STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Drive Post Acute	2500 Country Drive Fremont, CA 94536

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 2) received advance notice of a roommate change, when Resident 6 was moved into Resident 2's room. This failure had the potential to result in avoidable psychosocial distress.During a review of Resident 2's admission Record (AR) dated 2/23/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis that included encounter for removal of internal fixation device (a medical procedure involving the removal of hardware, such as screws, plates, or rods, that were previously implanted to stabilize a bone or joint), anxiety disorder (a mental health condition characterized by excessive worry, nervousness, or fear that can interfere with daily activities), and depression (a mood disorder marked by persistent feelings of sadness, hopelessness, and loss of interest in activities).During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 11/11/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13. A BIMS score of 13-15 is an indication of intact cognitive status.During a concurrent interview and record review on 2/20/26 at 3:54 p.m. with Assistant Director of Nursing (ADON), ADON stated the facility does not provide a written notice when a resident acquires a new roommate. ADON stated a written notice is only provided to residents when they are moving to a new room.During a review of the facility's policy and procedure (P&P) titled Room or Roommate Change, effective date 6/27/22, the P&P indicated that residents or their representatives will receive timely advance notice before a room or roommate change. This notice can be given verbally, in writing, or both.During a concurrent interview and record review on 2/23/26 at 12:14 p.m. with ADON, facility's daily census from 11/7/25 to 11/23/25 was reviewed. ADON stated Resident 2 was admitted on [DATE] and shared a room with Resident 6, until 11/12/25 when Resident 6 was transferred to the hospital. ADON stated, on 11/17/25, Resident 2 received a new roommate without advanced written notice, only verbal notice, which was not documented in the clinical record.

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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Country Drive Post Acute	2500 Country Drive Fremont, CA 94536

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 5) had their personal funds safeguarded when Resident 5's wallet containing $140, which had been entrusted to the facility's Social Services Director (SSD), was not secured in accordance with facility procedures. This failure resulted in Resident 5's $140 going missing, which had the potential for psychosocial outcomes including anxiety, distress, and reduced trust in the facility's ability to safeguard belongings.During a review of Resident 5's admission Record (AR) dated 2/23/26, the AR indicated Resident 5 was admitted to the facility in July 2025 with diagnoses that included diabetes mellitus (a chronic condition characterized by high levels of sugar in the blood due to the body's inability to produce or use insulin effectively), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that can cause urinary problems in men), and chronic gout (a long-term form of arthritis caused by the buildup of uric acid crystals in the joints, leading to pain and inflammation). The AR indicated Resident 5 was self-responsible.During a review of Resident 5's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 11/25/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13. A score of 13-15 is an indication of intact cognitive status.During a concurrent interview and record review on 2/23/26 at 11:03 a.m. with Administrator (ADM), ADM stated, on 11/21/25, Resident 5 handed over a wallet with $180 cash to SSD for safekeeping. The SSD placed the wallet in an unlocked drawer in the SSD office. In December 2025, Resident 5's family requested $140 from Resident 5's money but found only $40 remaining. ADM stated SSD no longer works at the facility.During a review of Resident 5's Social Services Progress Notes from 10/15/25 to 12/26/25, the progress notes did not indicate Resident 5 was informed about the missing $140. SSD had discussed it with Resident 5's family but not with Resident 5.During an interview on 2/23/26 at 11:22 a.m. with Resident 5, Resident 5 stated the facility still had the wallet, stated a man had visited his room and provided a number to call to regarding the missing money.During a review of the facility's policy and procedure (P&P) titled Management of Residents' Personal Funds last revised March 2021, the P&P indicated if a resident chooses to have the facility manage his personal funds, a written authorization from the resident or the resident representative is required and documented in the resident's clinical record. The facility acts as a fiduciary, holding, safeguarding, managing and accounting for the personal funds.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide notice of rights and services prior to or upon admission for four of five sampled residents (Resident 1, 2, 3, and 4), when admission agreements were either delayed or not provided at all.This failure had the potential to result in unnecessary emotional stress, diminished autonomy in making healthcare choices and violation of resident rights.During an interview on 2/23/26 at 11:41 a.m. with Admissions Director (AD), AD stated the admission agreement is very important as it covers information about resident rights, advanced directives, facility and Ombudsman information, arbitration agreement and details on what residents should expect. AD stated the resident or the resident's decision-maker should sign the admission agreement within 72 hours of admission.1.During a review of Resident 1's admission Record (AR) dated 2/20/26, the AR indicated Resident 1 was admitted to the facility on [DATE]. The AR also indicated Resident Representative (RR) 1 as Resident 1's Emergency Contact and that Resident 1 was self-responsible (able to make decisions for themselves). Resident 1 was transferred to the hospital after a medical emergency on 10/10/25.During a review of the State-specific admission Agreement (SAA) titled California Standard Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, the SAA indicated it was signed by RR 1 on 10/2/25, eight days after Resident 1's admission.2. During a review of Resident 2's AR dated 2/23/26, the AR indicated Resident 2 was admitted to the facility on [DATE]. The AR indicated Resident 2 was self-responsible but listed RR 2 as emergency contact. The AR also indicated Resident 2 was discharged home on [DATE].During a concurrent interview and review of the clinical records on 2/23/26 at 12:33 p.m. with Assistant Director of Nursing (ADON), ADON stated there was no signed admission agreement for Resident 2 in the clinical records.3. During a review of Resident 3's AR dated 2/20/26, the AR indicated Resident 3 was admitted to the facility on [DATE]. The AR indicated Resident 3 was self-responsible and listed RR 3 as the emergency contact, Resident 3 was discharged home on [DATE].During a telephone interview on 2/18/26 at 1 p.m. with RR 4, RR 4 stated the admission agreement was given to RR 3 only on the day Resident 3 was discharged . RR 4 also stated Resident 3 and family were unaware of the care and services were provided while at the facility.During a review of Resident 3's SAA, the SAA indicated Resident 3 was issued the admission agreement on 12/5/25, the day Resident 3 was going home.4.During a review of Resident 4's AR dated 2/20/26, the AR indicated Resident 4 was admitted to the facility on [DATE]. The AR indicated Resident 4 was self-responsible.During a review of Resident 4's SAA, the SAA indicated Resident 4 signed the admission agreement on 1/2/26, more than one month after Resident 4 was admitted .During a review of the facility's policy and procedure (P&P) titled admission Agreement last revised December 2025, the P&P indicated that each resident must have an admission agreement, signed and dated by the resident or resident representative at the time of admission and filed in the resident's clinical record.

