STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555499	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Healthcare Center LLC	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool used to direct care) for one of three sampled residents (Resident 2) was completed and coded accurately for wander guard [an electronic monitoring device, usually worn as a bracelet or anklet]. This failure placed Resident 2 at risk of not receiving the care and services appropriate to his needs, due to an inaccurate reflection of Resident 2's clinical status on the MDS assessment.Findings:During a review of Resident 2's admission Record (AR) printed on 4/16/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficits, and other psychoactive substance dependence.A review of Resident 2's MDS dated [DATE], indicated, Resident 2's Brief Interview for Mental Status (BIMS, an assessment to detect cognitive impairment) score of 8, indicating moderate cognitive impairment. The MDS also indicated, code ?0' for Wander/Elopement alarm indicating not used.A review of Resident's 2 elopement (leaving the facility unauthorized, without notifying staff) evaluation, dated 3/13/26, indicated, Resident 2 had a history of elopement or attempted leaving the facility without informing staff.A review of Resident 2's care plan, initiated 3/13/26, revised date 4/2/26, indicated, Resident 2 had Exit seeking behavior or elopement . The goal indicated, resident will have no episode or attempting to go out of the facility. Further review of the care plan also indicated .Monitor functioning (performance of the system) of Wander guard every shift.Monitor Placement of Wander guard every shift on left arm wrist.During a concurrent telephone interview and record review on 4/20/25, at 11:30 a.m., with the Director of Nursing (DON), Resident 2's MDS section P, dated 3/16/26, was reviewed and indicated 0 meaning it was not used. DON stated Resident 2's MDS was an inaccurate assessment. DON stated the MDS coordinator (MDSC) coded the assessment and that the MDSC was currently not available. DON stated Resident 2 had the wander guard on March 16. DON stated it was important to ensure staff put the correct documentation for patient safety that coincides with their needs.A review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised date March 2022 indicated, .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements.admission Assessment (Comprehensive).A comprehensive assessment include: .development of the comprehensive care plan.A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised date March 2022 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.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide adequate supervision to reduce the risk of elopement (leaving the facility unauthorized, without notifying staff), for three out of three sampled residents, when their wander guards (electronic monitoring devices, usually worn as a bracelet or anklet) were not being consistently monitored for functioning (performance of the system).1. For Resident 1, there was no documented evidence that the wander guard was monitored for functioning, every shift, from 12/15/25 until 4/17/26 (approximately four months).2. For Resident 2, there was no documented evidence that the wander guard was monitored for functioning, every shift, from 3/13/26 until 3/17/26 (13 days).3. For Resident 3, there was no documented evidence that the wander guard was monitored for functioning, multiple times on various days, in September 2025, and on 8/8/25 for functioning and placement of the wander guard.These deficient practices had the potential to place the residents at risk of elopement, which could lead to harm.Findings:1.During a review of Resident 1's admission Record (AR) printed on 4/16/26, the AR indicated, Resident 1 was admitted on [DATE] and originally admitted on [DATE], with diagnoses that included vascular Dementia and Adult failure to thrive.A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool to direct care), dated 12/1/25 indicated a Brief Interview for Mental Status (BIMS, an assessment to detect cognitive impairment) score of 9, indicating moderate cognitive impairment.A review of Resident 1's elopement evaluation dated 12/4/25, indicated, Resident 1 had a history of elopement or an attempted elopement while at home, and also had a history of elopement or attempted leaving the facility without informing staff, and that Resident 1 did wander in the past.A review of Resident 1's progress note (PN) dated 12/4/25, indicated, Resident 1 eloped from the facility during the early morning of 12/4/25, and two police officers brought him back to the facility after he was found at a gas station. The PN indicated, Resident 1 did not have his wander guard on when he returned, and that Resident 1's wander guard was found on his bed.A review