STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of quality for one of two sampled Residents (Resident 7) when nursing staff did not follow the physician's order for Resident 7's oxygen therapy. This failure had the potential to cause health complications to Resident 7. Findings: During a review of Resident 7's face sheet, undated, indicated Resident 7 was admitted to the facility on [DATE].During a review of Resident 7's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/20/26, indicated Resident 7 had a Brief Interview for Mental Status (BIMS- assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 2 out of 15. Meaning, Resident 7 had severe cognitive impairment. The MDS also indicated Resident 7 had multiple diagnoses that included anemia (when a body doesn't have enough healthy red blood cells to carry oxygen to organs and tissues) and interstitial pulmonary disease (inflammation and permanent scarring in lung tissue).During a concurrent observation and interview on 6/10/26 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 7's room, Resident 7 was receiving oxygen (O2) therapy via nasal cannula (NC - tube used to deliver supplemental oxygen) set at a flow rate of 5 Liters per minute (LPM- measurement of oxygen being delivered). LVN 1 stated, Resident 7 was supposed to receive O2 at 3 LPM as ordered by the doctor. LVN 1 further stated, it was my responsibility to check and make sure oxygen is running at right order, there was risk for oxygen toxicity when Resident 7 received more oxygen than needed.During an interview on 6/10/26 at 9:48 a.m. with the Director of Nursing (DON), outside Resident 7's room, DON stated, LVN 1 should have checked Resident 7's oxygen flow at the beginning of shift to ensure Resident 7 received oxygen therapy as ordered by the physician. During a review of Resident 7's Physician Order Report dated 6/7/26, indicated Resident 7 had an order for Oxygen inhalation via Nasal cannula at 3LPM.Every Shift; Shift 1 07:00 AM - 03:00 PM.During a review of Resident 7's Care Plan (a personalized roadmap nurses use to guide patient's treatment) dated 6/4/26, indicated Resident 7 had Alteration in Respiratory status due to Dx (diagnosis) PNA (pneumonia - lung infection) and one of the interventions were .Administer oxygen as ordered.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, undated, indicated under PROCEDURE .9. Turn the unit on to the desired flow rate.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 27 and 80) received treatment and care in accordance with professional standards of practice when:1. Direct Care Staff did not follow physician's orders to assess Resident 27 for bleeding and did not follow up with Resident 27's physician regarding her orders to hold or to restart Eliquis (an anticoagulant medication used to prevent and treat blood clots, and lower stroke risk in patients with atrial fibrillation, an irregular and often very rapid heart rhythm) for a period of over six months. Resident 27 experienced extensive deep vein thrombosis (DVT), through the bilateral (having two sides) common femoral veins (a major deep blood vessel in the groin) through the popliteal veins (a major deep vein located behind the knee responsible for carrying oxygen-depleted blood away from the lower leg).2. Facility staff did not explain and/or document the risks and benefits of refusing to receive acute care at the acute care hospital (ACH) when Resident 80 complained of chest pain. Resident 80 developed more complications and needed an emergency transfer to ACH after five days from the original change of condition, indicating delayed acute care medical evaluation (a comprehensive diagnostic assessment performed by a healthcare provider to assess overall health, identify the root causes of symptoms, and determine treatment options).Findings:1. During a review of Resident 27's Acute Care Hospital (ACH) Emergency Department (ED) Note, dated 4/9/25, the ACH ED Note indicated, Resident 27 had a past medical history of DVT and pulmonary embolism (a sudden blockage in a lung artery, typically caused by a blood clot that has traveled from a deep vein in the leg or pelvis) and is not on any anticoagulants. The ACH ED Note indicated, Resident 27 did not have evidence of deep venous thrombosis in the left lower extremity upon US (ultrasound, a safe, noninvasive imaging test that uses high-frequency sound waves to capture real-time images or videos of internal organs, tissues, and blood flow).During a review of Resident 27's Face Sheet, dated 6/11/26, the Face Sheet indicated, Resident 27 was admitted in the facility on 4/11/25 with a diagnosis of acute embolism (a sudden blockage of a blood vessel by a foreign object most commonly a blood clot that has traveled from elsewhere in the body) and thrombosis (the formation of a blood clot inside a blood vessel, which restricts or blocks the flow of blood) of unspecified deep vein of right lower extremity and paroxysmal atrial fibrillation (an occasional, irregular heart rhythm where the upper chambers of the heart beat chaotically and out of sync).During a review of Resident 27's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 4/18/26, the MDS indicated, Resident 27'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) score was 15 out of 15, indicating intact cognitive response.During an interview on 6/9/26 at 9:07 a.m. with Resident 27, Resident 27 stated, the doctor had taken her off Eliquis in April 2025. Resident 27 stated going to the hospital in October 2025 due to blood clots in her legs.During a concurrent interview and record review on 6/11/26 at 8:51 a.m. with the Director of Nursing (DON), Resident 27's Physician's Order Report, dated 4/12/25 was reviewed. The Physician's Order Report indicated, Eliquis tablet; 5 milligram (mg); amt: 1 tab; oral, special instructions: med on hold per MD until bleeding resolved, FYI. The DON stated the Eliquis was on hold because Resident 27 had bleeding in her leg in 04/2025.During a concurrent interview and record review on 6/11/26 at 9:09 a.m. with the DON, Resident 27's Medication Administration History, dated 4/11/25 to 4/30/25 was reviewed. The Medication Administration History indicated, the Eliquis order was marked with x on 4/11/25, 4/13/25 to 4/30/25 and the Licensed Vocational Nurse (LVN) 3's initials on 4/12/25 had parenthesis indicating Eliquis was not administered. The DON stated, the x meant Eliquis was not given to Resident 27.During a concurrent interview and record review on 6/11/26 at 9:14 a.m. with the DON, Resident 27's Medication Administration History, dated 5/1/25 to 5/31/25, 6/1/25 to 6/30/25, 7/1/25 to 7/31/25, 8/1/25 to 8/30/25, 9/1/25 to 9/30/25, 10/1/25 to 10/13/25 was reviewed. