STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055874	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Healthcare & Wellness Center	1805 West Street Hayward, CA 94545

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on interview and record review, the facility failed to ensure medication was given according to the physician's order for three of three sampled residents (Resident 1, 2, 3) when: 1. Resident 1 did not receive the medication Gabapentin (used for nerve pain, which can be caused by different conditions, including diabetes.) 2. Resident 2 did not receive the medication Humalog insulin (helps control blood sugar levels after meals.) 3. Resident 3 did not receive the medication Hydralazine (used to treat high blood pressure.) This deficient practice had the potential for worsening of Resident 1, 2 and 3's clinical condition. Findings: 1. During a record review of Resident 1's undated Admission Record , the Admission Record printed on 2/6/25 indicated, Resident 1 was admitted in the facility on 6/29/16 with an admission diagnosis of diabetes mellitus (a condition that happens when blood sugar is too high). During a record review of Resident 1's Minimum Data Set (MDS- an assessment used to guide plan of care) dated 11/19/24, indicated Resident 1's Brief Interview of Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score was 13 out of 15, indicating intact cognitive status. During a concurrent interview and record review on 1/24/25 at 1:39 p.m. with Registered Nurse (RN) 1, Resident 1's Medication Administration Record (MAR) was reviewed. The MAR indicated, Resident 1's three capsules of Gabapentin 300 milligrams (mg) scheduled at 1:00 p.m. on 12/14/24 was blank. RN 1 stated the blank record in the MAR meant the medication administration was not documented. RN 1 stated MAR documentation made sure there was a record that the medication was given. During a concurrent observation and interview on 2/6/25 at 12:43 p.m. with Resident 1, in Resident 1's room, Resident 1 stated yes when asked if she was aware of taking Gabapentin for nerve pain. Resident 1 was unable to state the location of the pain. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Order Summary dated 1/19/22, the order indicated, Resident 1 had an order of three capsules of Gabapentin 300 mg three times a day for neuropathic pain (a chronic pain condition caused by damage or dysfunction in the nerves themselves). During a record review of Resident 1's Pain Medication Therapy Care Plan dated 9/10/21, indicated, one of the pain medication therapy interventions was to administer medications that relieve pain as ordered by the physician. 2. During a record review of Resident 2's undated Admission Record , the Admission Record printed on 2/6/25 indicated, Resident 2 was admitted in the facility on 2/24/24 with an admission diagnosis of diabetes mellitus. During a record review of Resident 2's MDS dated [DATE], indicated Resident 2's BIMS score was 12 out of 15, indicating moderate impairment of cognitive status. During a concurrent interview and record review on 2/6/25 at 3:29 p.m. with the Director of Nursing (DON), Resident 2's MAR was reviewed. The MAR indicated, Resident 2's 17 units of Humalog 100 unit/ milliliter (ml) insulin scheduled at 12:00 p.m. on 12/14/24 was blank. The DON stated the nurse probably forgot to document. During an interview on 2/6/25 at 3:59 p.m. with Resident 2, in Resident 2's room, Resident 2 stated it was important for him to receive his medication as scheduled. Resident 2 stated staff checked his blood sugar daily. During a record review of Resident 2's Order Summary dated 10/28/24, the order indicated, Resident 2 had an order of 17 units of Humalog 100 unit/ milliliter (ml) insulin with meals. 3. During a record review of Resident 3's undated Admission Record , the Admission Record printed on 2/6/25 indicated, Resident 3 was admitted in the facility on 10/15/21 with a diagnosis of hypertension (high blood pressure). During a record review of Resident 3's MDS dated [DATE], indicated Resident 3's BIMS score was 6 out of 15, indicating severe cognitive impairment. During a concurrent interview and record review on 2/6/25 at 3:32 p.m. with the Director of Nursing (DON), Resident 3's MAR was reviewed. The MAR indicated, Resident 3's one tablet of Hydralazine 50 mg scheduled at 6:00 a.m. and 12:00 p.m. on 12/14/24 was blank. The DON stated the nurse probably forgot to document. During a record review of Resident 3's Order Summary dated 4/18/24, the order indicated, Resident 3 had an order of one tablet of Hydralazine 50 mg three times a day. During a record review of Resident 3's Hypertension Care Plan dated 12/18/21, indicated, one of the hypertension interventions was to give antihypertensive (drugs used to treat high blood pressure) medication. During an interview on 2/6/24 at 3:39 p.m. with the Administrator (ADM), the ADM stated, nurses should document the medication given to the resident to know the medication was administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up phone interview on 2/19/25 at 12:09 p.m. with RN 1, RN 1 stated if the medication administration was not documented in the MAR, it meant the medication was not given. During a review of the facility's policy and procedure (P&P) titled Medication Administration , dated 1/1/12, the policy indicated, IX. Documentation: A. The time and dose of the drug administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug; B. Recording will include the date, the time and the dosage of the medication; C. Initials is recorded on the medication record.