

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 05/17/2024
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>46194</p> <p>Based on interview, record review, and review of the Centers for Medicare & Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments. Specifically, the facility failed to accurately code the presence of an indwelling urinary catheter for 1 (Resident #5) of 3 sampled residents who had urinary catheters and failed to accurately code the use of an antiplatelet medication for 1 (Resident #19) of 1 resident reviewed for MDS discrepancies.</p> <p>Findings Included:</p> <p>1. The CMS Long-Term Care Facility RAI 3.0 User's Manual, version 1.18.11, dated October 2023, SECTION H: BLADDER AND BOWEL, revealed, Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube). The user's manual further indicated, for section H0300 Urinary Continence staff should, Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output.</p> <p>An Admission Record revealed the facility originally admitted Resident #5 on 03/29/2018 and readmitted the resident on 12/19/2019. According to the Admission Record, the resident had a medical history that included a diagnosis of retention of urine.</p> <p>Resident #5's care plan revealed a Focus area, initiated on 09/25/2019, that indicated the resident had a suprapubic catheter related to a diagnosis of urinary retention.</p> <p>Resident #5's Order Summary Report, listing active orders as of 05/14/2024, revealed an order, dated 06/03/2021, for a suprapubic catheter.</p> <p>An annual MDS, with and Assessment Reference Date (ARD) of 04/08/2024, revealed Resident #5 had moderate impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems, per a staff assessment of mental status (SAMS). Section H0100 was coded as none of the above and did not reflect the presence of an indwelling urinary catheter. Section H0300 was coded to reflect the residents was always incontinent of urine, instead of a 9 to reflect not rated due to the presence of an indwelling catheter.</p> <p>(continued on next page)</p>		

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 05/15/2024 at 12:39 PM, the MDS Coordinator stated the presence of suprapubic catheters should be coded in Section H of the MDS. The MDS Coordinator stated that Resident #5's MDS was not coded correctly, and it was inaccurate.</p> <p>During an interview on 05/16/2024 at 10:19 AM, the Director of Nursing (DON) stated that she believed there was a section of the MDS to code the presence of indwelling catheters. The DON stated Resident #5's MDS was not coded correctly.</p> <p>During an interview on 05/16/2024 at 10:29 AM, the Administrator stated there was a section of the MDS to code the presence of a suprapubic indwelling catheter. The Administrator stated if a resident had an indwelling catheter, this section of the MDS should be accurately coded to ensure the resident received proper treatment.</p> <p>37935</p> <p>2. The CMS Long-Term Care Facility RAI 3.0 User's Manual, version 1.18.11, dated October 2023, section N0415: High Risk Drug Classes: Use and Indication, indicated, Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. The user's manual indicated, N041511. Antiplatelet: Check if an antiplatelet medication (e.g. [exempli gratia, for example], aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).</p> <p>An Admission Record indicated the facility admitted Resident #19 on 04/21/2018. According to the Admission Record, the resident had a medical history that included a diagnosis of cerebral infarction due to cerebral venous thrombosis, nonpyogenic (a form of stroke).</p> <p>Resident #19's care plan revealed a Focus area, initiated on 06/12/2022, that indicated the resident received Plavix (clopidogrel, an antiplatelet medication) related to cerebral infarction.</p> <p>Resident #19's Order Summary Report, listing active orders as of 05/14/2024, contained an order, dated 06/01/2018, for Plavix Tablet (Clopidogrel Bisulfate) 75 mg [milligrams] give 1 [one] tablet by mouth in the morning.</p> <p>A quarterly MDS, with an Assessment Reference Date (ARD) of 03/16/2024, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of a 4, which indicated the resident had severe cognitive impairment. Section N0415 was coded to reflect that the resident was taking an anticoagulant medication and did not indicate that the resident was taking an antiplatelet medication.</p> <p>During an interview on 05/15/2024 at 12:44 PM, the MDS Coordinator stated Resident #19 was receiving Plavix. The MDS Coordinator said the resident's MDS was coded to reflect the resident received an anticoagulant because she considered Plavix an anticoagulant, instead of an antiplatelet medication.</p> <p>During an interview on 05/15/2024 at 3:03 PM, the Administrator stated facility staff should follow the RAI manual instructions for MDS coding.</p> <p>During an interview on 05/16/2024 at 9:20 AM, the Director of Nursing (DON) stated the MDS Coordinator was responsible for completing MDS assessments and ensuring they were accurate.</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2024 at 9:27 AM, the Administrator stated that the MDS Coordinator was responsible for completing and coding MDS assessments accurately.

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to complete a baseline care plan within 48 hours of admission for 1 (Resident #207) of 3 residents reviewed for baseline care plans.</p> <p>Findings included:</p> <p>A facility policy titled, Care Plans - Baseline, revised in 12/2016, revealed, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.</p> <p>An Admission Record, indicated the facility admitted Resident #207 on 05/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of atherosclerotic heart disease, end stage renal disease, dependence on renal dialysis, chronic pain syndrome, and insomnia.</p> <p>Resident #207's Baseline Care Plan, dated 05/12/2024 at 6:36 PM, revealed a status of In Progress. The sections addressing Dietary/Nutritional Status, Therapy, Social Services, Comments [and preferences], Plan of Care, and signatures of staff completing the baseline care plan, the resident, and the resident's representative were not complete.</p> <p>During an interview on 05/16/2024 at 9:20 AM, the Director of Nursing (DON) stated Resident #207's baseline care plan was not complete.</p> <p>During an interview on 05/16/2024 at 4:20 PM, Licensed Vocational Nurse (LVN) #6 stated baseline care plans were to be completed within 48 hours of admission and said staff must have just missed following up on the completion of Resident #207's baseline care plan.</p> <p>During a follow-up interview on 05/16/2024 at 10:25 AM, the DON stated baseline care plans should be completed within 48 hours of a resident's admission. She stated the baseline care plan for Resident #207 was not completed timely.</p> <p>During an interview on 05/16/2024 at 10:35 AM, the Administrator stated baseline care plans should be initiated at the time of a resident's admission and should be completed within 48 hours of admission.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46194</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to develop a care plan addressing the use of anticoagulant medications for 1 (Resident #47) of 5 sampled residents reviewed for unnecessary medications and failed to develop a care plan addressing urinary catheters for 2 (Resident #13 and Resident #50) of 3 sampled residents with indwelling urinary catheters.</p> <p>Findings included:</p> <p>A facility policy titled, Anticoagulation - Clinical Protocol, revised in 11/2018, revealed, 1. As a part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated.</p> <p>A facility policy titled, Catheter Care, Urinary, revised in 08/2022, revealed, Preparation 1. Review the resident's care plan to assess for any special needs of the resident.</p> <p>1. An Admission Record revealed the facility admitted Resident #47 on 02/13/2024. According to the Admission Record, the resident had a medical history that included diagnoses of personal history of pulmonary embolism and heart failure.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was taking an anticoagulant medication.</p> <p>Resident #47's care plan, last updated on 05/08/2024, revealed no Focus area that addressed the use of anticoagulant medication.</p> <p>Resident #47's Order Summary Report, listing active orders as of 05/15/2024, contained an order, dated 02/14/2024, for Eliquis (an anticoagulant) 5 milligram (mg) by mouth twice daily for blood clots.</p> <p>During an interview on 05/15/2024 at 2:11 PM, Licensed Vocation Nurse (LVN) #4 stated the nurse admitting a resident updated the care plan but all nurses were responsible for ensuring care plans were updated. She stated the use of anticoagulant medication should be addressed on the care plan. LVN #4 reviewed Resident #47's care plan and stated the use of an anticoagulant was not addressed on the care plan.</p> <p>During an interview on 05/15/2024 at 3:00 PM, the Director of Nursing (DON) stated the use of anticoagulants should be addressed on the care plan and residents taking anticoagulant medications should be monitored for signs and symptoms of bruising and bleeding. The DON stated the use of an anticoagulant was not addressed on Resident #47's care plan. She stated that nurses, as well as the MDS Coordinator, were responsible for updating care plans.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/16/2024 at 10:43 AM, the Administrator stated the use of anticoagulants should be addressed on the care plan.</p> <p>2. An Admission Record revealed the facility originally admitted Resident #13 on 04/12/2024 and readmitted the resident on 04/23/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident did not have an indwelling urinary catheter at the time of the assessment.</p> <p>Resident #13's care plan revealed a Focus area, initiated on 04/13/2024, that indicated the resident had bowel and bladder incontinence. The care plan did not address the presence of an indwelling urinary catheter.</p> <p>A hospital Discharge Summary, dated 04/23/2024, revealed the resident had renal failure and was being discharged from the hospital to a skilled nursing facility with hospice services. The Discharge Summary did not indicate the resident had an indwelling urinary catheter.</p> <p>On 05/13/2024 at 10:14 AM, the resident was observed sitting on their bed with an indwelling urinary catheter in place.</p> <p>During an interview on 05/15/2024 at 10:10 AM, Licensed Vocational Nurse (LVN) #4 reviewed Resident #47's care plan and stated that she did not see any information about the resident's indwelling urinary catheter. LVN #4 stated it was the admitting nurse's responsibility to ensure the information regarding an indwelling catheter was entered on the resident's care plan.</p> <p>During an interview on 05/15/2024 at 11:03 AM, the Director of Nursing (DON) stated an indwelling urinary catheter should be addressed on the care plan. After reviewing Resident #13's medical record, the DON stated Resident #13 was readmitted from the hospital with a catheter. The DON then reviewed the resident's care plan and confirmed the care plan did not address the resident's indwelling urinary catheter. The DON said the nurse that admitted the resident back from the hospital should have added the catheter to the resident's care plan.</p> <p>During an interview on 05/16/2024 at 10:39 AM, the Administrator stated there should be a care plan in place addressing the presence of an indwelling urinary catheter.</p> <p>36105</p> <p>3. An Admission Record revealed the facility originally admitted Resident #50 on 04/19/2024 and readmitted the resident on 05/10/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2024, revealed Resident #50 had short-term and long-term memory problems and had severe cognitive impairment for daily decision making, per a staff assessment of mental status (SAMS). The MDS revealed Resident #50 was always incontinent of bowel and bladder and did not indicate that the resident had an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #50's care plan, last updated on 05/10/2024, revealed no Focus area addressing the presence of an indwelling urinary catheter.</p> <p>Observations on the following dates and times revealed Resident #50 had an indwelling urinary catheter:</p> <ul style="list-style-type: none"> - 05/13/2024 at 2:07 PM, - 05/14/2024 at 6:53 AM, - 05/14/2024 at 7:10 AM, - 05/14/2024 at 10:58 AM, - 05/14/2024 at 12:07 PM, - 05/14/2024 at 1:29 PM, and - 05/15/2024 at 11:07 AM. <p>During an interview on 05/15/2024 at 11:23 AM, Licensed Vocation Nurse (LVN) #4 stated there should be a care plan for Resident #50's catheter, but she did not find one.