

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Redwood Healthcare Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3145 High Street Oakland, CA 94619	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to ensure fall risk care plan interventions were implemented for two out of two sampled residents (Residents 1 and 2) who were at risk for falls, when their call lights were not within reach. This deficient practice had the potential to result in falls, injury, and harm to the residents. 1. A review of Resident 1's admission record, undated, indicated Resident 1 had diagnoses that included compression fracture of the vertebra (a break in a vertebra - a bone in the spine, which may be caused by a fall or accident), and repeated falls. During an observation on 3/16/26 at 11:55 a.m. in Resident 1's room, Resident 1 was observed from the hallway. Resident 1 stood up from her bed, grabbed her walker, held onto it, and went to the bathroom unassisted. Resident 1 appeared unsteady on her feet. During concurrent observation and interview on 3/16/26 at 12:03 p.m. in Resident 1's room, Certified Nursing Assistant (CNA) 1 stated Resident 1 needed staff assistance to the bathroom as she was at risk of falling. She stated sometimes Resident 1 was steady and sometimes she was not. CNA 1 stated CNA 2 was Resident 1's assigned CNA was on lunch break and would be back soon. CNA 1 stated she would go and assist Resident 1. CNA 1 assisted Resident 1 back to her bed. Resident 1 was now lying in bed, alert. CNA 1 stated Resident 1 was hard of hearing. Resident 1 stated she could hear better in her left ear. CNA 1 then spoke to her in her left ear. CNA 1 stated Resident 1 was supposed to call for assistance. When asked for her call light, Resident did not understand or hear well. CNA searched for Resident 1's call light and she found Resident 1's call light on the floor somewhere behind Resident 1's nightstand. The nightstand was not very close to Resident 1's bed. CNA 1 then pinned the call light to Resident 1's bed, showed it to her and instructed her how to use it, then Resident 1 pressed the call light button. During an interview on 3/16/26 at 12:40 p.m. with CNA 1, CNA 1 stated the call light should be attached, snapped on the pillow or bed, or blanket where the residents can reach it. During an interview on 3/16/26 at 1:55 p.m. with CNA 1, CNA 1 stated the call light should be next to the residents because it is a means of communication to call staff. A review of Resident 1's care plan initiated 2/1/26 indicated, Risk for falls, fall related injury secondary to Gait/bal (balance), cognitive problem, unaware of safety. with interventions including, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 2. A review of Resident 2's admission record, undated, indicated Resident 2 had diagnoses that include seizures, and benign prostatic hyperplasia (a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer) with lower urinary tract symptoms. During a concurrent observation and interview on 3/16/26 at 12:20 p.m. in Resident 2's room, Resident 2 was lying on his bed, sleeping. CNA 3 stated Resident 2 is a fall risk and he had a weak right side. When asked, CNA 2 stated Resident 2 had not called today. When asked about Resident 2's call light, CNA 3 looked around for it and found it on the floor, picked it up, and attached it to Resident 2's pillow. CNA 3 stated the call light was not supposed to be on the floor. She stated the call light needs to be reachable by the resident so that he can call if he needs anything. When asked, CNA 3 stated in her last round, she did not check if Resident 2's call light was within reach. CNA 3 stated the call light should be attached, snapped in the pillow or bed, blanket where they can reach it. During an interview on 3/16/26 at 2:18 p.m. with CNA 3, CNA 3 stated it is important to have the call light within residents' reach in case (continued on next page)</p>

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>they need help.for safety, to prevent falls or accidents.During a review of Resident 2's progress note (PN) dated 2/18/26, the PN indicated Resident 2 had an unwitnessed fall in his room. The PN indicated, reason for fall: resident was self-transferring from bed to his wheelchair.During a review of Resident 2's care plan dated and initiated on 2/18/26 it indicated: Risk for injury: Fall occurred. Goal - Resident will be free of further falls.During an interview on 3/16/26 at 3:05 p.m. with Licensed vocational nurse (LVN) 1, LVN 1 stated call lights should be within arm's reach of the resident. During an interview on 3/16/26 at 3:20 p.m. with the Director of Nursing (DON), DON stated the call lights should always be close to the residents at all times and should be at arm's reach of the resident per their preference whether they want it pinned on the bed or pillow. During an interview on 3/16/26 at 5 p.m. DON stated as she stated before, the call light should be within reach of the residents all the time considering their preference as long as it is reachable for the resident. DON acknowledged it should not be on the floor.During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, dated September 2022, the P&P indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.During a review of the facility's P&P titled, Fall and Fall Risk, Managing, revised March 2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and to minimize complications.</p>