STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Leandro Healthcare Center	368 Juana Avenue San Leandro, CA 94577

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38534 Based on observation and interview, the facility failed to provide clean and comfortable home like environment for 4 residents residing in two of 25 rooms in the facility when the shared bathroom in these 2 rooms had a towel on the floor and the toilet seat was dirty with brown particles on the toilet seat. This failure placed all 4 residents residing in these rooms at increased risk for healthcare-associated infections (HAIs), which could result in longer recovery times, additional medical treatments, and even hospitalization s and negatively impact the residents' overall well-being and quality of life. Findings: During a concurrent observation and interview on 11/4/24 at 10:14 a.m. with the Social Worker (SW), the shared bathroom between room [ROOM NUMBER] and 21 was observed. A towel was on the floor and the toilet seat was dirty with brown particles on the toilet seat. SW confirmed the toilet seat was not clean, with brown particles and towel on the floor, and stated the bathroom should always kept clean to prevent of risk of infection. During a review of the facility's policy and procedure (P and P) titled, Homelike Environment, revised on February 2021, the P & P indicated, . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include a. clean, sanitary, and orderly environment .).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 51446 Based on interview and record review, the facility failed to complete and transmit Discharge Minimum Data Set (MDS, an assessment tool to guide patient care) for one of one sampled resident (Resident 11) to Centers of Medicare and Medicaid Services (CMS) for over 120 days. This failure resulted in reflecting Resident 11 as an active resident while he was already discharged from the facility. Findings: During a review of Resident 11's Admission Record (a record with residents' basic information) printed on 11/6/24, the record indicated Resident 11 was admitted to the facility in June 2024. During a concurrent interview and record review on 11/6/24 at 12:53 p.m. with the MDS Coordinator (MDSC), Resident 11's progress notes dated 7/12/24 was reviewed. The MDSC stated Resident 11 was discharged from the facility on 7/12/24. MDSC stated facility was required to complete a Discharge MDS Assessment upon residents' discharge from the facility. The MDSC stated, Resident 11's discharge MDS was not completed and/or transmitted to CMS till date. A review of the CMS guide,Resident Assessment Instrument (RAI) Version 3.0 User Manual 10/2023, showed the discharge MDS required completion within 14 calendar days of discharge, and transmission date within 14 days following completion date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51446 Based on observation, interview and record review, the facility failed to accurately assess and code active diagnosis for one of 21 sampled residents (Resident 31) in the Admission Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) assessment when Resident 31's admission MDS assessment was inaccurately coded with a Yes for diagnoses of Pneumonia (an infection of one or both lungs caused by bacteria, viruses or fungi causing difficulty in breathing, cough, fever, and chills) and Septicemia (a life-threatening blood infection) during the look back period). During this period, Resident 31 did not have active Pneumonia and Septicemia. This failure resulted in an outdated and inaccurate reflection of Resident 31's medical/clinical status. Findings: During a review of Resident 31's Admission Record (a record with residents' basic information) printed on 11/6/24, the record indicated Resident 31 was admitted to the facility in October 2024. During a record review of Resident 31's Admission MDS assessment dated [DATE], the assessment indicated Resident 31 had active diagnoses of Pneumonia and Septicemia. The assessment indicated Resident 31's Brief Interview for Mental Status (BIMS, an assessment tool used to screen and identify memory, orientation, and judgement status of the resident) score was 15 out of 15, indicating Resident 31 has little to no cognitive impairment. During a concurrent observation and interview with Resident 31 on 11/4/24 at 10:58 a.m., Resident 31 was lying in bed, with the head of the bed slightly elevated, awake, and able to communicate needs. Resident 31 showed no signs and symptoms of respiratory distress and was breathing comfortably. Resident 31 stated she had no current infections and was not taking any antibiotics to treat any infection. During an interview with Certified Nursing Assistant (CNA) 4 on 11/4/24 at 11:10 a.m., CNA 4 stated she was the assigned nursing assistant for Resident 31 and did not observe any signs of infections, such as fever, shortness of breath or coughing. CNA 4 also stated she did not receive any report from the Charge Nurse if Resident 31 had an infection. During a concurrent interview and record review on 11/5/24 at 8:19 a.m. with the Licensed Vocation Nurse (LVN) 2, Resident 31's Electronic Health Record (EHR) for physician's orders and progress notes was reviewed. LVN 2 stated she was a regular charge nurse for Resident 31 and did not observe any signs and symptoms of infections related to Pneumonia and Septicemia since Resident 31's admission to the facility in October 2024. LVN 2 stated Resident 31's vital signs were normal and had no difficulty breathing since admission. LVN 2 also stated there were no progress notes and records of any antibiotic ordered by a physician to treat such infections. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/6/24 at 11:46 a.m. with the MDS Coordinator (MDSC), Resident 31's EHR for clinical record was reviewed. MDSC stated she could not locate any documentation indicating Resident 31 had active diagnosis of Pneumonia and Septicemia in the History and Physical, Progress Notes, Medication Administration Record, Xray and Lab results within the look back period (a time period over which the resident's condition or status is captured in the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD), from 10/15/24 through 10/21/24. MDSC stated the MDS was important assessment tool as it provided an overview of a resident's health condition for developing care plans, and incorrect coding could impact the care provided to the resident. During a record review of the facility's Policy and Procedure (P&P) dated 10/2020, titled, Resident Assessments, the P&P indicated, Information in the MDS assessment will consistently reflect information in the progress notes, plans of care and resident observations/interviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, for one of five sampled residents (Resident 17) reviewed for activities of daily living (ADL) care, the facility failed to implement a comprehensive-centered ADL plan of care. This failure had the potential to result in delayed provision of care. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated, Resident 17 was admitted to the facility in February 2024 with diagnoses that included morbid obesity, acute and chronic respiratory failure (acute or chronic impairment of gas exchange between the lungs and the blood), chronic pain syndrome, paraplegia (the loss of muscle function in the lower part of the body including both legs), and pain in left knee. During a review of Resident 17's Minimum Data Set (MDS, an assessment tool used to direct resident care) assessment dated [DATE] indicated Resident 17 had impairment on both lower extremities and totally dependent on staff for toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), and lower body dressing. The MDS also 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 15 (A BIMS score of 13-15 is an indication of intact cognitive status). During an interview on 11/4/24 at 10:15 a.m. with Resident 17, Resident 17 stated the staff had said there was no assigned CNA for the night shift on 10/21/24. Resident 17 stated only after calling the cops to the facility he got get the help for personal hygiene. During an interview on 11/5/24 at 1:08 p.m. with Director of Nursing (DON), DON stated, on 10/21/24, Certified Nursing Assistant (CNA) 7 was assigned to Resident 17 but CNA 7 had refused to enter Resident 17's room. DON stated being aware of a prior incident when CNA 7 became uncomfortable after Resident 17 hurled curses and racial insults at CNA 7. DON stated also being aware of several incidents of being rude and racist toward staff especially CNAs. DON stated, although the staff assignment indicated CNA 7 was assigned to Resident 17, CNA 7 routinely switched assignment with another CNA to avoid having to go to Resident 17's room, an arrangement that the facility management was not aware of. During a telephone interview on 11/6/24 at 10:44 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated CNA 7 was assigned to Resident 17, but CNA 7 refused to go to Resident 17's room to help with ADLs. LVN 3 stated the other two CNAs from the other station also refused to go to Resident 17's room. During a review of Resident 17's ADL care plan dated 4/22/24, the care plan indicated Resident 17 required staff assistance to turn and reposition in bed, with dressing and personal hygiene and oral care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17's care plan to address verbal aggression to staff during ADLs revised on 9/2/24, the care plan indicated for staff to always go Resident 17's room in pairs. During an interview on 11/7/24 at 12:06 p.m. with Patient Care Coordinator (PCC) 3, PCC 3 stated was making the staffing schedule but was not aware CNA 7 could not be assigned to Resident 17. During a review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), Supporting last revised March 2018, the P&P indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, in accordance with the plan of care, including appropriate support and assistance with, hygiene, mobility, elimination, dining, and communication. During a review of another P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program last revised April 2021, the P&P indicated to ensure adequate staffing and oversight/support to prevent burn out and stressful working situations, adequately prepare staff for caregiving responsibilities, Provide staff with opportunities to express challenges related to their job and work environment .help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38534 Based on observation and record review the facility failed to provide Activities of Daily Living (ADL) for one of 17 sample selected residents (Resident 157), when Resident 157 was observed with long, broken finger nails and black particles under nails. This failure placed Resident 157 at risk for skin damage and infection and also affect his comfort and dignity, contributing to a lower quality of life and possible emotional distress. Findings: A review of Resident 157's Admission Record indicated, Resident 157 was admitted to the facility with multiple disease including Cerebral Palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture). During