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	02/19/2025

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 0686 Level of Harm - 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** 46658 Based on interview and record review, the facility failed to provide pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence) care for one of three sampled residents (Resident 1), when staff: 1. did not notify the provider to obtain wound treatments for nine days, 2. did not provide Resident 1 with a low air loss mattress (LAL mattress, pressure relieving device to prevent skin and tissue breakdown) for four days and, 3. did not complete a care plan for Resident 1 ' s sacral pressure ulcer. This failure resulted in Resident 1 ' s sacral pressure ulcer growing from one by 1.5 centimeters (cm, a unit of measurement) to seven by six cm over nine days. Findings: A review of Resident 1 ' s admission record indicated Resident 1 was admitted on [DATE] to the facility for stroke (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain), hemiplegia (the loss of muscle function on one side of the body), hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body), type 2 diabetes (chronic disease in which the body cannot regulate the amount of sugar in the blood) and dysphagia (difficulty swallowing). During a record review of Resident 1 ' s admission minimum data set (MDS, an assessment tool to guide resident care), dated 10/20/24, the MDS indicated Resident 1 had upper and lower extremity impairment and was completely dependent on staff for bed mobility (turning and repositioning in bed) and activities of daily living such as toileting, eating and transferring out of bed. The MDS also indicated Resident 1 was at high risk of developing pressure ulcers and did not have any pressure ulcers. During a record review of Resident 1 ' s skin assessment record titled, Braden Scale (assessment score to predict risk of pressure sore development with a score of 13-14 indicating moderate risk for pressure ulcers) for Predicting Pressure Sore Risk, dated 10/16/24, the record indicated Resident 1 had a Braden Score of 13. (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1 ' s physician order set titled, Order Summary Report, dated 12/30/24, the order set indicated Resident 1 had wound care orders for: Low air loss mattress, check for functionality every shift, dated 11/7/24, and Sacral-coccyx-cleanse with wound cleaner, pat dry, apply triad paste, leave it open to air every shift for 14 days, dated 11/12/24. The order set also indicated Resident 1 had an order to be transferred to another facility dated 11/13/24. During an interview on 12/24/24, at 8:15 a.m., with resident representative (RP), RP stated Resident 1 did not have a sacral wound on admission to the facility. RP stated, on 11/4/24, Registered Nurse 1 (RN 1) reported to her that Resident 1 had a wound on the tail bone. RP stated the facility did not perform sacral wound treatments until 11/12/24. RP stated when Medical Doctor 1 (MD 1) assessed Resident 1 on 11/11/24, MD 1 was upset because Resident 1 was not on a low air loss mattress. RP stated MD 1 had ordered a low air loss mattress the previous week, but the facility did not have one available. During a record review on 12/30/24, at 10:19 a.m., Resident 1 ' s progress note titled, Change of Condition, dated 11/3/24, by RN 1, the progress note indicated RN 1 assessed open wound as superficial stage 2 [pressure ulcer]. Wound measure 1.5 x 1.0 cm. During a concurrent interview and record review on 12/30/24, at 11:05 a.m., with treatment nurse (TR), a wound assessment note titled, Wound Assessment, dated 11/12/24, and a progress note, dated 11/3/24, by RN 1 was reviewed. TR stated on 11/12/24, Resident 1 had a sacral wound which TR measured seven by six cm. TR stated she was first aware of the pressure ulcer on 11/12/24 and communicated the findings to MD 1 who then ordered a sacral-coccyx wound treatment for Resident 1. After review of the progress note by RN 1, TR stated she was not informed by other nursing staff about the presence of the sacral wound prior to 11/12/24. After reviewing Resident 1 ' s order history and progress notes, TR was not able to find sacral wound treatment orders between 11/3/24 to 11/12/24. TR stated any residents with a wound would have provider assessment and treatments for the wound. During a concurrent phone interview and record review on 12/30/24, at 1:03 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 ' s progress note titled, Nurses Note, dated 11/10/24, was