STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555851	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Area Healthcare Center	1833 10th Avenue Oakland, CA 94606

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, for one of two sampled residents (Resident 1), the facility failed to implement written policies and procedures when an abuse allegation was not reported to the State Survey Agency and to the Law Enforcement.This failure resulted in the abuse allegation not being formally investigated by the State Survey Agency.During a review of Resident 1's admission Record (AR) printed 1/29/26, the AR indicated Resident 1 was admitted to the facility in December 2019 with diagnoses that included dependence on respirator (ventilator, a life-support machine that breathes for patients unable to do so independently) status, unspecified intellectual disabilities, muscular dystrophy (progressive weakness and degeneration of skeletal muscles, often leading to reduced mobility and, in some types, heart or breathing issues) and myoneural disorder (progressive muscle weakness, wasting, spasms or fatigue).During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/13/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13 (a BIMS score of 13-15 is indication of intact cognitive status).During an interview on 1/29/26 at 2:02 p.m. with Resident 1, Resident 1 stated, in 2025, the wall-mounted vital signs machine failed while a staff member attempted to check her vitals. Resident 1 stated the blood pressure cuff did not work, and Registered Nurse (RN) 1 entered, approached Resident 1, and slapped her arm. Resident 1 stated she reported this incident to Social Services Director (SSD), who responded that it would be her word against RN 1's word.During an interview on 1/29/26 at 2:18 p.m. with SSD, SSD stated she was aware of Resident 1's allegation. SSD stated Resident 1 had changed her story, claiming RN 1 was rough with her. SSD also stated she informed Assistant Administrator (AA) about the allegation and the matter was investigated.During a review of Resident 1's Social Services (SS) notes dated 6/27/25, the SS notes indicated Resident 1 alleged an RN smacked her right arm 2 days earlier. The SS notes indicated the allegation would be investigated but no SOC 341 was provided related to this allegation on 6/27/25.During a review of SS notes dated 10/25/25, the SS notes indicated, Resident 1 informed NP about RN 1 smacking her arm, referring to the June 2025 incident. The SS notes also indicated Resident 1 telling NP that SSD was investigating the incident.During a review of SOC 341 (a mandatory document used by mandated reporters, such as facility staff, to report suspected physical, mental, or financial abuse, neglect, or isolation of individuals aged 65 or older or dependent adults) dated 10/26/25, the following details were noted:On 10/23/25, Nurse Practitioner (NP) asked Resident 1 about a previously documented abuse allegation in Resident 1's clinical record, in which Resident 1 alleged that a nurse had struck her on the arm. The SOC 341 indicated NP urged the facility to report this incident to the Ombudsman. The SOC 341 also indicated an incident from 6/27/25 when a Certified Nursing Assistant (CNA) checked Resident 1's temperature. RN 1 verified Resident 1's temperature and tapped Resident 1 on the arm to assess skin temperature due to the thermometer reading 99 degrees (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fahrenheit. This incident was reported to both the physician and to the Regional Case Manager, who determined that Resident 1 had a history of fabricating stories. As a result, SOC 341 was not filed at that time. Furthermore, the SOC 341 indicated that the abuse allegation made by Resident 1 to NP on 10/23/25 was not reported to the State Agency. The section titled Written Report, which specifies the agencies to which the incident was reported, was left blank.During a telephone interview on 1/29/26 at 2:54 p.m. with Administrator (ADM), ADM stated, on 10/26/25, the facility reported the incident to the Local Ombudsman, believing that was sufficient. ADM stated she did not send a written report to the State Survey Agency.During a review of the facility's policy and procedure (P&P) titled Abuse Prevention and Mandated Reporting, undated, the P&P requires the Administrator to report suspected abuse or allegations to the California Department of Health within 24 hours.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two sampled residents (Resident 2), the facility failed to ensure treatment and services were done to heal and prevent re-opening of a coccyx (tailbone) pressure ulcer (damage to skin and underlying tissue caused by prolonged pressure or friction, commonly occurring over bony prominences like the heels, tailbone, or hips) when physician ordered treatment was not done and the open area was not measured during assessment.This failure had the potential to result in delayed healing and re-opening of the pressure ulcer.During a review of Resident 2's admission Record (AR) printed 1/29/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (high blood sugar resulting from insulin resistance or insufficient insulin production), chronic kidney disease (a long-term condition characterized by a gradual loss of kidney function over months or years), and left hemiplegia (paralysis