| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to provide Registered Nurse (RN) coverage eight hours a day, seven days a week. This failure presents a threat to residents reaching their highest practicable level of well-being and had the potential to endanger the health and safety of residents. During a concurrent interview and record review on 8/27/25 at 11:06 a.m. with the Staffing Coordinator (SC), the facility's licensed staffing schedules for the month of January 2024 through March 2024 were reviewed, the staffing schedule indicated there were no Registered Nurses (RN) scheduled to work eight hours a day during the following dates:1. For the month of January 2024: 1/10/24; 1/11/24; 1/16/24 and 1/25/24.2. For the month of February 2024: 2/8/24; 2/9/24 and 2/13/24. During a concurrent interview and record review on 8/27/25 at 11:06 a.m., with the SC, the facility's licensed staffing schedules for the month of April 2024 through June 2024 indicated there was no RN scheduled to work eight hours a day during the following date:1. For the month of April 2024: 4/29/24. During an interview on 8/28/2025, at 9:26 a.m. with the Director of Nurses (DON), stated the facility should have an RN eight hours in a day per facility policy. DON further stated, the residents needed an RN to assess them if there were any changes in the residents' condition. During a review of the Payroll-Based Journal (PBJ) Staffing Data Report submitted by the facility to Centers for Medicare & Medicaid Services (CMS) for January 2024 until June 2024, the PBJ indicated that there were days when there were no RN scheduled to work eight hours a day on some days in the facility (PBJ system is a requirement for nursing homes to electronically submit detailed staffing data to the government, this data is used to monitor staffing levels and ensure quality care for the residents; CMS is a government agency and one of its functions is to monitor the PBJ staffing submitted by the facilities). During a review of the facility's policy and procedure (P&P) titled Staffing, revised October 2017, indicated, . Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system. |

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 |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview and record review, the facility failed to ensure:1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted for on the medication administration record (MAR) and the Controlled Drug Record (CDR, an accountability record) for three of four randomly selected residents (Residents 11, 20, and 101);2. The intravenous (IV, administered into the vein) supplies, narcotic, and intramuscular (IM, injected into the muscle) emergency kits (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) were replaced according to facility policy and procedure (P&P) after use; 3. Routine medication for one of 50 sampled residents (Resident 16) was available for administration. 4. The method of disposition and destruction of unwanted and unused medication prevented diversion and/or accidental exposure.These failures resulted in the facility not having accurate accountability of controlled medications, potential for abuse or misuse of medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.1. A review of Resident 101's medical record indicated a physician's order for oxycodone (a narcotic medication to treat pain) immediate release (IR) 10 milligrams (mg, a unit of measurement), give 1 tablet by mouth every 6 hours as needed for severe pain 8-10/10, dated 8/17/25. The CDR indicated oxycodone was removed from the medication cart on 8/19/25 at 7:50 p.m. and 8/19/25 at 12:02 p.m., but their respective administrations were not documented on the MAR. During a concurrent interview and record review on 8/27/25 at 9:01 a.m. with Director of Nursing (DON), Resident 101's CDR and MAR dated August 2025 were reviewed. DON confirmed the identified discrepancies. DON stated whenever a resident asked for narcotic pain medication, the nurse was expected to document the removal of the medication from the bubble pack on the CDR then document in the MAR once given. She stated it was important for the two documents (CDR and MAR) to match because it was a part of controlled substance accountability. A review of Resident 20's medical record indicated a physician's order for tramadol (a narcotic medication to treat pain) 50 mg, give 1 tablet by mouth every 6 hours as needed for pain, dated 8/10/25. The CDR indicated tramadol was removed from the medication cart on 8/12/25 at 2 p.m. but the administration was not documented on the MAR. During a concurrent interview and record review on 8/27/25 at 9:02 a.m. with DON, Resident 20's CDR and MAR dated August 2025 were reviewed. DON confirmed the above identified discrepancy.A review of Resident 11's medical record indicated a physician's order for hydrocodone/APAP (a narcotic medication to treat pain) 5/325 mg, give 1 tablet by mouth every 6 hours as needed for pain management, dated 11/6/24. The CDR indicated hydrocodone/APAP was removed from the medication cart on 8/25/25 at 9 a.m. but the administration was not documented on the MAR. During a concurrent interview and record review on 8/27/25 at 9:12 a.m. with DON, Resident 11's CDR and MAR dated August 2025 were reviewed. DON confirmed the above identified discrepancy. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 6/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines. 17. Sign MAR after administered. 18. If medication is a controlled substance, sign narcotic book. 2. During a concurrent interview and inspection on 8/25/25 at 9:48 a.m. with Registered Nurse Supervisor 1 (RNS 1) of the Pine Tree Medication Storage Room, an opened IV supplies e-kit was identified. Inside the e-kit was one log indicating one bag normal saline 0.9% (used to administer medications through an IV line) 100 milliliter (ml, a unit of measurement) and two normal saline 0.9% 10 ml flushes (used to clear IV lines) had been removed from the e-kit on 8/17/25. RNS 1 confirmed the e-kit had not been replaced almost eight days after opened. RNS 1 stated the supplier pharmacy knew to replace an e-kit whenever it was opened because nursing staff had to call them to obtain a code to authorize entering the kit. She stated that was the process for replacing e-kits after use and if it was not replaced with the regular evening delivery from the pharmacy, it was the<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | responsibility of the next nursing shift to follow up with them. RNS 1 stated it was important to replace e-kits timely to ensure emergency medications and supplies were always available for resident use. During a concurrent interview and inspection on 8/25/25 at 10 a.m. with RNS 1 of the Juniper Medication Storage Room, an opened narcotic e-kit was identified. Inside the e-kit was a log indicating two hydromorphone (a pain medication) 2 milligrams (mg, a unit of measurement) tablets were removed on 8/14/25. An opened IM e-kit was also identified with a log inside indicating one cefazolin (an antibiotic) 1 gram (g, a unit of measurement) vial, 10 ml sterile water, and one lidocaine (an anesthetic) 1% 20 ml vial had been removed on 8/19/25. RNS 1 confirmed the finding and stated both e-kits should have been replaced. During an interview on 8/26/25 at 4:10 p.m. with Director of Nursing (DON), DON stated when nursing staff opened an e-kit, the re-order sticker was removed from the kit and faxed to the pharmacy to reorder a replacement. DON stated it was important for e-kits to be replaced timely so if multiple doses were needed or another resident needed medication, supplies would be readily available. During a review of the facility's policy and procedure (P&P) titled, Emergency Medications Policy, dated 5/1/23, the P&P indicated, Policy Interpretation and Implementation. 9. Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order. 3. During a medication pass observation on 8/25/25 at 10:40 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed preparing medications for Resident 16 which included amantadine (a medication to treat Parkinson's disease, a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), docusate sodium (medication to soften the stool), furosemide (medication to rid the body of excess water), losartan (medication to lower blood pressure), metoprolol tartarate (medication to lower blood pressure), vitamin D, and lidocaine 4% patches.A review of Resident 16's medical record indicated a physician's order for lactulose (medication to help slow the progression of chronic kidney disease by stimulating bowel movements to rid the body of harmful toxins) 20 g/30 ml, give 30 ml by mouth three times a day related to chronic kidney disease, stage 2 (mild) hold for loose stools, dated 3/3/24.During a concurrent interview and record review on 8/25/25 at 2:33 p.m. with LVN 1, Resident 16's physician's orders were reviewed. LVN 1 confirmed he did not administer Resident 16's lactulose because it was not available for administration and that he would need to follow up with the pharmacy to have it delivered.A review of Resident 16's MAR dated August 2025 indicated he missed all three scheduled doses of lactulose on 8/25/25 at 9 a.m., 1 p.m. and 5 p.m.During a medication pass observation on 8/26/25 at 8:59 a.m. with LVN 3, LVN 3 was observed preparing medication for Resident 73 which included Stiolto Respimat (an inhaled medication to treat chronic obstructive pulmonary disease (a progressive lung disease) to make breathing easier) 2.5/2.5 microgram (mcg, a unit of measurement) inhaler.A review of Resident 73's medical record indicated a physician's order for Stiolto Respimat 2.5/2.5 mcg inhaler, 2 puffs inhaled orally one time a day related to chronic obstructive pulmonary disease, dated 1/6/23.During the same medication pass observation with LVN 3, LVN 3 instructed Resident 73 to place her mouth on the inhaler, counted down, then tried to administer a dose. LVN 3 was unable to administer the dose and stated, I think it ran out, and said he would have to reorder it. LVN 3 looked at the meter on the inhaler and confirmed the arrow was at the end of the red section of the cannister and the inhaler was locked, indicating it was empty. LVN 3 stated he was not aware of the meter indicating the number of doses left on the inhaler prior to that day.A review of the manufacturer's labeling for Stiolto Respimat, revised 1/2025, indicated, When to get a new STIOLTO RESPIMAT inhaler: The scale on your inhaler will show the number of puffs you have, if used as indicated. The dose indicator will show you approximately how much medicine is left. When the dose indicator enters the red area of the scale, it will show you approximately how many puffs are left before you need a refill or new prescription. When the dose indicator reaches the end of the red scale, your STIOLTO RESPIMAT is empty and automatically locks. At this point, the clear base cannot be turned any further.During an interview on 8/26/25 at 4:13 p.m. with DON, DON stated nursing staff were expected to reorder a resident's routine medication when they popped the pill out<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | of the bubble pack with the reorder sticker attached to it. She stated this would ensure they received the medication before the resident was out. DON stated nursing staff were expected to observe dose counters or meters on inhalers to know when it was time to reorder them and observe levels of liquid medications to request refills timely from the pharmacy. During a review of the facility's P&P titled, Pharmacy Services Overview, revised 4/2019, the P&P indicated, Policy Interpretation and Implementation. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 4. During a concurrent inspection and interview on 8/25/25 at 10:40 a.m. with LVN 1 of Medication Cart Split Juniper, a red sharps container (a plastic container used to dispose of used syringes) was identified in the bottom drawer of the cart. Inside the container were hundreds of whole tablets and capsules that could have been poured out through a large opening by tipping the container over. LVN 1 stated the sharps container was used to dispose refused or dropped doses of medication. LVN 1 stated all medications, including narcotics, were disposed of in the same container. He stated narcotic medications required a second nurse to witness and sign for the disposal of the medication into the container.During a concurrent inspection and interview on 8/26/25 at 11:54 a.m. with LVN 4 of Medication Cart Juniper, a red sharps container was identified in the bottom drawer of the cart. Inside the container there were approximately 15 tablets. LVN 4 stated the container was designated for the disposal of dropped or refused doses of medication. She stated the tablets and capsules were placed whole inside the container, then the container was later picked up by the supervisor.During an interview on 8/26/25 at 4:16 p.m. with DON, DON stated nursing staff were expected to dispose of dropped or refused doses of medication whole into the red sharps containers located in the medication carts. DON confirmed the method of disposal implemented did not render the medications unusable and irretrievable and did not limit unwanted exposure to staff. During a review of the facility's P&P titled, Discarding and Destroying Medications, undated, the P&P indicated, Policy Explanation and Compliance Guidelines: 1. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>Based on observation and interview, the facility failed to ensure medications were not stored on top of medication carts (med carts) when left unattended, med carts were locked when left unattended, medications with shortened expirations after use were labeled with an opened date, and med carts were kept clean and orderly. The deficient practices had the potential for unauthorized staff/residents to access medications, for residents to receive medications with unsafe and reduced potency, for residents to suffer hazardous cross-contamination to their medications, and for medications to not be safely administered to residents.During a medication pass observation on 8/25/25 at 12:19 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed preparing medications for a Resident 40. LVN 1 removed insulin lispro (a rapid acting insulin) from the med cart, drew up the dose, left the vial on top of the cart and walked into the resident's room to administer the medication without locking the cart. The medication cart was angled out towards the hallway and accessible to staff and residents passing by.During an interview on 8/25/25 at 3 p.m. with LVN 1, LVN 1 confirmed he had left Resident 40's insulin on top of the medication cart unattended and that he had forgotten to lock the cart when he left to administer the medication.During a concurrent inspection and interview on 8/25/25 at 11 a.m. with LVN 3 of Med Cart Split Pine Tree, one loose white tablet and one opened and undated vial blood glucose test strips (a strip used to measure blood sugar levels) were identified in the cart. LVN 3 stated the nurse who opened the vial of test strips should have written an opened date on it. LVN 3 confirmed the vial did not have a date on it and the manufacturer's labeling on the container indicated to use within six months after opening. LVN 3 stated loose tablets were to be disposed of in a sharps container located on the med carts.During a concurrent inspection and interview on 8/25/25 at 12:24 p.m. with LVN 1 of Med Cart Split Juniper, four and a half loose capsules and tablets were identified in the drawers. LVN 1 confirmed the finding and stated the pills should have been disposed of. Three vials ipratropium bromide and albuterol (medication to treat asthma) 0.5 milligram/3 milligrams (mg/mg, a unit of measurement) per 3 milliliters (ml, a unit of measurement) were identified outside of the manufacturer's foil packaging. LVN 1 confirmed the manufacturer's labeling on the foil pouch indicated to use the vials within two weeks once they were removed. LVN 1 acknowledged the shortened expiration date once the vials were removed from the packaging and confirmed there was no date to indicate when the vials were removed from the pouch.During a concurrent inspection and interview on 8/25/25 at 12:30 p.m. with Assistant Director of Nursing (ADON) of Med Cart Juniper, seven loose tablets and capsules were identified along with nicotine (used to help with smoking cessation) and scopolamine (medication to treat nausea and vomiting) topical patches stored underneath bottles of oral medication in the med cart. ADON confirmed the finding and stated it was acceptable to store small patches with oral medications in the top drawers and larger patches were to be stored in the bottom drawers of the medication cart.During an interview on 8/26/25 at 4:22 p.m. with Director of Nursing (DON), DON stated medications that were administered internally were to be stored separate from medications administered externally. DON stated medications were to be stored according to manufacturer guidelines. DON stated nursing staff were expected to store medications securely in a locked med cart and it was not acceptable to store them on top of cart if they stepped away from it. DON stated medications left on the cart could be taken by another resident.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 3/1/23, the P&P indicated, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) . c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 3. External Products: Disinfectants and drugs for external use are stored separately from internal and injectable medications. 4. Internal Products: Medications to be administered by mouth are stored separately from other formulations. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure infection control measures were maintained for six of 51 sample residents (8,25,65,105,93, and 83). This failure had the potential to result in six sampled residents developing and transmitting infections when:1a. Central Supply 1 did not sanitize hands when entering and existing Contact Precaution rooms [ROOM NUMBERS].1b. Central Supply 1 refilled 1/2 empty glove boxes from Contact Precautions rooms [ROOM NUMBERS] using bare hands1c. Registered Nursing Supervisor 1 did not disinfect / sanitize reusable medical equipment (scissors).1d. Certified Nursing Assistant did not know effective properties and dwell time of Sani Wipes for shared COVID reusable medical equipment .1e. Laundry Assistant 1 did not clean the dryer lint trap at the scheduled time and appropriately initial the dryer lint log.2a.BP cuff not sanitized/ disinfected after use.2b. Insulin aspart hub was not sanitized/ disinfected before pen needle was attached.2c. Nursing staff had long artificial nails.3 License Nurse did not sanitize her hands in between glove changes.<br><br>1 a. During an observation on 8/25/25 at 9:38 a.m. in front of Resident 93's room and Resident 83's, Central Supply 1 (CS1) was observed existing room [ROOM NUMBER] and entering room [ROOM NUMBER] and 2 without gelling hands upon entering and exiting. Resident 93 and Resident 83's room doors had Contact Precaution sign (Contact precautions are infection control measures used to prevent the spread of infections that are transmitted through direct or indirect contact with an infected person or their environment) before entering.<br><br>During a review of Resident 83's admission Record, printed on 8/28/25, the AR indicated Resident 83 was admitted in May 2025 with a diagnosis of enterocolitis (an inflammation of both the small intestine and the large intestine) due to clostridium difficile (gram positive bacteria) and methicillin resistant staphylococcus aureus infection (MRSA - a strain of Staphylococcus epidermidis bacteria that is resistant to methicillin and other beta-lactam antibiotics) infection and pseudomonas (gram-negative bacterium that can cause a wide range of infections).<br><br>During a review of Resident 93's admission Record, printed on 8/28/25, the AR indicated Resident 93 was admitted in June 2025 with diagnosis of enterocolitis (an inflammation of both the small intestine and the large intestine) due to clostridium difficile (gram positive bacteria) and candidiasis (fungal infection caused by an overgrowth of Candida yeast species).<br><br>During a concurrent interview and record review on 8/25/25 at 9:40 a.m. with CS1, the Contact precaution sign on the door (undated) indicated stop everyone must clean their hands, including before entering and when leaving the room. CS1 stated they did not know they needed to gel their hands before entering and exiting room [ROOM NUMBER] and room [ROOM NUMBER]. CS1 read aloud the Contact Precaution sign on the room door. He stated he did not touch the resident's; therefore he did not need to gel hands. The Infection Preventionist (IP) stated the staff should have sanitized hands upon entering and exiting rooms. The IP stated CS1 should have waited until the glove box was empty or thrown away the 1/2 full box.<br><br>During a review of Handwashing/ Hand Hygiene _ F880 policy (undated), the policy indicated all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents. hand hygiene is indicated after touching the resident's environment.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of Isolation -Initiating Transmission- Based Precautions- F880 policy (undated) indicated the signage on the room entrance door informs the staff of the type of CDC precautions (s), instructions for use of PPE, and or to see a nurse before entering.<br><br>1b. During an observation on 8/25/25 at 9:38 a.m. in front of Resident 93's room and Resident 83's, Central Supply 1 (CS1) was observed taking half empty glove boxes from the wall in room [ROOM NUMBER] and room [ROOM NUMBER] and filling them with clean gloves and replacing the boxes back in each room Contact room respectively.<br><br>During a concurrent interview and record review on 8/25/25 at 9:42 a.m. with CS1, the Contact precaution sign on the door (undated) indicated use dedicated or disposable equipment. CS1 read aloud the Contact Precaution sign on the door for room [ROOM NUMBER] and room [ROOM NUMBER] door. CS 1 stated he did not know if what he was doing was an infection control issue. CS1 stated they did not want to waste the 1/2 empty box, so refilled and replaced the boxes. The IP stated CS1 should have waited until the glove box was empty or thrown away the 1/2 full box and replaced with a new box of gloves.<br><br>1c. During a concurrent observation and interview on 8/27/25 at 11:49 p.m. with Treatment Nurse (TN 1) and Registered Nurse 1 (RN 1). Observed TN 1 perform Negative Pressure Wound Therapy on Resident 25 and use reusable medical equipment (scissors). TN 1 used the scissors during the dressing change to trim the sponge dressing material, the barrier dressing and to trim a hole in the dressing. After the dressing change, RNS 2 was observed taking the used reusable scissors into Resident 25's bathroom and washing them. RN 1 wrapped scissors in brown paper towels, removed the scissors from Resident 25's room, walked up the hall and placed the scissors on a desk in an office behind the nurse's station. RN 1 came out of the office, washed hands at the nurses' station and returned to the office. RN 1 came out of the office with scissors wrapped in white tissue paper and attempted to give to the wound care nurse. RNS2 stated washed hands and the scissors with soap and water in Resident 25's bathroom. RN 1 was unable to state the process for cleaning /disinfecting reusable medical equipment. RNS 2 was not able to state why disinfecting the scissors before removing them from Resident 25's room was important.<br><br>During a review of Resident 25's admission Record, printed on 8/28/25, the AR indicated Resident 25 was admitted in August 2025 with a diagnosis of open wound left lower leg and pneumonia. Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 14/15. BIMS score of 14 indicated no cognitive impairment. Care Plan for impairment to left lower leg indicated wound vac continuous at 125 mmHg. Cleanse area with normal saline and pat dry. Apply white foam to undermining and black foam into wound bed. Cover with a transparent film.<br><br>During an interview on 8/27/25 at 11:55 a.m. with TN1, TN1 stated the reusable scissors should have been disinfected with the purple germicidal wipes before removing them from the resident room.<br><br>During an interview on 8/28/25 at 8:47 am with the Director of Staff Development (DSD), DSD stated staff should wash the reusable scissors with normal saline. Sanitize, dry then wrap in tissue and place in treatment cart.<br><br>During an interview on 8/29/25 at 2:10 p.m. with Director of Nursing (DON), DON stated the reusable scissors should have been disinfected before leaving the resident room and returned to the wound care nurse.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of Cleaning and Disinfection of Resident -Care Items and equipment dated 2001, the policy indicated reusable items are cleaned and disinfected or sterilized between residents. Most non-critical items can be decontaminated where they are used .<br><br>During a review of Negative Pressure Wound Therapy F686 (undated) indicated the scissors are used to trim the sponge dressing material, barrier dressing and to trim a hole in the dressing.<br><br>1 d. During a concurrent observation and interview on 8/26/25 at 8:30 a.m., with CNA 3, CNA3 stated Resident 65 was COVID -19 positive and Resident 105 had not resulted positive for COVID- 19. CNA 3 stated to sanitize shared medical equipment between residents they use Sani clothes. CNA 3 stated the Sani clothes were water based, and the [NAME] time was 1 minute.<br><br>During a review of Resident 65's admission Record, printed on 8/28/25, the AR indicated Resident 65 was admitted to thefacility in July 2025 7/1/25 with a diagnosis of intracranial injury with loss of consciousness and generalized epilepsy, epileptic syndromes and COVID -19. Brief Interview for Mental Status (BIMS. an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 10/15. BIMS score of 10 indicates moderate cognitive impairment. Resident xxx tested positive for COVID -19 on 8/26/25.