

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Hayward Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1628 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091</p> <p>Based on observation, interview and record review, the facility failed to conduct an accurate assessment of one resident's functional capacity when Resident 42's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) was coded incorrectly for dental condition. This failure had the potential to cause health decline, and to inhibit or delay proper care planning and treatment.</p> <p>Findings:</p> <p>During a record review of Admission Record, printed December 5, 2024, Resident 42 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis), Aphasia (a brain disorder that affects how you speak and understand language) following Cerebral Infarction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain), and Hemiplegia (paralysis or weakness of one side of the body).</p> <p>During a concurrent observation and interview on 12/2/24, at 2:57 p.m., Resident 42 began to talk but had to remove her upper and lower dentures from her mouth to speak effectively. Resident 42 stated her dentures were loose, and even after applying denture cream, the plates would stay in place for only five minutes or so. Resident 42 also stated she had to remove her teeth to eat meals effectively. Resident 42 stated this made her feel uncomfortable and she wished that something could be done to improve this situation.</p> <p>During a record review of Resident 42's MDS Section C (Assessment of Cognitive Status), dated 11/4/24, Resident 42's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) showed a score of 14, which indicated normal cognitive function.</p> <p>During a record review of MDS Section L (Assessment of Oral/Dental Status), dated 11/4/24, the coding indicated no oral/dental problems were present for Resident 42.</p> <p>During an interview on 12/5/24, at 1:30 p.m., with the Minimum Data Set Nurse Coordinator (MDSC), the MDSC stated if the MDS assessment is not completed correctly, the resident may not receive appropriate care planning and treatment.</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 an interview on 12/5/24, at 1:15 p.m., with the Social Services Director (SSD), the SSD stated Resident 42 had financial concerns affecting her dental care, but other arrangements for reduced-price dental care were possible to obtain for her.</p> <p>During a record review of policy and procedure (P&P) titled, Resident Assessments, dated 2001, the P&P indicated, the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091</p> <p>Based on interview and record review, the facility failed to refer one resident with a serious mental disorder for level II Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that 1. all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2. be offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and 3. receive the services they need in those settings. Regulations governing PASARR are found at 42 CFR S483.100-138) screening when Resident 57's Level 1 PASARR did not accurately show the resident's diagnosed psychiatric condition. This failure had the potential for the resident to receive inappropriate or ineffective care, treatment, or services.</p> <p>Findings:</p> <p>During a record review of Resident 57's Admission Record, printed 12/5/24, the Admission Record indicated that Resident 57 was admitted to the facility on [DATE] with diagnoses including paraplegia (the loss of muscle function in the lower part of the body including both legs), generalized muscle weakness, bipolar disorder (a mental condition in which a person has wide or extreme swings in their mood. Periods of feeling sad and depressed may alternate with periods of intense excitement and activity or being cross or irritable), and personal history of other mental and behavioral issues.</p> <p>During a record review of Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.), Section C, dated 11/14/24, the MDS indicated that the resident Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 15, indicating normal, intact cognitive function.</p> <p>During a record review of MDS, Section I, dated 11/14/24, the MDS was coded to indicate Resident 57 had bipolar disorder.</p> <p>During a record review of Department of Health Care Services (DHCS) Preadmission Screening and Resident Review (PASSR) Level 1 Screening, dated 11/8/24, PASSR Level 1 indicated Resident 57 did not have a serious mental illness.</p> <p>During a record review of facility policy and procedure (P&P) titled, Admission Criteria, dated 2001, the P&P indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASSAR) process .the disciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. Regarding residents that receive a positive level I PASSAR, and a subsequent level II PASSAR screening, the facility would be provided with notification of any specialized or rehabilitative services available, and whether placement in the facility is appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/5/24, at 12:15 p.m., with the Administrator (ADM) and Director of Nursing (DON), the DON stated if a newly admitted resident's Level 1 PASSAR did not correctly identify a diagnosed psychiatric condition, this information would be captured and corrected by the Minimum Data Set Nurse Coordinator(MDSC) during the initial 14 day MDS assessment. At that time, the PASSAR process would restart, leading to a positive level I and a subsequent level II.</p> <p>During an interview 12/5/24, at 1:30 p.m., with the MDSC, the MDSC stated an inaccurate PASSAR screening could result in the resident failing to receive all available services for psychiatric or developmental problems.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766</p> <p>Based on observation, interview, and record review, the facility failed to ensure one out of five sampled residents (Resident 38) received the necessary services to maintain good grooming, and personal hygiene when Resident 38's shower schedule was not consistently followed and reason for refusals were not documented and acted upon.</p> <p>This failure resulted in Resident 38 having unmet physical, physiological, and psychological needs.