

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 02/18/2026
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure for one out of four residents (Resident 1), rights were protected. Resident 1 was having increasing pain during prolonged sitting in the Hoyer lift sling, and Resident 1 wished to be transferred back to bed instead of trying to be fitted to his wheelchair. Resident 1 had an emotional outburst due to staff not following his wishes. This failure resulted in Resident 1's right to have dignity being violated during care. Findings: A review of facility's admission Record (AR) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included Chronic systolic (congestive) heart failure and morbid (severe) obesity due to excess calories. Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 01/06/2026, 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 15, (BIMS score of 00 - 07: severe impairment; 08 - 12: moderately impaired; and 13 - 15: cognitively intact). During an interview on 02/18/2026 at 09:58 p.m. with Resident 1, Resident 1 was lying in bed. Resident 1 stated that his bariatric bed was not functioning properly and needed to be changed. Resident 1 stated that during the incident there were several staff involved including the staff from Kaiser for the wheelchair fitting. Resident 1 stated he thought the process would take about five to 10 minutes, and he would be able to tolerate the process. Resident 1 stated he was lifted out of his bed using a sling attached to the Hoyer lift (medical device designed to safely transfer patients with limited mobility). Resident 1 stated the Restorative Nursing Assistant (RNA) 1 operated the Hoyer lift. Resident 1 stated that he started having pain in his left hip. Resident 1 stated a staff from the rehabilitation department helped by supporting him to help decrease the pain. Resident 1 stated that process took longer than expected, and at about 15 - 20 minutes, the pain was increasing. Resident 1 stated that when the bariatric bed was adjusted to fit through the door, and was removed from the room. The new bed was not brought in, but instead, the staff from Kaiser wheeled the wheelchair in the room to try to fit him in the wheelchair. Resident 1 stated that he was having excruciating pain at this point and would rather not be fitted in the wheelchair. Resident 1 stated that he started screaming and cussing since due to excruciating pain, and the staff were not listening to him. Resident 1 stated that wheelchair was removed from his room, and the new bariatric bed was brought in the room. Resident 1 stated that he wanted to go back to bed because he was in so much pain already. Resident 1 stated he could have been readjusted in bed for comfort then try to be fitted in the wheelchair. During a review of Resident 2's Progress Notes dated 06/19/2025, it indicated Resident 1 reported an alleged abuse which happened on 6/18/2025. Per patient around 1 pm, I was in my Hoyer left [lift] transferring to a wheelchair. I changed my mind and wanted to be in bed. I was in pain. The staff member tried to talk me into going to the wheelchair. They did not put me back to bed, but I feel this was assault when they didn't put me in bed immediately. During a review of</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056052	Facility ID: 056052 If continuation sheet Page 1 of 4

