STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555341	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Creek Post-Acute	22103 Redwood Road Castro Valley, CA 94546

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to safely transfer one of three sampled residents (Resident 1) from wheelchair to bed using a Hoyer lift (a mechanical device used to lift and transfer residents with limited mobility), when one of loops/straps of the sling (a supportive fabric, shaped like a hammock which holds the residents. Loops of the sling are attached to the bars of the Hoyer lift) broke, causing Resident 1 to land directly onto the floor. This failure resulted in Resident 1 hitting his left leg onto the bottom bar (base) of Hoyer lift, sustaining a laceration (deep cut in the skin) on left shin, requiring transfer to an acute care hospital for staples (metal or plastic clips applied to close a tear in the skin) and Resident 1 feeling lack of confidence in facility's capabilities. During a review of Resident 1's admission record, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of bilateral Osteoarthritis of knee (natural wear and tear of the knee causing pain) and obesity (indicates a very high amount of excess body fat). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 9/10/25, indicated Resident 1's 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) score was 15 out of 15, indicating normal thinking and memory. During a review of Resident 1's Care Plan for left foot ulcer (slow healing open sore), dated 9/4/25, the Care Plan indicated Resident 1 required a mechanical lift for transfers to prevent further injury. The Care Plan for falls, dated 9/5/25, indicated Resident 1 was at risk for falls due to impaired balance and decreased coordination and he required assistance with activities of daily living.During an interview on 1/12/26 at 10:26 a.m, Resident 1 stated, a few months ago he was being transferred from wheelchair to bed, when the strap of the Hoyer Lift sling broke, causing him to fall on the floor. Resident 1 stated he had a cut on his leg and went to the hospital where staples were placed. Resident 1 stated I rather forget, it did not build any confidence in them [facility staff] talking about how he felt after the incident.During an interview on 1/12/26 at 12:06 p.m., Certified Nursing Assistant (CNA 1) stated on 10/30/25, while using the Hoyer lift to transfer Resident 1 from his wheelchair to bed, the strap of the sling broke causing Resident 1 to fall straight to the floor, hitting the base (bottom bar) of the Hoyer lift. CNA 1 stated Resident 1 was bleeding. CNA 1 stated the sling used during the time of the fall seemed to be too small compared to Resident 1's body size. CNA 1 stated they used the sling that was available for use at that time.During a concurrent interview and record review on 1/12/26 at 12:27 p.m. with Licensed Vocational Nurse 1 (LVN 1), Resident 1's progress notes, dated 10/30/25, were reviewed. LVN 1 stated that she heard a loud noise followed by a scream in Resident 1's room, upon arrival she found Resident 1 on his buttocks, sitting on the floor, in between the base of the Hoyer lift, with visible blood on the floor. LVN 1 noted a laceration (deep cut) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on Resident 1's left shin, LVN 1 applied pressure and ice packs to control bleeding. Resident 1 complained of 10 out of 10 pain (severe pain) that required Norco (strong pain medication). LVN 1 indicated upon inquiry, Resident 1 stated he had been dropped. LVN 1 stated she inspected the sling and confirmed that it was broken. Resident 1 was sent out to the acute hospital for further evaluation.During a review of Resident 1's After Visit Summary from acute care hospital dated 10/30/2025, the summary indicated Resident 1 received staples to close the laceration on his left shin. During an interview on 1/12/26 at 1:08 p.m. with the Director of Nursing (DON), DON stated Resident 1's fall could have been avoidable if facility staff checked the slings, for example, for loose threads prior to the fall.During a review of Hoyer lift manual, dated 5/2011, the manual indicated Maintenance Safety Inspection Checklist; Slings and hardware - Check all sling attachment each time it is used to ensure proper connection and patient safety. Inspect sling material for wear.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility failed to report a fall incident for one of three sampled residents (Resident 1) to the State Agency when Resident 1 was being transferred from wheelchair to bed using a Hoyer lift (a mechanical device used to lift and transfer residents with limited mobility from one surface to the other). One of loops/straps of the sling (a supportive fabric, shaped like a hammock which holds the residents. Loops of the sling are attached to the bars of the Hoyer lift) broke, causing Resident 1 to land directly onto the floor. Resident 1 hit his left leg onto the bottom bar (base) of the Hoyer lift, sustained a laceration (deep cut in the skin) on left shin, requiring transfer to the emergency room of an acute care hospital for staples (metal or plastic clips applied to close a tear in the skin).This failure resulted in facility being non-compliant with unusual occurrence reporting to the State Agency. (Cross Reference F689)During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 9/10/25, the assessment indicated Resident 1's Brief Interview for Mental Status (BIMS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) score was 15 out of 15, indicating normal thinking and memory. During an interview on 1/12/26 at 10:26 a.m. with Resident 1, Resident 1 stated a few months ago he fell out of the Hoyer lift while facility staff were transferring him from the wheelchair to the bed. Resident 1 stated the strap of the Hoyer lift sling broke, causing him to fall onto the floor. He got a deep cut on his leg and was sent to the hospital for treatment. During a concurrent interview and record review on 1/12/26 at 12:27 p.m. with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Progress Notes, dated 10/30/25, were reviewed. LVN 1 stated upon inquiry, Resident 1 stated he had been dropped. LVN 1 inspected the sling and confirmed that it was broken. Resident 1 complained of 10 out of 10 pain (severe pain) and she gave Norco (pain medication) to Resident 1, and he was sent out to the acute hospital for further evaluation. During an interview on 1/12/26 at 11:10 a.m. with the Director of Nursing (DON), DON stated she was aware of Resident 1's fall related to broken loop of the Hoyer lift sling on 10/30/25. DON stated however, the incident was not reported to the State Agency (California Department of Public Health). DON stated it did not occur to her that it was an unusual occurrence requiring reporting to State Agency because they knew what caused Resident 1 to fall out of the Hoyer lift.During an interview on 1/12/26 at 1:15 p.m. with the Administrator (Adm), Adm stated it was unusual for a resident to fall or have injuries related to Hoyer lift use and unusual occurrences are reportable. Adm stated he didn't report Resident 1's fall that happened on 10/30/25 because the facility was focused on the cause of the fall and managing Resident 1's injuries. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, dated 12/2007, the P&P indicated, As required by federal or state regulations, facility reports unusual occurrences which affect the health, safety and welfare of the residents.Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.