STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056422	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fremont Healthcare Center	39022 Presidio Way Fremont, CA 94538

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow its Abuse policy and procedures to investigate, and report to local, state, and federal agencies suspected incident of resident allegation of abuse for one (Resident 14) of three sampled residents when Resident 14 screamed out during a visit with three facility staff and Resident 14 called 911. This failure had the potential to place Resident 14 at risk for emotional distress, mistreatment, neglect or abuse. During a review of Resident 14's Annual Minimum Data Set (MDS- a federally mandated resident assessment and care guide tool), dated 4/23/25, the MDS indicated Resident 14's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) Resident 14's score was 15 meaning intact cognition. Resident 14 had clear speech, usually understand, and understood others. MDS indicated Resident 14 had no potential indicator of Psychosis, no hallucination or delusion. Resident 14 had verbal and other behavioral symptoms directed toward others e.g., screaming at others, threatening others, cursing directed towards others. MDS indicated Resident 14 exhibited rejection of care occurred daily. Resident 14's behavioral symptoms significantly put Resident 14 at risk for physical illness or injury. Resident 14's diagnosis included Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).During an interview on 9/15/25 at 11:05 a.m. with Resident 14, in her room. Resident 14 stated three staff came to her room. Resident 14 identified three staff as Social Services Assistant (SSA), Activities Director (AD) and Licensed Vocational Nurse/Infection Preventionist (IP). Resident 14 stated SSA told Resident 14 that they do not want her in the facility anymore and Resident 14 had to leave. Resident 14 said SSA swung her around in her wheelchair. Resident 14 said SSA hurt her left arm. Resident 14 stated that she called 911.During an interview on 9/16/25 at 4:46 p.m. with SSA, SSA stated together with AD and IP, a meeting was held with Resident 14 in Resident 14's room. SSA stated discharge plan was discussed. SSA stated Resident 14 was told that if she was not happy with care at the facility to consider another placement. SSA stated she did not tell Resident 14 that Resident 14 had to leave facility. SSA said she did not swing Resident 14 around in her wheelchair.During an interview on 9/17/25 at 8:27 a.m. with Registered Nurse/Unit Manager (RN1), RN1 stated Resident 14 was one of her residents. RN 1 stated she heard Resident 14 screamed out and saw SSA, AD and IP came out of Resident 14's room and closed the door. RN1 stated that she did not inquire about what happened. RN1 said Resident 14 did not like RN1. RN1 stated Resident 14 did not want RN1 in Resident 14's room. During an interview on 9/17/25 at 8:37 a.m. with Administrator (Admin), Admin stated he heard Resident 14 screamed because Resident 14's room is next to Admin's office. Admin stated Police came to the facility and met with him. Admin said the police came to follow up with Resident 14's 911 call. Admin stated he took the police to Resident 14's room and shortly police left after Resident 14 became agitated. Admin stated he did not investigate further because Resident 14 did not like him. Admin said he did not investigate or report because there were no abuse and no need for investigation.During an interview on 9/17/25 at 2:55 p.m. with Resident 14's Medical Doctor (MD1), MD1 stated Resident 14 has capacity to make decisions. MD1 stated Resident 14 was not in medical distress. During a review of the facility's policy and procedure (P&P), Abuse Investigation & Reporting, dated 4/22/24, the P&P indicated, If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.