

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Sage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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 record review, for one of three sampled residents (Resident 1), the facility failed to ensure Resident 1, identified as a high risk for falls, was provided consistently close monitoring/supervision to minimize complications and prevent falls when Resident 1 slipped out of the sling (a mobility aid used to safely move, lift, or reposition an individual with limited physical strength or balance) and fell on the floor during a 2-person mechanical lift (Hoyer Lift, a specialized lifting device used to safely transfer patients between beds, wheelchairs, toilets and/or floor) transfer from bed to wheelchair (w/c). This failure resulted in Resident 1 sustaining a laceration to the left (L) forehead, transferred to the hospital for evaluation, and was found with serious head injuries. 1. A review of Resident 1's admission Record, printed on 7/8/26, indicated Resident 1 was originally admitted to the facility in 2018 with diagnoses that included traumatic brain injury (disruption of normal brain function caused by an external force), Down Syndrome (Trisomy 21, a genetic condition caused by an extra full or partial copy of chromosome 21 [smallest human autosome]), epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [a sudden, abnormal surge of electrical activity in the brain]) and impulse disorder (a mental health condition characterized by an inability to resist harmful urges). A review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 4/10/26, indicated, Resident 1 was sometimes understood and can sometimes understand, with severely impaired cognition. Resident 1 was totally dependent (helper does all the effort to complete the activity) on all activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). Resident 1 has impairment to both upper (shoulder, elbow, wrist hand) and lower (hip, knee, ankle and foot) extremities, required w/c use, and a two (2) person transfer with a mechanical lift. A review of Resident 1's Care Plan, initiated date of 8/8/18, indicated Resident 1 was at high risk for falls related to (r/t) Down Syndrome, seizure disorder, muscle weakness, and poor safety awareness. A review of Resident 1's Care Plan, initiated date 9/25/18, indicated Resident 1 has an ADL self-care performance deficit r/t his medical condition which required total dependence on transfer by two staff, to move between surfaces and as necessary. A review of Resident 1's Care Plan, initiated date 4/27/26, indicated Resident 1 had an actual fall on 4/23/26 with serious injuries. Interventions/Tasks included, do not attempt to move resident during seizure activity and if seizure occurs, staff to return resident to bed and assume recovery position. A review of Resident 1's Care Plan, initiated date 4/27/26, indicated Resident 1 had a cerebral vascular accident (CVA, a stroke), affecting L frontal lobe hemorrhage (bleeding inside the brain tissue) r/t fall from mechanical lift. A review of Resident 1's Fall Risk Assessment, dated 7/10/25, indicated a reason for assessment request was due to other reasons. Resident 1 had no history of falls within the last six months, was (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 0689 Level of Harm - Actual harm Residents Affected - Few	confined to a chair, and oriented. A review of Resident 1's Fall Risk Assessment, dated 4/23/26, indicated a reason for assessment request was due to recent fall. Resident 1 had no history of falls within the last six months, was confined to a chair, and oriented. A review of Resident 1's Skin Integrity Sheet, dated 4/23/26, indicated Resident 1 sustained a laceration (a jagged, deep tear) to the L eyebrow, with scant amount of bleeding, and was sent out to the hospital for evaluation. A review of Resident 1's Situation Background Appearance Review and Notify (SBAR, a communication tool used to transfer critical patient information between members of the team) Change of Condition Notes, dated 4/23/26, indicated Resident 1 had a fall from the mechanical lift and sustained a cut above the L eyebrow, with slight bleeding. Resident 1 was alert at this time with no change in level of consciousness. A review of Resident 1's Facility Reported Event, dated 4/24/26, indicated Resident 1 had taken a fall on 4/23/26, during the morning shift while Resident 1 was being transferred from bed to w/c, with two-person assistance using the mechanical lift. Resident 1 was noted to be cooperative but was wiggling a lot during the transfer and slid through the L side of the sling to the floor and was sent out to the hospital for further evaluation. A review of Resident 1's Hospitalist Discharge summary, dated [DATE], indicated Resident 1 was admitted to the hospital on [DATE], at 10:04 a.m., indicated reason for admission was due to laceration to L forehead. Work up showed unremarkable labs. Computed Tomography of the Head (CTH, rapid, non-invasive x-ray scan used by neurologists and emergency rooms to quickly identify bleeding, strokes, tumors, or severe trauma in the brain) with Impression, indicated, 1. Moderate hemorrhagic contusion (a brain bruise) involving the L frontal lobe. 2. L frontal scalp hematoma (a blood clot). 