STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 implement Resident 3's oncology referral ordered by the General Acute Care Hospital (GACH) upon the resident's discharge to the facility (oncology is a specialized branch of medicine dedicated to the diagnosis, treatment, and prevention of cancer).This failure resulted in Resident 3 having a delay in the referral for her cancer treatment. During a phone interview on 3/5/26, at 9:37 a.m., with Resident 3's Family Member (FM) 1, FM 1 stated, the facility failed to timely refer the resident to an oncologist. FM 1 stated that this caused a referral delay until she intervened on 1/14/26. FM 1 also stated that the facility referral to oncologist was only made due to FM 1's follow-up (an oncologist is a doctor who diagnoses and treats cancer).During a review of Resident 3's admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE].During a review of Resident 3's Nurse Practitioner Progress Notes dated 1/16/26 , it indicated that Resident was transferred from the facility to the GACH on 12/25/25 due to unresponsiveness and was readmitted to the facility on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities), and malignant pleural effusion (defined as an abnormal accumulation of fluid containing cancer cells within the pleural space). During a review of Resident 3's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/17/26, it indicated that the resident's cognition was severely impaired.During a concurrent interview and record review on 3/5/26 at 3:23 p.m. with Social Services Assistant (SSA), Resident 3's Hospitalist Discharge Summary and Transfer Instruction (HDSTI) to the facility dated 1/6/26 was reviewed. HDSTI indicated an order to refer the resident to oncology. SSA further stated that on 1/14/26, FM 1 approached her and pointed out in the HDSTI the order to refer Resident 3 to oncology. SSA stated that on 1/14/26, the facility did not know of the resident needing to be referred to oncology.During a review of Resident 3's Physician's Orders (PO) dated 1/7/26, the PO did not indicate an order to refer the resident to oncology. During a concurrent interview and record review on 3/6/26 at 12:00 p.m. with the Director of Nursing (DON), Resident 3's HDSTI dated 1/6/26 and the facility's PO dated 1/7/26 were reviewed. The DON acknowledged that while the HDSTI ordered a referral to oncology, the facility's PO did not. She stated it was the reviewing nurse's responsibility to follow up with the facility physician regarding the oncology referral. Furthermore, the DON acknowledged that the failure to act on this referral could cause a worsening of Resident 3's malignant pleural effusion.During a review of the facility's policy and procedure (P&P) titled, Transportation schedule, Updated 5/2023, the P&P indicated, . Procedures.1 Licensed nurse shall check physician order sheet for any existing orders for medical appointments, consults or procedures provided outside of the facility .

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to protect Resident 1 from hitting his right foot and toes during care on two separate occasionsThis resulted in Resident 1 sustaining right foot and toes pain and swelling. During a review of Resident 1's Facesheet (information containing contact details, brief medical history at-a-glance) dated 3/5/26 indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis caused by stroke (hemiplegia is a form of paralysis that affects one side of the body, usually due to a brain injury and hemiparesis is weakness on one side of the body). During an interview on 3/5/26 at 10:21 a.m., Resident 1 stated that the staff repeatedly accidentally hit his right foot and toes in the door and bathroom wall while being transported in the shower chair and commode. The resident stated this caused pain and swelling to his right foot and toes. Resident 2 requested that staff take more care during transfers. A review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/2/26, indicated a Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 15, reflective of Resident 1 being cognitively intact. The MDS Section GG titled, Functional Abilities and Goals scored Resident 1as being unable to walk and was dependent for mobility and toileting, meaning helper does all the effort; the resident does none of the effort to complete the activity, thereby needing the assistance of two or more helpers to complete the activity.During a review of Resident 1's nurses' notes dated 12/1/26 at 6:47 p.m. showed: resident had his toe accidentally struck by the bathroom door while he was being assisted out of the restroom. At that time, he stated the toe was painful.During an interview on 3/6/26 at 10:04 a.m. with Certified Nursing Assistant (CNA)1, CNA 1 stated that on 12/1/25 at around 6:15 p.m., while maneuvering Resident 1 on the commode to exit the bathroom, the resident's right foot toes accidentally struck the edge of the bathroom door frame. CNA 1 acknowledged she should have