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration History indicated, there was no Eliquis order for Resident 27. The DON stated, Resident 27 did not receive the Eliquis from May 2025 up to October 2025 and was sent out to the hospital. The DON stated the nurses were expected to follow up with the doctor when the Eliquis needed be resumed. The DON stated Resident 27 was at high risk of embolism for not receiving the Eliquis.During a concurrent interview and record review on 6/11/26 at 9:43 a.m. with the DON, Resident 27's Progress Note, dated 4/12/25, was reviewed. The Progress Note indicated, MD in the facility with new orders:. Left lower extremity (LLE) venous ulcer (a slow-healing open sore). Monitor for bleeding every (q) 2 hours x 4 then q shift if stopped. Hold Eliquis till bleeding resolved. The DON stated the order for monitoring the LLE for bleeding should have been placed in the physician's order and transcribed in the treatment administration record (TAR), however she was unable to find that in the MAR or the TAR. The DON stated the nurses should have monitored for the bleeding and updated the doctor.During a follow up concurrent interview and record review on 6/11/26 at 9:47 a.m. with the DON, Resident 27's Physician's Order Report and TAR, dated 4/11/25 to 4/30/25 was reviewed. The DON stated the order for monitoring LLE for bleeding was not in the physician's order and TAR. The DON stated there was no documentation in the TAR that Resident 27's LLE was monitored for bleeding. The DON stated no documentation of monitoring meant the monitoring was not done.During a review of Resident 27's Doppler (usually refers to a doppler ultrasound, a noninvasive test uses high-frequency sound waves to measure the speed and direction of blood flow through the arteries and veins) Report, dated 10/13/25, the Doppler Report indicated Resident 27 had an extensive bilateral DVT from the posterior tibial veins (paired deep blood vessels in the lower leg that carry oxygen-depleted blood from the feet and calves back toward the heart) to the common femoral veins.During a review of Resident 27's Observation Detail List Report, dated 10/13/25, indicated, Registered Nurse (RN) 1 received the result of doppler [NAME] (ultrasound) (thrombosis on both legs). Received a call from MD with verbal order. send out resident for ER (emergency room) evaluation.During a review of Resident 27's ACH ED Note, dated 10/13/25, the ACH ED Provider Note indicated, Resident 27 had bilateral lower extremity (BLE) swelling and tenderness (pain or discomfort that is elicited when a specific area of the body is touched or pressed by a clinician) on the calfs upon exam. The ACH ED Provider Note indicated, Resident 27's US showed extensive DVTs, combination of occlusive (refers to the narrowing or complete blockage of a blood vessel) and nonocclusive, through the bilateral common femoral veins through the popliteal veins.During a review of the facility's policy and procedure (P&P) titled, Medications on Hold, undated, the P&P indicated, Purpose. To establish a standardized process for safely placing medications on hold, monitoring residents during the hold period, ensuring timely provider notification and follow-up, and preventing adverse (an unintended, harmful, or undesirable effect associated with a medical product, treatment, or procedure) outcomes related to interrupted medication therapy. B. Anticoagulant Medications. Examples:. Eliquis . Nursing Responsibilities. 1. Assess for bleeding. 4. Clarify restart date and conditions. 2. During a review of Resident 80's Face Sheet, dated 6/11/26, the Face Sheet indicated, Resident 80 was admitted in the facility on 4/25/15 with a diagnosis of chronic pulmonary embolism (occurs when blood clots in the lungs fail to completely dissolve or repeatedly occur over time, transforming into hard, scar-like tissue), atrial fibrillation (an irregular and often very rapid heart rhythm), unspecified dementia (a clinical or diagnostic classification used when a patient exhibits a clear decline in cognitive abilities such as memory loss or problem-solving, but the underlying cause or specific type of dementia cannot be definitively determined).During a review of Resident 80's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 2/13/26, the MDS indicated, Resident 80'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) score was 15 out of 15, indicating intact cognitive response.During a review of Resident 80's ?Physician Order Report, dated 1/17/18, the Physician Order Report indicated, Resident 80 has the capacity to make healthcare decisions: YES. FYI.During a concurrent interview and record (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review on 6/11/26 at 9:52 a.m., with the Director of Nursing (DON), Resident 80's Observation Detail List Report, dated 4/26/26 at 3:00 p.m., was reviewed. The Observation Detail List Report indicated, Registered Nurse (RN) 2 documented, During rounds, resident noted sitting on bed & verbalized, I do not feel good, I have pain in my chest & my left arm is hurting. Resident describes the pain as non-radiating & he is experiencing it since yesterday . Resident appears pale & clammy (skin or surfaces that are unpleasantly damp, sticky, and often cool to the touch). Resident also added, I feel hot & nauseous. I vomited three times too. Per report from outgoing nurse, resident refused his meals in the AM (morning) shift. BP medication administered, offered pain medication, resident refused. Medical Doctor (MD) 1 notified with order to send resident to Acute Care Hospital (ACH) for check-up. Resident refused to be sent, I will be fine. I do not want to go to the hospital. Resident refused meal. The DON stated she was unable to find any documentation indicating the licensed nurses ever explained the risks and benefits of refusing the acute care hospital transfer, specially when Resident 80 was not at his normal baseline. During a review of Resident 80's Progress Note, dated 4/26/26 to 4/27/26, the Progress Note indicated, there were no documentation that the risk of refusing the hospital transfer was explained to Resident 80.During a review of Resident 80's Observation Detail List Report, dated 4/27/26 at 2:21 a.m., indicated, Resident 80 was monitored closely for any changes.During a review of Resident 80's Observation Detail List Report, dated 4/27/26 at 10:26 p.m., indicated, Resident 80's plan of care was ongoing.During a review of Resident 80's Observation Detail List Report, dated 4/28/26 at 1:00 a.m., indicated, Resident 80 was continued to be monitored.During a review of Resident 80's Observation Detail List Report, dated 4/28/26 at 1:56 p.m., indicated, Resident 80's nursing care and monitoring continued.During a review of Resident 80's Observation Detail List Report, dated 4/28/26 at 10:44 p.m., indicated, Resident 80's plan of care was ongoing.During a review of Resident 80's Observation Detail List Report, dated 4/29/26 at 1:06 a.m., indicated, Resident 80 was continued to be monitored for any changes.During a review of Resident 80's Observation Detail List Report, dated 4/29/26 at 1:22 p.m., indicated, Resident 80's nursing care and monitoring continued.During a concurrent interview and record review on 6/11/26 at 10:01 a.m. with the DON, Resident 80's Progress Note, dated 5/2/26, was reviewed. The Progress Note indicated, Licensed Vocational Nurse (LVN) 1 documented, Resident 80 c/o (complained of) midsternal chest pain, N/V (nausea and vomiting), and noted with fluctuating O2 (oxygen level). Resident noted to have poor oral intake, consumed approximately 25% breakfast and refused to eat lunch. Resident observed pale and cold extremities. MD notified with order to send out to hospital for further eval (evaluation). The DON stated Resident 80 was sent to the hospital. The DON stated Resident 80 never came back to the facility.During a review of Resident 80's Physician Order Report, dated 5/2/26, indicated, Resident 80 had an order to be transferred to ACH via ambulance d/t (due to) fluctuating O2 levels, N/V and midsternal chest pain for further evaluation and management.During a concurrent interview and record review on 6/11/26 at 10:16 a.m. with the DON, the facility's policy and procedure (P&P) titled, Refusal of Treatment, undated, was reviewed. The P&P indicated, Policy. The facility honors a competent resident's request not to receive medical treatment as prescribed by his or her physician. Background. Treatment is defined as care provided for purpose of maintaining/restoring health, improving functional level, or relieving symptoms. Procedure. 1. The resident is not forced to accept any medical treatment and may refuse specific treatment even though a physician prescribes it. Risk versus benefits will be discussed by the assigned staff with the resident/resident representative . The DON stated the importance of explaining the risk of refusing treatment was for residents to fully understand the outcome of refusing treatment.

