

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Alameda Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2070 Clinton Ave Alameda, CA 94501	

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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect one of three sampled residents, (Resident 1), from physical and emotional abuse when Resident 2 punched Resident 1 in the face twice with his fist and put him in a choke hold. This failure resulted in Resident 1 having a contusion (an area of skin discoloration caused by broken blood vessels under the skin, which happens when soft tissue is damaged by an impact), on Resident 1's face requiring transfer to an acute care hospital. Resident 1 stated he was fearful of Resident 2 and did not feel safe at the facility. During a review of Resident 1's admission Record, printed on 11/25/25, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of anxiety (excessive worry, racing thoughts and feeling of impending danger that is uncontrollable and interferes with daily life) and 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). During 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 10/23/25, Section B indicated Resident 1 was able to make himself understood usually and was usually able to understand others. During a concurrent observation and interview on 11/25/25 at 11:25 a.m. with Resident 1, in the dining room, Resident 1 was sitting in his wheelchair at a table having lunch. Resident 1 stated he remembered Resident 2 coming up to him, hitting him in the face and choking him. Resident 1 stated he was surprised at the time. Resident 1 stated the incident scared him and he did not feel safe at the facility. During a review of Resident 2's admission Record, printed on 11/25/25, the record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of cognitive communication deficit, (communication difficulty resulting from changes in attention, memory or problem-solving), and dementia with psychotic disturbance, (condition that involves a loss of contact with reality, and disorganized thinking or speech). During a review of Resident 2's MDS assessment, dated 10/7/25, Section C, (Cognitive Patterns), the assessment indicated Resident 2's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) was 13 out of 15 indicating intact cognitive status. During a review of Resident 2's Care Plan (CP), printed on 11/17/25, the CP indicated Resident 2 had four separate instances of aggressive behavior on 3/2/25, 5/10/25, 10/23/25 and 11/13/25 where he had altercations towards other residents. During a concurrent observation and interview on 11/25/25 at 2:00 p.m. with Resident 2 while walking in the hallway, Resident 2 denied having an altercation with anyone at the facility. During an interview on 11/25/25 at 11:10 a.m. with Restorative Nurse Aide (RNA) 1, RNA1 stated on 11/13/25 she saw Resident 2 get up from his seat and abruptly turned to Resident 1. RNA 1 stated she saw Resident 2 punch Resident 1 in the face and wrap Resident 2's arm around Resident 1's neck as if to choke Resident 1. RNA 1 stated Resident 2 punched Resident 1 in the face again. During a telephone interview on 11/26/25 at 9:51 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated he was assigned to Resident 2 on 11/13/25 as a sitter, (a nonclinical caregiver who provides continuous one-on-one observation and support for facility residents needing close monitoring, focusing on preventing falls, self-harm or confusion while also offering basic comfort and companionship). CNA 1 stated Resident 2 got up from the chair and moved toward the exit of the dining room. CNA 1 stated Resident 2 suddenly turned and went to Resident 1, and hit Resident 1, Resident 2 put Resident 2's arm around Resident 1's neck and hit Resident 1 again. CNA 1 stated Resident 2's behavior can change from calm to aggressive without warning. During a telephone interview on 12/3/25 at 11:35 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she assessed Resident 1 immediately after the incident on 11/13/25. LVN 1 stated Resident 1 complained of pain to the left side of Resident 1's face. LVN 1 stated she also noted slight bleeding from the front upper gum. LVN 1 stated she did not observe a contusion at that time. During a review of Resident 1's Nurses Notes, dated 11/13/25, the notes indicated LVN 1 documented around 10:50 a.m., she was called to assess Resident 1. [Resident 1] noted with bleeding on front gum . [complaint of] 10/10 pain on his [left] face. PRN [as needed] Tylenol administered . [applied] cold pack to face . 911 was called . per doctor's order for further evaluation to acute hospital . [Resident 1] left the facility at 12:15 p.m. During a review of Resident 1's Emergency Department Provider's Notes from Acute Care Hospital, dated 11/13/25, the notes indicated Resident 1 status post assault at skilled nursing facility and sustained a contusion to his face. During a record review of</p>		