reviewed. LVN 1 stated Resident 1 had a recently developed sacral wound but did not recall any treatments ordered for the sacral wound. LVN 1 stated a LAL mattress was not available for Resident 1 and had endorsed to the next shift to obtain one. The progress note indicated resident ' s [family] are requesting LAL mattress at 8pm. They mentioned it has already been a week, and they are concerned because the resident has an open wound on his coccyx. The writer checked all rooms for an available [LAL mattress], but none were found. During a concurrent interview and record review on 12/30/24, at 1:20 p.m., with the Director of Nursing (DON), a record of a LAL mattress order ticket titled, [Vendor] Delivery Ticket, dated 11/11/24 was reviewed. The DON stated the ticket indicated an outside company had delivered the LAL mattress on 11/11/24. During a phone interview on 12/30/24, at 1:28 p.m., with RN 1, RN 1 stated he had completed a change of condition documentation for Resident 1 ' s sacral wound on 11/3/24. RN 1 could not recall if he had notified the provider about the wound or created a care plan for the wound. RN 1 did not recall starting any orders for Resident 1 regarding the sacral wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 12/30/24, at 1:45 p.m., with MD 1, Resident 1 ' s physician note titled, SNF Rounding Note, dated 11/11/24, by MD 1 was reviewed. MD 1 could not recall if she was notified of the sacral wound before 11/11/24. After review of the physician note, MD 1 stated she had documented Resident 1 was still not on a LAL mattress for the open area over the sacrum, and she may have given a verbal order for the LAL mattress. MD 1 did not find any records of facility staff notifying any provider about Resident 1 ' s sacral wound between 11/3/24 and 11/11/24. During a concurrent interview and record review on 12/30/24, at 2:40 p.m., with the DON, Resident 1 ' s physician orders, care plans and RN 1 ' s change of condition progress note, dated 11/3/24, were reviewed. The DON stated after review of Resident 1 ' s physician orders for November 2024, orders for sacral wound treatment prior to 11/12/24 were not found. The DON stated after a review of Resident 1 ' s care plans, a care plan for the sacral wound was not completed. The DON stated the progress note by RN 1 did not indicate the provider was notified about the sacral wound. The DON stated provider notification was expected to be carried out and documented by the nurse who found the change of condition. During a concurrent interview and record review on 12/30/24, at 3:20 p.m., with RN 2 and the DON, a progress note titled, Nurses Note, dated 11/7/24, by RN 2 was reviewed. The progress note indicated, This note is a follow up to 11/3/24 9:05:00 Change of Condition [Author: [RN1]]. RN 2 stated she had measured and documented the size of Resident 1 ' s sacral wound at four by four cm. RN 2 did not recall updating the provider about the size of the sacral wound. RN 2 clarified she had corrected the documented location of the wound from the perineum to the sacrum. RN 2 recalled Resident 1 was not on a low-air loss mattress for that day and did not recall when the low- air loss mattress arrived. The DON stated the mattress would not be delivered during the weekend. During a record review of Resident 1 ' s transfer record titled, Admission/Discharge To/From Report, dated 12/30/24, the record indicated Resident 1 was transferred to another facility on 11/13/24. During a record review of receiving facility ' s admission skin assessment for Resident 1 titled, Skin Assessment, dated 11/13/24, the skin assessment indicated Resident 1 was admitted to the second facility with a sacral pressure ulcer and was placed on a LAL mattress. During a review of facility policy and procedure (P&P) titled, Policy and Procedure on Pressure Sore Risk Assessment, dated 5/2023, the P&P indicated, It shall be this facility ' s policy to assess .and provide necessary care and services that will meet patient needs and promote skin integrity .plans of care shall be developed to address risk factors to development or further development of pressure ulcer. During a review of facility P&P titled, Change in a Resident ' s Condition or Status, dated 5/2017, the P&P indicated, the nurse will notify the resident ' s Attending Physician or physician on call when there has been a .discovery of injuries of an unknown source .notifications will be made within twenty-four hours of a change occurring in the resident ' s medical/mental condition or status.