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	056447	A. Building B. Wing	06/11/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store and label medications and enteral feeding supplements for nutrition in accordance with professional standards when:1a. Expired, discontinued, and compromised drugs and biologicals in medication storage room were not disposed.1b. Pharmaceutical waste container filled with unused drugs was not labeled with date of first use and dispose of by.1c. Two full drug buster (medication disposal system) containers were not discarded.2. Enteral feeding supplements, nutritional shake and meal replacement products were not stored within the required storage room temperature range of 59 F to 77 F (Fahrenheit - temperature scale)3. Medication cart 4 was left unlocked and unattended on two separate occasions.4. Four of five medication carts observed had multiple loose unidentified pills scattered inside the drawers.Findings: 1a. During a concurrent observation and interview on 6/9/26 at 3:13 p.m. with the Director of Nursing (DON) in medication storage room, the following drugs, biologicals and drug disposal containers were stored: (a) two expired 0.5 FL OZ (fluid ounce – unit of measurement) boxes of Carbamide Peroxide (medication used to soften earwax) ear drops (b) one open box of enema [treatment procedure to relieve constipation where liquid is gently squirted into the rectum (lower part of the bowel)] had dried and crusted white substance on surrounding lid (c) one medication disposal bin was full and did not have start and disposal date (d) two drug buster (medication disposal system) containers filled with discontinued/outdated/unused medications were not disposed (e) enteral feeding nutritional supplements were stored in room with temperature of 82 degrees F and without adequate air circulation. (f) four medication carts had multiple unidentified loose medications (g) Licensed Nurse left medication cart unlocked and unattended on two separate occasions (h) 1 bottle of opened Milk of Magnesia (MOM- laxative). During an interview on 6/9/26 at 3:29 p.m. with the DON, in the medication storage room, DON stated, the expired ear drops will have to be discarded because they were expired and unsafe to use. DON also stated, enema will be discarded because it was open and had crusted substance around the squirt bottle. During an interview on 6/9/26 at 3:33 p.m. with the DON, in the medication storage room, DON stated, licensed staff were expected to label the pharmaceutical waste container with date of first use and dispose of by because there was timeline the discarded drugs should be disposed. DON also stated, two full drug buster containers should have been removed from the medication storage room for destruction of medications accordingly. 2. During a concurrent observation and interview on 6/9/26 at 4:00 p.m. with DON, in the central supply room (CSR), there was no adequate ventilation or airflow and the wall mounted thermometer reading was 82 degrees F. A second thermometer on the shelf also read 82 degrees F. The CSR stored the following items: 15 - 33.8 fl oz Glucerna Tube Feeding (TF) formula, eight-33.8 fl oz Jevity TF formula, 20- 8 oz (ounce) carton of Nepro, 2 boxes containing 48 - 4 fl oz cups thickened lemon-flavored water (used for individuals with difficulty swallowing), 72- 4 oz cups of apple sauce stored in three boxes and 1 bottle of Prostat (protein supplement). DON stated, the required temperature for storing enteral feeding supplies and supplements should not exceed 77 degrees F. DON stated, the supplements were stored in inappropriate temperature and can lead to gastric (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problems like diarrhea, food poisoning or death to the residents. During a concurrent observation and interview on 6/9/26 at 4:10 p.m. with the Regional Director Of Clinical Operations (RDCO), RDCO seen removing enteral feeding supplements from the CSR. RDCO then stated, these supplements were stored inappropriately and will be discarded because they are not safe for consumption. RDCO further stated, the formulas could cause gastrointestinal (GI-digestive system) issues if consumed by the residents. During a concurrent observation and interview on 6/9/26 at 4:51 p.m. with the Maintenance Supervisor (MS), MS re-checked the temperature inside the CSR using a hand-held thermometer which read 81 degrees F. MS stated, food items should be stored in 60 degrees F to 70 degrees F for safe consumption. 3a. During a concurrent observation and interview on 6/10/26 at 12:34 p.m. medication cart 4 was unlocked, unsupervised and unattended outside room [ROOM NUMBER] with drawers facing outward. Registered Nurse (RN) 2 came out of room [ROOM NUMBER], walked towards medication cart 4 and then locked the drawers. RN 2 stated, she did not notice she left medication cart 4 unlocked before going to another resident's room. RN 2 also stated, there was potential risk for other residents to take pills from unlocked and unattended medication cart. RN 2 further stated, unlicensed staff could also potentially take medications from the unlocked medication cart. During an interview on 6/10/26 at 12:40 p.m. with the DON, DON stated RN 2 was supposed to keep medication 4 locked when not in use because there was potential for other residents to take medications from the drawer. DON also added, there was potential for drug diversion if unlicensed staff or other individuals get a hold of the medications from unsecured medication cart. DON further added, RN 2 was expected to lock the medication cart when not in use with drawers facing the wall for added security. 3b. During an observation on 6/10/26 at 2:43 p.m., RN 2 walked away from the Medication Cart 4 while it was unlocked and unattended in the hallway near resident rooms. During an interview on 6/10/26 at 2:45 PM, RN 2 stated she thought since state agency surveyor was in the hallway, she left it unlocked and unattended. RN 2 then stated the cart should be locked. During a record review on of the facility's policy and procedure (P&P) titled Use of Medication Cart, the P&P indicated that The medication cart and its storage bins are kept locked until the specified time of medication administration, and that staff must Lock the medication cart with the key or the locking bar. 4a. During a concurrent observation and interview on 6/10/26 at 2:15 p.m. with Licensed Vocational Nurse (LVN) 2, Medication cart 1 had multiple loose unidentified pills scattered inside drawers. LVN 2 stated, the loose pills could potentially fall on the floor and residents can take the pills. LVN 2 then proceeded to remove the loose pills from the drawers and discarded in the drug receptacle. b. During a concurrent observation and interview on 6/10/26 at 2:28 p.m. with LVN 1, medication cart 2 had multiple loose and unidentified medication pills inside drawers. LVN 1 stated, residents can take the pills if it falls on the floor during medication pass. c. During a concurrent observation and interview on 6/10/26 at 2:34 p.m. with RN 3, medication cart 3 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had multiple loose and unidentified medication