

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER All Saint's Subacute & Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interviews and record reviews, the facility failed to ensure the implementation of hydration monitoring for one of three sampled residents (Resident 1), when Resident 1's intake (I, fluid consumed) and (&) output (O, fluid excreted) monitoring during the PM shift (7:00 p.m. to 7:00 a.m.) was not maintained and the total 24-hour I&O (it is the clinical window used to evaluate fluid balance and it sums all fluid consumed against all fluid excreted over the preceding 24 hours to track trends and detect dehydration [loss of fluid] or fluid overload [too much fluid in the body]) was not calculated on 6/15/26, to evaluate Resident 1's overall fluid balance and hydration status. This deficient practice placed Resident 1 at risk for delayed identification of changes in fluid balance, including dehydration or fluid overload, and delayed implementation of appropriate interventions. During a record review of Resident 1's admission Record (AR), dated 6/23/26, AR indicated Resident 1 was originally admitted to the facility in March 2015, with diagnoses including traumatic brain injury (TBI, a disruption in normal brain function caused by an outside physical force), post traumatic seizures (abnormal electrical disturbances in the brain caused by a TBI), gastrostomy status (a surgical opening into the stomach (G-tube) used for long-term nutritional support) and persistent vegetative state (a severe neurological condition where an individual has completely lost cognitive function and awareness of their environment, yet retains basic, involuntary autonomic functions like breathing, heartbeat, and regular sleep-wake cycles). During a record review of Resident 1's Care Plan (CP), the CP for dehydration (occurs when your body loses more fluid than it takes in) initiated on 4/7/25, indicated Resident 1 was at risk for dehydration or electrolyte imbalance (occurs when minerals in your body like sodium, potassium, or calcium become too high or too low) related to enteral nutrition (delivers liquid formulas containing essential nutrients directly into the stomach or small intestine). Additionally, Resident 1's CP for indwelling catheter (often called a Foley catheter, is a flexible tube inserted through the urethra into the bladder to continuously drain urine) initiated on 9/22/16, indicated Resident 1 had an indwelling catheter related to neurogenic bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Both CPs indicated monitoring for Resident 1's intake and output in accordance with the facility protocol as an intervention. During a record review of Resident 1's Order Summary Report (ORS) dated 6/23/26, the ORS indicated Resident 1 had a physician order dated 4/28/26, to monitor I&O each shift, calculate the total 24-hour I&O every night shift by combining the total I&O from the previous AM shift (7:00 a.m. to 7:00 p.m.) and PM shift, and to report any significant changes in Resident 1's fluid balance to the physician. During a record review of Resident 1's Medication Administration Record (MAR) dated from 6/1/26 through 6/30/26, the MAR did not reflect Resident 1's I&O monitoring for PM shift and the calculated total 24-hour I&O for 6/15/26, as ordered by the physician. During a concurrent interview and record review on 6/23/26 at 11:25 a.m., with the Director of Nursing (DON), Resident 1's MAR dated 6/1/26 through 6/30/26 was reviewed. DON confirmed Resident 1's MAR did not reflect the PM shift I&O monitoring and the 24-hour total I&O on 6/15/26 was not implemented and recorded. DON stated the licensed nurse should have provided and documented the I&O monitoring to determine Resident 1's hydration status because monitoring and documenting total I&O were necessary to identify potential dehydration or fluid imbalance. During a record review of the facility's undated policy (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555809 If continuation sheet Page 1 of 7

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and procedures (P&P), titled, Intake, Measuring and Recording, the P&P indicated The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period.Preparation.1. Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy.Steps in Procedure.8. Record the amount noted on the intake side of the I&O record.9. Record the time the intake was measured.Documentation.3. The amount of liquid consumed.During a record review of the facility's undated P&P, titled, Output, Measuring and Recording, the P&P indicated The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period. Preparation.1. Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy.Steps in the Procedure.8. Record the amount noted on the output side of the I&O record .Documentation.4. The amount and character of output.