<br><br>During a review of Resident 105's admission Record, printed on 8/28/25, the AR indicated Resident 105 was admitted to the facility in August 2025 with a diagnosis of closed fracture of shaft of left Fibula, chronic obstructive pulmonary disease, malnutrition and COVID-19. Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15/15. Resident 105 tested positive for COVID on 8/27/25. Placed on contact and droplet isolation precaution for positive COVID-19 test.<br><br>During an interview on 8/26/25 at 8:38 a.m. with Infection Preventionist (IP), IP stated the purple Sani Clothes are used to wipe down non-critical resident care equipment. The IP stated the dwell time is 2 minutes and allow the item to dry between resident use.<br><br>During a concurrent interview and record review on 8/26/25 at 3:12 p.m. with the Director of Staff Development (DSD), in DSD's office CNA 3 education file was observed. DSD stated educational records do not indicate education on using Super Sani wipes. DSD stated the instructions are on the container. DSD stated staff are educated to sanitize reusable items between residents. DSD stated the Super Sani-cloth are germicidal disposable wipes. Surfaces are to be wiped, allowed to remain wet for 2 minutes, then air dry.<br><br>The PDI general guidelines for Super Sani-Cloth Germicidal Wipes dated 2021 , indicated Super Sani-Cloth is a germicidal disposal wipe, use as a disinfectant on hard, nonporous surfaces, and disinfects in 2 minutes .<br><br>During a review of Isolation -Categories of Transmission -Based Precautions – F880 (undated) indicated if re-use of non-critical resident care equipment items such as stethoscope, sphygmomanometer is necessary, then the items will be cleaned and disinfected according to current guideline before use with another resident.<br><br>1e.During concurrent observation and interview on 8/27/25 at 9:31 am with the Maintenance Director (Maint. D), MD removed the dryer lint door on dryer number 2 and large lint balls were observed. Observed the dryer lint removal log dated 8/27/25, the log had been completed for the entire day by<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 9:45 a.m. The staff had placed initials in the 8 a.m.,10 a.m., 12 p.m. and 1:30 p.m. time slot. The dryer lint removal log indicated the lint trap will be cleaned at the scheduled time above and initialed for both the AM shift and Pm shift. Check the lint screen for tears and holes and report any problems to the maintenance department. The Maint. D stated the log should have been completed and initialed at the appropriate scheduled time. The Laundry aide 1 (LA1) aide stated the log was completed before the arranged time.<br><br>2a. During an observation on 8/25/25 at 8:40 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 used a blood pressure cuff on a rolling cart to measure Resident 16's blood pressure. After the resident's blood pressure was taken, LVN 1 removed the cuff and placed it back onto the rolling cart without sanitizing and disinfecting it.<br><br>During an interview on 8/25/25 at 2:29 p.m. with LVN 1, LVN 1 stated he normally sanitized and disinfected the blood pressure cuff after each use and confirmed he had forgotten to do so after he used it on Resident 16.<br><br>During an interview on 8/26/25 at 4:19 p.m. with Director of Nursing (DON), DON stated nursing staff were expected to sanitize and disinfect the blood pressure cuff with the appropriate wipe after each use.<br><br>During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 7/2014, the P&P indicated, Policy Interpretation and Implementation. 1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care. d. Reusable items are cleaned and disinfected or sterilized between residents (e.g. stethoscopes, durable medical equipment) . 3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.<br><br>2b. During a medication pass observation on 8/25/25 at 11:20 a.m. with LVN 2, LVN 2 was observed preparing medications for Resident 49. LVN 2 was observed with approximately one-inch-long polished fingernails on most fingers of both hands with some nails short and unpolished. LVN 2 was observed preparing Resident 49's insulin aspart (a fast-acting insulin to treat diabetes) pen. LVN 2 removed the cap from the pen, then attached a needle onto the rubber seal without first sanitizing and disinfecting it.<br><br>During an interview on 8/25/25 at 2:17 p.m. with LVN 2, LVN 2 stated the facility did not train nursing staff to sanitize and disinfect the pen prior to attaching a needle. She stated it was not necessary to do so because the needle was clean when attached to the pen. LVN 2 stated the facility did not have a policy that prohibited artificial nails and that staff were allowed to have them.<br><br>During an interview on 8/26/25 at 4:19 p.m. with DON, DON stated insulin pens needed to be wiped with an alcohol prep pad prior to attaching a needle. She stated it was the same process that was followed if an insulin vial was used as opposed to a pen. DON stated nursing staff were not permitted to have long artificial nails.<br><br>A review of the manufacturer's labeling for NovoLog FlexPen (brand for insulin aspart) revised 4/2015 indicated, Instructions for Use. Preparing your NovoLog FlexPen. A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab.<br><br>During a review of the facility's P&P titled, Medication Administration, dated 6/1/23, the P&P<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | indicated, Policy Explanation and Compliance Guidelines. 14. Administer medication as ordered in accordance with manufacturer specifications.<br><br>A review of an article published by the CDC titled, Clinical Safety: Hand Hygiene for Healthcare Workers, undated, indicated, Know when to clean your hands: Immediately before touching a patient. Immediately after glove removal. Maintain fingernail and jewelry safety: Natural nails should not extend past the fingertip. Do not wear artificial nails or extensions when having direct contact with high-risk patients. Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html; accessed 9/2/25)<br><br>During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 8/2015, the P&P indicated, Policy Interpretation and Implementation. 11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents.<br><br>3. A review of Resident 8's admission Record, printed on 8/28/25, indicated resident was admitted on [DATE], with multiple diagnoses which included osteomyelitis (inflammation of bone caused by infection), Stage 4 pressure ulcer (a severe condition that involved deep tissue damage) of sacral region (the area of the lower back where the sacrum bone is located), and paraplegia (paralysis of the legs and lower body caused by spinal injury or a disease) .<br><br>A review of Resident 8's Physician Order (PO), with start date of 8/1/25, indicated a treatment order for sacrum Stage 4 pressure injury (upon admission): Cleanse with normal saline (dilute salt water), pat dry. Pack loosely with calcium alginate (a gel that helps maintain a moist wound environment ideal for healing) and cover with foam dressing daily. Every day shift for Wound Care Management Another PO with start date 8/1/25, indicated a treatment order for right ischium (lower, back bone of the pelvis, also known as the sit bone) Stage 4 pressure injury (upon admission): Cleanse with normal saline, pat dry. Pack loosely with calcium alginate and cover with foam dressing daily. Every day shift for Wound Care Management.<br><br>During an observation on 8/27/25, at 8:30 a.m., with Treatment Nurse 1 (TN 1) and Nurse Practitioner 1 (NP 1), in the resident's room, TN 1 performed Resident 8's wound dressing treatment. TN1 with her gloved hands, removed the soiled dressing from resident's sacrum. TN 1 then removed her soiled gloves (first time) and without performing hand hygiene, TN 1 donned a new pair of gloves and started to cleanse the sacrum with normal saline. TN 1 removed her soiled gloves (second time), and without hand hygiene, applied a new pair of gloves, used a swab stick and applied the calcium alginate to the wound. After the gel application, TN 1 removed her soiled gloves (third time), and without doing hand hygiene, wore a new pair to assist NP 1 in wound measurement. Again, TN 1 did not perform hand hygiene a fourth time after another glove change.<br><br>During an interview on 8/27/25, at 2:51 p.m., TN 1 stated she did not perform hand hygiene and/or hand washing in between glove changes, while performing clean and dirty procedures during Resident 8's wound dressing change. TN 1 stated the importance of hand hygiene to prevent the spread of infection.<br><br>During an interview on 8/28/25, at 8:07 a.m., with the Director of Staff Development (DSD), DSD stated licensed staff should wash their hands with soap and water after each glove change. DSD also stated licensed staff should sanitize their hands and after three to four times of performing hand<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | hygiene, licensed staff should perform good hand washing with soap and water again.<br><br>Review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, undated, indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Indications for Hand Hygiene 1. Hand hygiene is indicated.c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident.f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.5. The use of gloves does not replace hand washing/hand hygiene. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' medical records were updated to show documentation that advanced directives (written statement of a person's wishes regarding the medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor), were discussed with the residents and/or responsible parties for 14 of 51 sampled residents (Residents 1,2,4,6,7,8,10,11,12,28,33,53,57 and 77).This had potential for the facility to provide treatment and services against the residents' wishes.<br><br>1. During a review of Resident 1's admission Record (AR), dated 8/29/25, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a sickness characterized by weight loss, decreased appetite, poor nutrition, and inactivity).<br><br>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 6/10/25 indicated Resident 1's short and long-term memory was impaired and had moderately impaired decision-making capacity.<br><br>During a review of Resident 1's Physician Orders for Life-Sustaining Treatment (or POLST) form, dated 6/5/25, under information and signatures, under information and signatures, under information and signatures indicated the resident did not have an advanced directive.<br><br>During a review of Resident 4's AR, dated 8/29/25, AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses that included kidney failure.<br><br>Review of Resident 4's MDS dated [DATE] under Section C, indicated she had a brief interview for mental status or BIMS of 10 (BIMS score of 8–12 indicates moderate cognitive impairment).<br><br>During a review of Resident 4's POLST form, dated 7/14/25, under information and signatures indicated the resident did not have an advanced directive. During the record review there was no documentation in the EHR, the advance directive was discussed or offered to Resident 4 or the resident representative.<br><br>During a review of Resident 28's AR, dated 8/29/25, AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities).<br><br>Review of Resident 28's MDS dated [DATE] under Section C, indicated Resident 1's short and long-term memory was impaired and had moderately impaired decision-making capacity.<br><br>Review of Resident 28's medical records showed a POLST dated 7/16/24, and the POLST indicated under information and signature section, the resident did not have an advanced directive. During the record review there was no documentation in the EHR, the advance directive was discussed or offered to Resident 28 or the resident representative.<br><br>During a review of Resident 53's AR, dated 8/29/25, the AR indicated Resident 53 was admitted to the facility on [DATE] with diagnoses that included respiratory failure.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 53's MDS dated [DATE] under Section C, it indicated BIMS score of 14, meaning Resident 53 was cognitively intact.<br><br>During a review of Resident 53's POLST form, dated 1/11/23, under information and signatures, the POLST indicated the resident did not have an advanced directive. During the record review there was no documentation in the EHR, the advance directive was discussed or offered to Resident 53 or the resident representative.<br><br>During a review of Resident 77's AR, dated 8/29/25, the AR indicated Resident 77 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (kidney disease).