STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055434	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Gardens Post Acute	1628 B Street Hayward, CA 94541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a qualified and competent director of nursing had oversight of the facility when Assistant Director of Nursing (ADON), who did not have a Registered Nursing license, assumed the director of nursing duties and during the survey, assigned Registered Nurse Supervisor/Director of Nursing (RNS)/[DON], who was not trained nor competent in the role, as director of nursing. The facility was previously cited for assigning ADON as the director of nursing and did not follow their plan of correction which was submitted to the state agency on 12/12/2024.This failure resulted unqualified nursing leadership for 15 months which resulted in nursing staff failing to follow provide adequate mental health services to Resident 1 after Resident 1's suicide attempt (see F tag 742).During a record review of facility statement of deficiencies document titled, Department of Health and Human Services Centers for Medicare and Medicaid Services Statement of Deficiencies and Plan of Corrections, dated 12/12/2024, the document indicated ADON was assigned the facility Director of Nursing for seven months. The document indicated the facility would hire a registered nurse for the Director of Nursing position.During a record review of facility roster titled, [Facility] Employee Roster Report, dated 11/20/24, the roster indicated ADON was listed as the Director of Nursing and RNS/[DON] was listed RN (AM Supervisor).During record review of state registered nursing board records, on 8/4/25, the records did not indicate ADON had a Registered Nurse license.During a concurrent observation and interview on 8/6/25, at 9:21 a.m. with Operations Assistant (OA), OA greeted surveyors at the facility entrance and introduced ADON as the Director of Nursing, OA went to summon ADON for the entrance conference and then corrected themselves and stated ADON was not the Director of Nursing.During a concurrent observation, interview and record review on 8/6/25, at 11:30 a.m. with RNS[DON], Resident 1's nursing progress note titled, [Facility] Progress Notes *NEW*, dated 5/3/25, was reviewed. RNS[DON] stated they entered a progress note indicating they found Resident 1 with wiring around their neck attempting to strangle himself. The progress note indicated it was signed RNS[DON] - RN Supervisor [e-SIGNED]. When RNS[DON] was asked if they had notified the Director of Nursing about the incident, RNS[DON] replied not because RNS[DON] had been the Director of Nursing for the past two years. RNS/[DON] was wearing a badge indicating they were the RN supervisor and did not wear anything else that identified them as the Director of Nursing. RNS/[DON] stated they had assigned ADON all the DON duties because RNS/[DON] typically spent their time at the front nurses station.During an interview on 8/6/25, at 12:12 p.m. with pharmacist consultant (PC), PC stated they had been the pharmacist consultant with the facility for two years and stated RNS/[DON] was not the Director of Nursing.During an interview on 8/6/25, at 12:25 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated ADON was the Director of Nursing.During an interview on 8/6/25, at 12:51 p.m. with occupational therapist assistant (OTA), OTA stated ADON was the facility Director of Nursing.During an interview on 8/6/25, at 12:56 p.m. with admission manager (AM), AM stated ADON and Director of Staff Development reviewed potential residents to determine if they were appropriate for the facility. AM did not specifically state ADON was the (continued on next page)

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Director of Nursing. AM stated they would text the Director of Nursing if AM had questions about the medical appropriateness of potential residents. Once a resident has been approved for admission, their information is populated in the electronic medical record (EMR). AM stated RNS/[DON] was a Nurse Supervisor and would be able to see the EMR information after a resident was accepted.During a record review of facility staff sign in sheet titled, Nursing Staffing Assignment and Sign-in Sheet, dated 1/17/25, 3/28/25, 5/3/25 and 7/4/25 and facility staff ratio sheet [Facility] Estimated Daily DHPPD, dated 1/17/25, 3/28/25, 5/3/25 and 7/4/25, the staff sign-in sheet indicated RNS/[DON] had signed as the Nursing Supervisor for all four dates. The sign-in sheets dated 1/17/25, 5/3/25 and 7/4/25 indicated ADON was listed as the Director of Nursing. The sign in sheet, dated 3/28/25, indicated ADON and RNS/[DON] were the Director of Nursing with RNS/[DON]'s name was handwritten on the sheet compared to typed names for other staff. The facility staff ratio sheets dated 1/17/25 and 3/28/25, indicated there was both a Supervisor nurse (RN) and DON working on those dates. The facility staff ratio sheets dated 5/3/25 and 7/4/25, indicated a Supervisor nurse (RN) working, but no DON was working on those dates.During a concurrent interview and record review on 8/6/25, at 2:11 p.m. with OA, RNS/[DON]'s human resources (HR) file titled View Worker [RNS/[DON]], dated 8/6/25, was reviewed. OA stated this was the current HR file for RNS/[DON] The HR file indicated