STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Post-Acute Care Center of Hayward	25919 Gading Road Hayward, CA 94544

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 32717 Based on interview and record review, for one of one sampled resident (Resident 70) investigated for resident assessment, the facility failed to electronically transmit Minimum Data Set (MDS, an assessment tool used to direct resident care) Discharge assessment within the required 14 days. This failure had the potential to result in the lack of specific information for quality measure purposes. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated Resident 70 was admitted to the facility for idiopathic aseptic necrosis (A condition in which there is a loss of blood flow to bone tissue, which causes the bone to die) of right femur. During a concurrent joint interview and record review on 6/26/24 at 12:15 p.m. with Minimum Data Set Coordinator (MDSC) and Licensed Vocational Nurse (LVN) 1, MDSC stated Resident 70's discharge assessment, dated 2/6/24, was completed on 2/16/24 but was transmitted late on 6/24/24, well beyond the required 14 days after completion date. MDSC stated there was an error in their computer system where some MDS assessments were missed.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45875 Based on interview and record review, the facility failed to accurately complete the Preadmission Screening and Resident Review (PASRR) assessment for one (1) of two (2) sampled residents (Resident 35) when Resident 35's PASRR assessment did not indicate diagnoses of Schizophrenia (A mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), and Depression (mental condition where the affected feels negative emotions more strongly than ever). This failure placed Resident 35 at risk to not receive care and services appropriate to his needs. Findings: During a review of Resident 35's Admission Record, printed on 6/25/24, the Admission Record indicated Resident 35 had medical diagnoses of Schizophrenia and Depression. During a concurrent interview and record review, on 6/26/24, at 11:30 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 35's Preadmission Screening and Resident Review (PASRR) Level I Screening, submitted on 2/27/24 was reviewed. LVN 1 confirmed Resident 35's PASRR Question 10. Does the individual have serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizoaffective Disorder, or symptoms of psychosis, and /or mood Disturbance? was answered No. During a concurrent interview and record review, on 6/26/24, at 11:32 a.m., with LVN 1, Resident 35's Minimum Data Set (MDS, a resident assessment tool used to guide care), dated 4/3/24 was reviewed. The MDS indicated Resident 35 had medical diagnoses of Schizophrenia and Depression. The LVN 1 stated the facility was expected to code Yes to Question 10 on the PASRR Level I Assessment submitted on 2/27/24. LVN 1 also stated the documentation in the PASRR Level 1 assessment coding was incorrect and completing the PASRR Level I assessment accurately was important to identify if residents with mental disorder required Level II evaluation or not. LVN 1 stated if coded correctly, a Level II evaluation would be completed. LVN 1 also stated a Level 2 evaluation would help with providing any special accommodations or recommended services needed for Resident 35's care and well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on observation, interview and record review, for one of three (Resident 33) sampled residents investigated for limited range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point), the facility failed to ensure the comprehensive care plan that addressed Resident 33's limited range of motion was revised. This failure had the potential to result in the lack of coordination of care for Resident 33. Findings: During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 had diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) affecting the right dominant side, weakness, and cognitive communication deficit (person has difficulty communicating both verbal and non-verbal). During an observation on 6/24/24, at 10:36 a.m., Resident 33 was sitting at the edge of the bed, wearing a hospital gown that was coming off both shoulders. Resident 33, unable to move right hand, attempted to swing entire right arm to put the hospital gown back on both shoulders. Resident 33 did not have a splint or a rolled towel on the right hand. During another observation on 6/25/24, at 1:02 p.m., Resident 33 was up in a wheelchair sitting in front of the nurses' station. Resident 33 did not wear a splint or rolled hand towel. During a review of Resident 33's Minimum Data Assessment (MDS, an assessment tool used to direct resident care), dated 2/23/24, the MDS indicated Resident 33 had functional limitation in range of motion on one side of the upper and lower extremity. Resident 33's MDS, dated [DATE], also indicated functional limitation in range of motion on one side of upper and lower extremity. During a review