of Resident 1's care plan, initiated 12/4/25, revised date 3/6/26, indicated, Resident 1 had Exit seeking behavior or elopement related to: Alzheimer's disease, dementia, history of elopement. The goal indicated, resident will have no episode or attempting to go out of the facility. Further review of the care plan also indicated, interventions initiated 12/4/25 that included .Monitor functioning of wander guard every shift.Monitor Placement of Wander guard every shift on left arm wrist .Monitor skin for any discoloration or skin issues around the wander guard on left arm.During an interview on 4/16/26 at 3:45 pm, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated they do check the wander guard for residents on wander guard at least once a shift and they document in the progress report.During an interview on 4/16/26 at 5:15 p.m., with the Regional Nursing Home Administrator (RNHA), RNHA stated the facility does not have a wander guard policy. RNHA stated it is just an added measure to the elopement and wandering policy.A review of Resident 1's physician orders details provided on 4/16/26, included: A prescriber written Physician order (PO) dated 12/3/25 indicated, Monitor functioning of wander guard every shift. A phone PO, dated 12/3/25 ,indicated, Monitor placement of wander guard every shift on right arm wrist every shift Another phone PO, dated 12/3/25, indicated, Monitor placement of wander guard on left arm/wrist. A phone PO, dated 12/3/25, indicated, Monitor functioning of wander guard on left wrist/arm. A phone PO, dated 12/4/25, indicated, Monitor placement of wander guard on right arm/wrist every shift. The prescriber written PO, dated 3/17/26, indicated, Monitor placement of wander guard on left arm/wrist every shift and another PO dated, 3/17/26, indicated, Monitor skin for any discoloration or skin issues around the wander guard on left arm/wrist every shift.A review of the Resident 1's Medication Administration Record (MAR), dated December 2025, indicated, Monitor functioning of wander guard on left wrist/arm start date 12/3/25 D/C (discontinue) date 12/15/25. A review of Resident 1's January 2026 MAR and February 2026 MAR, both with start date 12/4/25 and D/C date 3/17/25 also (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, monitoring placement of the wander guard and monitoring skin for any discoloration or skin issues around the wander guard on right arm/wrist were all with checkmarks and initials every shift. However, there was no indication or documented evidence that the functioning of the wander guard was monitored.A review of Resident 1's MAR dated March 2026, indicated, placement of the wander guard was monitored, on Right arm/wrist from 3/1/26 every shift to 3/17/26 on day shift as there were checkmarks and initials by nurses. Resident 1's March MAR also indicated, from night shift of 3/17/26 to 3/31/26, placement of the wander guard on the left arm/wrist and skin was monitored and signed by staff. There was no indication on Resident 1's MAR for March 2026, that staff monitored the functioning of the wander guard.During an interview on 4/17/26 at 11a.m., with the Maintenance Supervisor (MS), MS stated he was responsible for wander guard adjustment from his end and the nurses were responsible for checking battery life using the detector device. MS stated the nurses also register the number in order to know the number on the alarm door wander guard pad.During a telephone interview on 4/20/26 at 10 a.m., with the Director of Nursing (DON), DON stated wander guard is part of the elopement care plan interventions.During a concurrent interview and record review on 4/21/26 at 5:05 p.m., with DON, Resident 1's order summary report dated 3/17/26 was reviewed. The report indicated, Monitor placement of Wander Guard on left arm/wrist every shift active order prescriber written; the report also indicated, Monitor skin for any discoloration or skin issues around the Wander Guard on left arm/Wrist every shift. No order indicated for monitoring functioning of the wander guard and no documented evidence it was being monitored for Resident 1. DON stated the order for monitor functioning of Resident 1's wander guard was not there and DON did not have the answer.During a concurrent interview and record review on 4/21/26 at 5:20 p.m., with the DON, DON confirmed the wander guard for Resident 1 was not monitored for functioning on every shift, from 12/15/25 to 4/17/26 (approximately four months). DON stated they were supposed to check the wander guard with the wander guard device to make sure it was ringing. DON stated, if it is not documented, it means it was not done.2. During a review of Resident 2's admission Record (AR) printed on 4/16/26, the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included cognitive communication deficits, and other psychoactive