STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056348	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay View Rehabilitation Hospital, LLC	516 Willow Street Alameda, CA 94501

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order for interventions/treatment for one of three sampled residents (Resident 1) pressure injury to sacrococcyx (tailbone).This failure resulted in slow healing of Resident 1's pressure injury and had the potential for infection. During a review of Resident 1's admission record, dated 4/10/26, the admission record indicated Resident 1 was admitted to the facility on [DATE].During a review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), dated 1/30/26, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 11. A score of 11 indicated Resident 1 had moderate cognitive impairment. MDS also revealed, Resident 1 had multiple diagnoses that included malnutrition, Diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing) and Cerebrovascular Disease (CVA - stroke). MDS further revealed, Resident 1 had hemiplegia (complete loss of muscle control or paralysis on one side) or hemiparesis (partial weakness on one side of the body). MDS showed, Resident 1 had Stage 3 pressure ulcer that was present upon admission. MDS also showed, Resident 1 required application of nonsurgical dressings (with or without topical medications). During a review of Resident 1's, Discharge Summary Notes from acute care hospital dated 1/23/26, the notes indicated under Wound Care: .1. Cover sacrum (bony structure in lower back) with optiview hydrogel dressing (clear medical patches designed to protect vulnerable skin and heal wounds). 2. Assess every shift. 3. Change as needed. Do not leave dressing on for more than 7 days. 4. Reconsult wound care for any worsening of sacral wound.During a review of Resident 1's admission notes, dated 1/23/26, under B. Narrative note, Resident 1 had sacrococcyx redness 0.3 cm by 0.2 cm (cm-centimeter, a unit of measurement).During a review of Resident 1's January 2026 TREATMENT RECORD, the record showed Resident 1 did not receive hydrogel dressing to the sacrum on multiple days (1/24/26, 1/25/26, 1/26/26 and 1/27/26) as ordered by the physician.During a review of Resident 1's Skin Condition Reassessment, dated 1/23/26, the document indicated, Resident 1 had Stage III (full thickness tissue loss or a deep crater-like bedsore) pressure ulcer on sacrococcyx.During a review of Resident 1's Surgical Consult, dated 1/27/26, the document indicated under reason for visit, consultation and evaluation of wounds that included sacrococcyx. Under assessment and plan, Resident 1 had multitude of wounds that included sacrococcyx. Surgical consult also showed Resident 1 had risk factors including limited mobility and diabetes which might exacerbate the worsening of the pressure injury. Furthermore, Resident 1 required continued topical wound dressing therapy on sacrococcyx. During a telephone interview on 4/28/26 at 11:42 a.m. with the Treatment Licensed Nurse (TLN) 1, TLN 1 stated, treatment record showed Resident 1 did not receive treatment on sacrum on 1/24/26, 1/25/26, 1/26/26 and 1/27/26. TLN 1 also added, she does not recall providing wound treatment on Resident 1's sacrum on the dates with missing signature. TLN 1 further stated, if wound treatment record was not signed, it was not done. During a telephone interview on 4/28/26 at 11:59 a.m. with Wound Care Physician (WCP), WCP stated, the expectation from TLN 1 was to follow Resident 1's wound treatment regimen to prevent the pressure injury worsening. During (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a telephone interview on 4/28/26 at 1:29 p.m., with the Director of Nursing (DON), DON stated, Resident 1 had state 3 pressure ulcer. DON added, Resident 1 had a physician order for hydrogel dressing to Resident 1's sacrum but did not receive it on multiple days. DON also stated, it was important for the TLN 1 to provide wound treatment to Resident 1 within 24 hours of admission to prevent pressure injury from worsening. DON further stated, the expectation was for TLN 1 to follow doctor's order.During a review of Resident 1's care plan (personalized treatment plan that outlines patient's needs), dated 1/24/26, indicated Resident 1 had a pressure ulcer . The care plan also indicated one of the interventions were: .Treatment as ordered and evaluate effectiveness. During a review of facility's policy and procedures (P&P) titled, POLICY AND PROCEDURE ON PHYSICIAN ORDERS, dated 10/2014, indicated under Policy: It shall be this facility's policy to provide care and services to the resident in accordance with physician orders. Under Procedure: 1. All aspect of resident's care, including but not limited to the following shall only be provided if ordered by the physician: .treatments .During a review of facility's P&P titled, POLICY AND PROCEDURE ON PRESSURE ULCERS, dated 10/2010, indicated under policy: The facility shall ensure that a resident who enters the facility with pressure ulcer and/or develops unavoidable pressure ulcers while being in the facility, must receive treatment and services necessary to promote healing, prevent infection and prevent new ulcers from developing. Under procedures: .2. Assessment of pressure ulcers shall be done at least once every week or as wound condition changes. 3. Document general findings in the weekly skin and would progress report. 4.c. Pressure ulcer treatment orders shall be evaluated for effectiveness every 21 days and as needed.P&P titled, POLICY AND PROCEDURE ON NURSING admission ASSESSMENT, dated 10/2019, indicated under Procedures.7. Verify orders with physician and communicate with other disciplines necessary treatment and/or services to meet resident's needs.