

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Windsor Post-Acute Care Center of Hayward		STREET ADDRESS, CITY, STATE, ZIP CODE 25919 Gading Road Hayward, CA 94544	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>42766</p> <p>Based on observation, interview, and record review, the facility failed to maintain resident's privacy for one of three residents (Resident 1) when the privacy curtain was not fully drawn, exposing resident's body, brief (diaper), and legs during provision of care for activities of daily living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating).</p> <p>This deficient practice had the potential to result in public exposure of Resident 1's body during provision of care and cause emotional distress.</p> <p>Findings:</p> <p>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 3/21/24, indicated Resident 1 was totally dependent on the assistance of two staff for ADLs.</p> <p>During an observation on 6/6/24 at 11:15 am, Resident 1 was in an occupied 2-bed room with Resident 1's bed on the side of the room near the window. Certified Nursing Assistant (CAN) 1 was assisting Resident 1 with a bed bath and incontinent care. The curtain on the foot of the bed was not pulled and the curtain at the window was not fully drawn for complete enclosure. Resident 1 laid flat in bed with no clothing on while CNA 1 assisted Resident 1 with ADL care. On two occasions, a staff person was observed walking past the window rolling the laundry hamper.</p> <p>During an interview on 6/6/24 at around 12:25 pm with CNA 1, CNA 1 acknowledged the privacy curtains were not fully drawn when she was performing ADL care for Resident 1. CNA 1 stated they have in their policy to always maintain resident's visual privacy during ADL care.</p> <p>During an interview on 6/6/24 at 4 pm with Director of Nursing (DON), DON stated staff should always have the privacy curtains drawn and can close the door when they are changing residents or doing ADL care.</p> <p>A review of the facility's policy and procedure (P&P) titled SNFCLINIC Resident Rights, revised December 2021, indicated Policy .Employees shall treat all residents with .respect, and dignity .Federal and state laws .basic rights to all residents .include the resident's right to a dignified existence .</p> <p>(continued on next page)</p>

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, SNFCLINIC Resident Rights Guidelines for all Nursing Procedures, revised October 2010, indicated, . Close the room entrance door and provide for the resident's privacy .		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary services to maintain bathing, personal hygiene, turning & repositioning for one of three resident samples (Resident 1), when one staff instead of two staff provided care for activities of daily living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) for Resident 1.</p> <p>This failure caused undue pain and distress for Resident 1.</p> <p>Findings:</p> <p>A review of Resident 1's Admission record indicated Resident 1 was admitted with diagnoses that included diabetes, generalized muscle weakness, lack of coordination, hypertension, and depression.</p> <p>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 3/21/24, the MDS indicated Resident 1 was totally dependent on the assistance of two staff for ADLs, Helper does ALL the effort. Resident does none of the effort to complete the activities. Or the assistance of 2 or more helpers is required for the resident to complete the activity for performances such as toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, ., personal hygiene; roll left and right, .</p> <p>During an interview on 6/6/24 at 10:45 am with Resident 1, Resident 1 stated he was blind and only able to see slightly with the right eye. Resident 1 stated he could not move and can only move his legs a little. Resident stated it was always uncomfortable and painful when staff move and turn him in bed. Resident 1 stated it has always been one staff assisting him with turning.</p> <p>During an observation on 6/6/24 at 11:30 am in Resident 1's room, Certified Nursing Assistant (CNA) 1 assisted Resident 1 with a bed bath and incontinent care. CNA 1 urged Resident 1 to help with turning during the ADL care. Resident 1 informed CNA1 that he was unable to and never did help turn. CNA 1 attempted to place her hands on Resident 1 ' s left arm and shoulder to turn him, Resident 1 cried out in pain and asked CNA 1 to use the drawsheet under him instead. Then CNA 1 turned Resident 1 with the drawsheet, but Resident 1 still cried out in pain. The skin on Resident 1's buttocks area was red and had abrasions (scrapes). Resident 1 had wounds on his right leg and left foot, with dressings on them. Resident 1 was moved and turned by CNA 1 three times during the ADL care for Resident 1. After changing the bed sheet, placing a clean brief, and putting on a clean gown for Resident 1, CNA 1 then moved Resident 1 up in the bed with the draw sheet which was also uncomfortable and painful for Resident 1.</p> <p>During an interview on 6/6/24 at 12:15 pm with CNA 1, CNA 1 acknowledged Resident 1 is dependent and needed two people to change and turn him to ensure resident was comfortable and for safety.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/6/24 at 12:40 pm with Licensed Vocation Nurse (LVN) 1, Resident1's MDS, dated [DATE], was reviewed. LVN 1 stated two people were needed to change Resident and it was indicated in the MDS that Resident 1 is dependent and requires two or more helpers to complete the activity for turning/repositioning.</p> <p>During a concurrent interview and record review on 6/6/24 at 12:58 pm with LVN 1, Resident 1's Physician Orders, dated June 2024, were reviewed. The Physician Orders indicated Gabapentin (medication to treat nerve pain) for Resident 1. LVN 1 stated Resident 1 did not have PRN (as needed) pain medication ordered.</p> <p>During an interview on 6/6/24 at 3:30 pm with Director of Nursing (DON) and assistant DON (ADON), DON stated that they are supposed to have two staff to change and reposition dependent residents such as Resident 1. DON and ADON stated they gave all staff in-service yesterday.</p> <p>During a review of the weekly summaries dated 5/12, 5/19, 5/26, and 6/5/24, the weekly summaries indicated one person performed ADLs for Resident 1.</p> <p>During a review of the facility's policy and procedure (P&P) titled, SNFCLINIC Activities of Daily Living (ADLs) Supporting Personal Care, revised March 2018, indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with: Hygiene (bathing, dressing .). A resident's ability to perform ADLs will be measured using clinical tools, including the MDS .</p> <p>During a review of the P&P titled, SNFCLINIC Repositioning, Positioning and Moving, revised May 2013, the P&P indicated, Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs .resident level of participation and the number of staff required to complete the procedure .Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed.</p>		