STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555809	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All Saint's Subacute & Transitional Care	1652 Mono Avenue San Leandro, CA 94578

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure necessary treatment and care services in accordance with professional standards of practice, comprehensive assessment, and care plan for three of 23 sampled residents (Residents 6, 45 and 58) when:Facility did not provide proper oral care for Resident 45 and 58Facility did not provide timely incontinent care for Resident 6These failures had the potential for Resident 45 and Resident 58 to suffer from oral infections, discomfort and an increased risk for pneumonia, and for Resident 6 to not received the necessary care and services to maintain skin integrity. 1.During a record review of Resident 45’s “admission Record” (AR), printed on 8/20/25, the “AR” indicated Resident 45 was admitted to the facility on [DATE] with diagnoses of diffuse traumatic brain injury (widespread damage occurs to the brain, often resulting in prolonged loss of consciousness and potential long-term disability), dependence on ventilator status (a type of breathing apparatus that provides mechanical ventilation to a patient who is physically unable to breathe), and gastrostomy status (state of having a surgically created opening in the stomach for the purpose of feeding). During a record review of Resident 58’s “AR”, printed on 8/20/25, the ‘AR” indicated Resident 58 was admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing) following cerebral infraction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain), dependence on ventilator status, and gastrostomy status. During an interview and record review on 8/20/25 at 11:30 a.m., with Minimum Data Set Coordinator (MDSC), Residents 45's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized carte plan) dated 6/21/25 and Resident 58's MDS assessment dated [DATE] were reviewed. The MDSC stated Residents 45 and 58 were totally dependent on the staff for oral hygiene. During an observation on 8/18/25 at 9:34 a.m., Resident 45 was lying in bed with eyes closed and mouth open. Dried, light, tan-colored matter was noted on Resident 45’s lips and brown-colored, dry matter at the corners of the mouth. When Resident 45 was smacking their lips, sticky, creamy matter was observed between the lips and inside the mouth. During an observation on 8/18/25 at 9:40 a.m., Resident 58 was lying in bed with eyes open and non-verbal. Resident 58’s upper lip was dry and coated with off white, thick, peeling layer of skin. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/19/25 at 8:17 a.m., with Licensed Vocational Nurse (LVN) 1, in Resident 45 and 58’s shared room, LVN 1 stated Resident 58’s mouth was dry, peeling and needed oral care. LVN 1 stated both Resident 45 and 58 tended to bite their lips and teeth to cause bleeding, and maybe the brown dry matter around Resident 58’s mouth was dried blood. LVN 1 further stated the night shift Respirator Therapist (RT) should have performed oral care for Residents 45 and 58 during the night shift. During an interview on 8/20/25 at 9:01 a.m., with Director of Nursing (DON), the DON stated poor oral care could lead to bacteria growth in the mouth, cause tooth decay, and increase risk for aspiration pneumonia (when food, liquid, saliva, or vomit accidentally goes down into the lungs instead of the stomach and cause an infection in the lungs). During a concurrent interview and record review on 8/20/25 10:34 a.m., with RT Manager (RTM), reviewed Resident 45 and 58’s oral care performed by RT records, printed on 8/20/25. The records indicated Resident 45 and 58’s oral care was performed by RT on 8/17/25 at 02:21 a.m. and 8/17/25 at 02:22 a. m. RTM stated that RT staff were supposed to perform oral care with Chlorohexidine solutions (a special liquid often used in medical setting to clean the skin, mouth or medical equipment to prevent infection by killing germs) every shift and as needed for each resident. RTM stated it usually took a day or two to build up thicken, creamy matter in their mouths. RTM stated poor oral care could cause oral odors, dental problems and make residents feel unwell. Review of facility’s policy (P&P) titled “Oral Care for the Residents with Special Needs” released July 2025, indicated “The facility will provide oral care to residents with special needs every shift and as needed”. 