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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to provide adequate supervision and interventions to prevent elopement (leaving a facility or safe area unnoticed often due to confusion), for one of three sampled residents (Resident 1), with cognitive impairment (difficulties in one or more mental abilities such as memory, learning, language, attention, problem-solving, or decision-making that are more pronounced than expected for a person's age or education level) when Resident 1 was sent to a doctor's appointment without an escort despite needing an escort.This failure resulted in Resident 1 wandering off to the streets alone in cold and rainy weather for approximately three hours. Resident 1 was later located by Emergency Medical Services, (group of personnel who respond to medical emergencies in the community), approximately four blocks from the location of the appointment and was found to be wet and confused. Resident 1 was taken to an acute care hospital and received treatment. During a review of Resident 1's Face Sheet printed on 4/2/26, the Face Sheet indicated, Resident 1 was admitted to the facility in November 2025 with multiple medical diagnoses including dementia, (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and metabolic encephalopathy (any brain disease that alters brain function or structure, manifested by declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms).During a review of Resident 1's Minimum Data Set Assessment (MDS[a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan]), dated 11/8/25, the MDS, Section C, Cognitive Patterns indicated, Resident 1 had a 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 function (the ability to think, learn and remember). Resident 1 had a BIMS score of 10 out of 15 indicating moderate loss of cognitive function.During a review of Resident 1's admission documents, the Discharge Summary from the acute care hospital, dated 11/1/25 was reviewed. The Discharge Summary indicated Resident 1 .does not have capacity to make his/her own health decisions due to: Dementia.During a review of Resident 1's Order Audit Report, dated 11/6/25, the Order Audit Report indicated, Resident 1 had a scheduled medical appointment on 11/13/25 at 11:00 a.m.During a review of an untitled document for Resident 1, dated 11/6/25, the document indicated, Resident 1 needed transportation, a wheelchair and an escort for the appointment on 11/13/25.During a telephone interview on 4/2/26 at 4:00 p.m. with Charge Nurse 1, (CN 1), CN1 stated, she was made aware of the scheduled medical appointment for Resident 1 and the need for an escort in the morning of 11/13/25 during the change of shift. CN 1 stated she instructed Certified Nursing Assistant 1, (CNA 1), to get Resident 1 ready for his appointment.During an interview on 4/2/26 at 11:30 a.m. with Certified Nursing Assistant 1, (CNA1), CNA1 stated, he was told to prepare Resident 1 for his appointment. CNA1 stated he got Resident 1 bathed, dressed and placed in a wheelchair. CNA 1 stated he brought Resident 1 to the lobby to await transport. CNA1 stated he was not aware he needed to accompany Resident 1 to the appointment. During an interview on 4/2/26 at 4:02 p.m. with CN 1, CN 1 stated, at approximately 11:00 a.m. on 11/13/25, she saw CNA (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	1 on the unit and asked CNA 1 why he did not go with Resident 1 to the appointment. CN 1 stated, CNA 1 had no answer. At approximately 11:30 am, upon realization that Resident 1 did not have an escort, CN 1 stated she called the medical office and asked the staff to watch the resident until transport arrived. CN 1 stated she notified the facility to arrange transport for Resident 1 back to the facility.During a telephone interview on 4/2/26 at 4:05 p.m. with CN 1, CN 1 stated, at approximately 1:00 p.m. on 11/13/25, she received a call from the medical office asking if Resident 1 had been picked up and returned to the facility because he was no longer in the office lobby. CN1 stated, Resident 1 was not back at the facility at that time. CN1 stated, at approximately 2:45 p.m. the facility received a call from the medical office stating staff had located Resident 1. CN1 stated, around 3:00 p.m. the facility received a call from the medical office stating the person they had located was not Resident 1. During an interview on 4/2/26 at 3:00 p.m. with the Director of Staff Development, (DSD), the DSD stated, on 11/13/25 at approximately 3:15 p.m. she was told that Resident 1 was still missing and to call local law enforcement. The DSD stated she was told by law enforcement that a 911 call had been received about an individual that met the description of Resident 1 and he was taken to the acute care hospital.During a telephone interview on 4/2/26 at 3:15 p.m. with Resident 1's RP1, (Responsible Party), the RP1 stated she was not told about any medical appointments needed for Resident 1. The RP1 stated she had been attending appointments with Resident 1 for a year and would have gone with him to the appointment on 11/13/25 had she been told about it. During a review of Resident 1's Interdisciplinary Team Note, (IDT [a team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners]), dated 11/14/25, the record indicated, Spouse to be made aware of all appointments so she can accompany resident. Reinforce education of residents with BIM<13 to be accompanied by family or escort.During a telephone interview on 4/3/26 at 1:30 p.m., with the Director of Nursing, (DON), the DON stated, escorts are provided for residents when family members cannot attend appointments. She stated the decision to provide an escort for the resident is made by the licensed nurse once the appointment is made. She stated there was an escort ordered for Resident 1 and not provided.During a telephone interview on 4/15/26 at 9:30 a.m. with Medical Assistant 1(MA1), MA1 stated Resident 1 did not have an escort while at the medical office on 11/13/25.During a review of Resident 1's acute hospital emergency services records dated 11/13/25, the records indicated, Resident 1 was transported by ambulance to the hospital after being found in a wheelchair on the street, confused and in cold, rainy weather. The record indicated upon arrival in the Emergency Department Resident 1 did not know how he came to be on the street. The record indicated, Resident 1 was wet and disheveled. During a telephone interview on 4/2/26 at 3:17 p.m. with RP1, RP1 stated, she was scared when she heard Resident 1 was missing because it was cold and raining outside, and he is often confused. RP 1 stated, when she arrived at the hospital, she saw Resident 1 in bed, covered with blankets and shivering. RP1 stated Resident1's clothing had been removed because it was wet and he was confused.During a concurrent interview and record review on 4/14/26 at 2:00 p.m. with the NS, (Nursing Supervisor), Resident 1's medical record was reviewed. The NS stated she was unable to locate documentation that the RP1 was notified of Resident 1's medical appointment. NS stated it is important to inform families/RPs of care plans, changes in condition or appointments so they know what is going on and can participate in the residents' plan of care.During review of Resident 1's Baseline Care Plan dated 11/10/25, the care plan indicated Resident 1 was an elopement risk.During a review of the facility's policy and procedures titled P-NP137 Dementia Care dated 3/25/26 indicated, The facility shall implement appropriate safety measures based on the Resident's assessed needs.