STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056052	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Healthcare Center	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to identify that a licensed nurse (Assisted Director of Nursing, ADON) increased a dose of medication without a physicians ' order. This failure resulted to Resident 1 ' s Seroquel ' s (Quetiapine -medication used to treat illness that affects thoughts and behavior) dose was increased to 50 milligram (mg) tablets given two times a day from 12/2024 through 4/2025 without indication. Findings: Cross reference to F605 During a review of Resident 1 ' s Order Summary Report for December 2024 indicated Seroquel Quetiapine Fumarate Oral Tablet 50 mg. Give 50 mg tablet by mouth two times a day for anxiety m/b [manifested by] visual and auditory hallucination lading [leading] to distress with an order date of 12/5/2024. During a review of facility ' s MAR for the months to 12/2024 through 4/25 indicated Resident 1 was given Seroquel 50 mg tablet one tablet two times per day starting 12/6/2024 through 4/2/2025. During a concurrent interview and record review on 4/30/25 at 12:58 p.m., with ADON, ADON stated that she entered the verbal order to increase Resident 1 ' s Seroquel 50 mg twice to Resident 1 ' s electronic health record. ADON reviewed Resident 1 ' s electronic health record for December 12/5/2024, and could not find the indication that the physician had ordered to increase Resident 1 ' s Seroquel dose. During an interview on 6/5/25 at 3:10 p.m., with Director of Nursing (DON), DON stated they investigated the incident, and it was determined that ADON put in the order to increase Resident 1 ' s Seroquel 50 mg tablet given one tablet twice a day without physicians' orders. DON stated when ADON increased the medication dose, it was beyond the scope of her license (refers to the activities and duties that a professional was legally permitted to perform within their specific field).

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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident 1), Resident 1 ' s rights were not protected when Seroquel (Quetiapine -medication used to treat illness that affects thoughts and behavior) dosage was increased without physician ' s orders, indication, and no informed consent. Resident 1 ' s Seroquel ' s dose was increased to 50 milligram (mg) tablets given two times a day. This failure resulted in Resident 1 ' s right being violated due to unnecessary increase of medication dose. Findings: During a review of Resident 1 ' s admission Record indicated Resident 1 was admitted on [DATE], with diagnoses that included schizoaffective disorder (mental health disorder that affects mood, thoughts, and behavior), and unspecified dementia. Resident 1 ' s Minimum Data Set (MDS - resident assessment tool) dated 3/22/25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident ' s cognitive status regarding attention, orientation, and ability to register and recall information) score of 06, (BIMS score of 0 - 7, suggest severe cognitive impairment). During a review of Resident 1 ' s Psychoactive Drug Review and Interdisciplinary Team Meeting (PDRITM) dated 11/12/24 indicated Treatment Intervention: Seroquel Oral tablet 25 mg (Quetiapine Fumarate) Give 25 mg by mouth two times a day for schizophrenia m/b [manifested by] visual and auditory hallucinations leading to distress. Resident 1 ' s PDRITM plan indicated to continue current prescribed medication. During a concurrent interview and record review on 4/30/25 at 12:21 p.m., with Director of Nurses (DON), DON reviewed Resident 1 ' s medication administration records (MAR) for Monitor episodes of Schizoaffective Disorder M/B [manifested by]: Visual Hallucinations Q [every] shift. Enter the # of episodes during your shift, for the months of November and December 2024. DON stated there was no indication that Resident 1 had an increase in episodes of hallucinations. During a review of Resident 1 ' s Order Summary Report for December 2024 indicated Seroquel Quetiapine Fumarate Oral Tablet 50 mg. Give 50 mg tablet by mouth two times a day for anxiety m/b [manifested by] visual and auditory hallucination lading [leading] to distress with an order date of 12/5/2024. The new order did not match the indication and monitoring of schizoaffective disorder manifestation. During a concurrent interview and record review on 4/30/25 at 12:58 p.m., with Assistant Director of Nursing (ADON), ADON stated that she took the verbal order to increase Resident 1 ' s Seroquel 50 mg twice a day and entered the new order to Resident 1 ' s electronic health record. ADON stated that the physician ' s order was given to her during the PDRITM in December 2024. ADON reviewed Resident 1 ' s PDRITM dated 12/17/24, and stated there was no order to increase Seroquel. ADON reviewed Resident 1 ' s electronic health record for December 12/5/2024, and could not find the indication that the physician had ordered to increase Resident 1 ' s Seroquel dose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s MAR for the months to 12/24 through 4/25, the MAR indicated Resident 1 was given Seroquel 50 mg tablet one tablet two times per day starting 12/6/2024 through 4/2/2025. During a review of Resident 1 ' s Psychotropic Medication Consent V.2024 dated 02/24/2025 for Seroquel 50 mg tablet given two times a day. The written consent was blank for Resident 1 ' s Responsible Party, and there was no physician signature. During an interview on 4/30/25 at 1:15 p.m., with ADON, ADON stated she obtained verbal consent from Resident 1 ' s RP. ADON reviewed Resident 1 ' s Psychotropic Medication Consent V.2024 dated 02/24/2025, ADON stated she did not obtain and verify the consent with RP until 2/24/25, because the Resident 1 ' s RP was on vacation when Seroquel 50 mg tablet given twice a day was started on 12/6/25. ADON opened the Resident 1 ' s health care records binder, and written notes indicated Resident 1 ' s RP was in town until 12/14/24. During an interview on 4/30/25 at 12:21 p.m., with DON, DON stated after the provider obtained the informed consent from the resident or responsible (RP) party, the facility would verify and get a written consent. DON stated written consent Psychotropic Medication Consent form would be generated from the resident ' s electronic health record, and when the facility obtained the wet signature from the resident or RP, the consent form would be scanned and filed into the resident ' s electronic health record. During a review of facility ' s Psychotropic Medication Use policy statement indicated Residents do not receive psychotropic medication that are not clinically indicated and necessary to treat a specific condition documented in the medical record . Assessment and Evaluation of the Resident. 1. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident ' s: a. physical, behavioral, mental, and psychosocial status; b. comorbid conditions; c. expressions or indications of distress; d. change in functional status; e. resident complaints, behaviors, and symptoms; and f. the state PASARR evaluation.