that affects only one side of the body).During a review of Resident 2's Weekly Pressure Ulcer Injury Record (WPUIR), a clinical tool used to monitor the healing progress and effectiveness of treatment for pressure ulcers, documenting the stage, size, wound bed tissue type and surrounding skin color) dated 11/3/25, the WPUIR indicated Resident 2 had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed) pressure ulcer on the coccyx that measured 1 x 0.3 cm.During a review of Resident 2's pressure ulcer care plan dated 11/3/25, the care plan indicated interventions to promote discomfort and to prevent development of infections around the area that included providing treatment as ordered.During a review of Resident 2's Order Summary Report (OSR) dated 1/29/26, the OSR indicated a physician's order to apply moisture barrier cream on the buttocks and coccyx pressure ulcer every shift and as needed.During a concurrent telephone interview and review of Resident 2's Weekly Assessment dated 11/12/25, on 1/29/26 at 10:07 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he did not do treatments during the night shift. He also stated when he assessed Resident 2's pressure ulcer on 11/12/25, there was a small open area on the coccyx, but LVN 1 did not measure as he just made a quick look at it. During another concurrent telephone interview and review of Resident 2's Weekly Assessment dated 11/19/25, on 1/29/25 at 10:41 a.m. with LVN 2, LVN 2 stated she completed the weekly assessment dated [DATE] and wrote there was a stage 2 pressure ulcer on the coccyx but did not measure it because it has already healed. LVN 2 stated she only wrote that a pressure ulcer was there as reminder that there once was a pressure ulcer on Resident 2's coccyx.During a review of the facility's policy and procedure (P&P) titled Pressure Ulcers, undated, the P&P indicated multiple factors in management of pressure ulcers that included wound assessment. The P&P indicated to monitor wound status with each dressing change documenting wound assessment parameters using quantitative instrument such as Bates-[NAME] Wound Assessment Tool (BWAT, a more detailed wound assessment tool that evaluates multiple characteristics that included wound size and depth and condition of wound edges and surrounding skin).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of two sampled residents (Resident 2), the facility failed to ensure medical records were accurately documented.This failure had the potential to result in gaps in communication and uncoordinated care.During a review of Resident 2's admission Record (AR) printed 1/29/26, the AR indicated Resident 2 was admitted to the facility in on 11/3/25 with diagnoses that included type 2 diabetes mellitus (high blood sugar resulting from insulin resistance or insufficient insulin production), chronic kidney disease (a long-term condition characterized by a gradual loss of kidney function over months or years), and left hemiplegia (paralysis that affects only one side of the body).During a review of Resident 2's Weekly Pressure Ulcer Injury Record (WPUIR) dated 11/3/25, the WPUIR indicated Resident 2 had a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, pressure ulcer is damage to skin and underlying tissue caused by prolonged pressure or friction, commonly occurring over bony prominences like the heels, tailbone, or hips) on the coccyx (tailbone) that measured 1 x 0.3 cm. The WPUIR is a clinical tool for monitoring the healing progress and effectiveness of treatment for pressure ulcers, documenting stage, size, wound bed tissue type, and surrounding skin color.During a concurrent telephone interview and review of Resident 2's Weekly Assessment dated 11/12/25, on 1/29/26 at 10:07 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he did not perform treatments during the night shift. He also stated when he assessed Resident 2's pressure ulcer on 11/12/25, there was a small open area on the coccyx, but LVN 1 did not measure as he just made a quick and superficial look at it. During a review of Resident 2's Treatment Administration Record (TAR) for November 2025, the TAR indicated the following treatment orders: to coccyx pressure ulcer, wash with soap and water, pat dry, apply moisture barrier cream and keep open to air every shift and as needed. to moisture-associated skin damage on the coccyx, right and left perineum, wash with soap and water, pat dry, apply moisture barrier cream every shift and as needed.The TAR indicated LVN 1 signed off seven out of 20 scheduled NOC shift treatments for Resident 2.During another concurrent telephone interview and review of Resident 2's Weekly Assessment dated 11/19/25, on 1/29/25 at 10:41 a.m. with LVN 2, LVN 2 stated she completed the weekly assessment dated [DATE] and wrote there was a stage 2 pressure ulcer on the coccyx but did not measure it because it has already healed. LVN 2 stated she only wrote that a pressure ulcer was there as reminder that there once was a pressure ulcer on Resident 2's coccyx.During a review of the facility's policy and procedure (P&P) titled Weekly Nurses Progress Notes, undated, the P&P indicated the Weekly Nurses Progress Notes is part of the resident's medical record. It will summarize the resident's condition during the week, based upon the nurse's assessment, and reflect the nurse's assessment at the time of the documentation.