</p> <p>During an interview on 05/15/2024 at 12:39 PM, the MDS Coordinator stated that when a resident readmitted to the facility with a catheter, the admitting nurse or the nurse the next day should update the resident's care plan to include the catheter. She stated she had not been to the facility since Resident #50 readmitted , but the nurse who identified the catheter should have added it to the care plan.</p> <p>During an interview on 05/16/2024 at 9:49 AM, the Director of Nursing (DON) stated catheter information should be added to the care plan by the admitting nurse.</p> <p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the admitting nurse to complete a readmission assessment to capture catheter information. The Administrator stated the nurse should have updated the care plan when she identified Resident #50 had a catheter.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36105</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure that residents who entered the facility with indwelling urinary catheters were assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrated that catheterization was necessary, and failed to ensure physician's orders were in place for the placement of the catheter and any associated catheter care. This deficient practice affected 2 (Resident #50 and Resident #13) of 3 sampled residents with indwelling urinary catheters.</p> <p>Findings included:</p> <p>A facility policy titled, Catheter Care, Urinary, revised in 08/2022, revealed, Catheter Evaluation included 2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use a standardized tool for documenting clinical indications for catheter use. 3. Remove the catheter as soon as it is no longer needed.</p> <p>1. An Admission Record revealed the facility originally admitted Resident #50 on 04/19/2024 and readmitted the resident on 05/10/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2024, revealed Resident #50 had short-term and long-term memory problems and had severe cognitive impairment for daily decision making, per a staff assessment of mental status (SAMS). The MDS revealed Resident #50 was always incontinent of bowel and bladder and did not indicate that the resident had an indwelling urinary catheter at the time of the assessment.</p> <p>Resident #50's care plan, last updated on 05/10/2024, revealed no Focus area addressing the presence of an indwelling urinary catheter.</p> <p>Observations on the following dates and times revealed Resident #50 had an indwelling urinary catheter:</p> <ul style="list-style-type: none"> - 05/13/2024 at 2:07 PM, - 05/14/2024 at 6:53 AM, - 05/14/2024 at 7:10 AM, - 05/14/2024 at 10:58 AM, - 05/14/2024 at 12:07 PM, - 05/14/2024 at 1:29 PM, and - 05/15/2024 at 11:07 AM. <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #50's hospital SNF [Skilled Nursing Facility] Orders, dated 04/19/2024, revealed no orders for a urinary catheter when Resident #50 was originally admitted to the facility from the hospital.</p> <p>Resident #50's Admission/Re-Admission-Resident Data Collection nursing assessment, dated 04/19/2024, revealed no indication Resident #50 had an indwelling urinary catheter when admitted to the facility. The section of the assessment titled CATHETER had an area to list 1. Catheter Type/Size, but no information was recorded.</p> <p>Resident #50's History and Physical, dated 04/22/2024, revealed no indication Resident #50 had a urinary catheter.</p> <p>Resident #50's Order Summary Report, listing active orders as of 04/30/2024, revealed the resident did not have a physician's order for an indwelling urinary catheter.</p> <p>Resident #50's hospital Discharge Summary, dated 04/23/2024, revealed the resident had renal failure and was being discharged from the hospital to a skilled nursing facility with hospice services. The Discharge Summary did not indicate the resident had an indwelling urinary catheter.</p> <p>Resident #50's hospital Discharge Summary, dated 05/10/2024, revealed no indication that Resident #50 was discharged with an indwelling urinary catheter.</p> <p>Resident #50's Order Summary Report, listing active orders as of 05/14/2024, after the resident's readmission to the facility, revealed the resident did not have a physician's order for an indwelling urinary catheter.</p> <p>Resident #50's Progress Notes for the timeframe from 04/20/2024 through 05/15/2024 revealed no notes regarding an indwelling urinary catheter.</p> <p>Resident #50's SNF [Skilled Nursing Facility] Visit Note records, signed by a nurse practitioner, dated 04/29/2024, 05/03/2024, and 05/15/2024, revealed no indication Resident #50 had an indwelling urinary catheter.</p> <p>Resident #50's History and Physical, dated 05/13/2024, revealed no indication Resident #50 had an indwelling urinary catheter.</p> <p>Observations on 05/15/2024 at 8:21 AM revealed Certified Nursing Assistant (CNA) #5 gave Resident #50 a bed bath and provided indwelling urinary catheter care.</p> <p>During an interview on 05/15/2024 at 11:19 AM, CNA #5 stated she knew how to care for each resident by checking the CNA care plan or a nurse informed her. CNA #5 stated a nurse informed her that Resident #50 had a urinary catheter when they readmitted to the facility.</p> <p>During an interview on 05/15/2024 at 11:23 AM, Licensed Vocational Nurse (LVN) #4 stated there should be physician's orders for Resident #50's catheter, for catheter care, and for changing the catheter, but she could not find any orders in the resident's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/15/2024 at 11:44 AM, LVN #3 stated a nurse should inform the physician about the presence of a catheter when a resident was admitted from a hospital. She stated there should be orders for the use of a catheter, catheter care, changing the catheter, and typically orders to monitor the placement of the catheter and the resident's urinary output.</p> <p>During an interview on 05/15/2024 at 1:10 PM, LVN #8, a treatment nurse, stated she did not admit Resident #50, and there were no orders for her to complete any catheter treatments for the resident.</p> <p>During an interview on 05/15/2024 at 11:32 AM, the Director of Nursing (DON) stated Resident #50 readmitted from the hospital with a catheter. She stated there was no physician's order for the catheter in the resident's medical record. The DON stated the admitting nurse should have documented in their assessment that the resident had a catheter, but the nurse did not do it. She stated that the physician should have been contacted for orders when nursing staff saw the catheter, but they did not contact the physician.</p> <p>During an interview on 05/16/2024 at 11:30 AM, the DON stated that a nurse did not complete an admission/readmission document and did not indicate that a head-to-toe assessment had been completed when the resident was readmitted to the facility on [DATE], so the resident's catheter was missed.</p> <p>During an interview on 05/16/2024 at 1:16 PM, Physician #7 stated Resident #50 returned from the hospital with a urinary catheter. The physician stated, of course the admitting nurse should have informed him of the catheter and received orders from him.</p> <p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the admitting nurse to complete a readmission assessment to capture catheter information. The Administrator stated the nurse should have called the physician to get orders for the catheter when they identified the resident had one.</p> <p>46194</p> <p>2. An Admission Record revealed the facility originally admitted Resident #13 on 04/12/2024 and readmitted the resident on 04/23/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident did not have an indwelling urinary catheter at the time of the assessment.