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NAME OF PROVIDER OR SUPPLIER: Country Drive Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 2500 Country Drive Fremont, CA 94536	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 3) received a summary of the baseline care plan, when neither Resident 3 nor Resident 3's Representative (RR 3) were provided with the required summary.This failure had the potential to place Resident 3 at risk for unmet needs, inconsistent care and adverse health outcomes.During a review of Resident 3's AR dated 2/20/26, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included fractured left pubis (a break in the left side of the pubic bone, which is part of the pelvis), sacrum (the triangular bone at the base of the spine), and upper end of left humerus (a break near the top of the left upper arm bone), dementia (a general term for a decline in mental ability severe enough to interfere with daily life, often involving memory loss and impaired judgment), difficulty in walking, and delirium (a sudden and severe confusion due to rapid changes in brain function, often temporary but serious). The AR indicated Resident 3 was self-responsible (able to make decisions for themselves) and listed RR 3 as the emergency contact.During a concurrent interview and record review on 2/20/26 at 11:38 a.m. with Assistant Director of Nursing (ADON), Resident 3's Interdisciplinary Care Conference (ICC) dated 11/21/25 was reviewed. ADON stated she was not sure whether a summary of the baseline care plan was provided to Resident 3 or RR 3, as the notes did not indicate this. ADON also stated a representative of Resident 3 participated in the care conference, but the record did not indicate who it was. The ICC indicated attendees that included only seven facility representatives, and the section on whether the care plan summary copy was provided was left blank.During a telephone interview on 2/18/26 at 1 p.m. with RR 4, RR 4 stated RR3 received the admission agreement only on the day Resident 3 was to be discharged . RR 4 also stated Resident 3 and family were unaware of the care and services to be provided at the facility. During a review of the facility's policy and procedure titled Care Plan-Baseline effective 8/25/21, the P&P indicated the baseline care plan includes the instructions for effective, person-centered care of the resident and be developed and implemented by the Interdisciplinary Team (IDT, a group composed of staff representing different departments of the facility) for each resident. The P&P did not indicate when or how to provide a summary of the baseline care plan to the resident or their representative.