospital. 3. During random reviews of Resident Change of Conditions (COC, any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual), Resident 9, Resident 10, and Resident 11's COCs indicated resident COCs were created by the licensed nurses (LNs) on 5/20/26 in real time. Resident 9, Resident 10, and Resident 11's COCs also indicated signed by the Director of Nursing (DON) on 5/21/26. During in-person random interviews, on 6/11/26 to 6/12/26, with Licensed Vocational Nurses (LVN), both LVN 1 and LVN 2 confirmed DON had instructed the LNs to leave electronic records (e-Record, any information captured, created, or stored in a digital format) saved but unlocked so DON can edit the e-Records as needed and complete resident COCs according to DON's standards. 4. During in-person random interviews, on 6/12/26, with Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their residents) members (IDT M), both IDT M2 and IDT M4 stated resident COCs were discussed during IDT meetings and DON routinely edited the COCs. IDT M2 and IDT M4 also stated DON entered notes and recommendations and added the names of the IDT members, and made it look like the members were present at the time of creation. During an interview on 6/11/26, at 1:11p.m., with the Administrator (ADM), ADM stated there was no documentation of Resident 1's room changes on 6/3/26 and 6/4/26, there was no room change notification on 6/3/26, only on 6/4/26. ADM also stated Resident 1 and Resident 2's mixed room management was not normal practice, but ADM had to accommodate all parties involved. ADM confirmed that overall decision-making regarding welfare of the residents and the facility was ADM's responsibility. During (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview and record review on 6/12/26, at 12:10 p.m., with the DON, Resident Census from 6/2/26-6/4/26 revealed multiple room changes for multiple residents who had been in the facility. The Resident Census, dated 6/2/26, indicated Resident 2's admission, with two male residents switched rooms. Resident Census, dated 6/3/26, indicated Resident 1's readmission and four female residents room changes. Resident Census, dated 6/4/26, indicated three admissions and three male resident room changes. DON stated the multiple room changes that took place from 6/2/26 to 6/4/26 were necessary to meet the residents and facility needs. During follow-up interview on 6/12/26, at 12:20 p.m., with DON, DON emphasized that few of the facility's LNs were new graduates who currently needed guidance and education on incidents so that documentations were not locked to ensure resident COCs were completed thoroughly after DON's review. A review of the facility's policy and procedure (P&P) titled Compliance Plan and Program, undated, indicated, .The facility is committed to prevention, detection and to take all appropriate action to assure compliance with all legal requirements and to promote honest and ethical behavior in all work-related activities.to ensure that quality patient care is provided. in a manner that fully complies with all applicable state and federal laws and regulations.(1) all employees are educated about the applicable laws and trained in matters of compliance, (2) there is periodic auditing, monitoring, and oversight of compliance with those laws, (3) there exists an atmosphere that encourages and enables the reporting of noncompliance without fear of retribution or retaliation, (4) responsibility is not delegated to persons with a propensity to act in a non-compliant manner, and (5) mechanisms exist to investigate, discipline and correct non-compliance. Supervisors and administrators are expected to report issues of suspected non-compliance issues through established management channels. The facility's Administrator/Executive Director shall serve as the facilities own Corporate Compliance Officer to implement and oversee the compliance program responsibilities specific to the facility.The facility's Corporate Compliance Officer shall be responsible for the day-to-day oversight of compliance efforts at the facility.