STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056463	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Post Acute Care - Hayward	26660 Patrick Avenue Hayward, CA 94544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44823 Based on interview and record review, the facility failed to have the ordered medication Levetiracetam or Keppra (used to prevent and control seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) for one resident (Resident 1). This failure of Resident 1 not receiving Keppra on 8/14/24 resulted in Resident 1 ' s delayed treatment which had the potential to result in seizure episodes. Resident 1 subsequently had two seizure episodes in the morning of 8/15/24. Findings: During a review of Resident 1 ' s face sheet, undated, the face sheet indicated Resident 1 was admitted to the facility on [DATE] at 2:55 p.m., with a diagnosis of seizures. During a review of Resident 1 ' s Order Details, the Order Details indicated a physician order on 8/14/24 at 1531 (3:31 p.m.) for Levetiracetam Oral Tablet 500 mg, give 1 tablet by mouth two times a day for seizure precautions. During a review of Resident 1 ' s Medication Administration Record (MAR) for August 2024, the MAR indicated Resident 1 did not receive Levetiracetam Oral Tablet 500 mg scheduled for 8/14/24 at 1700 (5:00 p. m.). During a review of the pharmacy ' s Consolidated Delivery Sheets, the Consolidated Delivery Sheets indicated Levetiracetam 500 mg tablet for Resident 1 was delivered to the facility on [DATE] at 1200 a.m. (midnight). During an interview on 9/11/24, at 10:50 a.m., with Registered Nurse (RN) 1, RN 1 stated when Keppra was not available for the 1700 medication pass, the situation should have been elevated to the Administrator especially since Resident 1 had a significant history of seizures. The medication could have been ordered for delivery ASAP (as soon as possible). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During an interview on 9/30/24, at 11:55 a.m., with Registered Nurse (RN) 2, RN 2 stated Keppra was a seizure medication. RN 2 stated when a dose is missed, patient could have a seizure. RN 2 also stated when Keppra was not available for the evening dose, the Director of Nursing (DON) should have been involved. During an interview on 9/30/24, at 1:00 p.m., with the DON, the DON stated Keppra needed to be administered on time otherwise it could trigger a seizure episode. The DON stated the facility should have informed the physician Keppra was not available and also followed up with the pharmacy to make the order stat (immediate). DON also stated the situation was a system failure and the issue was not elevated. During a review of the facility ' s policy and procedure (P&P) titled, Pharmacy Services Overview, undated, the P&P indicated, . the facility assure that medications are requested, received, and administered in a timely manner as ordered by authorized prescribers.