STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056471	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Harbor Healthcare Center	442 Sunset Boulevard 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 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. 50474 Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of one sampled resident (Resident 1) when: 1. Resident 1 did not receive a medication called albuterol sulfate (used to prevent and treat wheezing, a high-pitched sound that occurs during breathing when the airways in the lungs become narrowed or blocked, and shortness of breath caused by breathing problems) inhalation according to physician's order. 2. Resident 1's oxygen saturation (amount of oxygen you have circulating in the blood) level was not monitored from 1/27/25 to 1/29/25 appropriately when Resident 1 had complaints of shortness of breath and wheezing. This failure had the potential to worsen Resident 1's respiratory condition. Findings: During a record review of Resident 1's Admission Record , printed on 2/25/25, the Admission Record indicated Resident 1 was admitted to the facility in January 2025 with multiple diagnoses including osteomyelitis (inflammation or swelling that occurs in the bone) of left ankle and foot, type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar), and lobar pneumonia (a type of lung infection that affects one or more lobes of the lungs). During a record review of Physician's Progress Notes dated 1/28/25, the progress note indicated, Resident 1 was seen by the physician for hypoxia (low levels of oxygen in the body), wheezing. The physician's progress notes also indicated Resident 1 had complaints of shortness of breath and was noted to have left chest wall swelling. During a record review of Resident 1's Order Summary , dated 3/6/25, the Order Summary indicated Resident 1 had an order of albuterol sulfate inhalation with an instruction to give Resident 1 one puff and inhale orally every 6 hours for wheezing. The albuterol sulfate inhalation had was ordered to start on 1/28/25. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Medication Administration Record (MAR), dated 1/1/25 to 1/31/25, the MAR indicated Resident 1 did not receive the albuterol sulfate inhaler on 1/28/25 at 8:30 p.m., 1/29/25 at 2:30 am, 8:30 a.m., 2:30 p.m., and 8:30 p.m. During a concurrent record review and interview on 3/6/25 at 11:15 a.m. with the Director of Nursing (DON), Resident 1's Progress Notes and vital signs record were reviewed. The DON stated the physician ordered a chest x-ray and the medication albuterol sulfate inhaler because Resident 1 had complaints of shortness of breath and wheezing. The DON stated Resident 1 did not receive the albuterol sulfate inhalation for two consecutive days before Resident 1 passed away on 1/30/25 because the medication was not available on hand. The DON stated the licensed nurses (LNs) documented that the albuterol sulfate inhaler was not given to Resident 1 because the pharmacy had not delivered it to the facility. The DON stated the licensed nurses (LNs) should have called the pharmacy and followed up for Resident 1's albuterol sulfate inhaler. The DON further stated the LNs should have also called the physician to inform about the missing albuterol sulfate inhaler and asked for alternative medication for Resident 1. The DON stated the albuterol sulfate inhaler should have helped relieve Resident 1's complaints of shortness of breath and wheezing. The DON further stated Resident 1's oxygen saturation level was last monitored on 1/26/25 and there were no records of oxygen saturation levels were documented on 1/27/25 to 1/29/25. The DON stated the LNs and/or the Certified Nurse Assistants (CNAs) should have monitored and documented Resident 1's vital signs daily including the oxygen saturation level to assess if Resident 1's oxygen level was dropping. The DON stated a low oxygen saturation level could have indicated the need for a supplemental oxygen. During a record review of the facility's policy and procedure (P&P), dated 3/1/23, the P&P indicated, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice . During a record review of the facility's P&P, titled, Provisions of Quality of Care , dated 6/1/23, the P&P indicated, The facility will ensure that residents receive treatment and care by qualified persons in accordance with standards of practice, the comprehensive person-centered care plans, and the resident's choices.

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50474 Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services and procedures that assure accurate dispensing and administration when Resident 1's Inhaler medication [Albuterol Sulphate (Medication that helps with breathing by relaxing the muscles of the airways)] was not available on hand per physician's order. This failure had the potential to cause Resident 1's worsened respiratory condition including respiratory arrest (occurs when breathing stops). Findings: During a record review of Resident 1's Admission Record , printed on 2/25/25, the Admission Record indicated Resident 1 was admitted to the facility in January 2025 with multiple diagnoses including osteomyelitis (inflammation or swelling that occurs in the bone) of left ankle and foot, type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar), and lobar pneumonia (a type of lung infection that affects one or more lobes of the lungs). During a record review of Resident 1's Order Summary , dated 3/6/25, the Order Summary indicated Resident 1 had an order of albuterol sulfate inhalation with an instruction to give Resident 1 one puff and inhale orally every 6 hours for wheezing. The albuterol sulfate inhalation was ordered to start on 1/28/25. During a record review of Resident 1's Medication Administration Record (MAR), dated 1/1/25 to 1/31/25, the MAR indicated Resident 1 did not receive the albuterol sulfate inhaler on 1/28/25 at 8:30 p.m. and on 1/29/25 at 2:30 am, 8:30 a.m., 2:30 p.m., and 8:30 p.m. During a concurrent record review and interview on 3/6/25 at 11:15 a.m. with the Director of Nursing (DON), Resident 1's Progress Notes dated 1/28/25 and 1/29/25 were reviewed. The DON stated the licensed nurses (LNs) documented in the progress notes that the albuterol sulfate inhaler was not given to Resident 1 for two consecutive days because the medication was not delivered by the pharmacy. The DON stated the pharmacy should have delivered Resident 1's albuterol sulfate inhaler the same day it was ordered. The DON stated the LNs should have called the pharmacy and followed up when the albuterol sulfate inhaler did not arrive for Resident 1 to use. The DON further stated the LNs should have also called the physician to inform about the missing albuterol sulfate inhaler and should have asked for an alternative medication. The DON stated the albuterol sulfate inhaler medication should have helped relieve Resident 1's complaints of shortness of breath and wheezing. During a record review of the facility's policy and procedure (P&P), dated 3/1/23, the P&P indicated, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P, titled, Pharmacy Services , dated 6/1/24, the P&P indicated, The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.