ADON was the manager of RNS/[DON] and did not indicate RNS/[DON] was the facility Director of Nursing. The file indicated a management structure listing ADON as the facility's Director of Nursing throughout the file.During an observation on 8/6/25, at 2:13 p.m., RNS/[DON] was in the Director of Nursing's office, during a general review of Resident 1's medical record, RNS/[DON] did not know how to view or print copies of Resident 1's past progress notes and care plans. RNS/[DON] needed to ask for assistance to find the information.During an interview on 8/6/25, at 2:49 p.m., with RNS/[DON], an inquiry was made into RNS/[DON]'s function as the Director of Nursing. RNS/[DON] was unable to answer questions about the facility process of creating a quality assurance performance improvement (QAPI) plan and did not know of any current QAPI projects. RNS/[DON] was unable to describe what a QAPI plan was. RNS/[DON] was unable to describe AM's process for screening resident's appropriateness for the facility, and stated they only learned about resident after their records appear on the electronic medical record.During a phone interview on 8/6/26, at 7:44 p.m. ADON was on the phone with RNS/[DON] coaching RNS/[DON] to remain calm. ADON stated RNS/[DON] recalled having an interdisciplinary team (IDT) meeting regarding Resident 1's suicide attempt but did not write down or recall the exact date and did not recall details about the meeting. RNS/[DON] stated the IDT meeting might have been on 5/5/25 or 5/6/25 with Medical Doctor 1(MD1).During a phone interview on 8/6/26 at 7:46 p.m. with MD 1 and with ADON in the room, MD 1 stated there was no IDT meeting during week following Resident 1's suicide attempt.During a record review of facility Quality Assurance and Performance improvement (QAPI) meeting sign in sheet titled, Weekly IDT Meeting Sign Sheet Topic: QUAPI [DATE], dated 3/11/25 and Weekly IDT Meeting Sign Sheet Topic: QAPI May, dated 6/10/25, the QAPI sign in sheets indicated RNS/[DON] was not present for both meeting. Both sheets indicated ADON was present for the QAPI meeting.During record review of facility policy and procedure (P&P) titled, Quality Assurance and Performance Improvement Program - Governance and Leadership, dated 3/2020, the P&P indicated the QAPI committee include the director of nursing services.During a record review of ADON's HR file titled, ADON: ADON, dated 8/6/25, the file indicated ADON was hired as Asst. Director of Nursing (RN)-S. The HR file indicated ADON had received discretionary monthly payments titled, DON monthly bonus from 11/2024 to 7/2025.During a phone interview on 8/11/25, at 8/11/25, at 1:49 p.m. with Administrator (ADM), the ADM stated they had hired and trained RNS/[DON] as the Director of Nursing on 12/24 but did not have any supporting documentation.During a record review of an email sent by ADM, dated 8/12/25, the email indicated they did not have records of RNS/[DON]'s training or job description as the DON and would be backdating documents when RNS/[DON] returned from vacation.During a phone interview on 8/21/25 at 11:11 a.m. with the Ombudsman (OM), the OM stated the ADON had introduced themselves as the DON and did not recall RNS/[DON] as the DON.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observation, interview and record review, the facility failed to provide adequate and timely mental health services for one of four sampled residents (Resident 1) who attempted suicide by strangulation when facility:1. allowed Resident 1 access to the same ligature implement used in their suicide attempt for more than three months and, 2. did not provide Resident 1 with adequate follow up care when the Assistant Director of Nursing, who had been acting as director of nursing, provider and police were not informed of Resident 1's suicide attempt.This failure resulted in Resident 1's continued thoughts of suicide without appropriate care or follow up interventions for more than three months.A review of Resident 1's admission record indicated Resident 1 was admitted for hemiplegia (loss of muscle function on one side of the body) and hemiparesis (relatively mild loss of strength in the arm, leg and sometimes face on one side of the body) following cerebral infarction (death of an area of brain tissue when there, low back pain, weakness, and history of falling.During a record review of Resident 1's progress notes titled, [Facility] Progress Notes *NEW*, dated 8/6/25, Resident 1's progress note dated 5/2/25, at 9:24 p.m., was reviewed. The progress note indicated Licensed Vocational Nurse 1 (LVN 1) documented Resident 1's Change in Condition which indicated at 5/2/25, at 9:20 p.m., Resident 1 was yelling ?I want to kill myself' over and over. Resident 1 cannot be distracted from his suicidal ideation. MD notified.During a concurrent interview and record review on 8/7/25, at 2:30 p.m., with Operations Manager (OM), the police call report titled City of [City] Emergency Communications Center Call for Service Detail Report - CFS 1005, dated 5/2/25, at 9:39 p.m., was reviewed. OM stated the record was the only police record for the month of May. The report indicated Resident 1 was threatening to hurt himself.upset that mother passed away recently.yelling can hear him in the background. The report indicated [City] officers were