STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055338	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Post Acute	1832 B Street Hayward, CA 94541

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview and records review the facility failed to supervise one of three sampled residents (Resident 1), when Resident 1 was left unsupervised and unattended in a shower chair in her room.This deficient practice resulted in Resident 1 falling out of shower chair, sustaining L5 (5th lumbar- lower back bone) compression fracture (broken bone due to a collapse).During a review of Resident 1' admission Record (record that contains biographical information) printed on 5/11/26, indicated Resident 1 was admitted to the facility in March 2016, with multiple diagnosis including muscle weakness, dementia (decline in cognitive function), osteoarthritis of knees (chronic degenerative joint disease). During a review of Resident 1's Minimum Data Set (MDS, an assessment to plan care) assessment dated [DATE] indicated, Resident 1's Brief Interview for Mental Status (BIMS, an evaluation for mental status) score was eight (8) out of 15, indicating Resident 1's mental status was moderately impaired. The assessment indicated Resident 1 required facility staff supervision or touching assistance, where staff provided verbal cues and/or touching/steadying as she completed upper body dressing, lower body dressing, showers and personal hygiene. During a review of Resident 1's fall risk assessment (an evaluation to determine likelihood of falling) dated 6/24/25, indicated Resident 1 was at moderate risk for falls related to use of medications to control blood pressure, impaired recall ability, impaired vision, incontinence of bladder (involuntary leakage of urine), and her being confined to bed. During a review of Resident 1's fall risk care plan dated 9/13/24 indicated Resident1 was at moderate risk for falls due to gait/balance problems, vision loss, her preference to perform self-care and mobilization with walker and wheelchair. The care indicated for all facility staff to anticipate and meet her needs. During an observation and interview with Resident 1 on 5/11/26 at 1:25 p.m., Resident 1 was standing in her room, trying to get her walker. Resident 1 stated she was almost blind and it was hard for her to see things. Resident 1 stated she could not remember how she fell. During an interview on 5/12/26 at 9:29 a.m., with Certified Nursing Assistant (CNA 1, who was the assigned staff when Resident 1 fell on 3/4/26), CNA 1 stated that she helped Resident 1 to take the shower, took Resident 1 back to her room in a shower chair. CNA 1 stated Resident 1 asked her to bring water for her, CNA 1 left room while Resident 1 was still in the shower chair (unsupervised and unattended) to bring water. CNA 1 stated when she went back to the room, she saw Resident 1 was on the floor next to the bed. CNA 1 stated she did not know Resident 1 was at risk for falls. During a review of Resident 1's nursing progress notes dated 3/4/26 indicated, [Resident 1] found on the floor in sitting position next to shower chair in her room after being left to dress independently following a shower. [Licensed nurse, LN 1] assessed the resident immediately after the fall. [Resident 1] was alert and oriented and complained of neck pain and back pain. Rectal bleeding (blood passing through anus) was noted during assessment. No other visible external bleeding noted [Resident 1] assisted back to bed with staff assistance .Due to complaints of pain and noted bleeding 911 activated and [Resident 1] transferred to [Acute Care Hospital Emergency Room] for further evaluation. During a review of Resident 1's Acute Care Hospital- History and Physical progress notes dated 3/4/26, indicated Resident 1 had L5 (the fifth lumbar vertebra [lower (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	back]) compression fracture after the ground level fall at the facility. During an interview on 5/11/26 at 2:10 p.m., with the Director of Nursing (DON), the DON stated CNAs should make sure to transfer residents to their bed after shower to make sure they are safe and secure before leaving the resident's room. A review of facility's policy and procedure titled Bath, Shower/Tub revised [DATE], indicated .31. Assist with dressing and grooming as needed. 32. Assist the resident into bed or chair. 33. Place the call signal within easy reach of the resident. A review of the facility's policy and procedure Fall and Fall Risk Managing revised December 2007, indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.