an observation on 11/4/24 at 12:00 p.m. inside Resident 157's room, Resident 157 was observed with long finger nails, with broken and black particles under the nails. During an interview on 11/4/24 at 2:30 p.m. with Certified Nurse Assistant (CNA) 2, CNA 2 confirmed the long , broken and black particles under Resident 157's finger nails and stated the licensed nurses did not ask him to cut the nails. During an interview on 11/04/24 at 02:35 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that he did not know Resident 157 had long nails and its important to keep the nails short and clean because of infection prevention and risk for skin injury. A review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of Revised February 2018, the P &P indicated . Nail care includes daily cleaning and regular trimming .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51446 Based on the observation, interview and record review, the facility failed to safely administer and provide adequate supervision to one of 21 sampled residents (Resident 18) while using a hot water bag (a rubber container designed to hold hot water to apply warmth to specific areas of the body) on her body to keep herself warm for over 24 hours. This failure placed Resident 18 at risk for skin burns. Findings: During a review of Resident 18's Admission Record (a record with residents' basic information) printed on 11/4/24, the record indicated Resident 18 was admitted to the facility in Septembet 2024. During a record review of Resident 18's Minimum Data Set (MDS, an assessment used to guide care) dated 9/30/24, the assessment indicated Resident 18 had an active diagnosis of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). The assessment indicated Resident 18's Brief Interview for Mental Status (BIMS, an assessment tool used to screen and identify memory, orientation, and judgement status of the resident) score was 15 out of 15, indicating Resident 18's mental status was intact. During a concurrent observation and interview on 11/4/24 at 9:58 a.m. with Resident 18, Resident 18 was lying in bed, awake, with hot water bottle filled with hot water on her right side of the chest. Resident 18 stated one of the Certified Nursing Assistant (CNA 1) helped to fill it up with hot water that morning. Resident 18 stated her room was cold, so she needed the hot water bottle in addition to the blanket, to keep herself warm. Resident 18 stated she used it frequently since she purchased it online about three days ago. Resident 18 stated her nursing assistants were aware, they helped to fill up the water bottle with hot water. During an interview on 11/4/24 at 10:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated he filled up the hot water bag and gave it to Resident 18 during the start of his shift (usual start time for morning shift is 7:00 am). CNA 1 stated he was not the assigned nursing assistant for Resident 18, neither he told Resident 18's nurse, nor supervised Resident 18 while she used hot water bag. CNA 1 stated the hot water bag could cause skin burns if Resident 18 remained unsupervised. During an interview on 11/4/24 at 1:03 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated she was the assigned nursing assistant for Resident 18 on 11/3/24 morning shift (7am to 3:30pm). CNA 3 stated she saw Resident 18 using a hot water bag but did not communicate with Resident 18's charge nurse about it. CNA 3 stated she filled up Resident 18' hot water bag with hot water on 11/3/24, but was unsure if the water temperature was appropriate. CNA 3 stated she used her own skin to test the water temperature. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 11/6/24 at 4:14 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she was the assigned nursing assistant for Resident 18 during the 11/3/24 afternoon shift (3pm-11:30pm). CNA 6 stated she saw Resident 18 using the hot water bag on her body. CNA 6 stated she also filled up with hot water from the janitor closet on 11/3/24 but was not sure if the water temperature was appropriate. CNA 6 stated she had not received any training regarding the use of hot water bags. During an interview and record review on 11/4/24 at 2:22 p.m. with Licensed Vocation Nurse (LVN) 2 , Resident 18's physician orders and progress notes dated November 2024 were reviewed. LVN 2 stated she noticed Resident 18 using the hot water bag that day only. LVN 2 stated there were no written physician orders and progress notes pertaining to the use of the hot water bag. LVN 2 stated Resident 18 could suffer skin burns if unsupervised. During an interview on 11/6/24 at 12:32 p.m. with the Director of Nursing (DON), the DON stated a hot water bag could not be used in the facility as it increased the risk for burn injuries and other skin issues. The DON stated communication among staff, from licensed nurses to nurse managers and including herself was essential. During a record review of the facility's Policy and Procedure (P&P) revised 7/2017, titled, Safety and Supervision of Residents, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32717 Based on observation, interview and record review, the facility failed to establish a system of disposition of controlled drugs for accurate reconciliation when blister packs (also called a bubble pack, blister pack, a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles [or blisters] and each pack is secured by a strong, paper-backed foil that protects the pills until dispensed) of controlled medications with popped and taped shut blisters were stored. This