of Resident 33's Order Summary Report, the Order Summary Report indicated a physician order, dated 9/13/23, for staff to Use rolled hand towels for right hand splint refusals, check placement every shift. During an observation and concurrent interview, on 6/26/24, at 9:45 a.m., with Registered Nurse (RN) 3, Resident 33 was observed in bed watching TV and did not wear rolled hand towel on the right hand. RN 3 stated not knowing how often and for how long the splint was placed by the Restorative Nursing Assistant (RNA). RN 3 also stated not knowing if Resident 33 was on an RNA program. During an interview on 6/26/24, at 10 a.m., with RNA, RNA stated Resident 33 refused any hand splint on the right hand. RNA also stated having tried using the rolled hand towels but Resident 33 only held the towel for a few seconds before quickly refusing to hold it. RNA stated Resident 33's refusals to use the rolled hand towels were documented manually in the clinical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review, on 6/26/24, at 10:22 a.m., with Assistant Director of Nursing (ADON), ADON stated not being aware of Resident 33's refusal of the hand splint/rolled hand towels until this morning. ADON stated Resident 33's limited range of motion care plan will now be revised. Resident 33's clinical record did not indicate any limited range of motion/RNA care plan. During a review of Resident 33's limited range of motion/RNA care plan created on 9/13/23, the care plan indicated a revision date of 6/26/24. The care plan indicated interventions; monitor resident pain and discomfort and administer pain medications as needed, and notify responsible party and physician of any changes. During a review of the facility's policy and procedure (P&P), titled Care Plan Goals and Objectives, last revised November 2012, the P&P indicated goals and/or objectives are reviewed and revised at least quarterly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 38534 Based on observation, interview and record review, the facility failed to ensure two of four sample selected residents (Resident 193 and Resident 43) received the necessary services to maintain good grooming, and personal hygiene, when Resident 193 and 43's shower schedules were not followed as scheduled. This deficient practice resulted in Resident 193 and 43 not receiving showers and were unhappy about their hygiene. Findings: A review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility with multiple diagnoses including Hemiplegia (paralysis of one side of the body). A review of Resident 193's Admission Record indicated Resident 193 was admitted to the facility with multiple diagnoses including C-Diff (a bacterium that can infect the bowel and cause diarrhea) and Osteomyelitis (bone infection). A review of Resident Shower and CNA lunch schedule, dated 3/5/24, indicated Resident 193 and 43 were supposed to have showers during the P.M. shift, Resident 43 every Monday and Thursday, and Resident 193 every Tuesday and Friday. A review of Resident 193 and 43's follow up question report indicated Resident 43 did not have a shower on 6/10/24, and Resident 193 did not have any showers since admission to the facility. A review of Resident 43's ADL's care plan indicated, . Bathing: Avoid scrubbing and pat dry sensitive skin . A review of Resident 193's ADL's care plan indicated, . provide shower as scheduled and as needed . During an interview, on 6/24/24, at 12:30 p.m., with Resident 43, Resident 43 stated he took a shower once a week and preferred to take more showers but staff refused to give him more showers. During an interview, on 6/24/24, at 11:22 p.m., with Resident 193, Resident 193 stated he had been in the facility for the last three weeks and has not had a shower. Resident 193 stated he was unhappy and had only one sponge bath. During an interview, on 6/25/24, at 10:10 a.m., in Resident 193's room, with the Certified Nurse Assistant (CNA) 1, CNA 1 confirmed and stated she did not give Resident 193 the sponge bath as scheduled on 6/23/24, and documented on the Activities of Daily Living (ADL) sheet by mistake. CNA 1 stated she did not give Resident 193 a shower because he was on isolation and contact precaution. CNA 1 further stated giving sponge baths every day is important for the residents because they need to assess the resident's skin, and ensure the residents are clean for infection prevention. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 6/27/24, at 12:10 p.m., with the Director of Nursing (DON), the DON stated she was unable to find any shower sheets that indicated if Resident 43 refused showers or had a shower on 6/10/24. The DON stated they did not have any documents that indicated why Resident 43 missed a shower on 6/10/24. A review of the facility's policy and procedure (P&P) titled, Bath, Bed, revised March 2021, indicated, .The purposes of this procedure are to promote cleanliness, provide comfort and to observe the condition of the resident's skin . Notify the supervisor if the resident refuses the bed bath . A review of the facility's P&P titled, Activities of Daily Living (ADL's) Supporting revised March 2018, indicated, .1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADL's) do not diminish .