substance dependence.A review of Resident 2's MDS dated [DATE], indicated, Resident 2's Brief Interview for Mental Status (BIMS, an assessment to detect cognitive impairment) score was 8, indicating moderate cognitive impairment.A review of Resident's 2 elopement evaluation, dated 3/13/26, indicated Resident 2 had a history of elopement or attempted leaving the facility without informing staff.A review of Resident 2's care plan, initiated 3/13/26, revised date 4/2/26, indicated, Resident 2 had Exit seeking behavior or elopement . The care plan goal, indicated, resident will have no episode or attempting to go out of the facility. Further review of the care plan also indicated, .Monitor functioning (performance of the system) of Wander guard every shift.Monitor Placement of Wander guard every shift on left arm wrist.During an observation on 4/16/26 at around 11:55 a.m., Resident 2 was at the front exit door, and wanted to leave and the staff ran after the resident to redirect him, but the resident still would not leave the area despite redirection. During a concurrent telephone interview and record review on 4/20/26 at 11:09 a.m., with DON, Resident 2's MAR for March 2026 was reviewed. DON confirmed that there was no monitoring for functioning of the wander guard for Resident 2 for 13 days, from 3/13/26 to 3/26/26. DON stated it was important to monitor the wander guard functioning because they want to make sure that it was working well to eliminate elopement and safety of the patient.3. During a review of Resident 3's admission Record (AR) printed on 4/16/26, the AR indicated, Resident 3 was admitted to the facility on [DATE] with original admission on [DATE], with diagnoses that included dementia, multiple fractures of ribs, right side, and fracture of one rib, left side.A review of Resident 3's MDS, dated [DATE], indicated, Resident 3 had short-term and long-term memory problem. A review of Resident 3's elopement evaluation, dated 1/12/26, indicated, Resident 3 had a history of elopement or attempted leaving the facility without informing staff and the resident did wander in the past.A review of Resident 3's care plan, initiated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/1/24, revised date 4/4/25, indicated, Resident 2 had Exit seeking behavior or elopement related to.: Alzheimer's disease, dementia, history of elopement. The care plan goal, indicated, resident will have no episode or attempting to go out of the facility. Further review of the care plan also indicated, interventions initiated 9/5/25, included .Monitor functioning wander guard every shift.Monitor Placement of Wander guard every shift on left arm wrist.Monitor skin for any discoloration or skin issues around the wander guard on left arm.During an observation on 4/16/26 at 1:05 p.m., Resident 3 was standing close to the back exit door, looking outside through the glass door. Staff went after him when they heard the wander alarm beeped.During a concurrent interview and record review on 4/21/26 at 3:30 p.m., with DON, Resident 3's MAR for August 2025 and September 2025 were reviewed. Multiple days and shifts were not signed by staff for monitoring the functioning of Resident 3's wander guard, placement, and monitoring skin for any skin issues, discoloration around the wander guard. DON confirmed the days and shifts without check marks and initials and blank were: 8/8/25 evening shift, 9/1/25 evening shift, 9/13/25 night shift, 9/20/25 day shift, and 9/29/25 evening shift for Monitor functioning of wander guard; and missing checkmarks and initials on 8/8/25 evening shift, for Monitor placement of wander guard on left arm wrist Monitor skin for any discoloration or skin issues around the wander guard on left arm every shift. DON stated the nurses forgot to sign and would check if they have documented it in the progress notes.During an interview on 4/21/26 at 4:35 p.m. with DON, DON stated it seemed like the staff didn't do it [monitoring functioning and placement of wander guard and monitoring skin around the wander guard for Resident 3]. DON stated she could not find staff documentation in the progress notes or anywhere else.During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, revised date March 2019, the P&P indicated, If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised date March 2022, the P&P 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.During a review of the wander guard manual, titled, [NAME] Healthcare Data sheet WanderGuard BLUE Detector, undated, the manual indicated, .The detector is used to detect and activate Tags and check their battery level. It also enables Tags to be visible in the WanderGuard BLUE Manager.Any staff member can quickly and easily verify Tag battery status without disturbing residents or forcing them to walk to a door monitored by a WanderGuard BLUE controller.