failure had the potential to result in inaccurate reconciliation of controlled medications. Findings: 1. During an observation and concurrent interview and review on 11/4/24 between 1:41 p.m. and 2:19 p.m. with Licensed Vocational Nurse (LVN) 2, Station 1 medication cart was observed. Inside the medication cart narcotic (controlled) box was a blister pack of oxycodone hydrochloride (controlled pain medication/narcotic) 5 milligrams (mg) had two blisters, individual blister #7 count and # 8, that were popped and taped shut with a paper tape. The blister pack was inside Station 1 medication cart where medications ready for administration were stored. The Controlled Drug Record-Individual Patient's Narcotic Record (CDR-IPNR) for oxycodone 5 mg, the CDR-IPNR indicated #7 did not have any signature, while #8 indicated, a date and time that was crossed out with a single horizontal line and indicated one signature. Inside the two individual plastic blisters were half of a white round tablet. LVN 2 stated, the popped (punctured) medications were supposed to be signed by two licensed nurses but were not. 2. During an observation and concurrent interview on 11/4/24 at 2:20 p.m. with Director of Nursing (DON), contents of the narcotic file cabinet were observed. There was a blister pack of MS Contin (controlled/narcotic pain medication) that had one individual blister popped and taped shut. DON stated the medication was for a resident who has been discharged from the facility. DON also stated the blister pack that was taped shut should have been destroyed and signed by two licensed nurses, and not replaced in the blister pack because one would not know if it was the same medication as the one that was removed/popped. During a review of the CDR-IPNR for MS Contin, the CDR-IPNR indicated individual blister # 25 was popped and taped shut with a white paper tape. There was a date and time written that was crossed out with a single horizontal line and one signature. During a review of the facility's policy and procedure (P&P) titled Discarding and Destroying Medications last revised November 2022, the P&P indicated, Disposal of controlled and non-controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. A controlled medication policy and procedure that addressed popped blister packs was requested and was not provided during the entire survey.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on observation, interview, and record review, the facility failed to verify that residents understood binding arbitration agreements (a formal method of dispute resolution where a third party makes a decision instead of the dispute going to court) and/or that they were aware they could rescind the agreement within 30 days for 3 of 3 sampled residents (Resident 18, Resident 13, and Resident 49). This failure had the potential for residents to enter into an agreement without understanding their rights. Findings: During a review of the arbitration agreement made between the facility and three randomly selected residents (Resident 18, Resident 13, and Resident 49), the arbitration agreements included three boxes stating prior to signing this agreement the resident reviewed the voluntary arbitration program guide, the resident received a copy of this agreement after it's execution, and the resident is aware that he/she may rescind the agreement in writing at any time within thirty (30) days of the date of its execution. The boxes to indicate that these steps were completed were blank for all three residents. During a review of resident 13's admission record, Resident 13 was initially admitted to the facility in August 2024 with multiple diagnoses, including End Stage Renal Disease (ESRD, the final stage of long-term kidney disease when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body's needs.), Myocardial Infarction (heart attack), and Difficulty in Walking. During a review of Resident 13's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information.), dated 8/8/24, Resident 13 had a BIMS of 15, indicating intact cognitive status. During a concurrent interview and record review on 11/6/24 at 11:38 a.m. with Resident 13, Resident 13's binding arbitration agreement, dated 8/7/24, was reviewed. Resident 13 stated he remembers being given paperwork on admission and signing the documents. Resident 13 stated he does not remember having the arbitration agreement explained to him. During a review of Resident 49's admission record, Resident 49 was initially admitted to the facility in August 20204 with multiple diagnoses, including Hypertension (high blood pressure) and Difficulty in Walking. During a review of Resident 49's BIMS score, dated 8/28/24, Resident 49 had a BIMS score of 15, indicating intact cognitive status. During a concurrent interview and record review on 11/6/24 at 11:46 a.m. with Resident 49, Resident 49's arbitration agreement, dated 9/28/24, was reviewed. Resident 49 stated he signed a lot of papers during the admission process and doesn't remember anyone explaining that it was voluntary and/or if anyone checked if he understood the agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's admission record, Resident 18 was initially admitted to the facility in [DATE] with multiple diagnoses, including Hypertension and Surgical Aftercare (care while recovering from surgery). During a review of Resident 18's BIMS score, dated 9/25/24, Resident 18 had a BIMS score of 15, indicating intact cognitive status. During a concurrent interview and record review on 11/6/24 at 11:17 a.m. with Resident 18, Resident 18's