</p> <p>Resident #13's care plan revealed a Focus area, initiated on 04/13/2024, that indicated the resident had bowel and bladder incontinence. The care plan did not address the presence of an indwelling urinary catheter.</p> <p>A hospital Discharge Summary, dated 04/23/2024, revealed the resident had renal failure and was being discharged from the hospital to a skilled nursing facility with hospice services. The Discharge Summary did not indicate the resident had an indwelling urinary catheter.</p> <p>Resident #13's Order Summary Report, listing active orders as of 05/14/2024 revealed the resident did not have a physician's order for an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1832 B Street Hayward, CA 94541	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/13/2024 at 10:14 AM, the resident was observed sitting on their bed with an indwelling urinary catheter in place.</p> <p>On 05/15/2024 at 10:10 AM, Licensed Vocational Nurse (LVN) #4 stated there should be a physician's order for the indwelling catheter. The LVN reviewed Resident #13's physician's orders and stated she did not see an order for the catheter. She stated without physician's orders, she did not know how the staff would know what care to provide.</p> <p>On 05/15/2024 at 11:03 AM, the Director of Nursing (DON) stated the staff needed a physician's order for a catheter. The DON stated Resident #13 readmitted from the hospital with the indwelling urinary catheter. Per the DON, there were no orders related to the catheter in Resident #13's electronic health record.</p> <p>On 05/16/2024 at 10:39 AM, the Administrator stated there should be physician's orders for a catheter .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46194</p> <p>Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure narcotic medications were signed out according to professional standards for 1 (Resident #209) of 2 sampled residents reviewed for pain management and failed to ensure narcotic reconciliation counts were completed for 1 of 1 medication room and 1 of 2 medication carts.</p> <p>Findings included:</p> <p>A facility policy titled, Controlled Substances, revised in 04/2019, revealed, 8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The policy indicated, 12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. The policy further indicated, Upon Administration: a. The nurse administering the medication is responsible for recording: (1) name of the resident receiving the medication; (2) name, strength and dose of the medication; (3) time of administration; (4) method of administration; (5) quantity of medication remaining; and (6) signature of nurse administering medication.</p> <p>1. An Admission Record revealed the facility admitted Resident #209 on 05/11/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of pain to left hip.</p> <p>Resident #209's care plan included a Focus area, initiated on 05/12/2024, that indicated the resident was at risk for pain. An intervention dated 05/12/2024 directed staff to administer analgesics per physician's orders.</p> <p>Resident #209's Order Summary Report, listing active orders as of 05/14/2024, contained an order, dated 05/11/2024, for hydrocodone-acetaminophen (a pain medication) 10-325 milligrams (mg), give one tablet by mouth every four hours as needed (PRN) for pain.</p> <p>Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record, revealed the pharmacy filled nine tablets of the resident's hydrocodone-acetaminophen on 05/11/2024. Per the record, Licensed Vocational Nurse (LVN) #6 signed as having administered one tablet on 05/12/2024. However, the column to document the time was not completed.</p> <p>During an interview on 05/14/2024 at 4:11 PM, LVN #6 verified it was her initials on Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record and indicated she should have recorded the time she removed the medication and administered it to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 05/13/2024 at 12:25 PM, LVN #4 stated Resident #209 had complained of pain and had received their hydrocodone 10-325 about an hour prior to the interview. During the interview, a prefilled medication card containing Resident #209's hydrocodone-acetaminophen was observed. There were seven pills in the card with two empty slots that had been punctured. At this time, LVN #4 reviewed Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record, and she confirmed there was no documentation on the record indicating she had removed and administered a dose of the hydrocodone-acetaminophen approximately one hour earlier. LVN #4 said she failed to sign the medication out as she should have. In the presence of the surveyor, LVN #4 then signed Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record to reflect a tablet was removed and administered on 05/13/2024 at 10:50 AM. LVN #4 said she forgot to sign the medication out on the narcotic record.</p> <p>During an interview on 05/16/2024 at 10:10 AM, the Director of Nursing (DON) stated staff were to sign narcotics out on the narcotic record.</p> <p>During an interview on 05/16/2024 at 10:31 AM, the Administrator stated the staff should follow the rules of medication administration. The Administrator stated staff should sign narcotics out on the narcotic log.</p> <p>36105</p> <p>2. A Controlled Dugs Count Record for a Unit 2 Narcotic Box, dated 04/2024, revealed the form was formatted for the off-going and oncoming nurses to conduct controlled drug counts three times per day at shift change. There were six shift changes in which no nurse documented the performance of a drug count and 24 shift changes in which only one of two nurses documented the performance of the drug counts.</p> <p>An 8-Hour Controlled Drugs-Count Record for Unit 2A, dated 04/2024, revealed three shift changes in which no nurse documented the performance of a drug count and 15 shift changes in which only one of two nurses documented the performance of the drug counts.</p> <p>A Controlled Drugs Count Record for Unit 2A, dated 05/2024, revealed one shift change in which no nurse documented the performance of a drug count and ten shift changes in which only one of two nurses documented the performance of the drug counts.</p> <p>During an interview on 05/14/2024 at 7:42 AM, Licensed Vocational Nurse (LVN) #4 stated that nurses were supposed to sign the narcotic count sheets immediately after they counted the narcotics with another nurse during a shift change. She stated that both the oncoming nurse and off-going nurse signed the count sheet at shift change as documentation they verified the narcotic counts. LVN #4 further stated when nurses signed the count forms, they were taking accountability for the narcotic count. She stated the blank spaces on the count sheets should have been signed and stated that she could not say if the counts were completed or not because of the blank spaces.</p> <p>During an interview on 05/15/2024 at 9:49 AM, LVN #3 stated when nurses signed the narcotic count sheet, they were taking accountability for the narcotics and verifying the narcotic count was correct. LVN #3 acknowledged that the narcotic count sheets were the facility's documentation to show the count was completed and verified.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/2024 at 9:14 AM, the Infection Control Specialist (ICS) stated the nurse coming onto their shift and the nurse leaving their shift should go into the medication room to verify the lock and seal on the narcotic box was intact and sign the count sheet. He stated the blank spaces on the Narcotic Box count sheet for the emergency kit, and the narcotic count sheets for the medication carts should have been signed, to show the narcotics were accounted for. The ICS stated the only proof they had that they completed a narcotics count was the signed sheets.