STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555767	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellaken Skilled Nursing Center	2780 26th Avenue Oakland, CA 94601

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, facility failed to:Maintain a functional resident call light system for four residents (Residents 2, 3, 4, and 5)Maintain complete and accurate maintenance records for seven residents with broken call lights (Residents 1, 2, 3, 4, 5, 12, and 13)Maintain complete and accurate maintenance records for five call light repairs that affected five (Residents 6, 7, 8, 9, 10) out of 61 residents.These failures placed residents at risk of not having a reliable method to request assistance and increased the risk of delayed response to care needs potentially leading to resident falls or other adverse outcomes.During a concurrent observation and interview on 4/14/26 at 2:52 p.m. with Licensed Vocational Nurse 2 (LVN2), in Resident 2 and 3's shared room, LVN2 pressed the call buttons and stated the light outside the room should light up and it did not. LVN2 stated Resident 2 and 3's call lights were not working and they did not have alternative call bells. LVN2 stated he was not aware that Resident 2 and 3's call lights were not working. (See tag F656)During a concurrent observation and interview on 4/14/26 at 2:56 p.m. with LVN2, in Resident 4 and 5's shared room, LVN2 pressed the call buttons and stated the light outside the room should light up and it did not. LVN2 stated Resident 4 and 5's call lights were not working and they did not have alternative call bells. LVN2 stated he was not aware that the call lights in the room for Residents 4 and 5 were not working. During an interview on 4/14/26 at 3:00 p.m. with LVN2, LVN2 stated Resident 3 uses her call light to ask for help. During an interview on 4/14/26 at 4:19 p.m. with Certified Nursing Assistant 1 (CNA1), CNA1 stated she is the CNA for Resident 2 and 3. CNA1 also stated she knows Resident 3 well and stated Resident 3 sometimes uses her call light to ask for help. CNA1 stated she was not aware that Resident 2 and 3's call lights were not working.During an interview on 4/14/26 at 4:30 p.m. with CNA2, CNA2 stated she is the CNA for Resident 5. CNA2 stated she knows Resident 5 well and stated Resident 5 sometimes uses their call light to ask for help. CNA2 stated she was not aware that Resident 5's call light was not working.During an interview on 4/14/26 at 4:33 p.m. with LVN3, LVN3 stated she knows Residents 2, 3, 4, and 5 well. LVN3 stated Resident 3 uses her call light to ask for assistance. LVN3 stated she was not aware of any call light issues in the rooms for Residents 2, 3, 4, and 5.During an interview on 4/14/26 at 3:05 p.m. with facility administrator (ADMIN)., ADMIN stated he is aware of the call lights being out in rooms for Residents 1, 2, 3, 4, 5, 12, and 13. ADMIN stated Resident 1, 12, and 13 got a backup call light system and Resident 2, 3, 4, and 5 did not because those residents did not use their call lights. ADMIN stated Resident 5 did not need a call light because she is independent and able to walk. ADMIN also stated Resident 3 probably could use a call light.During a concurrent interview and record review on 4/14/26 at 4:54 p.m., with ADMIN, printed emails with the subject line, Bellaken - new facility form, dated 3/6/26, were reviewed. ADMIN stated the document indicated on 3/6/26 the facility escalated the issue with the call lights to a new vendor. ADMIN stated the emails indicated the call lights for Residents 1, 2, 3, 4, 5, 12, and 13 have been broken since prior to 3/6/26. Admin also stated there was no specific date the vendor was scheduled to come out to work on the call lights.During an interview on 4/14/26 at 12:55 p.m. with LVN1, LVN1 states that she often calls maintenance to report that things, including call lights, are broken, and doesn't enter them in the Maintenance Log.During a concurrent interview and record review on 4/14/26 at 1:29 p.m. with Maintenance Worker (MAIN) and (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADMIN, facility's document titled, Environmental & Maintenance Work Referral Sheet, dated 1/11/26 - 1/31/26, was reviewed. MAIN stated the Environmental & Maintenance Work Referral Sheet, dated 1/11/26 - 1/31/26 indicated on 1/25/26 the call light cord for the Resident 6 was broken and the document does not state when it was fixed. MAIN stated he does not remember when the call light was fixed for Resident 6. During a concurrent interview and record review on 4/14/26 at 1:33 p.m. with MAIN and ADMIN, facility's document titled, Environmental & Maintenance Work Referral Sheet, dated 2/5/26 - 4/5/26, was reviewed. MAIN stated the Environmental & Maintenance Work Referral Sheet, dated 2/5/26 - 4/5/26 indicated: on 3/23/26 the call light for Resident 7 was not working and there was no date recorded for when it was fixed. MAIN stated he does not remember when it was fixed. on 3/30/26, the call light for Resident 8 did not work and there was no date recorded when it was fixed. MAIN stated he does not remember when it was fixed. on 4/4/26 the call light for Resident 9 was broken and there was no date recorded for when it was fixedon 4/5/26 the call light for Resident 10 was broken and there was no date recorded for when it was fixed.During an interview on 4/14/26 at 1:40 p.m. with MAIN and ADMIN, MAIN stated that there are four rooms (Residents 1, 2, 3, 4, 5, 12, and 13) that have call lights that do not work and there is no mention of these four rooms on the Environmental & Maintenance Work Referral Sheet. MAIN stated there should be a record for tracking purposes. MAIN stated during the day, staff often call directly with maintenance requests, and the requests do not get recorded in the Environmental & Maintenance Work Referral Sheet. During a concurrent interview and review of facility's policy titled, Maintenance Work Orders, undated, on 4/14/26 at 1:40 p.m. with MAIN and ADMIN, MAIN stated that facility's policy titled, Maintenance Work Orders indicated staff should put requests in the Environmental & Maintenance Work Referral Sheet. MAIN stated it is important to put all maintenance requests in the log, so they are tracked.During a review of facility's policy titled, Maintenance Work Orders, undated, the policy indicated In order to establish a priority of maintenance service, work orders must be filled out in the Maintenance Request Log.