pills scattered inside drawers. RN 3 was observed removing the loose pills and discarded the pills in the drug receptacle. RN 3 then stated, there was potential for contamination of other medications in the drawers. RN 3 also added, there was potential for residents to take the medication by accident if it falls on the floor. d. During an observation and interview on 6/10/26 at 2:32 p.m., with Registered Nurse 2 (RN 2) Medication Cart 4 contained 15 loose, unidentified pills at the bottom of multiple drawers. RN 2 remained silent when asked about the loose pills floating in the medication cart. During a record review of facility's policy and procedure (P&P) titled, Cleaning Medication Storage Areas, the P&P indicated, Medication storage areas are kept neat and clean to prevent contamination of medications and treatment supplies and that Licensed staff should keep carts clean and organized. During a review of facility's policy and procedure (P&P) titled, Enteral Feeding Supplies Storage, undated, indicated under PURPOSE: To ensure enteral feeding supplies, nutritional products, feeding tubes, syringes, administration sets, and related enteral feeding equipment are stored, monitored, and maintained in a manner that preserves product integrity, prevents contamination, promotes resident safety. Under BACKGROUND: Enteral feeding products and supplies are considered resident care items that require proper storage conditions to maintain safety, effectiveness, and quality. Exposure to excessive heat.may compromise product integrity and increase the risk of contamination or resident harm. Furthermore, the P&P also indicated under PROCEDURE: A.2. Storage areas shall: .Allow adequate air circulation.B. Storage Temperature Requirements 1. The enteral feeding supplies storage area shall be maintained at a temperature not exceeding 77 degrees F. 2. Acceptable storage temperature range: 59 degrees F to 77 degrees F During a review of facility's P&P titled, Cleaning Medication Storage Areas, undated, indicated under PROCEDURE .3.Keep the medication room organized. Check for discontinued, outdated medications. Remove and dispose. 4.Licensed staff should keep carts clean and organized. Check for discontinued, outdated medications. Remove and dispose. During a review of facility's P&P titled, Use of Medication Cart, undated, indicated under BACKGROUND: Security; The medication cart and its storage bins are kept locked until the specified time of medication administration. Furthermore, the P&P also indicated The cart must be clearly visible to the person administering medications, and all outward sides must be inaccessible to persons passing by. Under PROCEDURE .18. Lock the medication cart with the key or the locking bar.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to maintain safe frozen and refrigerated food storage practices for two out of two freezers and three out of three refrigerators in the kitchen. Facility did not store foods in accordance with professional standards for food service safety for three of three residents (Resident 22, 30 and 53) when foods from outside sources was stored in one of four facility refrigerators.Freezer 1 had no documented temperature for two mornings (AM) and six evenings (PM) and meat freezer, produce refrigerator, vegetable refrigerator and refrigerator 1 did not have a documented temperature.These failures had the potential to result in foodborne illnessFindings:During a concurrent observation and interview on 6/8/26 at 9:33 a.m. with the Dietary Manger (DM), in the kitchen, one unlabeled freezer was observed with a document titled Freezer Temperature Log for Ice Cream/Supplement, dated 6/26, posted on the refrigerator door. There were no temperature logs posted on the meat freezer, produce refrigerator, vegetable refrigerator and one unlabeled refrigerator. The DM stated the Dietary Aide (DA) writes the temperature on the log. The DM stated each freezer and refrigerator should have a log.During a concurrent interview and record review on 6/8/26 at 9:35 a.m. with Dietary Aide (DA) 1, two documents titled Refrigerator Temperature Monitoring, dated June, was in a white binder labeled temperature, the two Refrigerator Temperature Monitoring document indicated, the year was blank and temperature were documented for dairy produce and DA milk only. DA 1 stated the cooks were responsible for checking the freezer and refrigerator temperature.During a concurrent interview and record review on 6/8/26 at 9:57 a.m. with [NAME] 1, Freezer Temperature Log for Ice Cream/Supplement, dated 6/26 was reviewed. The Freezer Temperature Log for Ice Cream/Supplement indicated, evening (PM) temperature were blank on 6/1/26, 6/2/26, 6/3/26 and 6/7/26 and two rows of date, AM temperature, PM temperature after 6/4/26 were blank. [NAME] 1 stated the unlabeled freezer was called Freezer 1. [NAME] 1 stated the DAs were responsible for checking the temperature of the freezers and refrigerators. [NAME] 1 stated the temperature logs should be posted on each freezer and refrigerator. [NAME] 1 stated not being sure where the meat freezer, produce refrigerator, vegetable refrigerator and one unlabeled refrigerator temperature logs were stored. [NAME] 1 stated the unlabeled refrigerator was called refrigerator 1. [NAME] 1 stated AM and PM temperature should be logged on the form.During an interview on 6/10/26 at 11:07 a.m. with RD 2, RD 2 stated the primary kitchen staff responsible for logging the freezer and refrigerator temperature were the AM and PM cook. RD 2 stated the importance of checking and logging the freezer and refrigerator temperature was to make sure the correct temperature range was maintained. RD 2 stated expecting the temperature logs to be labeled according to the name of the freezer and refrigerator and were posted on the freezer and refrigerator door.During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, indicated, Subject: Refrigerated Storage. Policy:. Refrigerated areas will be managed so that proper temperature is maintained to avoid food spoilage and time temperature abuse. Procedure:. 2. Refrigerator temperatures should be recorded two times each day.During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, indicated, Subject: Freezer Storage. Policy:. The freezer areas will be managed so that proper temperature is maintained to avoid food spoilage and time temperature abuse. Procedure:. 