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 32717 Based on observation, interview and record review, for one of four (Resident 33) sampled residents reviewed for activities of daily living care (ADL care), the facility failed to ensure Resident 33 received proper treatment and care to maintain good foot health when podiatry (branch of medicine devoted to the study, diagnosis, and treatment of disorders of the foot, ankle and lower limb) services were not provided. This failure had the potential to result in foot pain and loss of toenails for Resident 33. Findings: During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 had diagnoses of type 2 diabetes mellitus (long-term [chronic] disease in which the body cannot regulate the amount of sugar in the blood) and cognitive communication deficit (person has difficulty communicating both verbal and non-verbal). During an observation, on 6/24/24, at 10:36 a.m., Resident 33 had thickened, curly and yellowish gray toenails on both feet. During a review of Resident 33's Order Summary Report, dated 6/25/24, the Order Summary Report indicated a physician's order dated 3/20/23 for the podiatry service for treatment of hypertrophic (also called onychauxis, a nail disorder that causes toenails to grow abnormally thick, over time, the nails become curled and turn white or yellow, increasing the risk for developing a fungal infection. This thickening of the nail may force the nail plate [the part you paint with nail polish] to separate from the nail bed) toenails and other foot problems every 61 days as needed. During an observation and concurrent joint interview, on 6/25/24, at 10:16 a.m., with Licensed Vocational Nurse (LVN) 2, with Registered Nurse (RN) 1 present, LVN 2 stated body/skin assessments were done weekly and it indicated the status of the skin including the toenails. LVN 2 stated Resident 33's toenails were very thick and discolored (yellowish gray), with the left pinky toenails (little toe or baby toe, the outermost toe in our foot) absent, and right pinky toenail only covered one fourth of the nailbed (layer of cells under the toenail). LVN 2 stated Resident 33 needed podiatry service. Resident 33's skin on both feet very dry and scaly. During an observation and concurrent interview, on 6/25/24, at 10:25 a.m., with Assistant Director of Nursing (DON), ADON stated Resident 33's toenails were too thick for the staff to clip and needed podiatry services. During an interview, on 6/25/24, at 10:34 a.m., with Social Services Director (SSD), SSD stated residents have not had podiatry services since October 2023. SSD stated the podiatrist (foot doctor) re-scheduled visits multiple times until finally cutting down hours. SSD stated not knowing how to go about the shortage in podiatrists to provide the services. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Foot Care, last revised October 2022, the P&P indicated, Residents are assisted in making appointments and with transportation to and from specialists (podiatrist, endocrinologist, etc) as needed .Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals. Foot disorder that require treatment include .nail disorders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48616 Based on observation, interview, and record review, the facility failed to ensure effective storage of non-controlled medications when medications for disposal were not securely stored and rendered irretrievable. This failure had the potential for misuse of the medications. Findings: During an observation on 6/26/24, at 9:30 a.m., Licensed Vocational Nurse (LVN) 2 dispensed, crushed and placed four medications in separate 30 milliliters (ml) transparent plastic cup for a resident. However, LVN 2 was unable to administer and held these medications. During a concurrent observation and interview, on 6/26/24, at 9:40 a.m., with LVN 2, in room [ROOM NUMBER], LVN 2 discarded held medications in the trash bin attached to the right external side of the medication cart. Medication cart trash bin was left open. LVN 2 stated, non-controlled medications can be discarded in a regular trash bin or flushed in the toilet. During a concurrent observation and interview, on 6/26/24, at 10:45 a.m., with Director of Nursing (DON), in Station 2B hallway, DON showed stacks of 30 ml transparent plastic cups with wet and crushed white particles. DON stated, she retrieved the medications that was discarded by LVN 2 from the medication cart trash bin. DON further stated these medications should not be in that trash bin. During an interview, on 6/26/24, at 3:10 p.m., with DON, DON stated when the nurses were unable to administer and held medications, the nurse was to cover, label and give the medications to the DON or the Assistant Director of Nursing (ADON). The DON stated the DON/ADON disposed the medications in the medication collection receptacles located in their office. DON further stated medications not properly disposed can be easily accessed by anybody and could lead to an accidental ingestion of the medication. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated November 2022, Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste .non-controlled substances may be disposed of in the collection receptacle.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45875 Based on observation, interview, and facility document review, the facility failed to store, prepare, and distribute food in a safe and sanitary manner when: 1. Corn was rinsed in the handwashing sink, during food preparation, 2. Meat was thawed in still water, 3. There was no air gap (a gap of air between the floor and a drainpipe to prevent backflow of sewage into the equipment) for the 3-part compartment sink, 4. Hand Hygiene protocol was not followed during food preparation, and 5. Hand Hygiene protocol was not followed during tray line. These failures had the potential to cause food borne illnesses for 81 residents who received food from the kitchen for a facility census of 88. Findings: 1. During an observation in the kitchen, on 6/25/24, at 9:15 a.m., [NAME] 1 washed corn in the sink labeled and used for handwashing. During an interview, on 6/26/24, at 2:22 p.m., with Registered Dietician (RD) 2, RD 2 stated food should not be rinsed in the handwashing sink because it can cause bacterial or chemical cross contamination. During an interview on 6/27/24, at 9:10 a.m., with [NAME] 1, [NAME] 1 stated she should not have washed corn in the sink for handwashing sink. 2. During a concurrent observation and interview, in the kitchen, on 6/25/24, at 9:05 a.m., with Dietary Manager (DM), two meat bags thawed in still water in the sink. DM stated meat should be thawed under cold running water. During an interview, on 6/25/24, at 10:00 a.m., with RD 2, RD 2 stated if meat was thawed in water, it should be under running water to flush away any loose particles. 3. During a concurrent observation and interview, in the kitchen, on 6/27/24, at 9:10 a.m., with Maintenance Director (MD), the drainpipe from the 2-part compartment sinks currently used as food preparation sink connected directly into the floor and there was no air gap (a gap of air between the floor and a drainpipe) for the 2- part compartment sink. MD confirmed the sink water is pumped directly into the wastewater system/sewer. MD stated air gap is needed so there is no back flow into the sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 Federal Food Code, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. 4. During a concurrent observation and interview, in the kitchen, on 6/25/24, at 10:05 a.m., [NAME] 1 cut meat with gloved hands. [NAME] 1 without changing gloves, retrieved aluminum foil from the counter past the cooking stove. [NAME] 1 then touched the food processor, opened the processor, and transferred the meat into the cooking vessel. [NAME] 1 used the same gloved hand and covered the food with aluminum foil. [NAME] 1 then opened the oven without changing gloves and placed the cooking vessel inside the oven. [NAME] 1 then continued working on the meat. RD 2 stated is was not acceptable to use the same gloves used to cut meat to get other items and touch other kitchen surfaces and equipment. RD 2 stated it can cause cross contamination. RD 2 stated when something was on the gloves, it can be transferred to other items. 5. During an observation in the kitchen, on 6/25/24, at 12:15 p.m., [NAME] 1 served food in tray line. [NAME] 1 wore gloves and retrieved the soup ladle from above the food prep table. [NAME] 1 did not change gloves or performing hand hygiene. [NAME] 1 used the same gloved hands to break dinner rolls transferred one dinner roll each to Resident 239's and Resident 238's plates. During an observation in the kitchen, on 6/25/24, at 12:40 p.m., the lunch tray was served to Resident 239 and Resident 238 with the same dinner rolls in the dining room. During an interview on 6/26/24, at 12:24 p.m., with RD 2, RD 2 stated dinner rolls should be handled with tongs. RD 2 stated if food was handled improperly, it should be discarded. RD 2 also stated there was a risk of cross contamination and cross contact with bacteria and allergens. According to the 2022 Federal Food Code, food except when washing fruits and vegetables as, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable Utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipments. During a review of the facility's undated Policy and Procedure (P&P) titled, Food Preparation and Service, the P&P indicated, .3. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness .Thawing Frozen Food: 1. Foods are not thawed at room temperature . Appropriate thawing procedures include: .completely submerging the item in cold running water (70 degrees F or below) that is running fast enough to agitate and remove loose ice particles .