

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Eden Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 27350 Tampa Avenue Hayward, CA 94544	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46658</p> <p>Based on observation, interview and record review, the facility failed to ensure staff practiced safe patient handling for one of three sampled residents (Resident 1) when Resident 1 was left on a hooyer lift (a mechanical device used to lift and transfer residents from one place to another) unsupervised for 30 minutes and had only one staff member assist Resident 1 during a hooyer lift transfer.</p> <p>This failure resulted in Resident 1's discomfort during a hooyer lift transfer and had the potential for falls which could lead to injury or death.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated Resident 1 was admitted with diagnoses of polymyositis (a chronic disease in which the patient's own immune system attacks the body's muscle tissue resulting in generalized weakness), quadriplegia (paralysis of all extremities) and need for assistance with personal care.</p> <p>A review of Resident 1's minimum data set (MDS, an assessment tool to guide resident care), dated 8/30/24, indicated Resident 1 was totally dependent on staff person for eating, and personal hygiene, and two staff for bed mobility, transfer between surfaces, and toileting. The MDS indicated Resident 1 had a Brief Interview for Mental Status score of 15 (The Brief Interview for Mental Status is an assessment tool for a resident's orientation to time, and capacity to remember. The BIMS has a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status).</p> <p>During a concurrent observation and interview on 10/23/24, at 8:18 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 had exited Resident 1's room. CNA 1 stated Resident 1 was on the hooyer lift suspended over the bed to go to the bathroom. CNA 1 stated there were no other staff in the room, and staff were expected to be with the resident when they were on a hooyer lift. CNA 1 stated the next CNA scheduled for Resident 1's care would lower them down. CNA 1 stated they would not give report to the oncoming CNA because Resident 1 could make their needs known. CNA 1 did not reenter Resident 1's room.</p> <p>During an observation on 10/23/24, at 8:20 p.m., CNA 2 briefly entered and exited Resident 1's room.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/23/24, at 8:20 p.m., with Resident 1, Resident 1 was in their room on a hooyer lift suspended over their bed without staff present. Resident 1 stated they were on the hooyer lift for toileting and would be finished soon.</p> <p>During a continuous observation on 10/23/24, from 8:20 p.m. to 8:45 p.m., of the entrance to Resident 1's room, staff did not enter Resident 1's room to lower or supervise Resident 1 while they were on the hooyer lift.</p> <p>During an observation on 10/23/24, at 8:50 p.m., CNA 3 entered Resident 1's room to answer a call light to transfer Resident 1 off the hooyer lift. Resident 1 was still suspended over their bed on the hooyer lift.</p> <p>During concurrent observation and interview on 10/23/24, at 8:59 p.m., with Assistant Director of Nursing (ADON), the ADON was in Resident 1's room. The ADON stated hooyer lift transfers required two staff members and staff should remain with the resident while they are on the hooyer lift to prevent falls and to ensure resident comfort. The ADON then left the room.</p> <p>During an observation and interview on 10/23/24, at 9:00 p.m., with Resident 1, CNA 3 was in Resident 1's room with Resident 1 suspended on the hooyer lift. CNA 3 was working alone to transfer Resident 1 to the bed using the hooyer lift. Resident 1 stated they were uncomfortable because their legs were being lowered into an uncomfortable position. CNA 3 did not successfully reposition Resident 1's legs to a comfortable position while simultaneously lowering Resident 1 down to the bed.</p> <p>During an concurrent interview and record review on 1/2/25, at 11:20 a.m., with the Director of Nursing (DON), Resident 1's care plan titled, The resident is at risk for falls and/or injuries related to falls related to quadriplegia, need for assistance for ADLs (activity of daily living such as hygiene, transfers out of bed etc.), request for having BM (bowel movement) while in hooyer lift, history of non-compliance, and threatening behaviors towards staff, dated 7/25/23, was reviewed. The care plan indicated Resident 1 needed hooyer transfer as needed, 2 person assist for transfers. Educate resident on fall prevention and risks of requesting to stay in hooyer for extended time, risks of being in hooyer without direct supervision. The DON stated staff are expected to stay with any resident suspended on a hooyer lift to maintain resident safety regardless of resident preferences.</p> <p>During a review of facility policy and procedure (P&P) titled, Safe Resident Handling/Transfers, dated 7/1/24, the P&P indicated, all residents require safe handling when transferred to minimize risk of injury to themselves and the employees that assist them. staff members are expected to maintain compliance with safe handling/transfer practices. two staff members must be utilized when transferring residents with a mechanical lift.</p>		