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>the facility's Resident Abuse Investigation Report Form interview record dated 6/20/2025, it indicated Upon arrival, Hoyer lift transfer had already been initiated. Assisted with bed adjustment so that bed can fit through doorway, during this time patient continues to be in [H][NAME] sling lift, bed also need to be taken out of room in order to be measured for power chair. Upon extended periods of time in [H][NAME] sling patient stated increasing L [left] hip pain with prolonged sitting in sling. [P]atient requested to be return to BTB [back to bed] as soon as possible due to increasing pain. [W][NAME] bed could finally be rolled out of room. Kaiser representative brought the power chair, but patient had become agitated and demanded to be returned BTB due to increasing L [left] hip pain. [A]t this time this therapist attempted to support L [left] Hip in order to reduce risk of increasing pain. Patient continues to become more agitated demanding to return BTB. Kaiser representatives at this point had the power chair by the doorway and in the room in attempts to fit patient into the power chair. [P]atient continued to demand to return BTB due to increasing L[left] hip pain. Finally [K]aiser representatives removed power chair from the room and staff was able to place new bed back into the room. Once patient returned BTB, patient verbalizes displeasure with vulgar comments including the use of profanity regarding increased L[left] hip pain while in [H][NAME] sling. During a review of facility's policy and procedures titled Resident Rights dated 12/5/2025 indicated It is the policy of the facility to fully uphold the rights of all residents as outlined in the California Residents [NAME] of Rights. Residents shall not be denied their rights for any reason, and no staff member may retaliate against a resident who exercise their rights, voices concerns, or file grievance. Procedure/Guidelines. II. Resident Rights a. Dignity, Respect and Freedom i. Be treated with dignity and respect at all times. ii. Make choices about daily life.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one out of four residents (Resident 2), were free from abuse, when Resident 2 had an altercation with Resident 3. Resident 2 had lacerations on right eyebrow and right lower lid, contusion surrounding right eye and right side of the face. This failure resulted in being subjected to physical abuse that caused pain and injuries. Findings: A review of facility's admission Record (AR) indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included Metabolic encephalopathy (brain dysfunction caused by underlying condition), and pneumonia due to Coronavirus disease 2019. Resident 2's Minimum Data Set (MDS - resident assessment tool) dated 11/08/25 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 12, (BIMS score of 00 - 07: severe impairment; 08 - 12: moderately impaired; and 13 - 15: cognitively intact). During a review of facility's AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included Spinal stenosis (narrowing of the spine that puts pressure on nerves and spinal cord), and unspecified dementia, with unspecified severity, without behavior. Resident 3's BIMS dated 11/06/2025 indicated a score of 12, moderately impaired. During an interview on 02/18/2026 at 01:57 p.m. with Registered Nurse (RN) 1, RN 1 stated Licensed Vocational Nurse (LVN) 1, asked for assistance regarding the incident between Resident 2 and 3. RN 1 stated LVN 1 went to Residents 2 and 3's shared room, and found Resident 2 in the bathroom wiping the blood away for his head. During an interview on 02/19/2026 at 10:22 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was around 6 p.m., when Certified Nursing Assistant (CNA) 1 asked her to see Resident 2 in his room. LVN 1 stated Resident 2 stated that his roommate had hit his face. LVN 1 stated Resident 2 had an injury on his forehead. LVN 1 stated that Resident 3 was in the room sitting on his bed, and talking to himself. LVN 1 stated that during the police investigation, Resident 3 had a small drop of blood in his hand. LVN 1 stated that Residents 2 and 3 were ambulatory. During a review of Resident 2's Progress Notes dated 11/01/2025 23:00 stated Room change rendered to keep residents separated due to an altercation. Tx [treatment] rendered and assessment done by supervisor. Steri-strips applied: R. [right] lower lid and R. [right] eyebrows for the injury sustained by the resident to stop further bleeding. Before room change, Steri-strips were noted to be soiled with blood as the resident was getting transferred to his new room. Writer informed NP [Nurse Practitioner] immediately and informed regarding the increased swelling and eye bloodshot in color. NP approved to send to Hospital. A review of Resident 2's Progress Notes dated 11/03/2025 08:07 indicated At approximately 1910, CNA reported to LN that the resident [2], was observed washing his face in the bathroom with visible facial bleeding and an injury to the right eye. Upon assessment of the LN [licensed nurse], the right eye was noted to be swollen, red, and bloodshot, with laceration measuring approximately 4 cm [centimeter] x 0.5 cm on the right eyebrow and another laceration measuring approximately 2 cm x 0.5 cm on the right lower eyelid. The resident [2] verbalized that his roommate, identified as 44C (Resident 3), allegedly made contact with his right eye when he tried to talk to the resident about pacing back and forth in the room while talking on a cell phone, and when he asked 44C [Resident 3] to take the call into the hallway so he could rest, 44C [Resident 3] suddenly raised his arms and made contact with his right eye causing the injury. During a review of Resident 2's Emergency Departments Note dated 11/02/2025 at 01:04, it indicated The patient is here at this time to be evaluated for possible injuries after he was reportedly assaulted by his roommate at this [his] facility. At the time of arrival in the emergency room the patient</p> <p>(continued on next page)</p>		

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