2. Freezer temperatures should be recorded two times each day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to store foods in accordance with its policy on food brought in from outside for three of three sampled residents (Resident 22, 30 and 53). Resident 22's food was unlabeled with date stored, Resident 30's food was labeled only with room number and was stored longer than 72 hours and Resident 53's food was stored longer than 72 hours in resident food refrigerator.These failures placed Resident 30, 53 and 22 at risk for food borne illnesses.During an interview on 6/9/26 at 3:20 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated CNAs and nurses were responsible for storing food from outside sources in the refrigerator. CNA 6 stated CNAs and nurses were also responsible for writing the resident's name and date the food was received on the container. During a concurrent observation and interview on 6/9/26 at 3:22 p.m. with CNA 6, a paper printed with the words RESIDENT FOOD ONLY. ALL FOOD MUST BE DATED AND LABELED. FOOD OLDER THAN 48 HOURS OR UNLABELED WILL BE THROWN OUT! was posted on the black refrigerator door. CNA 6 opened the refrigerator, there was one white plastic bag with food labeled with Resident 22's room number and name; however, it was undated. There was one brown bag with food, labeled with a room number only dated as of 05/31/26 date. There was another brown bag with food, labeled with Resident 53's name and dated as of 4/19/26. CNA 6 stated housekeepers were responsible for removing expired food and cleaning the refrigerator.During an interview on 6/9/26 at 3:25 p.m. with Housekeeping (HSKP) 1, HSKP 1 stated the Janitors were responsible for removing the food and cleaning the resident food refrigerator. HSKP 1 stated the Janitor had left for the day. HSKP 1 stated the Janitor's supervisor was on vacation and Director of Staff Development (DSD) 1 was covering for the supervisor.During a concurrent observation and interview on 6/9/26 at 3:34 p.m. with DSD 1, DSD 1 was observed removing the white plastic bag and the two brown bags in the black resident food refrigerator. DSD 1 stated the importance of labelling foods with date was to track how long the food had been in the refrigerator. DSD 1 stated the food should not be in the refrigerator for more than 3 days. DSD 1 stated the foods should be discarded to prevent stomach problems for the residents.During a review of the facility's policy and procedure (P&P) titled, Resident/Patient Food Refrigerator Storage, undated, the P& P indicated, Background. Residents and their representatives may bring food items from home or receive food from visitors. Improper storage of perishable food can result in bacterial growth, contamination, foodborne illness, pest attraction, and regulatory non-compliance. C. Food Labeling. 1. Staff assisting residents shall ensure food items are labeled immediately upon placement in the refrigerator. 2. Labels shall be legible and include: Resident name. Date stored.has context menu

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective infection control program when:1.Certified Nursing Assistant (CNA 5) did not perform hand hygiene when serving meals to two of five sampled residents (Resident 47 and 60) after touching the doorway stop banner (a bright yellow, highˆvisibility banner with a red STOP message that mounts across doorways or halls using quickˆrelease straps or Velcro to visually deter wandering while staying collapsible for safety).2. Restorative Nursing Assistant (RNA 2) did not perform hand hygiene after touching Resident 47's finished plate then touching Resident 60's top part of her cup. 3. Infection Preventionist (IP 1) did not provide outbreak (sickness that is being spread to one or more people in a short span of time) daily line list (a list of affected persons used to track the outbreak) per public health recommendations.4. The silent knight pill crusher (a medical-grade device used to grind solid pills into a fine powder) on top of medication cart 5 had gray and white powder that has dried into a hardened, solid crust on its' surface and surrounding parts.5. Registered Nurse (RN) 2 did not clean or sanitize shared blood pressure cuff in between use for Resident 70 and Resident 32.6. RN 2 did not perform hand hygiene prior to administering medications to Resident 48. Findings: 1.During an observation on 6/8/26 at 12:49 a.m., Certified Nursing Assistant (CNA 4) left Resident 20's room, closed the stop sign banner against the side of the door, then opened the residents' food cart door (cart designed to deliver hot and cold meals from the kitchen directly to residents' rooms or dining areas), which was parked along the hallway. CNA 4 took out a meal tray, closed the food cart door, entered Resident 50's room, placed the meal tray on Resident 50's overbed table (an adjustable height table designed to extend over a patient's bed), took out the plate and mug lids to help Resident 50 to set up the meal, for ease of eating. Upon exit, CNA 4 closed the stop banner, attaching it against the door, opened the food cart again, then served meal to Resident 4. CNA 4 did not perform hand hygiene in between handling meal trays for both residents, touching surfaces like food cart and the stop sign banner. During an interview on 6/8/26 at 2:51 p.m., CNA 4 stated that staff are required to wash or sanitize their hands before serving food, especially after touching anything dirty, such as the doorway stop banner. CNA 4 stated that not doing so may cause stomach pain due to infection (when harmful germs enter the body and begin to cause damage or sickness). During an interview on 6/10/26 at 3:19 p.m., Infection Prevention Nurse (IP 1) stated staff must perform hand hygiene, including washing hands or using an alcohol gel or rub to kill germs on your skin, when serving and assisting with meals due to the risk of contamination (the process of making something dirty), which may lead to stomach infections such as diarrhea. During a review of facility's Policy and Procedure (P&P) titled, Hand Hygiene, undated policy, indicated Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water for the following situations: before and after handling food. 2. During an observation on 6/8/26 at 12:35p.m., Restorative Nursing Assistant (RNA 2) put away resident 47's finished plate then touched Resident 60's top part of her cup (the area where the mouth touches when someone drinks from it)with her bare hand then moved it closer to her, then touched Resident 47's cup, without performing hand hygiene in between assisting residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/8/26 at 2:44 p.m., RNA 2 stated that she helps with residents by passing tray, opening lids and putting away finished plates and in between those tasks, she needs to either wash or sanitize her hands. RNA 2 stated that she was sorry that she forgot to perform hand hygiene when she touched resident 47's dirty plate then handling Resident 47's cup, this action doesn't follow infection control practices. During an interview on 6/11/26 at 11:02 a.m., the Director of Nursing (DON) stated that for any procedure involving meals, including serving or assisting, staff must wash their hands or use hand sanitizer. The DON added that staff are expected to handle cups by the bottom or by the handle to prevent crossˆcontamination (unintentional spread of harmful germs), which may cause issues such as diarrhea or food poisoning. During a review of facility's Policy and Procedure (P&P) titled, Hand Hygiene, undated policy, indicated Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water for the following situations: before and after eating or handling food; before and after assisting a resident with meals. 