</p> <p>During an interview on 05/15/2024 at 2:54 PM, the Pharmacist stated she checked the narcotic count documents when she came to the facility and checked the narcotics inventory. She stated when the off-going and the oncoming nurse signed the narcotic count sheets, they were verifying that the count was correct and indicating the oncoming nurse was assuming responsibility for those narcotics at that time. The pharmacist stated if there were missing signatures on the narcotic count sheets, it was significant because the oncoming nurse was responsible if a medication was missing. She stated the count sheets were a way to identify any discrepancies immediately.</p> <p>During an interview on 05/16/2024 at 9:34 AM, the Director of Nursing (DON) stated the narcotic count sheets were intended to track the narcotics to make sure they were not being used by other people. She stated the count sheets were documentation to prove the counts were completed, and with the blank spaces, the facility could not prove the counts were completed.</p> <p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the off-going nurse and the oncoming nurse to count the narcotics together between shifts, to ensure the medications were accounted for.</p> <p>During an interview on 05/17/2024 at 9:29 AM, the DON stated she was ultimately responsible for auditing the narcotic sheets to ensure they were completed shift-to-shift .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #47) of 5 sampled residents reviewed for unnecessary medications was monitored for potential side effects related to the use of a prescribed anticoagulant medication.</p> <p>Findings included:</p> <p>A facility policy titled, Anticoagulation - Clinical Protocol, revised in 11/2018, revealed, The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria [blood in the urine], hemoptysis [coughing up blood], or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.</p> <p>An Admission Record revealed the facility admitted Resident #47 on 02/13/2024. According to the Admission Record, the resident had a medical history that included diagnoses of personal history of pulmonary embolism and heart failure.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was taking an anticoagulant medication.</p> <p>Resident #47's care plan, last updated 05/08/2024, revealed no Focus area that addressed monitoring the resident related to the use of anticoagulant medication.</p> <p>Resident #47's Order Summary Report, listing active orders as of 05/15/2024, contained an order, dated 02/14/2024, for Eliquis (an anticoagulant) 5 milligram (mg) by mouth twice daily for blood clots. The Order Summary Report did not include orders related to monitoring the resident for side effects related to the use of Eliquis.</p> <p>Resident #47's May 2024 Medication Administration Record (MAR) revealed documentation that indicated Resident #47 received Eliquis 5 mg twice daily from 05/01/2024 through 05/14/2024. The MAR contained no documentation of monitoring for potential side effects related to the resident's use of Eliquis.</p> <p>Resident #47's Progress Notes for the time frame 03/01/2024 through 05/16/2024 revealed no Nurses Notes addressing monitoring for potential side effects related to the resident's use of Eliquis.</p> <p>During an interview on 05/15/2024 at 2:11 PM, LVN #4 stated residents receiving anticoagulants should be monitored and the monitoring documented on the resident's MAR. LVN #4 said there was no monitoring on Resident #47's MAR, and there should have been.</p> <p>During an interview on 05/15/2024 at 4:01 PM, the Director of Nursing (DON) stated residents receiving anticoagulants should be monitored for bruising and bleeding. The DON said Resident #47 was taking Eliquis and should be monitored for bruising and bleeding on their MAR.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/16/2024 at 10:43 AM, the Administrator stated monitoring should be in place for residents receiving anticoagulants.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>36105</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure the medication error rate was not greater than 5 percent (%). The facility had 3 medication errors out of 32 total opportunities, resulting in a medication error rate of 9.38%, affecting 2 (Resident #15 and Resident #21) of 5 residents observed during medication administration.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised in 04/2019, revealed, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>An Admission Record revealed the facility originally admitted Resident #15 on 08/13/2021 and readmitted the resident on 02/15/2022.</p> <p>Resident #15's Order Summary Report, listing active orders as of 05/15/2024, revealed an order, dated 02/23/2024, for Multiple Vitamine-Minerals Tablet, one tablet by mouth one time daily for nutritional supplement.</p> <p>Observation of medication administration on 05/15/2024 at 8:07 AM revealed Licensed Vocational Nurse (LVN) #4 gave Resident #15 a multivitamin tablet without added minerals.</p> <p>During an interview on 05/15/2024 at 11:16 AM, LVN #4 stated she did not realize she gave Resident #15 a multivitamin rather than a multivitamin with added minerals and stated that she should have administered a multivitamin with minerals.</p> <p>An Admission Record revealed the facility originally admitted Resident #21 on 11/01/2019 and readmitted the resident on 04/24/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hypertension (high blood pressure).</p> <p>Resident #21's Order Summary Report, listing active orders as of 05/15/2024, revealed an order, dated 05/16/2023, for metoprolol tartrate (medication used to treat high blood pressure) 100 milligrams (mg), one tablet by mouth twice daily for hypertension. The Order Summary Report also contained an order, dated 11/08/2019, for Plavix (an antiplatelet medication) 75 mg, one tablet by mouth one time daily for a history of stroke.</p> <p>Observation of medication administration on 05/15/2024 at 9:06 AM revealed LVN #3 did not administer Resident #21's metoprolol tartrate or Plavix because the medications were not available. Following the observation, LVN #3 contacted the pharmacy.</p> <p>Resident #21's Medication Administration Record [MAR], dated 05/2024, revealed the transcription of the metoprolol tartrate order, which indicated the resident was to receive the medication at 9:00 AM and 5:00 PM. The MAR also revealed the transcription of the Plavix order, which indicated the resident was to receive the medication at 9:00 AM. The MAR revealed LVN #3 documented a 9 for the 9:00 AM administration of the resident's metoprolol tartrate and Plavix, indicating Other/See Progress Notes.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #21's Progress Notes revealed a note, dated 05/15/2024 at 9:37 AM, that indicated a new order for metoprolol tartrate had been faxed to the pharmacy. Progress Notes dated 05/15/2024 at 9:59 AM indicated that the pharmacy was contacted regarding the resident's Plavix. Resident #21's Progress Notes revealed no notes that indicated LVN #3 called the resident's physician.</p> <p>During an interview on 05/15/2024 at 9:40 AM, LVN #3 stated that she called the pharmacy regarding the resident's metoprolol tartrate and was told the pharmacy needed a new order, so she sent one.