in the facility on 5/2/25, at 10:14 p.m., and spoke to [Resident 1]. He wanted to hurt himself due to the fact of him having back pain.During a concurrent interview and record review on 8/6/25, at 11:30 a.m., with Registered Nurse Supervisor/Director of Nursing (RNS/[DON]), Resident 1's progress note titled, [Facility] Progress Notes *NEW*, dated 8/6/25, was reviewed, the note indicated on 5/3/25, at 6:20 a.m., RNS/[DON] found out patient succeeded to pull circadia (a electronic medical device attached to the wall used to monitor resident breathing and activity) wiring.and tried to strangle himself by using the wire to entangle to his neck. RNS/[DON] stated they were rounding and found Resident 1 with a cable around their neck. RNS/[DON] stated Resident 1 had suicidal ideation the previous day. After removing the cable around Resident 1's neck, they asked two certified nursing assistants to move Resident 1 out of the room. After a review of the progress note, RNS/[DON] stated they could not recall if the police or provider was called. RNS/[DON] stated they did not call the Director of Nursing because they stated, I was the Director of Nursing. RNS/[DON] stated the progress note they wrote did not indicate the police or provider were contacted. RNS/[DON] was unable to find documentation the circadia wire was removed from the room. RNS/[DON] stated there was an order for suicide monitoring.During a record review of Resident 1's physician order set titled [Facility] Order Review Report, Dated 8/6/26, the order set indicated Resident 1 had an order to monitor every shift for suicidal ideation: Repeatedly expressing desire to kill himself. The order set did not indicate any orders to remove strangulation implements from his vicinity. The order set also indicated two psych consults on 6/3/25 and 7/30/25. During a record review of Resident 1's psychology note titled [Contractor] Psychology Initial Evaluation Note], dated 6/12/25 and 6/16/25, both notes did not indicate any specific evaluation or treatment of the 5/3/25 suicide attempt.During a concurrent observation and interview of Resident 1's room, on 8/6/25, at 11:02 a.m., Resident 1 was in their room in bed with the covers over them. A bedside table was in front of them with a call bell next to the bed. Next to Resident 1's bed was the circadia device with wiring attached to the wall. Resident 1 stated they recalled a recent (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suicide ideation and attempt. When asked about the suicide attempt, Resident 1 began to cry inconsolably. Resident 1 was unable to answer questions verbally because of the crying and could only shake their head or nod due to the crying. Resident 1 nodded their head when asked if they used anything in the room for the suicide attempt and nodded when the surveyor pointed to the circadia device in the room. When asked if they still had thoughts of suicide, Resident 1 nodded and began to cry more intensely and was visibly shaking. Resident 1 continued to cry for 10 minutes with surveyor in the room. After Resident 1 stopped crying, Resident 1 stated they were not sent out for further evaluation, and the facility did not provide any follow up to the suicide attempt. Resident 1 stated they still wanted to get help and talk about the suicide attempt.During a concurrent interview and record review on 8/6/25, at 1:00 p.m., RNS/[DON] stated they were the Director of Nursing. RNS/[DON] stated Resident 1's medical record did not have a care plan, change in condition documentation, interdisciplinary team (IDT) meeting or specific interventions ordered to address the 5/3/25 suicide ideation. RNS/[DON] stated as Director of Nursing, they expected staff to follow policy and procedure for suicide attempts.During an interview on 8/6/25, at 3:00 p.m., with Medical Doctor (MD 1), MD stated they were notified of Resident 1's suicidal ideation twice during Resident 1's admission, once on 5/2/25 and once in June, but did not recall being informed of the suicide attempt. MD 1 stated they received one notification in May 2025 and one notification in June 2025. MD 1 stated they were not part of any IDT meeting regarding Resident 1's suicide attempt but expected staff to remove the strangulation implement and for Resident 1 to have a psychiatric consult.During an interview and record review on 8/6/25, at 7:30 p.m. with the Assistant Director of Nursing (ADON), Resident 1's medical record was reviewed. the ADON stated they were not previously informed of Resident 1's suicide attempt, did not have an IDT meeting about Resident 1's suicide attempt and did not have a care plan regarding Resident 1's suicide attempt.During an interview on 10/30/25, at 11:45 a.m. with Medical Consultant (MC), MC stated suicide attempts were psychiatric emergencies similar to a heart attack and would expect staff to provide immediate treatment and evaluation. Evaluation would include the provider and law enforcement to determine if there is danger to the resident.During a review of facility policy and procedure (P&P) titled, Response to Attempted Suicide and Suicide Attempts in Progress, dated 1/2025, the P&P indicated in response to suicide attempts staff must respond promptly, follow established procedures, and notify appropriate personnel, including the resident's physician, legal representative.and emergency service. The P&P further indicated in response to a suicide attempt in progress staff dial 911 immediately and notify them of a psychiatric emergency in progress.notify the charge nurse and/or the Director of Nursing (DON) at once.arrange for a psychiatric or psychological evaluation as soon as possible.follow provider recommendations for treatment or transfer to a psychiatric facility.update the resident's care plan to reflect suicide risk and prevention measures. Include behavioral management strategies and therapeutic interventions.Conduct a debriefing session with all staff involved.