3.During an interview on 06/09/2026 11:37 AM, Infection Preventionist (IP 1) stated the facility experienced an outbreak of experiencing one or more sickness such as: nausea (queasy feeling of being sick in the stomach), vomiting, and diarrhea (having three or more loose or watery stools a day) that started on 5/27/26 affecting 18 residents (Residents 12, 61, 64, 22, 62, 10, 51, 68, 58, 24, 36, 23, 8, 71, 20, 28, 29 and 25) and 1 kitchen staff (Cook 2). IP 1 stated that it is important to report outbreaks and follow local public health recommendations to monitor affected people and understand the steps needed to control the outbreak and prevent recurrence. IP 1 stated that they were not able to provide a daily line list (a list of affected persons used to track outbreaks) to the local public health department as recommended, and therefore were not able to follow state licensing requirements. During a phone interview on 6/12/26 at 10:36 a.m., the Acute Communicable Disease Registered Nurse (ACDRN) stated over the phone that they had recommended the facility send a daily line list so that local public health could monitor the outbreak and provide diseaseˆspecific recommendations regarding testing, isolation, environmental cleaning, and other precautions. ACDRN stated that although the facility reported that residents were no longer symptomatic (showing signs of illness), the outbreak remains an open case because the facility has not provided the requested line list. During a review of facility's undated Policy and Procedure (P&P) titled Reporting Diseases, the P&P indicated The designated Infection Preventionist is responsible for reporting. the required diseases according to state requirements. documentation.form designated by the local department of public health 4. During a concurrent observation and interview on 6/10/26 at 8:43 a.m. with Registered Nurse (RN) 3, the silent knight pill crusher (a medical-grade device used to grind solid pills into a fine powder) on top of medication cart 5 had gray and white powder that has dried into a hardened, solid crust on its' surface and surrounding parts. RN 3 stated, pill crusher is dirty. RN 3 also stated, the dirty pill crusher was an infection control issue. During a concurrent observation and interview on 6/10/26 at 8:54 a.m. with RN 2, the silent knight pill crusher had gray and brown powder that has dried into a hardened, solid crust on its' surface and surrounding parts. RN 2 stated the solidified dirt on the pill crusher had potential for contamination of (continued on next page)

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	056447	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications being given to the residents. RN 2 added, residents can get sick from contaminated medications. 5. During a concurrent observation and interview on 6/10/26 at 8:51 a.m. in Resident 70's room, RN 2 was observed taking Resident 70's blood pressure with a portable blood pressure device placed on Resident 70's bed. RN 2 then removed the blood pressure cuff from Resident 70's right arm, picked up the portable blood pressure device and exited Resident 70's room. RN 2 did not sanitize the blood pressure cuff and/or the device and placed it on top of medication cart 4. RN 2 then proceeded to take Resident 32's blood pressure using the un-sanitized blood pressure device. RN 2 stated not sanitizing the blood pressure device and stated she was supposed to sanitize the blood pressure after each resident use to stop spread of infection amongst residents. During an interview on 6/10/26 at 9:18 a.m. with the Director of Nursing (DON), DON stated RN 2 and RN 3 were expected to keep pill crusher clean, free of debris and sanitize after each resident use to prevent contamination of medications and spread of germs to residents. DON also stated, blood pressure cuffs are shared equipment and must be sanitized after each resident use to prevent infection spread of infection. During a review of facility's policy and procedure (P&P) titled, Sharing of Medical Equipment – Sanitation and Infection Prevention, undated, indicated under POLICY: It is the policy of this facility to ensure that all shared medical equipment is cleaned, disinfected and maintained according to evidence-based infection prevention standards. Equipment shall never be used on more than one resident without proper sanitation to prevent cross-contamination, healthcare-associated infections (HAIs), and to ensure compliance with CDC (Centers for Disease Control and prevention), CMS (Centers for Medicare and Medicaid Services), and facility infection control protocols. Under BACKGROUND: This policy applies to all healthcare workers (licensed nurses, CNAs, therapy staff, ancillary staff) who use, clean, or transport medical equipment within the facility. P&P also indicated that shared medical equipment: non-critical and semi-critical items used on multiple residents (e.g., blood pressure cuffs.), .Licensed Nurses & CNAs are responsible for cleaning/disinfecting equipment after each use. Furthermore, the P&P indicated under PROCEDURE 1. General Guidelines, Equipment must be cleaned and disinfected between each resident's use.3. Specific Equipment Protocols, Blood Pressure Cuffs/Stethoscopes: .disinfect cuffs, tubing, chest pieces after each use. During a review of facility's P&P titled, CLEANING AND DISINFECTING GUIDELINES MEDICATION CARTS, TREATMENT CARTS, AND PILL CRUSHERS, undated, under PURPOSE: To establish standardized procedures for cleaning and disinfecting medication carts, treatment carts, and pill crushers in the facility to reduce the risk of cross-contamination and infection transmission.Under BACKGROUND: Medication carts, treatment carts, and medication preparation equipment such as pill crushers are high-touch clinical items used throughout the facility and may become contaminated during medication administration, wound care, and resident-care activities.Maintaining clean medication and treatment equipment is an essential component of infection prevention in the facility. Furthermore, the P&P also indicated under PROCEDURE .C.Pill crushers must be cleaned and disinfected between each resident use. 6. During an observation on 6/10/26 at 8:58 a.m., with Registered Nurse 2 (RN 2), an Enhanced Barrier Precautions sign was posted outside Resident 48's room directing, Everyone must clean their hands, including before entering and when leaving the room. RN 2 prepared medications for Resident 48, put on gloves, removed a Velcro stop sign from Resident 48's door frame, and administered the medication to Resident 48 without performing hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of facility's policy and procedure (P&P) titled, Hand Hygiene, the P&P indicated, use an alcohol-based hand rub containing at least 62% alcohol or.soap and water for the following situations.Before preparing and handling medications.