</p> <p>During an interview on 05/15/2024 at 3:27 PM, LVN #3 stated the Plavix and the metoprolol tartrate had not arrived yet and confirmed the 9:00 AM doses were not administered. She stated she had not contacted the physician regarding the omission of the scheduled medications.</p> <p>During an interview on 05/16/2024 at 1:16 PM, Physician #7 stated if a resident missed a dose of metoprolol tartrate, nursing staff should monitor the resident's heart rate and blood pressure, and the nurse should contact the physician. He stated if any dose of medication was missed, the nurse should call the physician.</p> <p>During an interview on 05/15/2024 at 11:38 AM, the Director of Nursing (DON) stated she expected all ordered medications to be given and expected the nurses to read the label on the medication bottles to ensure they administered the correct medication.</p> <p>During an interview on 05/16/2024 at 9:38 AM, the DON stated the nurse should have given multivitamins with minerals to Resident #15. The DON also stated the nurse should have informed Resident #21's physician regarding the missed doses of Plavix and metoprolol tartrate and monitored the resident's blood pressure. She stated a potential outcome of missing a dose of metoprolol was an increase in the chance of the resident having a hypertensive crisis.</p> <p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the nurses to notify the physician if a dose of medication was missed, and to document it.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>36105</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #21) of 5 residents observed during medication administration was free of a significant medication error. Specifically, the facility failed to administer metoprolol to Resident #21.</p> <p>Findings included:</p> <p>The facility policy, Identifying and Managing Medication Errors and Adverse Consequences, revised April 2007 revealed, 1. The staff and practitioner shall strive to minimize adverse consequences by a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.</p> <p>An Admission Record revealed the facility originally admitted Resident #21 on 11/01/2019 and readmitted the resident on 04/24/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hypertension (high blood pressure).</p> <p>Resident #21's Order Summary Report, listing active orders as of 05/15/2024, revealed an order, dated 05/16/2023, for metoprolol tartrate (medication used to treat high blood pressure) 100 milligrams (mg), one tablet by mouth twice daily for hypertension.</p> <p>Observation of medication administration on 05/15/2024 at 9:06 AM revealed Licensed Vocational Nurse (LVN) #3 did not administer Resident #21 metoprolol tartrate because the medication was not available. Following the observation, LVN #3 contacted the pharmacy .</p> <p>Resident #21's Medication Administration Record [MAR], dated 05/2024, revealed transcription of the metoprolol tartrate order, which indicated the resident was to receive the medication at 9:00 AM and 5:00 PM. The MAR revealed LVN #3 documented a 9 for the 9:00 AM administration of the resident's metoprolol tartrate, indicating Other/See Progress Notes.</p> <p>Resident #21's Progress Notes revealed a note, dated 05/15/2024 at 9:37 AM, that indicated a new order for metoprolol tartrate had been faxed to the pharmacy. Resident #21's Progress Notes, revealed no notes that indicated LVN #3 called the resident's physician. The Progress Notes revealed another note, dated 05/15/2024 at 5:13 PM, that indicated the facility was still awaiting the pharmacy's delivery of Resident #21's metoprolol tartrate.</p> <p>During an interview on 05/15/2024 at 9:40 AM, LVN #3 stated that she called the pharmacy regarding the resident's metoprolol tartrate and was told the pharmacy needed a new order, so she sent one.</p> <p>During an interview on 05/15/2024 at 3:27 PM, LVN #3 stated the metoprolol tartrate had not arrived yet and confirmed the 9:00 AM dose was not administered. She stated she had not contacted the physician regarding the omission of the scheduled medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/16/2024 at 1:16 PM, Physician #7 stated if a resident missed a dose of metoprolol tartrate, nursing staff should monitor the resident's heart rate and blood pressure, and the nurse should contact the physician.</p> <p>During an interview on 05/16/2024 at 9:38 AM, the Director of Nursing (DON) stated the nurse should have informed Resident #21's physician regarding the missed dose of metoprolol tartrate and monitored the resident's blood pressure. The DON stated a potential outcome of missing a dose of metoprolol was an increase in the chance of the resident having a hypertensive crisis.</p> <p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the nurse to notify the physician if a dose of medication was missed and to document it.</p>

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 05/17/2024
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46194</p> <p>Based record review, interview, and facility document and policy review, the facility failed to ensure nursing staff documented the administration of as needed (PRN) pain medication for 1 (Resident #209) of 2 sampled residents reviewed for pain management.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised in 04/2019, revealed, 22. The individual administering the medication initials the resident's MAR [medication administration record] on the appropriate line after giving each medication and before administering the next ones.</p> <p>An Admission Record revealed the facility admitted Resident #209 on 05/11/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of pain to left hip.</p> <p>Resident #209's care plan included a Focus area, initiated on 05/12/2024, that indicated the resident was at risk for pain. An intervention dated 05/12/2024 directed staff to administer analgesics per physician's orders.</p> <p>Resident #209's Order Summary Report, listing active orders as of 05/14/2024, contained an order, dated 05/11/2024, for hydrocodone-acetaminophen (a pain medication) 10-325 milligrams (mg), give one tablet by mouth every four hours PRN for pain.</p> <p>Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record, revealed the pharmacy filled nine tablets of the resident's hydrocodone-acetaminophen on 05/11/2024. Per the record, Licensed Vocational Nurse (LVN) #6 signed as having administered one tablet on 05/12/2024 (no time specified), and LVN #4 signed as having administered another tablet on 05/13/2024 at 10:50 AM.</p> <p>Resident #209's May 2024 MAR revealed no documentation of the administration of the resident's doses of hydrocodone-acetaminophen signed out by staff on the narcotic record on 05/12/2024 and 05/13/2024.</p> <p>During an interview on 05/14/2024 at 4:11 PM, LVN #6 verified it was her initials on Resident #209's CONTROLLED DRUG RECORD Individual Patient's Narcotic Record. LVN #6 reviewed the resident's MAR and stated she failed to sign the MAR to indicate the medication was administered. LVN #6 said she thought she gave the medication at 6:30 PM. LVN #6 stated it was important to document the time of administration so other staff would know what time the next pill could be administered.</p> <p>During an interview on 05/13/2024 at 12:25 PM, LVN #4 confirmed she had administered a dose of Resident #209's hydrocodone-acetaminophen 10-325 about an hour prior to the interview. LVN #4 said the administration of medications should be documented on the electronic MAR when they were given, not at a later time.</p> <p>During an interview on 05/16/2024 at 10:10 AM, the Director of Nursing (DON) stated staff were educated to document on the MAR immediately after giving a medication.