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure, for residents 1-11, the scheduled (controlled medication, narcotic) medication record system was complete (all documents available) and accurate (data match). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs (Narcotic Take Back Log). The facility did not have complete records. The facility did not have accurate records.These failures resulted in the potential for undetected loss and diversion (theft). During an interview, on 8/7/25 at 9:20 a.m., Medical Record Director (MRD) was asked to describe the scheduled medication accountably (records of narcotic use) procedure. Her description included pharmacy Shipping Manifests and CDRs were scanned (electronic copies). The scanned copies were retained. The scanning process started on 3/23.During a concurrent observation and interview, on 8/7/25 at 10:20 a.m., at a medication cart (stores medication), Licensed Vocational Nurse (LVN 1) was asked to describe the schedule medication accountability procedure. Continuing the interview at 10:30 a.m., his description included receiving the scheduled medication and signing the Shipping Manifest. He then placed the scheduled medication into the medication cart. He filed the CDR at the cart. His description included handing remaining discontinued scheduled medication to the Director of Nursing (DON). LVN 1 and the DON counted the remaining medication. Both signed the CDR documenting the transfer of the medication to the DON. During an interview, on 8/7/25 at 11 a.m., ADON was asked to describe the scheduled medication accountability procedure. Her description included the unit nurse handed the remaining medication and the CDR to the DON. The amount transferred was documented in the Narcotic Take Back Book. The nurse and the DON signed the Narcotic Take Back Book documenting the amount transferred. The DON and the pharmacist destroyed the medication. The DON and the pharmacist signed the Narcotic Take Back Book to verify the amount destroyed. The CDR was filed in medical recordsDuring a concurrent interview and document review, on 8/7/25 at 12:35 a.m., ADON identified the Shipping Manifests, CDR, and Narcotic Take Back Log (Narcotic Take Back Book). The documents were from 1/1/24-3/31/24. During a concurrent interview and record review, on 8/8/25 at 9:55 a.m., ADON identified CDR 6510061 Resident 1 Hydrocodone (narcotic pain reliever)/APAP (acetaminophen, non-narcotic pain reliever) 5/325 mg (milligram) Tablet (on two prescription cards, CDRs with the same number). ADON acknowledged the CDRs had a space for Signature of Nurse Receiving Medication, Date and No. of Doses Received. ADON acknowledged both cards did not document the nurse signed, dated, and the doses received. During a concurrent interview and record review, on 8/8/25 at 12:45 a.m., ADON identified the Narcotic Take Back Log. The log required licensed nurse giving back or LN giving Nurse and Accepting RN to be completed for each line item (resident prescription). Inspection of the log entries on page 6 through page 22, showed 21 line items where one nurse signed as both licensed nurse giving back/LN giving Nurse and Accepting RN. Five instances are listed below.6234192 Resident 2 Hydromorphone (narcotic pain reliever) 2 mg tablet #556173765 Resident 3 Oxycodone (narcotic pain reliever) 10 mg #26120466 Resident 4 Hydrocodone/APAP 5/325 mg #95969962 Resident 5 Hydrocodone/APAP 5/325 mg #545673957 Resident 6 Hydrocodone/APAP 5/325 mg #5In addition, 79 line items were incomplete due to missing the LN giving signature. Five instances are listed below.6206149 Resident 7 Morphine (narcotic pain reliever) Sulf ER 15 mg tab #46264040 Resident 8 Oxycodone 5 mg T #546213128 Resident 9 Oxycodone 5 mg T #566130195 Resident 10 Oxycodone/APAP 10/325 mg #155621896 Resident 11 Hydrocodone/APAP 5/325 mg #13ADON acknowledged the above line items were missing the required signatures. The total number of all line items on pages 6-22 were 137. An administrative record review, of the policy for Controlled Substances (November 2022), showed Dispensing and Reconciling Controlled Substances, showed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispensing and Reconciling Controlled Substances, 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage.An administrative record review, of the policy for Controlled Substances (November 2022), showed Dispensing and Reconciling Controlled Substances, 14. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. An administrative record review, of the policy for Discarding and Destroying Medications (November 2022), showed References, OBRA Regulatory Reference Numbers, S483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.