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	05/29/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident's personal and medical information was communicated in a way that protects personal privacy and confidentiality for four out of four sampled residents (Resident 1, 2, 3, 4) when Resident 1's medical information, Resident 2's personal information, Resident 3 and Resident 4's first and last name were communicated via a group messaging system involving nursing staff's personal smart phone (a mobile phone that performs many of the functions of a computer, typically having a touchscreen and internet access).This failure resulted in violation of residents' right to a secure and confidential personal and medical information.During a phone interview on 5/28/26 at 10:31 a.m. with Registered Nurse (RN) 1, RN 1 stated some nurses participated in a group chat on their smart phones to communicate resident issues to the Director of Nursing (DON).During a concurrent observation and interview on 5/28/26 at 10:47 a.m. with the DON, the DON touched a green application with a figure of a handset of a telephone from her personal smart phone when questioned about the group chat. The DON stated the application was called WhatsApp. The DON stated the group chat was used by the nurses to communicate with each other regarding what is happening with the residents. The DON stated the process of ensuring resident's personal privacy and confidentiality were maintained during the use of the group chat by not disclosing resident's full names, by only including the resident's room number and only including the first two initials of the resident's first name and the first initial of the last name.During a follow up interview on 5/28/26 at 2:07 p.m. with the DON, the DON stated the facility had no policy and procedure on the use of WhatsApp. The DON stated the staff was already using the group chat when she started her role last October of 2025. The DON stated the Administrator (ADM) was aware of the application being used in the facility.During a concurrent observation and interview on 5/28/26 at 2:23 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 showed the WhatsApp application from her personal smart phone. LVN 1 stated the purpose of the group messaging system was to communicate significant changes with the residents among nurses.During a concurrent observation and interview on 5/29/26 at 9:35 a.m. with LVN 2, LVN 2 opened the WhatsApp application from her personal smart phone by touching the application when asked to show the process of communicating through the group chat. LVN 2 stated there was no username and password to log in to WhatsApp. LVN 2 stated Nursing was the name of the group chat. LVN 2 stated not indicating the resident's whole name in the group chat ensured resident's personal privacy and confidentiality.During an interview on 5/29/26 at 10:08 a.m. with the DON, the DON stated there was no staff in the facility who monitors staff compliance with ensuring the process of maintaining resident privacy and confidentiality was followed during the use of the group chat. The DON stated she had not encountered issues of staff not following the process. The DON stated expecting the staff to not disclose the resident's full names.During a concurrent observation and interview on 5/29/26 at 10:30 a.m. with the DON, a message from the Nursing group chat dated Fri, [DATE], edited at 21:23 showed the first four letters of a last name and the first three letters of a first name with only the fifth letter of the last name and fourth letter of the first name had an asterisk sign. The message also showed that the resident was under hospice care. The DON stated the name in the (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	message was Resident 1's last and first name. The DON stated the message was sent by RN 2.During a concurrent observation and interview on 5/29/26 at 10:32 a.m. with the DON, a message from the Nursing group chat dated Fri, [DATE] at 1:48 p.m. showed the first three letters of a last name and the first three letters of a first name with only the fourth letter of the last name and fourth letter of the first name had an asterisk sign. The message also showed that the resident was conserved (a judge has appointed an individual or institution to manage the personal or financial affairs of someone who is deemed incapable of doing so themselves to make decisions on their behalf). The DON stated the name in the message was Resident 2's last and first name. The DON stated the message was sent by RN 2.During a concurrent observation and interview on 5/29/26 at 10:34 a.m. with the DON, a message from the Nursing group chat dated Fri, [DATE] at 6:55 a.m. showed two individual's first and last names. The message also showed that the two individual's names came back from the Acute Care Hospital (ACH). The DON stated the names in the message were Resident 3 and Resident 4.During an interview on 5/29/26 at 11:43 a.m. with the ADM, the ADM stated expecting the staff to follow the process of ensuring resident's personal privacy and confidentiality were maintained. The ADM stated the WhatsApp was not an official communication tool mandated by the facility. The ADM stated the official and more secure option for communication in the facility was Point Click Care (PCC).