<br><br>During a review of Resident 77's MDS dated [DATE] under Section C, indicated she had a BIMS of 11 (BIMS score of 8–12 indicates moderate cognitive impairment).<br><br>During a review of Resident 77's POLST form, dated 2/22/25, under information and signatures, it showed no information on the presence of an advanced directive. During the record review there was no documentation in the EHR, the advance directive was discussed or offered to Resident 77 or the resident representative.<br><br>During a concurrent interview and record review on 8/29/25, at 10:02 a.m., with the Social Service Director (SSD), SSD stated he offered the advanced directives to the residents and their responsible parties and documented in the residents' records. SSD reviewed Residents 1,4,28,53 and 77's medical records and stated there were no documentation that advance directives were discussed and followed up with the residents and their responsible parties.<br><br>During an interview on 8/29/25, at 9:56 a.m., with the Director of Nursing (DON), DON stated the importance of advanced directives was to help ensure that the resident's wishes for medical care were carried out in case the resident becomes incapacitated.<br><br>2. A review of Resident 11's AR, printed on 8/28/25, indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included end stage renal failure (ESRD, final stage of chronic kidney failure) and was dependent on renal dialysis (a type of treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to).<br><br>A review of Resident 11's Minimum Data Set (MDS, a resident assessment tool used to guide care), dated 6/11/25, indicated Resident 11 had no Advance Directive.<br><br>A review of Resident 11's Physician Orders for Life-Sustaining Treatment (POLST, a medical document that outlines a patient's preferences for end-of-life care), dated 3/8/24, indicated the resident does not have an Advance Directive.<br><br>A review of Resident 33's admission record, printed on 8/29/25, indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (memory loss).<br><br>A review of Resident 33's MDS assessment, dated 6/6/25, indicated Resident 33 had not completed an Advance Directive.<br><br>A review of Resident 33's POLST, dated 6/2/25, indicated the resident does not have an Advance Directive.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 8's AR, printed on 8/29/25, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included Osteomyelitis (bone infection).<br><br>A review of Resident 8's MDS assessment, dated 6/23/25, indicated Resident 8 had not completed an Advance Directive.<br><br>A review of Resident 8's POLST, dated 6/17/25, indicated the resident does not have an Advance Directive. A review of Resident 10's admission record, printed on 8/29/25, indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure (CHF, a condition when the heart doesn't pump as much blood as well as it should).<br><br>A review of Resident 10's AR, printed on 8/29/25, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure (CHF, a condition when the heart doesn't pump as much blood as it should).<br><br>A review of Resident 10's MDS assessment, dated 6/6/25, indicated Resident 10 does not have an Advance Directive.<br><br>A review of Resident 10's POLST dated 5/6/25, indicated the resident does not have an Advance Directive.<br><br>A review of Resident 57's AR, printed on 8/29/25, the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus (high blood sugar).<br><br>A review of Resident 57's MDS assessment, dated 7/22/25, The MDS indicated Resident 57 does not have an Advance Directive.<br><br>A review of Resident 57's POLST, dated 7/21/25, indicated the resident does not have an Advance Directive.<br><br>A review of Resident 6's admission record, printed on 8/29/25, indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included quadriplegia (paralysis of all four limbs).<br><br>A review of Resident 6's MDS assessment, dated 6/26/25, indicated Resident 6 does not have an Advance Directive.<br><br>A review of Resident 6's POLST, dated 9/9/24, indicated the resident does not have an Advance Directive.<br><br>During an interview on 8/29/2025, at 10 a.m., with the Director of Nursing (DON), the DON stated Advance Directives will help the facility know what the resident's specific preference of medical care will be provided to the resident once resident become incapacitated, so that their last wishes are put in place.<br><br>During a concurrent interview and record review on 8/29/2025, at 10:02 a.m., with the Social Services Director (SSD), there was no documentation in Residents 11, 33, 8, 10, 57, and Resident 6's records, or either Resident Representative (RR) were provided information regarding the option to formulate an Advance Directive. SSD stated resident POLST and Advance Directives were asked of the residents and/or their RR and documented on the resident's chart during their initial care conference. SSD also (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated POLST and Advance Directive are the same.<br><br>During an interview on 8/29/25, at 11 a.m., SSD confirmed the necessary information were not provided to Residents 11, 33, 8, 10, 57, and Resident 6's or their RRs about the residents' option to formulate an Advance Directive.<br><br>A review of the sample POLST form, page 2, indicated, POLST does not replace the Advance Directive.<br><br>3. During a record review of Residents 2's AR printed on 8/29/25, the AR indicated Resident 2 was admitted to the facility on [DATE] with admitting diagnosis of disturbance psychotic disturbance, mood disturbance and anxiety and hypertensive heart disease (a condition where prolonged high blood pressure (hypertension) damages the heart muscle and affects its function).<br><br>During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to guide care), dated 6/8/25, the MDS indicated the Resident 2's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 6 out of 15, indicating severe cognitive impairment.<br><br>During a review on 8/28/25 of Resident 2's face sheet in the electronic health record (EHR), the face sheet indicated Advance DNR) comfort focused treatment, no artificial means of nutrition, including feeding tubes.<br><br>During a review of Resident's 2's [NAME] dated 3/20/24 indicated no advance directive. [NAME] indicated comfort focused treatment with no artificial means of nutrition, including tube feeding tubes. The POLST form indicated the POLST does not replace the Advance directive.<br><br>During a review of Resident 2's EHR on 8/29/25 at 8:59 a.m. there was no documentation an advance directive was discussed or offered<br><br>During a record review of Residents 7's admission record printed on 8/29/25, the admission record indicated Resident 7 was admitted to the facility on [DATE]. Resident 7's diagnosis was cerebral infraction (occurs when blood flow to the brain is interrupted, leading to brain tissue damage) due to occlusion, or stenosis of right middle cerebral artery, hemiplegia (paralysis on one side of the body) and type 2 diabetes mellitus with hyperglycemia (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 7's Minimum Data Set (MDS, an assessment tool used to guide care), dated 8/5/25, the MDS indicated the Resident 2's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 8 out of 15, indicating moderate cognitive impairment.<br><br>During a record review on 8/28/25 Resident 7's Physician Order for Life Sustaining Treatment (POLST) dated 11/3/22 indicated do not attempt resuscitation (DNR). The POSLT form indicated the resident had no advance directive. The POLST form indicated the POLST does not replace the Advance directive. During the record review there was no documentation in the EHR, the advance directive was discussed or offered to Resident 7 or he resident representative.<br><br>During a review of Resident 12's admission record printed on 8/29/25, the admission record indicated<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 12 was admitted to the facility on [DATE] with multiple medical diagnosis including hypertensive heart, chronic kidney disease with heart failure and type 2 diabetes mellitus etc.<br><br>During a review of Resident 12's Minimum Data Set (MDS, an assessment tool used to guide care), dated 8/5/25, the MDS indicated the Resident 2's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 9 out of 15, indicating moderate cognitive impairment.<br><br>During a review of Resident 12's Physician Order for Life Sustaining Treatment (POLST) dated11/1/23, the POLST indicated Resident 12 has compacity to make decisions.<br><br>During review of Resident 12's EHR there was no documentation the advance directive was offered or discussed with the resident.<br><br>During a concurrent interview and record review on 8/29/25 at 2:45 p.m. with Director of Nursing (DON), Resident 12's EHR was reviewed. The DON stated there was no documentation in the EHR that an advance directive was discussed or offered to Resident 12.<br><br>During an interview on 08/29/2025 at 10:00 a.m. with Director of Nursing (DON), DON stated advance directive will help the facility know the residents specific preference of medical care if and when they become incapacitated.<br><br>During an interview on 08/29/2025 at 10:02 a.m. with Social Services Director (SSD), SSD stated Section D on POLST inquiries about the resident's advance directive. SSD stated usually done with MD and nurse if the resident has mental capacity or has a legal decision maker (Resident representative.). The resident representative is asked if there is an advance directive. Sometimes the advance directive comes from the hospital. If the resident does not have an advance directive, no is marked on the POLST. The DSD stated the POLST updated quarterly during care conference, offered and documented during the Care Conference. SSD stated the POLST is the same as Advance directive. The POLST form indicates the POLST does not replace the advance directive.<br><br>During a review of the facility's undated policy and procedure (P&P) titled Code Status Advanced Directives and POLST indicated: Policy: It is a policy of this facility to adhere to residents' rights to formulate advance directives. 3. Upon admission, the facility will ask whether an Advanced Directive exists and provide information regarding the residents' right to make such decisions.<br><br>The CMS Interpretive Guidance states that facilities are required to obtain a written record of resident advance directives upon admission and maintained in the medical record. Importantly, residents have a right to refuse to create an advance directive so the advance directive or the refusal to create an advance directive must be documented. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview and record review, the facility failed to protect and keep secure when not in use, confidential resident health data and records for a census of 94. This failure had the potential to expose and disclose personal and confidential health information to unauthorized individuals.During a medication pass observation on 8/25/25 at 12:19 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1's computer screen was observed unlocked and accessible to residents and staff passing by when he left to administer medications to Resident 40. During an interview on 8/25/25 at 3 p.m. with LVN 1, LVN 1 confirmed he had left the computer unlocked and unattended when he went to administer medication to Resident 40. During an interview on 8/26/25 at approximately 4:30 p.m. with Director of Nursing (DON), DON stated nursing staff were to sign out from the computer system or lock the computer every time they walked away from it so resident information would not be exposed. During a review of the facility policy and procedure (P&P) titled, Electronic Medical Records, revised 3/2014, the P&P indicated, Policy Interpretation and Implementation. 3. Only authorized persons who have been issued a password and user ID code will be permitted access to the electronic medical records system. 4. The facility will make reasonable efforts to limit the use or disclosure of protected health information. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure maintenance services were provided to maintain a comfortable and homelike environment for seven of 51 sampled residents when:For Resident 33, Resident 14, Resident 74, and Resident 81, wall clocks were not provided in their rooms. This failure resulted in emotional distress for not having a wall clock and not knowing what time it was for the residents who occupied those rooms. 2. For Residents 36, 46, and 90, their rooms had peeling paint, missing baseboards, and exposed patchwork. These failures had the potential to decrease residents' quality of life.<br><br>Findings:<br><br>1a. A review of Resident 33's admission Record, printed on 8/27/25, indicated resident was admitted to the facility on [DATE] with multiple diagnoses that included disorientation and needs assistance with personal care.