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/16/2024 at 10:31 AM, the Administrator stated staff should follow the rules of medication administration. The Administrator stated staff should sign the MAR right after administering a medication.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46194</p> <p>Based on observation, interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure enhanced barrier precautions (EBP) were implemented and catheter collection bags were kept off the floor for 3 (Residents #13, #5, and #50) of 3 sampled residents with indwelling urinary catheters.</p> <p>Findings included:</p> <p>CDC guidelines titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, revealed Enhanced Barrier Precautions Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> - Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing <p>In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An undated facility policy titled, Enhanced Barrier Precautions, revealed, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The policy also indicated, 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. The policy also indicated, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The policy further indicated, 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</p> <p>A facility policy titled, Catheter Care, Urinary, revised in 08/2022, revealed, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Under the section titled, Infection Control, the policy specified, 2. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>1. An Admission Record revealed the facility originally admitted Resident #13 on 04/12/2024 and readmitted the resident on 04/23/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident did not have an indwelling urinary catheter at the time of the assessment.</p> <p>Resident #13's care plan revealed a Focus area, initiated on 04/13/2024, that indicated the resident had bowel and bladder incontinence. The care plan did not address the presence of an indwelling urinary catheter.</p> <p>A hospital Discharge Summary, dated 04/23/2024, revealed the resident had renal failure and was being discharged from the hospital to a skilled nursing facility with hospice services. The Discharge Summary did not indicate the resident had an indwelling urinary catheter.</p> <p>Resident #13's Order Summary Report, listing active orders as of 05/14/2024, revealed no orders related to an indwelling urinary catheter. The Order Summary Report also did not reveal any orders directing staff to implement EBP related to the presence of an indwelling urinary catheter.</p> <p>On 05/13/2024 at 10:14 AM, the resident was observed sitting on their bed with an indwelling urinary catheter in place. The resident's catheter bag was on the floor. There was no hanging device observed on the top of the catheter drainage bag to secure the bag to the bed. During the observation, Licensed Vocational Nurse (LVN) #4 came into the room and answered a question for the resident but did not address the catheter drainage bag being on the floor. At the time of the observation, there were no posted signs to indicate the resident was on EBP due to the resident having an indwelling urinary catheter.</p> <p>On 05/13/2024 at 11:44 AM, Resident #13's catheter drainage bag was observed on the floor in the resident's room.</p> <p>On 05/14/2024 at 4:04 PM, Resident #13 was observed in the dining area with the catheter drainage bag in a privacy bag, which was resting on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/15/2024 at 7:56 AM, Resident #13's catheter drainage bag was in a privacy bag, which was resting on the floor.</p> <p>On 05/15/2024 at 9:27 AM, Certified Nursing Assistant (CNA) #2 stated catheter drainage bags should be in a privacy bag, hung on the side of the bed and should not touch the ground.</p> <p>On 05/15/2024 at 10:10 AM, LVN #4 stated the catheter drainage bag should be in a privacy bag and it should not be on the floor because that was unsanitary.</p> <p>On 05/15/2024 at 4:06 PM, the Director of Nursing (DON) stated the catheter drainage bag should never be on the floor and indicated that it would be an infection control issue.</p> <p>On 05/16/2024 at 10:04 AM, the DON stated the facility required gloves for catheter care, and if there was a possibility for spillage, staff should wear a gown. The DON stated that she did not know about EBP.</p> <p>On 05/16/2024 at 2:49 PM, the DON stated they had educated themselves on EBP and would be implementing the needed PPE that day.</p> <p>On 05/16/2024 at 10:39 AM, the Administrator stated there should not be a catheter drainage bag on the floor and stated that that it was an infection control concern.</p> <p>On 05/16/2024 at 4:03 PM during a follow up interview, the Administrator stated they were not previously aware of EBP requirements.</p> <p>2. An Admission Record revealed the facility originally admitted Resident #5 on 03/29/2018 and readmitted the resident on 12/19/2019. According to the Admission Record, the resident had a medical history that included a diagnosis of retention of urine.</p> <p>Resident #5's care plan revealed a Focus area, initiated on 09/25/2019, that indicated the resident had a suprapubic catheter related to a diagnosis of urinary retention.</p> <p>Resident #5's Order Summary Report, listing active orders as of 05/14/2024, revealed an order, dated 06/03/2021, for a suprapubic catheter. The Order Summary Report did not reveal any orders directing staff to implement EBP.</p> <p>On 05/14/2024 at 9:03 AM, Resident #5's room was observed with no signage to indicate staff were to use EBP.</p> <p>During an observation on 05/15/2024 at 8:12 AM, staff provided Resident #5 a bed bath and only wore gloves to provide close contact care inside the resident's room. There was no signage on the door directing staff to implement EBP.</p> <p>On 05/15/2024 at 7:52 AM, Resident #5's catheter drainage bag was inside a privacy bag, and the privacy bag was resting on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/15/2024 at 9:27 AM, Certified Nursing Assistant (CNA) #2 stated catheter drainage bags should be put in a privacy bag and hung on the side of the bed and should not touch the ground. CNA #2 said Resident #5 was not on any type of precautions, so he only wore gloves when providing care to the resident.</p> <p>On 05/15/2024 at 11:39 AM Licensed Vocational Nurse (LVN) #8, a treatment nurse, stated she was required to wear gloves and a mask for the resident's and her protection. LVN #8 stated the resident was not on any infection control precautions.</p> <p>On 05/15/2024 at 11:48 AM, the Infection Control Specialist (ICS) stated gloves were the only required PPE for catheter care. He further stated catheters should not be on the floor due to infection control concerns because the floor was contaminated.</p> <p>On 05/15/2024 at 4:06 PM, the Director of Nursing (DON) stated the catheter bag should never be on the floor and indicated that it would be an infection control issue.</p> <p>On 05/16/2024 at 10:04 AM, the DON stated the facility required gloves for catheter care, and if there was a possibility for spillage, staff should wear a gown. The DON stated that she did not know about EBP.</p> <p>On 05/16/2024 at 2:49 PM, the DON stated they had educated themselves on EBP and would be implementing the needed PPE that day.</p> <p>On 05/16/2024 at 10:39 AM, the Administrator stated there should not be a catheter bag on the floor and stated that that it was an infection control concern.</p> <p>On 05/16/2024 at 4:03 PM during a follow up interview, the Administrator stated they were not previously aware of EBP requirements.