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to complete and maintain documentation for three of five sampled residents (Residents 14, 28 and 46) for Influenza (commonly known as Flu, a highly contagious viral infection that attacks your nose, throat, and lungs) and Pneumonia (PNA, an infection in one or both lungs that causes the tiny air sacs to become swollen and filled with fluid) vaccination (getting a shot to help the body safely build a defense against a specific harmful disease) This failure of having incomplete documentation had a potential of missed or delayed vaccinations to Residents 14, 28 and 46.Findings: During a record review of Resident 14's undated Resident Face sheet indicated Resident 14 was admitted to the facility on [DATE]. During a record review of Resident 28's undated Resident Face sheet indicated Resident 28 was admitted to the facility on [DATE]. During a record review of Resident 46's undated Resident Face sheet indicated Resident 46 was admitted to the facility on [DATE]. During a concurrent interview and record review on 6/9/26 at 1:52 p.m., with Infection Preventionist (IP 1), Electronic Health Record (EHR) for Residents 46, 14, and 28 were reviewed. IP 1 stated that the facility offered influenza vaccinations to all residents upon admission and annually during flu season. IP 1 stated facility offered pneumonia vaccinations to all residents upon admission and to any residents who have not yet received them. IP 1 stated that if a resident refused the vaccine, a consent/declination form (hard copy in paper chart) must be signed and dated by the resident or their responsible party; and documentation was maintained in residents' the progress notes in the EHR.IP 1 stated the following-- Resident 46 refused the influenza and PNA vaccination, IP 1 stated however she was unable to find the documentation in Resident 46's records regarding declination, explanation of risks and benefits for Influenza and/or PNA immunization. - IP 1 stated Resident 14's progress note dated 11/19/25 indicated a refusal of vaccination, but it did not identify which vaccine was refused, and IP1 stated she was unable to find any consent/declination and explanation of risks and benefits for Influenza and/or PNA vaccine given to Resident 14.- Resident 28 had a signed but undated declination form for Influenza vaccine, IP 1 stated that with incomplete documentation, there was no way to verify whether and when the vaccine was offered or declined. IP 1 stated that this information should be easily reviewable when checking a resident's chart (medical record). During a record review of the facility's undated Policy and Procedure (P&P) titled, Influenza vaccine, the P&P indicated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually. a resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. During a record review of the facility's undated P&P titled, Pneumococcal vaccine, the P&P indicated All residents will be offered pneumococcal vaccines to ais in preventing pneumonia/pneumococcal infections. if refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination.

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	056447	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of five sampled residents (Residents 14, 46, 29) had complete and accurate records for COVID- 19 (highly contagious illness of the lungs caused by virus) immunization (getting a shot to help the body safely build a defense against a specific, harmful disease). This failure resulted in incomplete immunization records for Resident 14, 46 and 29; and placed them at risk for not having been immunized for COVID-19. Findings: During a record review of Resident 14's undated Resident Face sheet indicated Resident 14 was admitted to the facility on [DATE]. During a record review of Resident 28's undated Resident Face sheet indicated Resident 28 was admitted to the facility on [DATE]. During a record review of Resident 46's undated Resident Face sheet indicated Resident 46 was admitted to the facility on [DATE]. During a concurrent interview and record review on 6/9/26 at 1:52 p.m., with Infection Preventionist (IP 1), Electronic Health Record (EHR) for Immunization for Residents 14, 46, 29 and nursing progress notes dated 11/19/25 for Resident 14 were reviewed. IP1 had paper copies for consent forms for COVID-19 immunization for Resident 29 at that time. IP 1 stated that COVID19 vaccinations are administered by an outside immunization agency, but the facility was still responsible for ensuring documentation was completed in the residents' charts. IP 1 stated Residents 14, 46, 29 must have refused COVID-19 vaccine. IP 1 stated the following for all four residents:Resident 14's progress notes dated 11/19/25 indicated a refusal of vaccination; however, it did not specify which vaccination was refused, and there was no consent/declination form in the EHR and/or paper chart. IP 1 stated she was unable to find Resident 46's COVID-19 consent and/or declination record in EHR and/or paper chart. She was unable to find the date on Resident 29's undated COVID-19 immunization consent/declination form and hence unable to stated when did Resident 29/their responsible party received an education on risks/benefits for COVID-19 immunization, and when did they decline to receive the immunization.During review of facility's undated Policy and Procedure (P&P) titled COVID-19 Vaccination-Residents, policy, indicated Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist. If the resident did not receive the COVID-19 vaccine due to . refusal, appropriate documentation is made in the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 28) was free from physical abuse when Resident 59 grabbed Resident 28's left arm in the facility hallway. This failure resulted in Resident 28 having a bruise (when blood pools under your skin after an injury, causes discoloration) and pain on the left arm. During a record review of Resident 28's admission record, the record indicated Resident 28 was admitted to the facility on [DATE]. The record indicated Resident 28 has diagnoses of dementia (a loss of brain function affecting memory, thinking, language, judgment, or behavior). During a record review of Resident 28's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care), dated 03/15/26, the MDS indicated, Resident 28 had a Brief Interview for Mental Status (BIMS, is 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 7 out of 15, indicating severe cognitive impairment. During a record review of Resident 59's admission record, the record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses of Major depressive disorder (A persistent sad, or empty mood, or a total loss of interest/pleasure in normally enjoyable activities, trouble concentrating, remembering, or making decisions), severe with psychotic symptoms. During a record review of Resident 59's MDS assessment dated [DATE], the assessment indicated Resident 59's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was 02 out of 15, indicating severe loss of ability with memory and thinking. During an observation on 6/10/26 at 10:48 a.m. Resident 28 was observed in the activity room. At 1:03pm Resident 28 was walking in the hallway holding a dog toy in her hand. During an observation on 6/10/26 at 11:31 Resident 59 is in his bed with eyes closed. During an interview on 6/11/26 at 11:40 a.m., Resident 28 stated that she was in hallway at the nursing station, when Resident 59 came out of nowhere and grabbed my left arm causing it to bruise. Resident 28 stated I screamed and then LVN 2 was able to help me and separate Resident 59's hand away from my left arm. Resident 28 stated I feel very scared from the incident. During a review of Resident 28's Progress note