<br><br>A review of Resident 33's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 6/6/25, indicated Resident 33 was able to understand others and be understood, and that the resident had adequate vision.<br><br>A review of Resident 14's admission Record, printed on 8/27/25, indicated resident was admitted to the facility on [DATE] with multiple diagnoses that included diabetes mellitus (high blood sugar) and dementia (memory loss).<br><br>A review of Resident 14's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 7/28/25, indicated Resident 14 was able to understand others and be understood. The MDS indicated that the resident had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score or 13-15 is an indication of intact cognitive status.) score of 10 which indicated the resident had a moderately impaired cognition. The MDS also indicated Resident 33 had adequate vision.<br><br>A review of the facility census, dated 9/24/25, indicated Resident 33 and Resident 14 shared a room.<br><br>During concurrent observation and interview on 8/25/25, at 11:27 a.m., in the shared room of Resident 33 and Resident 14, Resident 33 stated he felt singled out for not having a wall clock in their room. Resident 33 stated he liked to be able to tell time and not feel that something was missing which interfered with his daily life and functioning. Resident 33 stated since admission, he had requested several staff members multiple times, to provide a wall clock in their shared room. Resident 14 also stated, just like his roommate Resident 33, Resident 14 was also bothered about not having a wall clock in their shared room.<br><br>During an interview on 8/27/25, at 7:15 a.m., in the shared room of Resident 33 and Resident 14, Maintenance Director (MaintD) stated there was no wall clock in the shared room of Resident 33 and Resident 14. MaintD stated he was aware of the repeated requests as told to him by the Social Services Director (SSD) and Nursing Department but had overlooked the residents' request due to his busyness. MaintD stated it was important for the residents to have a wall clock in the rooms to be (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | able to tell time and to help avoid confusion.<br><br>A review of the facility policy and procedure (P&P) titled, Homelike Environment, dated 2001, indicated, Residents are provided with a safe, clean, comfortable and homelike environment.Staff provides person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences.<br><br>A review of the facility P&P titled, Dignity, revised 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.Staff are expected to treat cognitively impaired residents with dignity and sensitivity.<br><br>1b. During a concurrent observation and interview on 8/29/2025 at 9:20 a.m., with Resident 74 in the resident's room, room was observed to have no wall clock. Resident 74 stated, he could not tell the time because there was no wall clock. Further stated it would be better if there was a clock so he could know the time of the day.<br><br>During a review of Resident 74's Minimum Data Set (MDS, a comprehensive assessment tool) dated 8/1/25 indicated Resident 74 usually made himself understood by others and was usually able to understand others.<br><br>During a concurrent observation and interview on 8/29/2025 at 12:00 p.m., with Resident 81 in the resident's room, room was observed to have no wall clock. Resident 81 stated, he the wall clock was important for his room to have so he could tell the time of the day.<br><br>During a review of Resident 81's MDS dated [DATE] indicated Resident 81 was able to make himself understood by others and was able to understand others.<br><br>During an interview on 8/29/25, at 1:02 p.m., with the Director of Nursing (DON), DON stated, it was essential for the residents to have a wall clock in their rooms so they could tell the time.<br><br>During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P indicated, Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment . 1. Staff provides person centered care that emphasizes the residents' comfort, independence and personal needs and preferences.<br><br>2.During a review of Resident 36's admission sheet printed on 8/29/25, the admission sheet indicated Resident 36 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).<br><br>During a review of Resident 36's (room [ROOM NUMBER]) Minimum Data Sheet (MDS, an assessment tool used to guide care), dated 7/29/25, the MDS indicated Resident 36 s Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 15 out of 15, indicating no cognitive impairment.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 8/25/25 at 10:15 a.m. the baseboards in Resident 36's room were observed removed from the wall below the window, white patch work area exposed and unpainted. Resident 36 stated the room was unfinished on admission and asked if the facility would neglect his needs.<br><br>During a review of Resident 46's admission sheet printed on 8/29/25, indicated Resident 46 was admitted to the facility on [DATE] with diagnoses of sepsis due to streptococcus pneumoniae (an infection/inflammation in the lungs) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).<br><br>During a review of Resident 46's Minimum Data Sheet (MDS, an assessment tool used to guide care), dated 8/14/25, the MDS indicated Resident 46's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) score was 9 out of 15, indicating moderate cognitive impairment.<br><br>During an observation on 08/25/2025 at 10:51 a.m. in Resident 46's room the walls were painted yellow. At the bottom of the wall the base boards were removed exposing white patch work, brown areas under the yellow paint and indentations in wall with cracked plaster, unfinished patchwork and paint peeling from the wall. Observed area of patch work with holes in the wall around door frame as existing room.<br><br>During an observation on 08/25/2025 at 11:06 a.m. in Resident 90's room the wall was a solid green color with areas of green paint peeling from above the baseboard area. The baseboards had been removed exposing peeling paint, brown patches and exposed patch work. The resident stated he informed staff about the wall's disrepair.<br><br>During a review of Resident 90's (room [ROOM NUMBER]) admission sheet printed on 8/29/25, indicated Resident 90 was admitted to the facility on [DATE] with diagnoses of hereditary and idiopathic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and atelectasis (where tiny air sacs in the lungs (alveoli) become deflated, preventing them from exchanging oxygen and carbon dioxide).<br><br>During a review of Resident 90's (room [ROOM NUMBER]) Minimum Data Sheet (MDS, an assessment tool used to guide care), dated 6/18/25, the MDS indicated Resident 90 's Brief Interview for Mental Status (BIMS, a standardized assessment tool used to screen for cognitive impairment) indicated the resident is rarely / never understood and was unable to complete the interview.<br><br>During a concurrent observation and interview on 08/26/2025 at 3:53 p.m. with the Maintenance Director (Maint D). The Maint. D stated when something needs repair the staff should log the repair needed in the maintenance logbook. Maint. D should review logbook every day and perform repairs as requested. Review of Station 2 logbook with the Maint D dated [DATE] through August 2025 showed the rooms cited are not logged for repair. During observations of rooms 9, 11 and 12 the Maint. D stated he knew about the rooms needing repair due to the ongoing room renovations. Facility renovations started in May 25. Maint. D stated he is waiting for the rooms to be empty of residents before the repairs can be completed.<br><br>During a review of the facility's undated policy and procedure (P&P) titled Homelike Environment, P&P indicated Residents are provided with a safe, clean comfortable and homelike environment. –The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on interview and record review, the facility failed to ensure patient safety for medication use for three of 51 sample residents (Residents 11, 20 and 104) when:1. Multiple incomplete and unclear PRN (as needed) pain medication orders were not clarified for indication for use (e.g. mild, moderate, or severe pain) prior to administration.2. Insulin was not administered in accordance with manufacturer specifications and standards of practice.These failures had the potential to result in inappropriate medication administration, preventable medication errors, increased risk of adverse drug events, oversedation, and resident harm or death.1a. During a concurrent interview and record review on 8/27/25 at 9:02 a.m. with Director of Nursing (DON), Resident 20's physician's orders were reviewed. Resident 20's medical record indicated the following physician's orders for pain management:Tramadol (a potent pain medication to treat pain) 50 milligrams (mg, a unit of measurement): Give 1 tablet by mouth every 6 hours as needed for pain, ordered 8/10/25.Tylenol (a milder pain medication) Extra Strength 500 mg: Give 1 tablet by mouth every 6 hours as needed for pain, ordered 8/9/25.DON confirmed Resident 20's physician's orders for Tramadol and Tylenol were both ordered as needed and stated nursing staff should have clarified the order with the physician to know when it was appropriate to administer each medication.1b. During a concurrent interview and record review on 8/27/25 at 9:39 a.m. with DON, Resident 11's physician's orders were reviewed. Resident 11's medical record indicated the following physician's orders for pain management: Hydrocodone/APAP (a potent pain medication) 5/325 mg: Give 1 tablet by mouth every 6 hours as needed for pain management, ordered 11/6/24.Tylenol (a mild pain medication) 325 mg: Give 2 tablets by mouth every 4 hours as needed for mild pain (for pain score 1-3 (pain score, a patient's self-reported or observed rating of pain intensity, using a standardized scale like 0-10 where 0 means no pain and 10 is worst possible pain), ordered 5/4/25.DON confirmed the order for hydrocodone/APAP was ordered as needed and did not indicate what pain level to administer the medication to Resident 11. DON stated nursing staff should have clarified the order with the physician to include parameters (a pain scale) to know when to administer the medication.During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 6/1/23, the P&P indicated, Policy: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines. 20. Correct any discrepancies and report to nurse manager.2. During a medication pass observation on 8/26/25 at 9:38 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 was observed preparing medication for Resident 104. LVN 4 dialed Resident 104's Lantus SoloStar Pen and NovoLog FlexPen to the prescribed doses after priming the pens (a process which ensures the device is working appropriately) and entered the resident's room. LVN 4 wiped Resident 104's right middle abdomen with an alcohol pad then injected the Lantus SoloStar followed by the Novolog FlexPen, both at a 45-degree angle. LVN 4 did not pinch or grasp a fold of Resident 104's skin before injecting.During an interview on 8/26/25 at 11:54 a.m. with LVN 4, LVN 4 stated insulin could be injected into the skin at a 90 degree or 45-degree angle. LVN 4 stated either angle was appropriate for all residents. She stated she usually utilized the 45-degree angle when administering insulin because residents reported it was less painful.A review of the manufacturer's labeling for Lantus SoloStar, dated 2022, indicated, How to Use Your Lantus SoloStar. Step 5. Inject Your Dose. Keep the pen straight, insert the needle into your skin.During a review of the facility's P&P titled, Insulin Administration Purpose, revised 3/2025, the P&P indicated, Steps in the Procedure. 22. Lightly grasp a fold of skin and insert the needle into the skin at a 90-degree angle. For very thin residents, insert at a 45-degree angle to avoid intramuscular injection. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview and record review, the facility failed to ensure four of 51 sampled residents (Residents 10, 11, 20, and 101) were free from unnecessary medication when narcotic pain medication was administered not in accordance with physician's orders. This failure had the potential to unnecessarily expose residents to adverse consequences of medications and inadequate indication of use of medications.1. During a concurrent interview and record review on 8/27/25 at 9:02 a.m. with Director of Nursing (DON), Resident 20's physician's orders and Medication Administration Records (MARs) were reviewed. Resident 20's medical record indicated a physician's order for tramadol (a narcotic pain medication) 50 milligrams (mg, a unit of measurement), give 1 tablet by mouth every 6 hours as needed for pain, ordered 8/10/25. A review of Resident 20's MAR dated August 2025 indicated nursing staff administered pain medication to Resident 20 on 8/16/25 and 8/17/25 when the documented pain score (a patient's self-reported or observed rating of pain intensity, using a standardized scale like 0-10 where 0 means no pain and 10 is worst possible pain), was 0. DON confirmed the findings and stated it looked like the resident was not in pain and nursing staff administered the medication anyway. DON reviewed the nursing progress notes for 8/16/25 and 8/17/25 and stated there was no documentation that Resident 20 was in pain on those days.2. During a concurrent interview and record review on 8/27/29 at 9:26 a.m. with DON, Resident 101's physician's orders and MARs were reviewed. Resident 11's medical record indicated a physician's order for oxycodone (a narcotic pain medication) 10 mg, give 1 tablet by mouth every 6 hours as needed for severe pain 8-10/10, ordered 8/17/25. A review of Resident 101's MAR dated August 2025 indicated nursing staff administered oxycodone when the pain score was outside of the physician's parameters (below 8) on the following dates: 8/18/25 at 1:27 a.m., 8/18/25 at 1:46 p.m., 8/19/25 at 1:01 a.m., 8/19/25 at 6:54 p.m., 8/20/25 at 8:07 a.m., 8/20/25 at 8:39 p.m., 8/21/25 at 1:31 p.m., 8/22/25 at 12:31 a.m., 8/23/25 at 11:01 a.m., and 8/24/25 at 9:01 p.m. DON confirmed the finding and stated nursing staff were expected to contact the physician if the resident requested a stronger medication than the parameters in the orders allowed. DON stated the nurse was then expected to obtain a new order, otherwise they were not to deviate from the physician's order.3. During a concurrent interview and record review on 8/27/25 at 9:39 a.m. with DON, Resident 11's physician's orders and MAR were reviewed. Resident 11's record indicated a physician's order for the following medications for pain management:- Hydrocodone/APAP (a narcotic pain medication) 5/325 mg: Give 1 tablet by mouth every 6 hours as needed for pain management, ordered 11/6/24- Tylenol (a mild pain medication) 325 mg: Give 2 tablets by mouth every 4 hours as needed for mild pain (for pain score 1-3), ordered 5/4/25A review of Resident 11's MAR dated August 2025 indicated nursing staff administered Tylenol when Resident 11's pain level was above 3 on 8/3/25, 8/5/25, 8/6/25, 8/16/25, 8/25/25, and 8/27/25. DON confirmed the Tylenol order was indicated for a pain score of 1 to 3 and that the nurse had administered it on the indicated dates for pain levels higher than 3, as indicated in the order by the physician. The DON reviewed Resident 11's nursing notes and confirmed there was no documentation to indicate the resident preferred Tylenol (a milder pain reliever) instead of hydrocodone/APAP. DON confirmed nursing staff did not administer Tylenol in accordance with the physician's order.4. During a concurrent interview and record review on 8/27/25 at 1:26 p.m. with DON, Resident 10's physician's orders and MAR were reviewed. Resident 10's record indicated a physician's order for oxycodone 10 mg, give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (pain scale value is 4 to 10), ordered 8/10/25.A review of Resident 10's MAR dated August 2025 indicated nursing staff administered oxycodone when Resident 10's pain level was below 4 on 8/18/25 and 8/24/25. DON confirmed the finding and stated, What is she [the nurse who administered the medication] thinking? DON stated according to the physician's order, nursing staff should not have administered the medication.During a review of the facility's policy and procedure (P&P) titled, Administering Pain Medications, revised 4/2025, the P&P indicated, General Guidelines. 6. (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Administer pain medications as ordered.During a review of the facility's P&P titled, Medication Administration, dated 6/1/23, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and record review, the facility had a 11.63% error rate when five medication errors out of 43 opportunities were observed during a medication pass for four of eight Residents (Residents 16, 49, 73 and 104). This failure resulted in medications not given in accordance with the manufacturer's specifications and potential to affect the residents' clinical conditions.During a medication pass observation on 8/25/25 at 10:40 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed preparing medications for Resident 16 which included amantadine (medication to treat Parkinson's disease, a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), docusate sodium (medication to soften the stool), furosemide (medication to rid the body of excess water), losartan (medication to lower blood pressure), metoprolol tartarate (medication to lower blood pressure), vitamin D, and lidocaine (medication to treat pain) 4% patches.A review of Resident 16's medical record indicated a physician's order for lactulose (medication to help slow the progression of chronic kidney disease by stimulating bowel movements to rid the body of harmful toxins) 20 g/30 ml, give 30 ml by mouth three times a day related to chronic kidney disease, stage 2 (mild) hold for loose stools, dated 3/3/24.During a concurrent interview and record review on 8/25/25 at 2:33 p.m. with LVN 1, Resident 16's physician's orders were reviewed. LVN 1 confirmed he did not administer Resident 16's lactulose because it was not available for administration and that he would need to follow up with the pharmacy to have it delivered.A review of Resident 16's MAR dated August 2025 indicated he missed all three scheduled doses of lactulose on 8/25/25: at 9 a.m., 1 p.m. and 5 p.m.During an interview on 8/26/25 at 4:13 p.m. with DON, DON stated nursing staff were expected to reorder a resident's routine medication when they popped the pill with the reorder sticker attached to it. She stated this would ensure they received the medication before the resident was out. DON stated nursing staff were expected to observe dose counters or meters on inhalers to know when it was time to reorder them and observe levels of liquid medications to request refills timely from the pharmacy. During a review of the facility's P&P titled, Pharmacy Services Overview, revised 4/2019, the P&P indicated, Policy Interpretation and Implementation. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration.During a medication pass observation on 8/25/25 at 11:20 a.m. with LVN 2, LVN 2 was observed preparing insulin aspart (a fast-acting insulin to treat diabetes) pen for Resident 49. LVN 2 entered Resident 49's room, poked the resident's left pointer finger with a lancet and measured her blood sugar level with a glucometer. LVN 2 confirmed Resident 49's blood sugar was 326 milligrams/deciliter (mg/dl, a unit of measurement).A review of Resident 49's medical record indicated a physician's order for insulin aspart 100 units/milliliter (u/ml, a unit of measurement) injection solution, inject as per sliding scale: if 151-200= 2 units; 201-250 = 3 units; 251-300= 4 units; 301-350= 6 units; 351-400= 9 units; 401-500= 10 units. Reassess after 2 hours. If BS (blood sugar) still > (greater than) 400, call MD, subcutaneously before meals and at bedtime for DM (diabetes mellitus, a chronic condition where the body does not produce or use insulin properly), dated 8/5/24.LVN 2 removed the cap from the insulin pen, then attached a needle onto the rubber seal without first sanitizing and disinfecting it. LVN 2 then dialed the pen to eight units then pushed the button down until the dial reached six units while holding the pen needle facing down. She stated it was appropriate to prime (a process to ensure the pen measures and delivers the correct dose) the pen by dialing to two units and pressing the button to eject it, or to dial two more units than the resident's dose and eject until the prescribed dose was reached. During an interview on 8/25/25 at 2:17 p.m. with LVN 2, LVN 2 stated the facility did not train nursing staff to sanitize and disinfect the pen prior to attaching a needle. She stated it was not necessary to do so because the needle was clean when attached to the pen.A review of the manufacturer's labeling for NovoLog FlexPen (brand<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | for insulin aspart) revised 4/2015 indicated, Instructions for Use. Preparing your NovoLog FlexPen. A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. D. Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog Flex pain and contact [drug manufacturer's name] at. A small air bubble may remain at the needle tip, but it will not be injected.During an interview on 8/26/25 at 4:26 p.m. with the Director of Nursing (DON), DON stated nursing staff were expected to prime insulin pens first, then dial the dose. DON stated it was not acceptable to dial two units higher than the dose, dispense two units, then administer the rest. During a review of the facility's P&P titled, Medication Administration, dated 6/1/23, the P&P indicated, Policy Explanation and Compliance Guidelines. 14. Administer medication as ordered in accordance with manufacturer specifications.During a medication pass observation on 8/26/25 at 8:59 a.m. with LVN 3, LVN 3 was observed preparing medication for Resident 73 which included Stiolto Respimat (an inhaled medication to treat chronic obstructive pulmonary disease, a progressive disease, to make breathing easier) 2.5/2.5 microgram (mcg, a unit of measurement) and Refresh Tears (an eye drop to lubricate dry eyes).A review of Resident 73's medical record indicated the following physician's orders:- Stiolto Respimat 2.5/2.5 mcg inhaler, 2 puffs inhaled orally one time a day related to chronic obstructive pulmonary disease, dated 1/6/23.- Refresh Tears ophthalmic solution: Instill 2 drops in both eyes two times a day for dry eyes, dated 3/8/24During the same medication pass observation with LVN 3, LVN 3 instructed Resident 73 to place her mouth on the inhaler, counted down, then tried to administer a dose. LVN 3 was unable to administer the dose and stated, I think it ran out, and said he would have to reorder it. LVN 3 then administered one drop Refresh Tears into Resident 73's right and left eye. LVN 3 exited the resident's room, returned to the medication cart and looked at the meter on the inhaler. He confirmed the arrow was at the end of the red section of the cannister and the inhaler was locked, indicating it was empty. LVN 3 stated he was not aware of the meter indicating the number of doses left on the inhaler prior to that day.During a concurrent interview and record review on 8/26/25 at 11:35 a.m. with LVN 3, Resident 73's order for Refresh Tears was reviewed. LVN 3 confirmed the order indicated to administer two drops into each eye and stated he had only administered one.A review of the manufacturer's labeling for Stiolto Respimat, revised 1/2025, indicated, When to get a new STIOLTO RESPIMAT inhaler: The scale on your inhaler will show the number of puffs you have, if used as indicated. The dose indicator will show you approximately how much medicine is left. When the dose indicator enters the red area of the scale, it will show you approximately how many puffs are left before you need a refill or new prescription. When the dose indicator reaches the end of the red scale, your STIOLTO RESPIMAT is empty and automatically locks. At this point, the clear base cannot be turned any further.During a medication pass observation on 8/26/25 at 9:27 a.m. with LVN 4, LVN 4 was observed preparing nine medications for Resident 104, including amlodipine (a medication to treat high blood pressure) 5 mg tablet.A review of Resident 104's medical record indicated a physician's order for Norvasc (brand for amlodipine) 10 mg, give 1 tablet by mouth one time a day for hypertension (high blood pressure) hold for SBP (systolic blood pressure, the force of blood pushing against the artery walls when your heart beats and pumps blood out) < (less than) 100, dated 8/19/25. LVN 4 removed a bubble pack from the medication cart with a pharmacy label affixed to it with Resident 103's name and indicated the medication inside was amlodipine 5 mg. LVN 4 popped 1 tablet from the bubble pack into the medication cup, finished preparing the remaining medications for the resident, then turned to walk into Resident 104's room with the medications. The Surveyor stopped LVN 4 before she entered the room<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and asked LVN 4 to confirm the amlodipine that was prepared for Resident 104 by pulling it out of the medication cart. LVN 4 removed the bubble pack containing the amlodipine she prepared for the resident and confirmed she had prepared medication from the wrong resident's bubble pack.During an interview on 8/26/25 at 4:28 p.m. with DON, DON stated nursing staff were expected to compare the pharmacy label on the medication and compare it to the order in the computer, including the name, drug name, and drug dose. She stated nursing staff were expected to follow the most current physician order and needed to read the order in the computer as part of their medication preparation process.During a review of the facility's policy and procedure