3. Diffuse atrophy (widespread shrinkage of brain tissue) with concomitant ventricular dilation (enlargement of both lower heart chambers [left and right ventricles]). Resident 1's Final Diagnosis indicated, focal hemorrhagic contusion of cerebrum (a bruise on the brain tissue accompanied by bleeding) due to the fall and intracranial hemorrhage (a life-threatening medical emergency involving bleeding inside the skull). Further review of Resident 1's Discharge Summary indicated Resident 1 developed dysphagia (difficulty swallowing) and was placed on dysphagia diet following Speech Therapy Swallowing Evaluation. A review of the facility's document titled, Sling Sizes List, updated 7/7/26, indicated, 1. Each patient will have personal shower and transfer sling.3. Shower slings not to be used for transfers. During an interview on 7/8/26, at 1:42 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 4/23/26, during the morning shift (7 a.m. to 3:30 p.m.), Resident 1 was ready to be transferred from bed to w/c. While Resident 1 was in bed, the sling was placed under Resident 1, sling bar was lowered to Resident 1, all four sling straps attached to the sling bar, and made sure straps were securely attached to the clips. CNA 1 stated with two-person assistance using the mechanical lift, Resident 1 was cooperative but was wiggling a lot during the transfer. CNA 1 was controlling the hand-held remote in her hand standing behind the mechanical lift, while CNA 2 was trying to position the w/c in front of CNA 2 when Resident 1 slipped out from the L side of the sling and fell to the floor. Resident 1 fell on his L side and sustained a small laceration to the L eyebrow, with small amount of bleeding. CNA 1 denied seeing Resident 1 hit his head on an object. During concurrent observation and interview on 7/9/26, at 10:30 a.m., with the Director of Staff Development (DSD), DSD showed the sling used for Resident 1 at the time of the fall incident. A large-sized, mesh type sling was labeled with Resident 1's name. DSD stated this type of sling was to be used for showers only. DSD further stated on the day Resident 1 fell out of the sling with the two-person transfer using a mechanical lift, and with Resident 1 wiggling more than usual, the two CNAs should have lowered Resident 1 back to the bed for safety. During a follow-up observation and interview on 7/9/26, at 12:25 p.m., with CNA 1, CNA 1 demonstrated the scenario regarding Resident 1's fall incident. CNA 1 stated she was five feet two (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	inches tall, stood behind the lift controlling the lift and hand-held remote, and from the bed, slowly lifted the sling with Resident 1 at eye level when Resident 1 slipped out from the L side of the sling and fell to the floor between the mechanical lift and A bed. CNA 1 stated Resident 1 wiggled more than usual and was almost near the w/c from where CNA 2 stood behind waiting for Resident 1 to get lowered from the mechanical lift. None of the two CNAs guided or gently supported Resident 1 while being moved from bed to w/c. CNA 1 also stated she could not tell whether Resident 1 was having a seizure at the time of transfer on 4/23/26. CNA 1 stated she was aware what a seizure was but had no knowledge that Resident 1 had this medical condition. CNA 1 had no answer as to why on the day of the fall, a mesh-type shower sling, instead of the solid fabric transfer sling, was used on Resident 1's transfer from bed to w/c. During concurrent observation and interview on 7/9/26, at 1:02 p.m., with CNA 4, Resident 1 was situated in the hallway next to Nursing Station 1 and Resident 1's room. Resident 1 was reclined in a w/c, seated on a solid, blue-colored fabric with green piping sling underneath. CNA 4 stated since Resident 1's recent fall incident, Resident 1 has been placed on a three-person transfer using a mechanical lift, with one CNA controlling the hand-held remote, and two CNAs on each side gently guiding the resident during transfers. A review of the facility's In-service Training Records indicated, an in-service titled, All CNAs Must Use Gait Belt for Transfers, Use Sling for Hoyer Lift - 2 People All the Time, dated 1/15/26, was provided to all nursing staff. An in-service titled, Transfer Techniques & Hoyer Lift Sling Transfers, dated 3/6/26, was provided to the CNAs. Further review of the Training Records indicated another in-service titled, Safe Lifting Using a Mechanical Lift - Hoyer Lift 2 People at All Times, dated 4/23/26, was provided to all facility staff. A one-to-one in-service titled, Sling & Transfers, dated 4/23/26, was provided to CNA 1 and CNA 2. A review of the facility's policy and procedure (P&P) titled, Falls 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 risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. A review of the facility's P&P titled, Lifting Machine, Using a Mechanical, revised July 2017, indicated, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. Mechanical Lifts may be used for task that require transferring a resident from bed to chair. Before using a lifting device, assess the resident's condition. Is the resident agitated, resistant or combative. Check the resident's comfort level. Gently support the resident as he or she is moved. Double check the sling. A review of the facility's P&P titled, Safe Lifting and Movement of Residents, revised July 2017, indicated, In order to protect the safety and well-being of staff and residents, and to provide quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding to safe lifting and moving of residents. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Such assessments shall include. Cognitive status; Whether the resident is usually cooperative with staff. Enough slings, in the sizes required by the residents in need, will be available at all times. CNA 2 was unavailable for interview.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review for two of five sampled residents (Resident 4 and Resident 5), the facility failed to follow their policies and procedures (P&P) for reporting to appropriate agencies a verbal altercation, on 6/9/26 between Resident 4 and Resident 5. This failure to report promptly resulted in:1. No documentation reporting a verbal altercation between Resident 4 and Resident 5 to Law Enforcement within the required regulatory timeframe.2. Potential to negatively impact the protection of all 85 facility residents from abuse. A review of Resident 4's admission Record indicated Resident 4 was readmitted to the facility in 2025 with diagnoses that included dementia (memory loss; a group of thinking and social symptoms that interferes with daily functioning) and hearing loss. A review of Resident 4's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 4/4/26, indicated Resident 4 was sometimes understood and was able to sometimes understand, with severely impaired cognition. Resident 4 was totally dependent (helper does all the effort to complete the activity) on all activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility in 2026 with diagnoses that included dementia with other behavioral disturbance. A review of Resident 5's MDS, dated [DATE], indicated Resident 5 was sometimes understood and was able to sometimes understand, with severely impaired cognition. Resident 5 required substantial/maximal assistance (helper does more than half the effort to complete the activity) on all ADLs. A concurrent review of Resident 4 and Resident 5's Incident Reports, dated 6/9/26, indicated at 6:50 a.m., a Certified Nursing Assistant (CNA) reported to Licensed Vocational Nurse 2 (LVN 2) that Resident 4 was having a verbal argument with the roommate, Resident 5. Both LVN 2 and LVN 3 immediately went to the residents' room and found both residents already separated by a CNA. Resident 4 was lying in her bed while Resident 5 was seated in her own bed. When LVN 2 asked Resident 4 what the verbal argument was all about, Resident 4 stated, I am just waiting for a diaper change. When LVN 3 asked Resident 5 what happened, Resident 5 stated Resident 4 was lazy and needed to get up and work. A review of Resident 4's Situation Background Appearance Review and Notify (SBAR, a communication tool used to transfer critical patient information between members of the team) Change of Condition Notes, dated 6/9/26, indicated Medical Doctor (MD) was notified of the verbal altercation between Resident 4 and Resident 5, on 6/9/26, at 7 a.m. Resident 4's Responsible Party (RP) was notified on 6/9/26, at 12 p.m. A review of Resident 5's SBAR, dated 6/9/26, indicated MD was notified of the verbal altercation between Resident 4 and Resident 5, on 6/9/26, at 9 a.m. while Resident 5's RP was notified on 6/9/26, at 11 a.m. A concurrent review of Resident 4 and Resident 5's 5-Day Summaries, dated 6/11/26, indicated MD, both residents' respective RPs, and two state agencies were notified. Both state agencies were faxed supporting documents. However, the facility was unable to provide any written documentation that Law Enforcement was notified of the alleged incident. During concurrent interview and record review on 7/9/26, at 1:15 p.m., with LVN 2, LVN 2 stated Director of Nursing (DON) contacted the Law Enforcement Agency to report the alleged incident but was told to just follow facility protocol. LVN 2 was unable to provide documentation or record of telephone conversation placed by the DON to the Law Enforcement Agency. A review of the email conversation between this writer and the Administrator (ADM), on 7/13/26, indicated ADM was unable to provide a written documentation to support that DON contacted the Law Enforcement Agency to report the alleged incident between Resident 4 and Resident 5, A review of the facility's (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated July 2017, indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Reporting 1. All alleged violations involving abuse.will be reported by the facility Administrator, or his/her designee, to the following persons or agencies .e) Law enforcement officials.An alleged violation of abuse.will be reported immediately but not later than: a) Two (2) hours if the alleged violation involves abuse.3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.Notices will include as appropriate.What immediate action was taken by the facility.