arbitration agreement, dated 9/24/24, was reviewed. Resident 18 stated she does not remember anyone explaining the document to her. Resident 18 stated she was under stress when she got to the facility and signed all the papers she was given. During a concurrent interview and record review on 11/5/24 at 2:32 p.m. with Patient Care Coordinator1 (PCC1), Resident 49's arbitration agreement, dated 9/28/24, was reviewed. PCC1 stated she co-signed the arbitration agreement with Resident 49. PCC1 stated that she is not very familiar with the arbitration agreement and if the resident has questions, she would get another staff member. PCC1 stated she is not certain if residents can rescind the agreement after signing. During an interview on 11/6/24 at 12:29 p.m. with PCC3, PCC3 stated there are three boxes on the arbitration agreement and the process is to check the boxes on the arbitration agreement to verify that the information was reviewed with the residents. During a concurrent interview and record review on 11/6/24 at 1:55 p.m. with Administrator (ADM), Resident 49's arbitration agreement, dated 9/28/24, Resident 18's arbitration agreement, dated 9/24/24, and Resident 13's arbitration agreement, dated 8/7/24, were reviewed. ADM stated the documents have boxes that should be checked to verify that the resident reviewed the Voluntary Arbitration Program Guide, the resident received a copy of the agreement, and the resident is aware that the resident may rescind the agreement within thirty days. ADM stated the box yes was not checked on any of the documents and should have been. ADM stated the boxes should be checked to verify that the resident received and reviewed the document and if they are not checked, there is a chance that the information could not have been reviewed, resulting in the residents not understanding their rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: San Leandro Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 368 Juana Avenue San Leandro, CA 94577	

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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 49983 Based on observation, interview, and record review, the facility failed to provide a binding arbitration agreement (a formal method of dispute resolution where a third party makes a decision instead of the dispute going to court) that met the regulations. This failure had the potential for residents to enter into an agreement that did not protect their rights. Findings: During a review of the arbitration agreement made between the facility and three randomly selected residents (Resident 18, Resident 13, and Resident 49), the arbitration agreement for all three residents did not provide for the selection of a neutral arbitrator agreed upon by both parties and/or provide for the selection of a venue that is convenient to both parties. During a concurrent interview and record review on 11/6/24 at 1:55 p.m. with Administrator (ADM), Resident 49's arbitration agreement, dated 9/28/24, Resident 18's arbitration agreement, dated 9/24/24, and Resident 13's arbitration agreement, dated 8/7/24, were reviewed. ADM stated the documents do not have a section that provides for the selection of a venue that is convenient to both the resident and the facility. ADM stated the arbitration agreement does not provide for the selection of a neutral arbitrator agreed upon by both parties. ADM stated there is a risk that residents could not understand their rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49983 Based on observation and interview, the facility had 18 rooms (Rooms 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25) with multiple beds that provided less than 80 square feet (sq. ft.) per resident who occupied these rooms. This deficient practice had the potential to result in inadequate space for the delivery of care to each of the residents in each room, or for storage of the residents' belongings. After observation and interview, there was adequate space for residents and staff to move about without obstruction. Recommend granting waiver. Findings: During an interview with the Administrator (ADM) on 11/06/24 at 12:50 p.m., the following rooms and corresponding square footage per bed were identified: Room Activity Room Size Floor Area 7 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed 8 Bedroom [ROOM NUMBER] sq ft 70 sq.ft/bed 9 Bedroom [ROOM NUMBER] sq ft 70 sq.ft/bed 10 Bedroom [ROOM NUMBER] sq ft 70 sq.ft/bed 11 Bedroom [ROOM NUMBER] sq ft 72 sq.ft/bed 12 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 14 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 15 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 16 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 17 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 18 Bedroom [ROOM NUMBER] sq ft 73 sq.ft/bed 19 Bedroom [ROOM NUMBER] sq ft 72 sq.ft/bed 20 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	21 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed 22 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed 23 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed 24 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed 25 Bedroom [ROOM NUMBER] sq ft 71 sq.ft/bed During random observations of care and services from 11/4/24 through 11/7/24, there was sufficient space for the provision of care for the residents in all 18 rooms. Each resident had adequate personal space and privacy. Resident 49 was observed being able to ambulate in the room without difficulty. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the 18 rooms.