titled, Medication Administration, dated 6/1/23, the P&P indicated, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines. 10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, interview, and record review, the facility failed to implement their policy and ensure safety of self-administered medication for one resident (Resident 40) out of a census of 94, when Resident 40 self-administered insulin lispro (a fast-acting insulin to treat diabetes) without a physician's order, evaluation by the Interdisciplinary Team (IDT, a group of professionals, including the resident, their family, physicians, nurses, social workers, and therapists, who collaborate to develop, implement, and monitor the resident's individualized care plan) and applicable care planning. This failure increased the potential for Resident 40 to not receive the full therapeutic effect of the medication, and risk of injury and infection from the incorrect administration of medication.During a medication pass observation on 8/25/25 at 12:08 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed preparing insulin lispro for Resident 40. LVN 1 stated Resident 40 usually self-administered his insulin. LVN 1 drew seven units from the insulin lispro vial with a syringe and entered Resident 40's room. LVN 1 wiped Resident 40's right middle abdomen with an alcohol pad, handed him the insulin lispro that was drawn up into a syringe, and allowed the resident to self-inject the medication.A review of Resident 40's medical record indicated the following physician's order for insulin lispro:- Insulin lispro 100 unit/milliliter (u/ml, a unit of measurement): inject 3 units subcutaneously (under the skin) before meals for Type 2 DM (diabetes mellitus, a disease where your blood sugar levels are too high because your body does not make enough insulin or cannot use it properly), ordered 8/15/25- Insulin lispro 100 u/ml: inject as per sliding scale. Recheck BG (blood glucose/sugar) within 2 hours. Notify MD if BG still greater than 300. subcutaneously before meals and at bedtime for Type 2 DM, ordered 8/15/25During a concurrent interview and record review on 8/25/25 at 2:40 p.m. with LVN 1, Resident 40's physician's orders were reviewed. LVN 1 confirmed Resident 40 did not have an evaluation completed by the IDT or a physician's order to evaluate and approve the resident to self-administer medication.During a concurrent interview and record review on 8/26/25 at 4:32 p.m. with Director of Nursing (DON), Resident 40's physician's orders, IDT notes and care plans were reviewed. DON confirmed there were no physician orders or documentation that indicated Resident 40 could safely self-administer his medication. DON confirmed an IDT assessment should have been completed and a physician's order obtained prior to Resident 40 self-administering his medication. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, revised 2/2021, the P&P indicated, Policy heading: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of 51 sampled residents (Residents 10 and 13) was free from unnecessary psychotropic medication (drugs that affects brain activities associated with mental processes and behavior) when1. Resident 10 received Cymbalta (a psychotropic medication to treat depression) without implementation of non-pharmacological (non-drug) interventions in an effort to lower the dose or discontinue the medication.2. Resident 13 did not have the appropriate indications for the use of Seroquel (Seroquel is an antipsychotic medication; antipsychotic medications are medications that are used to treat symptoms of psychotic mental disorder such as delusions, hallucinations, paranoia, or confused thoughts).These failures had the potential to result in unnecessary use of medication.1.A review of Resident 10's medical record indicated he was admitted to the facility in May 2025 with diagnoses including depression, diabetes and high blood pressure.<br><br>A review of Resident 10's medical record indicated a physician's order for Cymbalta 20 milligrams (mg, a unit of measurement), 1 capsule orally once daily for depression manifested by verbalization of sadness, ordered 5/7/25.<br><br>During a concurrent interview and record review on 8/27/25 at 1:44 p.m. with Director of Nursing (DON), Resident 10's non-pharmacological interventions were reviewed. DON stated Resident 10 had non-pharmacological interventions implemented for pain but not for depression. DON stated non-drug interventions were implemented unless it was contraindicated.<br><br>During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated, the P&P indicated, Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Policy Explanation and Compliance Guidelines. 4. The indications for initiating, maintaining, or discontinuing medications, as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 5. Non-pharmacological approaches will be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication.<br><br>2.Review of Resident 13's admission Record dated 8/29/25 indicated Resident 13 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (a form of dementia that gets worse over time, eventually making it hard to perform daily tasks and eventually requiring complete care; dementia means the brain's memory, thinking and decision- making abilities are declining).<br><br>During an observation on 8/29/25 at 1155 a.m., Resident 13 was lying in bed, awake, pleasant and verbally responsive. Resident 13 stated she was doing okay.<br><br>Review of Resident 13's Physician's Orders (PO), dated 8/29/25, indicated an order of Seroquel (an antipsychotic medication) 37.5 milligrams (mg., a form of measurement) at bedtime for increased agitation. The PO had a start date of 7/10/25. The PO also indicated the behaviors monitored for the use of Seroquel were: easily gets frustrated, constant talking to the point of exhaustion causing distress, trying to get out of bed, etc.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 13's Minimum Data Set (MDS, a comprehensive assessment tool), dated 8/7/25, indicated Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 6 out of 15, which indicated, Resident 13 had severely impaired cognition. The MDS also indicated Resident 13 had no behavior episodes of physical symptoms (hitting, kicking, pushing, scratching, grabbing .) and verbal symptoms (threatening, screaming, cursing .) directed toward others.<br><br>During a concurrent interview and record review on 8/29/25 10:13 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 13's Electronic Health Record (EHR) for behavioral care plan dated 3/24/25 was reviewed. The behavioral care plan indicated a problem of: easily gets frustrated, constant talking to the point of exhaustion causing distress, trying to get out of bed, and one of the interventions was to refer Resident 13 to a mental health professional for evaluation. Upon review of Resident 13's EHR, MDSC was unable to find a documentation of Resident 13's referral to a mental health professional. Further stated that the only behavioral symptom Resident 13 had was yelling.<br><br>During an interview on 8/29/25 at 12:15 p.m., with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 13's only behavioral problem was yelling.<br><br>During a phone interview on 8/29/25 at 3:02 p.m., with the Consultant Pharmacist (CP), CP stated that Alzheimer's disease was not an adequate diagnosis for prescribing Seroquel for Resident 13. Stated yelling was not an appropriate behavior to prescribe Seroquel and the risk of prescribing Seroquel to residents with dementia was death.<br><br>During an interview on 8/29/25 at 1:02 p.m., with the Director of Nursing (DON), DON stated Resident 13 should have been referred to the mental health professional or psychiatrist, so the use of Seroquel was evaluated.<br><br>Review of the facility's undated policy and procedure (P&P) titled, Psychotropic Medication Use, indicated, It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on observation, interview and record review the facility failed to ensure one sample resident's (Resident 50) / out of 51 residents, English / Chinese picture board for communication was utilized to effectively communicate with others. This lack of effective communication resulted in Resident 50 feeling unable to communicate with staff and experiencing frustration. During an interview on 8/26/25 at 10:30 a.m. at the facility Resident Council meeting, Resident 50 stated she had a difficult time communicating with and understanding the staff. Resident 50 was noted to be articulate a with hearing deficit.During a record review of Resident 50's admission Record (AR), the AR indicated. Resident 50 was admitted to the facility in December 2025 with a diagnosis of metabolic and toxic encephalopathy (condition where the brain doesn't work properly because there's too much or too little of something in the blood (like sugar, oxygen, or toxins). It can happen due to things like liver or kidney failure, infections, or exposure to harmful substances.), delirium (sudden and serious change in a person's mental state that causes confusion, trouble focusing, and difficulty understanding what's going on around them) and depression. The admission record printed on 8/29/25 at 09:28 a.m. indicated the resident's primary language was Chinese. The Brief Interview for Mental Status (BIMS- an assessment tool used by facilities used to screen and identify memory, orientation, and judgement status of the resident) printed on 4/17/25 indicated BIMS score was 12/15. BIM score of 12 indicates moderate cognitive impairment. Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) printed on 7/17/25 score was 11/15. BIMS score of 11 indicates moderate cognitive impairment. During an interview on 8/28/25 at 1:15 p.m. with Resident 50, Resident 50 stated she understands some English. Resident 50 stated the staff speaks quickly and not always in her direction and she feels frustrated. During a concurrent observation and interview on 8/28/25 at 1:32 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 stated the resident speaks and understands English. CNA 2 stated the resident had a communication binder with health care related pictures. The health care pictures had the Chinese translation at the bottom of the picture. The communication binder allowed the resident to express her needs and ask questions. CNA 2 was observed searching Resident 50's room and clothes cabinet for the communication binder. CNA 2 stated they do not know how long the communication binder had been missing. Resident 50 stated to CNA 2 she cannot understand all English words. Resident 50 requested the facility staff write questions on paper and show them to her.During an interview on 8/28/25 at 1:45 p.m. with Registered Nurse 1 (RN 1), RN 1 stated Resident 50 can understand English. RN 1 stated she has not seen a communication binder in the last several weeks. RN 1 stated she does not know the resident's primary language. RN 1 stated she does not know Resident 50's interventions for the communication deficit. RN 1 stated she does not know the process to ensure the care plan interventions are carried out and evaluated for Resident 50. RN 1 stated no communication problems for Resident 50 had been reported. During a review of the care plan printed on 8/29/25 for Resident 50' s communication problems relating to hearing deficit, the care plan indicated the resident is usually understood and understands, Chinese speaking. Interventions on the care plan indicated anticipate and meet needs, Communication: allow adequate time to respond. Repeat as necessary. Do not rush. Request clarification from the resident to ensure understanding. Face when speaking, make eye contact, reduce noise in room, ask yes/ no questions. Use simple brief, consistent words/ cues. Use alternative tools. Provide translator as necessary to communicate. May utilize family by calling on the phone for better communication. Monitor / document report any changes in ability to communicate, potential contributing factors for communication problems. Report to nurse changes in communication, possible factors which cause/ make worse /make better any communication problems.During an interview on 8/29/25 at 2:30 p.m. with the Director of Nursing (DON), DON stated it is all staff's responsibility to review the resident's<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care plan, ensure the interventions are carried out and report if the interventions are ineffective. DON stated the care plan is a communication tool for the healthcare team and to assist in promoting resident independence. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, interview, and record review, for one of one sampled resident (Resident 14), the facility failed to provide treatment and care consistent with professional standards of practice when a resident was provided a wheelchair (w/c) that was inappropriate for resident's size. This failure had the potential to compromise Resident 14's safety and support while up in the w/c. A record review of Resident 14's admission Record' (AR), printed on 8/27/25, AR indicated resident 14 was admitted to the facility in November 2024 with multiple diagnoses that included diabetes mellitus (high blood sugar), dementia (memory loss), and muscle weakness. A review of Resident 14's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 7/28/25, indicated Resident 14 was able to understand others and be understood. The MDS indicated that the resident had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score or 13-15 is an indication of intact cognitive status.) score of 10 which indicated the resident had a moderately impaired cognition. The MDS also indicated Resident 14 used a w/c as a mobility device and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) during chair/bed-to-chair transfer. A review of Resident 14's Care Plan on Activities of Daily Living (ADL) Self Care Performance Deficit, date initiated on 11/27/24, indicated, Resident will maintain current level of function in bed mobility, transfers.Honor resident's choices and preferences whenever possible. During concurrent observation and interview on 8/25/25, at 11:27 a.m. in Resident 14's room, Resident 14 was up in a wheelchair with a wide seat (at least four inches space to both sides in between resident and w/c armrests), able to propel himself using his feet. Resident 14 stated he had been using the wide-seat w/c for a few months because the facility had not provided him with the appropriate -sized w/c he had been promised. During concurrent observation and interview on 8/27/25, at 7:15 a.m. with Maintenance Director (MaintD), in Resident 14's room, Resident 14 was seen up in a wheelchair with a wide seat. MaintD stated Resident 14 is currently using a bariatric wheelchair (a type of mobility device designed for individuals requiring a higher weight capacity and wider seat than standard wheelchairs). MaintD stated Resident 14 was using a w/c that was inappropriate for the resident's size and could be a safety hazard due to possible slipping as the w/c is too wide for the resident. MaintD also stated Rehabilitation and Maintenance coordinate together to measure and order a resident w/c. During an interview on 8/27/25, at 7:47 a.m. with Physical Therapist 1 (PT 1), PT 1 stated Director of Rehabilitation (DOR) identifies a resident's body size, provides a w/c that is appropriate for the resident depending on the medical condition of the resident. The DOR assesses the resident and if a w/c is available, a resident is fitted for an appropriate-sized w/c or if it is a special case, then a customized w/c that would provide safety and support to the resident, is ordered by the facility. During a concurrent observation and interview on 8/27/25, at 8:50 a.m., with the DOR, in Resident 14's room, resident was seen up in a regular-sized w/c. Resident 14 himself informed the DOR that resident had been using the wide seat w/c for a couple months at least. DOR stated she had no knowledge that Resident 14 was using an inappropriate fitting w/c. DOR stated the wide seat w/c was not the appropriate-sized w/c for the resident, so today, was temporarily replaced with a smaller w/c until the new ordered w/c is delivered and assembled for Resident 14's use. Review of the facility's policy and procedure (P&P) titled, Assistive Device and Equipment, undated, indicated, Our facility maintains and supervises the use of assistive devices and equipment for residents. Certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents .mobility devices (wheelchairs) .Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan .The following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment .Personal fit - the equipment or device is used only according to its intended purpose and is measured to fit the resident's size and weight . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to ensure a safe environment was provided for one of three sampled residents (Resident 57) when:1. Licensed Vocational Nurse 4 (LVN 4) failed to assess Resident 57 immediately after CNA 1 reported resident's unwitnessed fall incident. 2. CNA 1 assisted Resident 57 back to the chair without the appropriate Licensed Nurse knowledge and assessment, following the resident's unwitnessed fall to the floor in the resident's room.These failures resulted in delay in receiving the appropriate medical interventions necessary to meet the resident's nursing care needs and potentially placing Resident 57 at risk for further harm or injury post fall. A record review of Resident 57's admission Record printed on 8/27/25, the AR indicated Resident 57 was admitted to the facility in July 2025, with diagnoses that included alcohol dependence with alcohol-induced disorder (refers to a presentation of alcohol dependence in which a person is not currently experiencing acute complications such as intoxication, withdrawal, or alcohol-induced psychosis), diabetes mellitus (high blood sugar), and muscle weakness. A review of Resident 57's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 7/22/25, indicated Resident 57 was able to understand others and be understood. The MDS indicated that the resident had a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score or 13-15 is an indication of intact cognitive status.) score of 15 which indicated the resident had intact cognition. The MDS also indicated Resident 57 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) during chair/bed-to-chair transfer.During an observation and concurrent interview on 8/25/25, at 10:48 a.m., in Resident 57's shared room, Resident 57 was noted seated at the edge of the end of his bed with his legs crossed, right leg on top of the left leg. Resident 57 stated he had a fall this morning around 10 a.m. and had pain in his right hand, which was noted with swelling, without redness. A review of Resident 57's clinical record titled Nursing Admission/readmission Assessment, dated 7/17/25, indicated resident had a score of five (a total score of 10 or above represents high risk for falls). A review of Resident 57's Situation Background Appearance Review (SBAR, a communication framework used in nursing to structure conversations about patient updates between team members) Communication Form, dated 8/25/25, completed by LVN 4, at 11:05 a.m. indicated Resident 57 had an unwitnessed fall in his room at around 10 a.m. CNA 1 reported that the resident was found sitting on the floor on the left side of the bed. Resident 57 stated he hit his right arm and back of the head on the side rail of the bed. A small, elevated area was noted on the back of the resident's head and complained of 6/10 (pain scale where 0 means no pain and 10 being the worst) pain located on resident's right arm and shoulder. A review of Resident 57's clinical record, Nurse Practitioner 2's (NP 2's) Progress Notes, effective date 8/25/25, indicated LATE ENTRY, showed, .No loss of consciousness (LOC), no bleeding or major injury. No need for escalation of care. Monitor for any change of mental or physical status according to facility fall protocol and inform provider. During an interview on 8/25/25, at 10:57 a.m. with LVN 4, LVN 4 stated Resident 57 has chronic pain in his right arm and back and is on multiple routine pain medications. When asked about Resident 57's fall incident this morning, LVN 4 was unaware and stated that CNA 1 had come up to her earlier while she was giving medications to another resident in another room. LVN 4 stated CNA 1 had asked her to see Resident 57 but did not say resident had an unwitnessed fall which LVN 4 soon corrected herself, then stated maybe she and CNA1 had a miscommunication. During an interview on 8/25/25, at 12:34 p.m. with CNA 1, CNA 1 stated he could not recall the exact time when Resident 57's fall occurred. CNA 1 stated he was in the Nursing Station charting when he noticed a call light in Resident 57's room. Upon entrance to the shared room, Resident 57's roommates' call light was on and only to find out that Resident 57 was on the floor next to the bed.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA 1 stated he assessed Resident 57 and assisted the resident back to the chair. CNA 1 immediately rushed to the hallway to inform LVN 4 of Resident 57's fall. CNA 1 stated he was a new CNA and knew it was his duty to assess and assist resident back to bed or chair, then report to the nurse. CNA 1 stated he should have reported to the nurse right away, who was more knowledgeable of what to assess on the resident. According to CNA 1, LVN 4 stated she will come and check on Resident 57 soon as she is done passing medications to a resident. During an interview on 8/25/25, at 12:56 p.m. with the Director of Staff Development (DSD), DSD stated with fall incidents, CNA's responsibility was to keep the resident safe then inform the charge nurse immediately. DSD further stated new CNAs were trained to report any unusual incident/s, as with a fall for example, CNAs are not to move the resident and instead report to charge nurse immediately for a thorough assessment. During an interview on 8/28/25, at 8:44 a.m. with the Director of Nursing (DON), DON stated a charge nurse should have attended to the situation right away, did head-to-toe assessment and initiated a neurological check on Resident 57's unwitnessed fall. If Resident 57 obtained a serious injury at that time, there was delayed intervention to the situation. DON further stated CNA 1 should have emphasized to charge nurse that the resident fell and not moved the resident until thoroughly assessed by the charge nurse. During a follow-up interview and concurrent record review on 8/28/25, at 12:55 p.m. with the DON, Neurological Assessment Flow Sheet documentation was noted initiated at 10 a.m. when LVN 4 acted upon Resident 57's fall incident at 11 a.m., an hour after Resident 57's fall occurred. During a follow-up interview and concurrent record review on 8/28/25, at 1:20 p.m., with LVN 4, LVN 4 stated she misunderstood CNA 1 had told her, Resident 57 wanted pain medication when she knew she had just administered it to the resident. LVN 4 also stated Neurological Check was started at 11 a.m. and the form was mistakenly marked with start time of 10 a.m. by another licensed nurse who assisted her with the documentation. A review of the facility's policy and procedure (P&P) titled, Fall Prevention Program, dated 3/1/23, indicated, .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force.When any resident experiences a fall, the facility will: a. assess the resident.' A review of the facility's form titled, Certified Nursing Assistant, undated, under Duties and Responsibilities, indicated, Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurses soon as practical. Report all accidents and incidents you observe on the shift that they occur.Perform all assigned task in accordance with our established policies and procedures, and as instructed by your supervisors. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056471 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Harbor Healthcare Center | 442 Sunset Boulevard<br>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 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observation, interview and record review, the facility failed to ensure one of 51 sampled residents call light (Resident 89) was answered promptly. This failure had the potential for Resident 89's needs not to be met in a timely manner and had the potential to result in skin injuries. During an initial tour of the facility on 8/25/25 at 10:23 a.m. in Resident 89's room, the resident stated she had to wait for a long time before her call light was answered, and also, stated she had to wait a long time for her incontinent briefs to be changed. Call light response time was tested, and Resident 89 pressed her call light at 10:25 a.m. The Assistant Director of Nursing (ADON) was observed to answer the resident's call light at 10:48 a.m. The ADON stated it was not acceptable for the resident to wait for 23 minutes (the amount of time that had passed from 10:25 a.m. until 10:48 a.m.) to have her needs attended by the staff. Also stated the call light should be answered promptly due to risk of unattended needs. The ADON had also shown the call light monitor in the nurses' station and stated the nursing staff should look at the monitor to know who were the residents that needed assistance. During a review of Resident 89's Minimum Data Set (MDS, a comprehensive assessment tool) dated 5/28/25 under Section C, it indicated Resident 89 was able to make herself understood by others and was able to understand others. The MDS also indicated that Resident 89 was dependent to the staff in toileting hygiene which meant the helper, or the staff did all the effort to perform the toileting hygiene of Resident 89. During a review of the facility's undated policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, the P&P indicated, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light to allow residents to call for assistance. |