</p> <p>Findings:</p> <p>A review of Resident 38's face sheet indicated Resident 38 was admitted with diagnoses that included end stage kidney disease, dependence on kidney dialysis, diabetes, and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to guide care), dated 10/24/24, the MDS indicated, a Brief Interview Mental Status (BIMS, a brief scanner to help detect cognitive impairment) score of 15 indicated no cognitive impairment. The MDS also indicated, Resident 1 required partial/moderate assistance from staff for shower/bathe self.</p> <p>During a review of the shower schedule for Resident 38, the shower schedule indicated Resident 38 was to receive a shower every Monday and Friday.</p> <p>During a review of Resident 38's care plan, initiated 8/13/24, the care plan for activities of daily living (ADL)intervention/tasks indicated .Bathing assistance: Resident requires assistance of staff/others to wash and dry hair, trunk/extremities during scheduled bath days 2X/week and as needed . The care plan, initiated on 2/21/24 indicated, .Bathing/Showering: Avoid scrubbing & pat dry sensitive skin .</p> <p>During a concurrent observation and interview on 12/3/24, at 8:55 a.m., with Resident 38 in the lobby, Resident 38 sat in a wheelchair, waiting for transportation to an appointment. Resident had her head covered with a shawl. Resident 38 stated the facility had scheduled her showers on Monday and Friday, which were on her dialysis days. Resident 38 stated her dialysis days were Monday, Wednesday, and Friday - 10 a.m. was dialysis, breakfast was 7:30 a.m. and she was picked up at 9 a.m. She came back at 4 p.m. from dialysis. Resident 38 stated she had not had a shower for several weeks and no bed baths were given.</p> <p>During an interview on 12/4/24, at 12:30 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated showers were scheduled to be given to residents twice a week. CNA 1 showed the showers/bath daily schedule in a binder in the front station desk. CNA 1 stated staff currently charted on the shower and bed bath sheet noted as 'weekly body checklist' and placed the sheet in the Acting Director of Nursing (ADON) box on ADON's door.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/4/24, at 2:15 p.m., with Registered Nurse Supervisor (RNS) 1 and Medical Records Director (MRD), RNS 1 stated the CNAs documented on the weekly body checklist sheets and the checklist would indicate if a Resident had a bed bath or a shower. She stated the CNAs gave the checklists to the ADON who reviewed the sheets and gave them to the MRD to upload into the computer. The MRD provided four 'weekly body checklist' sheets each for October and November, for Resident 38. MRD stated she could not find any more checklists in the computer. A review of two of the four sheets for October, dated 10/18/24, indicated, Resident refused shower before dialysis, and dated 10/ 21/24, indicated, Resident refused. The checklists did not include reasons documented for Resident 38's refusals. A review of the November sheets indicated for dates 11/9/24, 11/22/24, 11/25/24, and 11/29/24, Resident 38 received bed baths, and there was no documentation for showers provided. RNS 1 stated Resident 38 left the facility for dialysis on Monday, Wednesday, and Friday. RNS 1 stated Resident 38 was usually very tired in the evening upon return from dialysis and refused showers then. RNS 1 stated if a resident refused a shower, the CNA should inform the charge nurse or supervisor, and then document the refusal in the progress note and inform the family.</p> <p>During an interview on 12/4/24, at 4:05 p.m., CNA 1 stated when a Resident refused a shower or bed bath, the CNA should notify the nurse.</p> <p>During an observation and interview on 12/5/24, at 9:35 a.m., with Resident 38, Resident was lying in her bed, alert, and waiting for assistance for bed bath. There was a cup of mouth rinse for brushed teeth on her overhead table. Resident stated she asked the receptionist a few weeks ago if they could change her showers to days that are not dialysis days. Resident 38 stated the receptionist reported it to RNS 2, but RNS 2 stated the days cannot be changed because they are always set.</p> <p>During an interview on 12/5/24, at 10:58 a.m., with the ADON, the ADON stated showers were scheduled for 2 times a week, and residents could ask for more if needed. The ADON stated there was no schedule for bed baths. The ADON stated refusals were documented in the shower sheet, and she stated Resident 38 had refusals of showers but was unable to state the reason for Resident 38's refusals of showers/bed baths. The ADON stated shower schedules should be able to be changed to accommodate the residents' preferences. The ADON stated the resident had the right to have showers and could get showers whenever they needed it.</p> <p>During a review of the bathing record, Task: Bathing 30 days look back for November, presented by the ADON on 12/5/24, at 11:30 a.m., the record from 11/6/24 through 12/1/24 indicated Resident 38 refused showers on 11/8/24 (scheduled shower day as well as dialysis day), 11/11/24 (scheduled shower day as well as dialysis day), and 11/16/24 (non-scheduled day for shower) without documented reasons for the shower refusals. The bathing record indicated no documentation of Resident 38 receiving a bed bath on 11/8/24 or 11/11/24 when Resident 38 refused a shower. The bathing record, Task: Bathing for the month of October 2024 was not provided. The documentation for Resident 38's refusal for showers/bed bath was not provided.</p> <p>During an interview on 12/5/24, at 12:38 p.m., with RNS 2, RNS 2 stated Resident 38 refused showers because Resident 38 did not want to be in a hurry to get ready for dialysis after breakfast. RNS 2 stated residents could reschedule the shower, but it would be difficult to switch the scheduled shower days as RNS 2 would have to switch the shower days with another resident.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Bath, Shower/Tub dated [DATE], and P&P titled Bath, Bed dated March 2021 indicated, The purpose of this procedure is to promote cleanliness, provide comfort and to observe the condition of the resident's skin . If the resident refused the shower/bed bath, document the reason(s) why and the intervention taken . Report other information in accordance with facility policy and professional standards of practice.</p> <p>During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, dated March 2018, the P&P indicated, interventions .in accordance with the resident's needs, preferences, stated goals .response to interventions will be monitored, evaluated and revised as appropriate.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Deficiency Text Not Available</p>