</p> <p>36105</p> <p>3. An Admission Record revealed the facility originally admitted Resident #50 on 04/19/2024 and readmitted the resident on 05/10/2024.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2024, revealed Resident #50 had short-term and long-term memory problems and had severe cognitive impairment for daily decision making, per a staff assessment of mental status (SAMS). The MDS revealed Resident #50 was always incontinent of bowel and bladder and did not indicate that the resident had an indwelling urinary catheter at the time of the assessment.</p> <p>Resident #50's care plan, last updated on 05/10/2024, revealed no Focus area addressing the presence of an indwelling urinary catheter.</p> <p>An observation on 05/13/2024 at 2:07 PM revealed Resident #50 lying in their bed with a urinary catheter in place. The resident's catheter drainage bag was hanging on the right side of the bed. The catheter drainage bag was on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 05/14/2024 at 6:53 AM revealed Resident #50 lying in their bed. The resident's catheter drainage bag was on the fall mat on the right side of the bed.</p> <p>An observation on 05/14/2024 at 7:10 AM revealed Resident #50 lying in their bed. The resident's catheter drainage bag was on the fall mat on the floor on the right side of the bed.</p> <p>An observation on 05/14/2024 at 10:58 AM revealed Resident #50 lying in their bed. The resident's catheter drainage bag was on the fall mat on the floor on the right side of the bed.</p> <p>An observation on 05/14/2024 at 12:07 PM revealed Resident #50's catheter drainage bag was on the fall mat on the floor on the right side of the resident's bed.</p> <p>During an observation on 05/15/2024 at 8:21 AM, Certified Nursing Assistant (CNA) #5 provided Resident #50 a bed bath and indwelling urinary catheter care. CNA #5 wore gloves but did not wear a gown while providing care.</p> <p>During an interview on 05/15/2024 at 11:19 AM, CNA #5 stated she knew how to care for each resident by checking the CNA care plan or a nurse would inform her. CNA #5 stated a nurse informed her Resident #50 had a urinary catheter when they readmitted to the facility. She stated when she provided care for Resident #50, she provided catheter care the way she learned in school. CNA #5 stated the appropriate personal protective equipment (PPE) for catheter care was gloves. She stated if the resident was on contact precautions, then appropriate PPE was a gown and gloves. CNA #5 stated the catheter drainage bag should not be on the floor because of a risk of infection.</p> <p>During an interview on 05/15/2024 at 11:23 AM, Licensed Vocation Nurse (LVN) #4 stated she did not know about EBP.</p> <p>During an interview on 05/15/2024 at 11:44 AM, LVN #3 stated she had not been educated about EBP. She stated catheter drainage bags should not be on the floor. LVN #3 stated there was a greater chance of infection from the drainage bag being on the floor or fall mat.</p> <p>During an interview on 05/15/2024 at 11:50 AM, the Infection Control Specialist (ICS) stated for catheter care and a bed bath, the appropriate PPE was gloves. He stated the catheter drainage bag should hang from the bed and not be on the floor. He stated the floor and the fall mat were contaminated and could cause an infection for the resident.</p> <p>During an interview on 05/15/2024 at 1:10 PM, LVN #8 stated she expected the catheter drainage bag to be off the floor or the fall mat because both were contaminated and posed a risk of infection.</p> <p>During an interview on 05/15/2024 at 4:06 PM, the Director of Nursing (DON) stated the catheter drainage bag should never be on the floor and indicated that it would be an infection control issue.</p> <p>During an interview on 05/16/2024 at 10:04 AM, the DON stated that she did not know about EBP.</p> <p>During an interview on 05/16/2024 at 2:49 PM, the DON stated they had educated themselves on EBP and would be implementing the needed PPE that day.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/2024 at 3:59 PM, the Administrator stated she expected the resident's catheter bag to not be touching the floor. She stated there was a potential risk of exposing bacteria into the drainage bag because anything touching the floor was exposed to germs and bacteria. The Administrator stated she had just become aware of EBP.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37935</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure multiple-resident bedrooms measured at least 80 square (sq) feet (ft) per resident in 6 (Rooms 5, 23, 26, 28, 29, and 30) of 45 resident rooms in the facility.</p> <p>There were no negative consequences attributable to the decreased space in the six rooms; nor were any safety concerns noted. Recommend granting of room waiver.</p> <p>Findings included:</p> <p>An undated facility policy titled, Resident Bedrooms, indicated, All residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The policy indicated 1. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. (Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the Resident's health and safety.)</p> <p>During observations on 05/15/2024 beginning at 2:16 PM, the Maintenance Supervisor measured all 45 resident rooms in the facility and the following multiple-resident rooms were identified as providing less than 80 sq ft per resident:</p> <ul style="list-style-type: none"> - room [ROOM NUMBER] had two beds and measured 145 sq ft, equaling 72.5 sq ft per resident; - room [ROOM NUMBER] had three beds and measured 230 sq ft, equaling 76.7 sq ft per resident; - room [ROOM NUMBER] had three beds and measured 220 sq ft, equaling 73.3 sq ft per resident; - room [ROOM NUMBER] had three beds and measured 220 sq ft, equaling 73.3 sq ft per resident; - room [ROOM NUMBER] had three beds and measured 225.5 sq ft, equaling 75.2 sq ft per resident; and - room [ROOM NUMBER] had three beds and measured 220 sq ft, equaling 73.3 sq ft per resident. <p>During the observations, resident rooms were observed with closets, nightstands, bedside tables, and medical equipment, including wheelchairs. No closets, doorways, or bathrooms were blocked by the furniture or equipment. Residents moved freely around their rooms, and no residents voiced concerns about their rooms.</p> <p>During an interview on 05/16/2024 at 8:55 AM, Certified Nursing Assistant (CNA) #1 said the size of some of the residents' rooms did not prevent her from providing proper care to the residents.</p> <p>During an interview on 05/16/2024 at 8:57 AM, CNA #2 said the size of some of the residents' rooms did not prevent her from doing her job or providing care to the residents.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/2024 at 9:00 AM, Licensed Vocational Nurse (LVN) #3 stated the size of some of the residents' rooms did not prevent her from providing care to the residents.</p> <p>During an interview on 05/16/2024 at 9:20 AM, the Director of Nursing (DON) stated she did not know what the residents' room size requirements were. She stated that she expected rooms to be large enough for staff to provide care for the residents and for the residents to have enough space for their belongings and to move around the room without having things in their way.</p> <p>During an interview on 05/16/2024 09:27 AM, the Administrator stated residents' rooms should provide 80 sq ft per resident. She stated the size of the room was important to allow the residents to move around and for staff to safely provide care to the residents. She stated she expected rooms to meet the 80 sq ft per resident requirement.</p>		