been more careful and could have prevented the incident.During a review of Resident 1's Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 12/4/25, it reflected: Resident 1 complained of pain to his right foot following a bump during a shower. Assessment revealed swelling on the right foot. During an interview and concurrent record review on 3/6/26 at 10:31 a.m. with LVN 2, Resident 2's clinical records were reviewed. LVN 2 stated that on 12/4/25 at 5:00 p.m., Resident 1 bumped his right foot while he was being maneuvered in the shower chair in the shower room. LVN 2 further stated that on her assessment, the resident's right foot was swelling. LVN 2 confirmed that no care plan was made or was in place to prevent this recurring injury.During a concurrent interview and record review on 3/6/26 at 12:00 p.m., with the Director of Nursing (DON), Resident 1's clinical records were reviewed. DON acknowledged the lack of a care plan for Resident 1 in preventing his right foot and toes injuries. Furthermore, the DON stated that these incidents were preventable had an appropriate care plan been in place. A review of the facility's policy and procedure (P&P) titled, (Protocol for Prevention, Monitoring and Recording of Accidents and Incidents), the P&P indicated, Policy. It is the policy of this facility to implement and enforce all safety procedures and rules to ensure the safety and well-being of residents, staff and visitors. Facility shall implement measures to prevent, monitor and record accidents and incidents whenever applicable .6. Immediate corrective actions should be taken to prevent accidents or incidents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a 17.39 % error rate when four medication errors out of 23 opportunities were observed during a medication pass for one of nine residents (Resident 2).These failures resulted in medications not given in accordance with the Physician's Orders and may affect Resident 2's health conditions. During a medication pass observation on 3/6/26 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed to give Resident 2 six medications, including 1. Docusate Sodium 250 milligrams (mg. a form of measurement) capsule, 2. Hydrochlorothiazide 12.5 mg tablet, 3. Metoprolol Tartrate 25 mg tablet, 4. Multiple Vitamins tablet, 5. Senna 8.6 mg tablet and 6. Vitamin B12, 2000 micrograms (mcg. is a form of measurement) tablet to Resident 2 (Docusate Sodium and Senna are medications that prevent constipation, Hydrochlorothiazide and Metoprolol Tartrate are medications that lower blood pressure and Vitamin B 12 is a vitamin the body uses to make and support healthy nerve cells).A review of Resident 2's Physician Orders dated 3/5/26 revealed that four scheduled 9:00 a.m. medications were not administered by LVN 1 when she was observed giving medications to the resident. The following medications which were not given: 1. Aspirin 81 Tablet delayed release 81 mg (Aspirin), give one tablet by mouth one time a day for CVA prophylaxis, 2. Folic Acid oral tablet 1 mg (folic acid), give one tablet by mouth one time a day for supplement, 3. Vitamin C tablet 250 mg. (Ascorbic acid), give one tablet by mouth one time a day for supplement and 4. Vitamin D3 oral tablet 25 mcg (Cholecalciferol), give one tablet by mouth one time a day for supplementation (CVA is cerebrovascular accident or stroke. Prophylaxis means preventive care. Aspirin is a medication given to prevent stroke. Folic Acid is a supplement that helps body create new cells, Vitamin C or Ascorbic Acid is a supplement that can help the body fight infections and Cholecalciferol is a supplement to build strong bones).During a joint interview and record review on 3/5/26 at 12:00 p.m. with LVN 1, and the Director of Nursing (DON), Resident 2's Physician's Orders and Medication Administration Record (MAR) were reviewed. The MAR indicated that LVN 1 signed the following medications as given to the resident at 9:00 a.m. : 1. Aspirin 81 Tablet delayed release 81 mg, give one tablet by mouth one time a day, 2. Folic Acid oral tablet 1 mg (folic acid), give one tablet by mouth one time a day for supplement, 3. Vitamin C tablet 250 mg (Ascorbic acid), give one tablet by mouth one time a day for supplement, and 4. Vitamin D3 oral tablet 25 mcg (Cholecalciferol), give one tablet by mouth one time a day. When questioned by the DON, LVN 1 admitted to falsely signing the MAR for these medications without actually administering them. During an interview on 3/5/26 at 1:19 p.m. with the DON, the DON stated LVN 1's actions were unacceptable and stated that the nurse failed to administer ordered medications and falsified the MAR. Furthermore, the DON stated that this omission placed Resident 2 at risk for poor bone health and nutritional deficiencies. A review of the facility's policy and procedure (P&P) titled, (Administering medications), the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed.19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication .