| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555341 | A. Building<br>B. Wing | 11/01/2024 |

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

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>51682<br><br>Based on interview, record review, facility policy review, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to complete annual Minimum Data Set (MDS) assessments within 14 calendar days following the Assessment Reference Date (ARD), which affected 3 (Residents #14, #27, and #29) of 3 residents reviewed for annual MDS requirements.<br><br>Findings included:<br><br>A facility policy titled, MDS Completion and Submission Timeframes, revised July 2017, revealed, Our facility will conduct and submit resident assessments in accordance with current federal timeframes. The policy revealed, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.<br><br>The Center for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.19.1 dated October 2024, revealed, The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA [Significant Change in Status Assessment] or an SCPA [Significant Correction to Prior Comprehensive assessment] has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s) [Care Area Assessment]/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates. The manual revealed, Assessment Management Requirements and Tips for Annual Assessments included The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).<br><br>1. An Admission Record indicated the facility admitted Resident #14 on 08/18/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified dementia with behavioral disturbance.<br><br>Resident #14's annual MDS, with an ARD of 08/19/2024, revealed the assessment was signed as completed (item Z0500B) on 10/25/2024. The completion date of the assessment was due by 09/02/2024.<br><br>2. An Admission Record indicated the facility admitted Resident #27 on 08/22/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of cerebral palsy.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #27's annual MDS, with an ARD of 08/07/2024, revealed the assessment was signed completed (item Z0500B) on 09/27/2024. The completion date of the assessment was due by 08/21/2024.<br><br>3. An Admission Record indicated the facility admitted Resident #29 on 08/22/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of benign neoplasm of the cerebral meninges (non-cancerous tumor that grows from the membranes that surround the brain and spinal cord).<br><br>Resident #29's annual MDS, with an ARD of 08/15/2024, revealed the assessment was signed as completed (item Z0500B) on 09/17/2024. The completion date of the assessment was due by 08/29/2024.<br><br>During an interview on 10/29/2024 at 1:18 PM, the MDS Coordinator stated that the facility had been unable to hire a consistent full-time person to assist her in completing the assessments since she started working at the facility in May 2024. The MDS Coordinator stated that the facility was without a social worker in July, which caused sections of the assessments to fall behind in completion. She stated that an influx of admissions and discharges had occurred since that time, which resulted in her inability to get assessments completed timely.<br><br>During an interview on 10/31/2024 at 9:41 AM, the Director of Nursing (DON) stated that she was aware the facility had assessments completed greater than the fourteenth day following the ARD. She stated that quality assurance performance improvement (QAPI) met monthly and there were frequent conversations related to late assessments. She stated that medical records staff completed daily MDS audits. The DON stated that although multiple members of the interdisciplinary team completed sections of the MDS assessment, the MDS Coordinator was responsible for the final completion. She stated that she expected that all assessments be open, completed, and transmitted timely.<br><br>During an interview on 11/01/2024 at 9:28 AM, the Administrator stated that he expected the regulation to be followed and for all assessments to be completed and transmitted timely. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>45555<br><br>Based on record review, interview, and a review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) for 1 (Resident #26) of 1 resident reviewed for hospice services.<br><br>Findings included:<br><br>On 10/31/2024 at 1:19 PM, the MDS Coordinator stated the facility followed the MDS 3.0 Resident Assessment Instrument manual.<br><br>The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 dated October 2024 revealed, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.<br><br>An Admission Record indicated the facility admitted Resident #26 on 04/27/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cirrhosis of the liver, chronic viral hepatitis C, hepatic encephalopathy (a brain dysfunction caused by a liver dysfunction), protein-calorie malnutrition, and palliative care (onset 09/06/2024).<br><br>Resident #26's Order Recap Report for orders from 07/01/2024 through 10/30/2024 revealed a physician's order dated 09/07/2024 to admit the resident to hospice services.<br><br>A SCSA MDS, with an ARD of 09/10/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was receiving hospice services. The MDS revealed the Registered Nurse (RN) Assessment Coordinator had not signed and dated Resident #26's MDS, verifying assessment completion.<br><br>Resident #26's care plan revealed no documented evidence the facility had developed a care plan with a focus area and interventions for hospice services.<br><br>Resident #26's Progress Notes revealed a Nurse Practitioner Note dated 10/09/2024 that indicated Resident #26 was receiving hospice care.<br><br>During an interview on 10/31/2024 at 10:24 AM, the Social Service Supervisor (SSS) stated she had worked at the facility since 08/01/2024 and had just learned how to identify when an MDS was open. The SSS stated a SCSA MDS should be completed if a resident was admitted to hospice services. She stated she was unsure why the facility MDS assessments were so far behind.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/2024 at 1:19 PM, the MDS Coordinator stated a SCSA MDS should be completed when a resident went on or came off hospice services. She stated some of the RNs and the Director of Nursing (DON) signed an MDS when it was completed. She stated Resident #26's SCSA MDS was opened on 09/10/2024; however, the MDS was incomplete because an MDS nurse had not finished a section of the MDS.<br><br>During an interview on 11/01/2024 at 9:26 AM, the DON stated a SCSA MDS should be completed if a resident was admitted to hospice services. The DON stated she was attempting to get additional staff assistance for the MDS Coordinator.<br><br>During an interview on 11/01/2024 at 9:50 AM, the Administrator stated MDS assessments should be completed. He stated that there had been some transitions in the MDS department that had resulted in a back log of assessments. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident’s assessment is updated at least once every 3 months.<br><br>51682<br><br>Based on interview, record review, facility policy review, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed within 14 calendar days following the Assessment Reference day (ARD), which affected 3 (Residents #13, #16, and #22) of 3 residents reviewed for quarterly MDS requirements.<br><br>Findings included:<br><br>A facility policy titled, MDS Completion and Submission Timeframes, revised July 2017, revealed, Our facility will conduct and submit resident assessments in accordance with current federal timeframes. The policy revealed, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.<br><br>The Center for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.19.1 dated October 2024, revealed, The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. The manual revealed, Assessment Management Requirements and Tips included The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).<br><br>1 An Admission Record indicated the facility admitted Resident #13 on 11/14/2012. According to the Admission Record, the resident had a medical history that included a diagnosis of paraplegia.<br><br>Resident #13's quarterly MDS, with an ARD of 09/03/2024, revealed the assessment was signed as completed (item Z0500B) on 10/10/2024. The assessment was due to be completed by 09/17/2024.<br><br>2. An Admission Record indicated the facility admitted Resident #16 on 02/12/2014. According to the Admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease.<br><br>Resident #16's quarterly MDS, with an ARD of 08/13/2024, revealed the assessment was signed as completed (item Z0500B) on 10/25/2024. The assessment was due to be completed by 08/27/2024.<br><br>3. An Admission Record indicated the facility admitted Resident #22 on 06/13/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy.<br><br>Resident #22's quarterly MDS, with an ARD of 09/12/2024, revealed the assessment was signed as completed (item Z0500B) on 10/25/2024. The assessment was due to be completed by 09/26/2024.<br><br>(continued on next page) |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/29/2024 at 1:18 PM, the MDS Coordinator stated that the facility had been unable to hire a consistent full-time person to assist her in completing the assessments since she started working at the facility in May 2024. The MDS Coordinator stated that the facility was without a social worker in July, which caused sections of the assessments to fall behind in completion. She stated that an influx of admissions and discharges had occurred since that time, which resulted in her inability to get assessments completed timely.<br><br>During an interview on 10/31/2024 at 9:41 AM, the Director of Nursing (DON) stated that she was aware the facility had assessments completed greater than the fourteenth day following the ARD. She stated that quality assurance performance improvement (QAPI) met monthly and there were frequent conversations related to late assessments. She stated that medical records staff completed daily MDS audits. The DON stated that although multiple members of the interdisciplinary team completed sections of the MDS assessment, the MDS Coordinator was responsible for the final completion. She stated that she expected that all assessments be open, completed, and transmitted timely.<br><br>During an interview on 11/01/2024 at 9:28 AM, the Administrator stated that he expected the regulation to be followed and for all assessments to be completed and transmitted timely. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>45555<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a person-centered comprehensive care plan for 1 (Resident #167) of 21 sampled residents.<br><br>Findings included:<br><br>A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, specified, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The policy indicated, 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS [Minimum Data Set] assessment.<br><br>An Admission Record indicated the facility admitted Resident #167 on 07/14/2023. According to the Admission Record, the resident had a medical history that included diagnoses of vascular dementia, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, alcohol dependence with alcohol induced persisting amnestic (memory loss) disorder, encephalopathy (disorder of the brain), and other specified disorder of the brain.<br><br>A quarterly MDS, with an Assessment Reference Date (ARD) of 10/02/2024, revealed Resident #167 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident did not exhibit the behavior of wandering during the assessment timeframe. The MDS indicated the resident required setup or clean-up assistance with toileting hygiene. The MDS revealed the resident did not receive antipsychotic medication since admission/entry or reentry, or the prior assessment.<br><br>Resident #167's care plan, included a focus area revised 04/21/2024, that indicated the resident was receiving medications with a black box warning that included quetiapine fumarate (an atypical antipsychotic) and was at significant risk of serious or life-threatening adverse effects. Interventions directed staff to administer the resident's medications as ordered (initiated 07/16/2023).<br><br>Resident #167's care plan, included a focus area revised 07/18/2024, that indicated the resident received psychotropic medications that included quetiapine. Interventions directed staff to administer the resident's medication as ordered (initiated 07/16/2023).<br><br>Resident #167's Order Recap [Recapitulation] Report, for the timeframe from 07/01/2024 through 10/30/2024, revealed the resident had an order dated 12/29/2023 for quetiapine 25 milligrams (mg), with instructions to give a half a tablet by mouth at bedtime. The Order Recap Report revealed the order was discontinued on 08/22/2024. The Order Recap Report revealed no active order for quetiapine.<br><br>The resident's care plan was not updated to exclude the use of the medication.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/2024 at 1:19 PM, the MDS Coordinator stated that if an antipsychotic medication was discontinued, the use of the medication should be taken off the care plan.<br><br>During an interview on 11/01/2024 at 9:26 PM, the Director of Nursing (DON) stated if an antipsychotic medication was discontinued, the use of the medication should be removed from the care plan. She stated that any time something was resolved, it needed to be resolved on the care plan.<br><br>Resident #167's care plan, included a focus area revised 07/18/2024, that indicated the resident was occasionally incontinent of bowel and bladder with a need for assistance with personal care. Interventions directed staff to adapt to the resident's toileting habit (initiated 07/16/2023); assess the resident's bowel and bladder status at least quarterly (initiated 07/16/2023); assess the resident's skin condition and perineal area daily and as needed (initiated 07/16/2023); check the resident for wetness at least every two hours (initiated 07/16/2023); consider a bowel and bladder retraining program if appropriate/indicated (initiated 07/16/2023); continuously monitor the resident for a decline in function (initiated 07/16/2023); keep the resident clean and dry, and provide clean and dry linens (initiated 07/16/2023); monitor and document intake and output as per facility policy (initiated 07/16/2023); monitor and document for signs and symptoms of a urinary tract infection (initiated 07/16/2023); and monitor, document, and report as needed any possible causes of incontinence (initiated 07/16/2023).<br><br>During an interview and observation on 10/28/2024 at 10:32 AM, Resident #167 had a strong odor of urine. Resident #167 stated they had a catheter, but the facility took it out and now they had to sit in wet briefs all the time.<br><br>Resident #167's Bowel & Bladder Retraining 14-Day Evaluation & Reevaluation, dated 07/14/2023, revealed the resident was continent or had an indwelling catheter, could walk to the bathroom or transfer to the toilet, and could manage their clothes, could clean their self, or use the urinal alone with reasonable speed. The assessment indicated that the resident was forgetful but could follow prompts and was always mentally aware of their toileting needs.<br><br>During an interview on 10/30/2024 at 2:12 PM, CNA #3 stated that Resident #167 was continent most of the time but when they were incontinent, the staff had to remind the resident to change their brief. She stated sometimes it would get on the resident's linens and cause an odor in the room. She stated Resident #167 was capable of changing their own brief; they just needed reminding.<br><br>During an interview on 11/01/2024 at 8:33 AM, CNA #5 stated that Resident #167 was incontinent sometimes, but would say that they would take care of it. She stated that she thought the resident's room had an odor because the resident put their wet briefs in the drawers. She stated they had to try and go into the room when the resident was not in there to take the soiled briefs out; otherwise, the resident thought they were stealing their stuff. She stated they would go to the laundry room to get clothes for the resident daily so that their clothes did not smell like urine.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/30/2024 at 2:03 PM, LVN #4 stated Resident #167 wanted a catheter and because they would not give it to them, the resident would urinate all over the place. She stated the resident agreed to be assisted with toileting at times, but other times refused. She stated the resident would take off their incontinence brief and put it in a drawer, causing all the other clothes in the drawer to have an odor. She stated that staff would have to take out all the clothes and wash them frequently; they usually kept the resident's clothes in the laundry room, so they did not get dirty. She stated that she did not know if that behavior had been documented or care planned.<br><br>During an interview on 10/31/2024 at 9:59 AM, RN #2 stated that Resident #167's incontinence was related to their dementia. She stated they would offer to provide incontinence care or assist the resident to the toilet, and they would refuse, stating they were fine, and they did not need any help. She stated she did not think the resident was incontinent; it was a behavior and a small sanitation issue. She stated the resident would get very defensive when they tried to assist the resident with toileting. She stated the resident was capable of changing their own briefs. She the resident's incontinence was behavioral.<br><br>During an interview on 10/31/2024 at 1:19 PM, the MDS Coordinator stated that the care plan was used to inform staff of how to care for a resident. She stated that target behaviors should be addressed on the care plan. She stated that refusal of care should be addressed on a care plan.<br><br>Resident #167's care plan revealed it did not reflect the behavior of Resident #167 putting their soiled incontinence briefs in the drawers, refusing to be assisted with toileting, or the need for the resident's clothes to be kept in the laundry room.<br><br>During an interview on 11/01/2024 at 9:26 AM, the DON stated the care plan should be updated by the nurses and then reviewed by the MDS staff to make changes as needed. She stated that target behaviors and the reason for the behaviors should be included on the care plan.<br><br>During an interview on 11/01/2024 at 9:50 AM, the Administrator stated that behaviors should be included on the resident's care plan. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>45555<br><br>Based on observation, record review, interview, and facility policy review, the facility failed to transcribe and carry out treatment orders for 1 (Resident #42) of 21 sampled residents.<br><br>Findings included:<br><br>A facility policy titled, Medication and Treatment Orders, revised 07/2016, revealed no information on transcribing and carrying out written physician orders.<br><br>An Admission Record indicated the facility admitted Resident #42 on 05/14/2024. According to the Admission Record, the resident had a medical history that included diagnoses of encephalopathy (disorder of the brain) and non-traumatic intracerebral hemorrhage (brain bleed).<br><br>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required substantial to maximal assistance with lower body dressing and putting on/taking off footwear.<br><br>Resident #42's care plan, included a focus area revised 06/02/2024, that indicated the resident was at risk for pressure ulcer development and skin breakdown. Interventions directed staff to administer treatment as ordered and monitor for effectiveness and assess for any skin breakdown during activities of daily living (ADLs) and report to the physician/nurse any significant findings.<br><br>During an observation on 10/31/2024 at 8:54 AM, Resident #42's paper chart had a Physician's Orders form flagged (sticking out the top) in the paper chart. The Physician's Order form revealed handwritten podiatry orders dated 10/01/2024 to examine and apply triple antibiotic to the left big toe and cover with a bandage twice daily for 10 days and to call for any questions or problems.<br><br>Resident #42's New/Follow-up Visit Podiatry Visit note dated 10/01/2024 indicated the resident had a lytic (lifting from the nail bed) toenail on the left big toe that was removed, and treatment was for a triple antibiotic ointment and dry sterile dressing twice a day.<br><br>Resident #42's Order Recap [Recapitulation] Report, for the timeframe from 07/01/2024 through 10/30/2024, revealed no evidence that the podiatry treatment orders dated 10/01/2024 were transcribed and entered into the resident's electronic health record.<br><br>During an interview on 10/30/2024 at 2:03 PM, Licensed Vocational Nurse (LVN) #4 stated she did not know why the podiatrist's orders were not transcribed to the electronic health record and implemented.<br><br>During a follow-up interview on 10/30/2024 at 2:18 PM, LVN #4 stated that when the doctors wrote orders, they would flag the order in the chart and leave the chart on the nurse's desk so that it could be noted and transcribed. She stated she would then put the order in the medical records basket to be scanned; the medical records were supposed to be put back into the paper chart.<br><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 |
|---|---|---|---|
| | 555341 | A. Building<br>B. Wing | 11/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Canyon Creek Post-Acute | 22103 Redwood Road<br>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.

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/2024 at 9:59 AM, Registered Nurse (RN) #2 stated that when physicians visited, they would hand any new orders to the nurse. She stated she had not been at the facility when the podiatrist was there. She stated the podiatrist had contact with social services, and the podiatrist assistant would give the orders to the nurse. She stated she was not aware of the order for Resident #42 from the podiatrist, but she stated she was going to follow up with the podiatrist to ensure they were giving the orders to the nurse and not just leaving them in the chart. She stated they did not have a system in place to check paper charts.<br><br>During an interview on 11/01/2024 at 9:26 AM, the Director of Nursing (DON) stated the nurses and supervisors were to check the paper charts for orders, get clarification if needed, and carry out the orders that day. She stated the paper charts should be checked every shift. The DON stated Resident #42's orders should have been implemented.<br><br>During an interview on 11/01/2024 at 9:50 AM, the Administrator stated that when the physician came in, the process should be that the physician was communicating with the nurses that there was an order. He stated the nurse should double check to make sure there were no new orders. |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37935<br><br>Based on interview, observation, facility document review, and facility policy review, the facility failed to ensure residents' rooms measured at least 80 square (sq) feet (ft) per resident in 2 (room [ROOM NUMBER] and room [ROOM NUMBER]) of 35 resident rooms.<br><br>Findings included:<br><br>A facility policy titled, Bedrooms, revised 05/2017, indicated, All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. The policy revealed, 2. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms.<br><br>A Client Accommodations Analysis document dated 10/28/2024 revealed room [ROOM NUMBER] had a total floor area that measured 154 sq ft, and two beds occupied the room, which yielded 77 sq ft per resident. Further review revealed room [ROOM NUMBER] had a total floor area that measured 154 sq ft, and two beds occupied the room, which yielded 77 sq ft per resident.<br><br>During an observation on 10/30/2024 at 9:11 AM, the Maintenance Director measured room [ROOM NUMBER] and room [ROOM NUMBER] and confirmed the following dimensions: In room [ROOM NUMBER], the total floor area measured 154 sq ft, and two beds occupied the room, which yielded 77 sq ft per resident; In room [ROOM NUMBER], the total floor area measured 154 sq ft, and two beds occupied the room, which yielded 77 sq ft per resident. Residents' rooms had closets, nightstands, bedside tables, and some had wheelchairs in them, along with bathrooms. At no time were any of these items observed to be blocking doorways, closets, or bathroom doors. Residents were observed being able to move freely around their rooms, and rooms also had privacy curtains. Staff were observed during the measuring of the rooms going in and coming out of residents' rooms providing care to the residents. At no time was care of residents observed to be impeded by the size of the rooms.<br><br>During an interview on 10/30/2024 at 9:50 AM, Resident #15 stated they liked their room and had plenty of space and storage for their belongings. Resident #15 stated staff had no problem providing care due to the size of the room.<br><br>During an interview on 10/30/2024 at 9:53 AM, Resident #40 stated they had no concerns with the size of their room. Resident #40 stated they had room for their belongings and wheelchair. Resident #40 stated staff were able to provide proper care regardless of the size of the room.<br><br>During an interview on 10/30/2024 at 11:10 AM, Certified Nursing Assistant (CNA) #1 stated she had worked at the facility since 08/28/2024. She stated the size of room [ROOM NUMBER] did not prevent her from providing proper care to the resident.<br><br>During an interview on 10/30/2024 at 11:15 AM, Registered Nurse (RN) #2 stated she had worked at the facility for a year. She stated she had no problem with the size of room [ROOM NUMBER] and stated the size of the room did not prevent her from providing proper care.<br><br>(continued on next page) |

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| | 555341 | A. Building<br>B. Wing | 11/01/2024 |

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| Canyon Creek Post-Acute | 22103 Redwood Road<br>Castro Valley, CA 94546 |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | During an interview on 10/30/2024 at 11:24 AM, the Director of Nursing (DON) stated she was familiar with room size requirements. She stated that she expected rooms to meet minimum requirements. The DON stated room sizes were important for patient comfort and proper patient care.<br><br>During an interview on 10/30/2024 at 11:28 AM, the Administrator stated that it was important rooms met minimum size requirements for residents to have room to move around and for staff to be able to provide proper care. He stated that he expected rooms to at least meet minimum requirements.<br><br>During random observations of care and services from 10/28/24 through 11/1/24, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with resident care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/ or safety concerns in the two rooms. Granting of room size waiver recommended. |