dated 04/15/26, the Progress note indicated that Resident 28 had a bruise to the left arm measuring 6cmX4cm. Further Record review of the Progress note indicated that Resident 28 complained of pain in the left arm. During a phone interview on 6/11/26 at 12:33 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that Resident 28 was asking for snack near my med cart when Resident 59 came and grabbed Resident 28's left arm. LVN stated I immediately separated the two residents. LVN 2 also stated that Resident 28 was very scared from the incident and requested to be moved to a different room away form Resident 59. During an interview on 6/11/26 at 1:36 p.m. with Director of Nursing (DON), DON stated that Resident 59 was not monitored for high-risk behavior. DON stated this incident could have been prevented if we had assessed the resident 59's needs and increased supervision. Review of the facility's undated Policy and Procedure titled, Abuse Prevention Program, indicated protect our residents from abuse by anyone including, but not limited to facility staff, other residents, volunteers, consultants, staff from other agencies, friends, visitors, or any other individual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056447	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayward Hills Health Care Center	1768 B Street Hayward, CA 94541

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review the facility failed to provide a contracture (permanent tightening and shortening of muscles, tendons, ligaments, or skin) assessment and range of motion (ROM, full movement potential of a joint) exercises for one of five sampled residents (Resident 26) when Resident 26 was not screened for left and right hands contractures on an ongoing basis.This failure placed Resident 26 at risk for further decline in range of motion of left and right hands. Findings:During a review of Resident 26's Face Sheet, dated 6/11/26, the Face Sheet indicated, Resident 26 was admitted in the facility on 9/20/24 with a diagnosis of parkinsonism (an umbrella term for a group of nervous system disorders that cause motor symptoms like tremors, slowed movement, rigid muscles, and balance issues), dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life) and personal history of other diseases of the musculoskeletal system and connective tissue (a documented past medical record of conditions affecting bones, joints, muscles, ligaments, or cartilage).During a review of Resident 26's Minimum Data Set (MDS, an assessment used to guide plan of care) dated 5/1/26, the MDS indicated, Resident 26's ability to express ideas and wants was usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time). The MDS indicated Resident 26's ability to understand verbal content was usually understands (misses some part or intent of the message but comprehends most conversation).During a concurrent observation and interview on 6/8/26 at 11:13 a.m. with Resident 26 in Resident 26's room, Resident 26 was observed with contracture on left and right hand. During an interview on 6/11/26 at 10:32 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 26 had tightness of the muscle on hands. CNA 4 stated she applied hand roll (a soft, cylindrical cushion placed in a patient's palm to keep the fingers from curling into a tight fist) to Resident 26's hands because Resident 26 was not able to open their hands anymore.During an interview on 6/11/26 at 10:50 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 26 had an order for passive range of motion (PROM, movement of a joint through the range of motion with no effort from the patient) exercises to bilateral (having two sides) lower extremity only. RNA 1 stated Resident 26 did not have an order for PROM exercises to the hands.During a concurrent observation and interview on 6/11/26 at 11:04 a.m. with Physical Therapist (PT) 1, in Resident 26's room, PT 1 assessed Resident 26's both hands and stated Resident 26 would have benefitted from range of motion exercises, splint or brace to prevent the hands to completely close. PT 1 stated if Resident 26's hands contracture continued to get worsened, she won't be able to use her hands to hold things anymore.During an interview on 6/11/26 at 11:21 a.m. with CNA 4, CNA 4 stated she did not remember since when Resident 26's hands were contracted, and that she had never told the nurse about Resident 26's hands contractures.During a concurrent observation and interview on 6/11/26 at 11:56 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 26's physician order in the Electronic Health Record (EHR) were reviewed. LVN 4 stated she had seen Resident 26 with hand roll a few times but there was no physician order to apply the hand roll either. LVN 4 stated she was unable to find an order for range of motion exercises for Resident 26.During a concurrent observation and interview on 6/11/26 at 12:07 p.m. with Rehab Director (RD) 1, in the Rehab Department room, Resident 26's EHR was reviewed. RD 1 stated there were no contracture assessment completed for Resident 26. RD 1 stated the purpose of contracture assessment was to make sure the contracture would not progress and lead to skin breakdown.During a review of the facility's policy and procedure (P&P) titled, Contracture Screen, undated, the P&P indicated, Purpose. The rehabilitation staff. ensures the appropriate assessment for rehabilitation services intervention through. ongoing assessment process. Procedure. 3. The contracture screen is performed, at least, quarterly with range of motion measurement taken. 4. The therapist will assess whether to. update plan of care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain complete and readily accessible medical records for one of three sampled residents (Resident 81), when Resident 81's medical record lacked required physician documentation at the time of review.This failure had the potential to result in staff not having essential information needed to understand Resident 81's overall care needs, which could delay or compromise safe and effective care.During a record review of Resident 81's Face Sheet, the Face Sheet indicated Resident 81 was admitted to the facility on [DATE] and discharged on 4/18/26.During a record review of Resident 81's medical record, Resident 81's medical record contained no physician progress notes or a History and Physical (a doctor's complete health report or assessment of the patient) for Resident 81's stay at the facility.During a concurrent interview and record review on 6/11/26 at 3:30 p.m., with facility's Regional Director of Clinical Operations (RDCO), Resident 81's electronic medical record was reviewed. RDCO stated that Resident 81's History and Physical (H&P) had been completed by a covering physician during Resident 81's stay, but she was unable to find it in Resident 81's Electronic Health Record . RDCO stated physician progress notes/H&P should be readily available and that she needed to obtain it from the covering physician.During a record review of facility's policy and procedure (P&P) titled, Medical Record Management, the P&P indicated Medical records shall be readily accessible and available for resident care twenty-four (24) hours per day.