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, for one of three sampled residents (Resident 2), the facility failed to ensure Resident 2, identified as a high risk for falls, was provided consistently with close monitoring/supervision and comprehensive care plan interventions to address Resident 2's nursing and safety needs were implemented, to minimize complications and prevent falls when Resident 2 had an unwitnessed fall inside Resident 2's room. This failure negatively impacted Resident 2's quality of care and services received resulting in Resident 2 being transferred to the emergency department (ED) for evaluation and found with fracture of surgical neck with greater tuberosity extension (a bony fracture that travels into the large bump at the top of the upper arm bone). A review of Resident 2's admission Record, printed on 5/1/26, indicated Resident 2 was admitted to the facility in 2024 with diagnoses that included Alzheimer's Disease (a brain condition that causes a progressive decline in memory, thinking, learning, and organizing skills) and osteoporosis (thinning of the bones). A review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 2/2/26, indicated, Resident 2's primary language was Vietnamese and had severely impaired cognition. Resident 2 required substantial/maximal assistance (helper does more than half the effort) to complete the activities of daily living (ADLs, the basic self-care tasks an individual does on a day-to-day basis). A review of Resident 2's Care Plan, initiated date 2/1/24, indicated the resident was at risk for falls/injuries related to (r/t) confusion, unaware of safety needs, and osteoporosis. Interventions included bed at lowest position, initiated 2/12/25, chair alarm when in chair to monitor rising and alert staff of unsafe transfers. Monitor for functioning and placement every shift, initiated 2/18/25, and bed in lowest position at night, initiated 2/1/24. A review of Resident 2's Care Plan, post fall, initiated date 4/25/26, indicated Resident 2 had an actual fall with unknown injury. Resident 2 with discoloration and swelling to right upper arm, and an 8/10 pain score. Interventions included, .Continue interventions on the at-risk plan. A review of Resident 2's Physician Order, dated 2/19/25, indicated Bed alarm, check placement and functioning every shift. A review of Resident 2's Physician Order, dated 4/27/26, indicated Provide floor mat on the floor every shift. A review of Resident 2's Fall Risk Assessment, dated 4/26/26, indicated Resident 2 had history of falls within the six months. A review of Resident 2's Situation Background Appearance Review and Notify (SBAR, a communication tool used to transfer critical patient information between members of the team) Change of Condition Notes, dated 4/26/26, indicated Resident 2 was found on the floor on resident's right side near the bed. There was no documentation of whether the bed was at the lowest position, nor a floor mat placed next to the bed. A review of Resident 2's Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their residents) Notes, dated 4/27/26, indicated an IDT recommendation of floor mat placed at bedside for fall prevention. A review of Resident 2's IDT Notes Addendum (an update added to the existing notes), dated 4/29/26, indicated an added recommendation of bed and pressure alarms applied. During a concurrent observation and interviews on 7/9/26, at 1:20 p.m., with Activity Assistant 2 (AA 2), and Certified Nursing Assistant 6 (CNA 6), Resident 2 was observed seated in a wheelchair (w/c) positioned in front of the Nurses Station 1. AA 2 confirmed Resident 2's chair alarm was not put in place. AA 2 further stated the chair alarm was used to alert the staff in case Resident 2 attempted to get up from the w/c. CNA 6 stated CNA 6 forgot to attach the chair alarm when Resident 2 was set up in the w/c in the morning. CNA 6 stated Resident 2 had a high risk for fall. During a follow-up concurrent observation, interviews, and record (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviews, on 7/9/26, at 1:30 p.m., with Registered Nurse 1 (RN 1) and Licensed Vocational Nurse 4 (LVN 4), inside Resident 2's room, the bed was observed without a floor mat in place. Both RN 1 and LVN 4 had no idea where the floor mat was stored when not in use. RN 1 confirmed Resident 2 had Physician Orders for bed alarm and/or chair alarm and floor mat next to the bed. RN 1 also stated there was no Informed Consent (IC) for ordered chair and bed alarm, only phone notification to Resident Representative (RR) was required since alarms were not considered as restraints according to the Administrator (ADM). During an interview on 7/9/26, at 1:40 p.m., with ADM, ADM stated Resident 2 was a high risk for falls, had poor safety awareness, and had no capacity to make medical decisions. According to the ADM, interventions to prevent further falls for Resident 2 included a bed and/or chair alarm, putting the bed in the lowest position, and a floor mat next to the bed. ADM further stated these interventions were indicated in Resident 2's Kardex (a snapshot of a patient's medical history, care plan, and daily needs) for staff's quick reference. During telephone interview on 7/9/26, at 3:45 p.m., with CNA 5, CNA 5 stated she was not made aware of Resident 2's Physician Order for a floor mat, bed or chair alarm. CNA 5 stated she only knew of the bed in low position. A review of the facility's policy and procedure (P&P) titled, Fall and Fall Risk, Managing, revised 2007, indicated, based on previous evaluations and current date, 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. In conjunction with the attending Physician, staff will identify and implement relevant interventions (e.g., hip padding [chair or bed alarm] or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.		