2.During a review of Resident 6's Annual-Minimum Data Set (MDS, Resident Assessment and care guide tool), dated 7/23/25, the MDS indicated Resident 6 was comatose (a state of coma meaning in a deep, prolonged and unarousable state of unconsciousness, unresponsive to stimuli). MDS indicated Resident 6 used external urinary condom catheter (is a urine collection device fits like a condom over penis). MDS indicated Resident 6 was always incontinent of bowel. MDS indicated Resident 6 was dependent for toileting hygiene, care givers do all the effort to complete the activity, or the assistance of two or more helpers is required to complete activity. MDS indicated Resident 6's diagnoses included Traumatic Brain Injury (Brain dysfunction caused by an outside force, usually a violent blow to the head). During a telephone interview on 8/20/25 at 8:59 a.m. with Family Member (FM 1), FM1 stated she visited Resident 6 on 8/14/25 in the morning around 10:00 a.m. and found Resident 6 laid on a draw sheet saturated with dry urine up to his shoulders and upper body. FM1 stated nursing staff did not reposition and changed Resident 6's soiled linen. FM 1 stated she reported incident to the facility staff. During a concurrent observation and interview 8/20/25 at 9:20 a.m. with Licensed Vocational Nurse (LVN 5) in Resident 6's room, Resident 6 laid in bed unconscious with tracheostomy (a surgical procedure that creates an opening in the neck to help the patient breathe) and on ventilator (breathing machine). LVN 5 stated Resident 6 used a condom catheter and was cleaned, repositioned and provided incontinent care. LVN 5 stated Resident 6 condom catheter was changed every shift and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 8/20/25 at 3:41 p.m. with Certified Nursing Assistant (CNA 4), CNA 4 stated he was assigned to care for Resident 6 on 8/14/25 night shift ending 7:30 am. CNA 4 stated Resident 6's condom catheter sometimes came off and it took time for licensed nurse to replace condom catheter. CNA 4 stated he provided Resident 6 incontinent care and repositioned Resident 6 every two hours. CNA 4 stated he did not observe Resident 6's draw sheet with urine stained. During a concurrent observation and interview on 8/20/25 at 9:02 a.m. with CNA 5, Resident 6 laid in bed. CNA 5 stated she was assigned to care for Resident 6 on 8/14/25 morning shift start time 7a.m. CNA 5 stated she checked on Resident 6 at around 8a.m. CNA 5 stated Resident 6 was clean and reposition. CNA 5 stated she does walk rounds with night shift CNA to check residents and make sure residents were cleaned and repositioned. CNA 5 stated she returned to Resident 6 around 10 a.m. for care because she has other residents to attend and was busy. CNA 5 said she did not see that Resident 6's draw sheet was stained with urine. During an interview on 8/20/25 at 10:18 a.m. with Director of Staff Development (DSD), DSD stated he was informed that Resident 6's FM1 complained that Resident 6's draw sheet was saturated with urine stain and not changed overnight. DSD stated CNA 5 was interviewed and stated Resident 6's condom catheter was loose and may be leaking. DSD stated he was shown a picture of Resident 6 wet bed with saturated urine-stained draw sheet underneath Resident 6. DSD stated he followed up with night shift nurse CNA 4 and reminded CNA 4 and CNA 5 to check, clean and reposition Resident 6 every two hours and stress the importance of checking residents' incontinence episodes. During an interview on 8/21/25 at 11:21 a.m. with Administrator (Admin), Admin stated facility was aware of a complaint on 8/14/25 that Resident 6 laid on a draw sheet that was saturated and stained with urine and had started investigation. During a concurrent interview and record review on 8/22/25 at 10:15 a.m. with Director of Nursing (DON), Resident 6's bladder and bowel continence records, safety checks every 2 hours including positioning and assistance in bowel and bladder records were reviewed. The safety checks every 2 hours records indicated on 8/14/25, Resident 6 was checked at 12:06 a.m. and next check was at 6:44 a.m. DON stated her expectation was for nursing staff to follow the safety protocol, and check residents every 2 hours for positioning, incontinence care so residents are comfortable, clean and prevent wounds. During a review of the facility's policy and procedure (P&P) titled, Repositioning, dated 2001, the P&P indicated, Residents who are in bed should be on at least an every-two-hour (q2hour) repositioning schedule. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting dated 2001, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.