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to provide care and services in accordance with professional standards of practice for two of five sampled residents (Resident 1 and Resident 2) for tracheostomy (a surgical procedure that creates an opening through the front of the neck directly into the trachea [windpipe]) care when: 1. Resident 1 did not have a physician order for tracheostomy suctioning (a sterile procedure that uses a flexible catheter inserted through the tracheostomy to mechanically clear excess mucus or secretions from the trachea [a critical tube that connects voice box to lungs]) as indicated in Resident 1's care plan, and the facility did not have time-specific documentation demonstrating when the tracheostomy suctioning was provided to Resident 1. 2. Resident 2's manual resuscitator bag (also known as bag-valve-mask, is a hand-held device used in emergencies to provide manual, positive pressure ventilation to patients who are not breathing adequately) maintained at the bedside for emergency respiratory use, was stored unlabeled and without a protective covering on top of the portable oxygen cylinder (provide compressed medical-grade gas for respiratory support), with the attached tubing in contact with the floor. These failures had the potential to result in failure to provide timely tracheostomy suctioning, inability to verify that necessary respiratory care was provided, increased risk tracheostomy related complications, including airway obstruction and trachea in the lungs bleeding (most frequently a complication caused by localized irritation, suctioning trauma, or life-threatening erosion into a major nearby blood vessel), and increased risk of infection associated with inadequate tracheostomy care and the improper storage and potential contamination of emergency respiratory equipment. 1. During a record review of Resident 1's admission Record (AR), dated 6/23/26, AR indicated Resident 1 was originally admitted to the facility in March 2015 with diagnoses including traumatic brain injury (TBI, a disruption in normal brain function caused by an outside physical force), persistent vegetative state (a severe neurological condition where an individual has completely lost cognitive function and awareness of their environment, yet retains basic, involuntary autonomic functions like breathing, heartbeat, and regular sleep-wake cycles) and tracheostomy. During a record review of Resident 1's Care Plan for tracheostomy, initiated on 10/18/25, indicated Resident 1 required a tracheostomy and was at risk for complications related to tracheal bleeding. The Care Plan furthermore indicated an intervention to suction Resident 1's tracheostomy for airway clearance as per physician order and as needed for emergency care. During a record review of Resident 1's Order Summary Report (ORS) ' dated 6/23/26, the ORS did not include an order for tracheostomy suctioning. During a record review of Resident 1's Respiratory Therapy (RT) Airway Assessment (RTAA), dated from 6/1/26 through 6/16/26, RTAA indicated that tracheostomy suctioning was provided every two hours and as needed. However, the RTAA did not include time-specific documentation that identified and verified when each routine and as needed suctioning intervention was performed. During a phone interview on 6/22/26 at 3:46 p.m., with Registered Nurse (RN) 1, RN 1 stated she was assigned to provide respiratory care to Resident 1 on 6/16/26. RN 1 stated she documented the tracheostomy suctioning that she provided in the RT's notes; however, the RT notes did not include the time-specific documentation identifying when each suction intervention was performed. During a concurrent record review and interview on 6/23/26 at 11:43 a.m., with the Respiratory Therapist Manager (RTM), Resident 1's tracheostomy 's Care Plan and the facility's undated policy and procedure (P&P)'s Suctioning were reviewed. Despite the facility's P&P required verification of a physician's order before performing suctioning, RTM stated tracheostomy suctioning was considered part of the facility's standard practice and was understood to be performed for residents with tracheostomies regardless of whether a physician's order existed. RTM stated it was more important to obtain a physician's order directing staff not to perform tracheostomy suctioning than to obtain an order authorizing suctioning for residents who required it. RTM stated that RTs and/or RNs determined when to perform suctioning based on endorsement (shift hand-off or verbal report from one staff member to another) rather than a (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled time. RTM stated he assumed RTs and/or RNs were providing tracheostomy suctioning because that was what they had been instructed to do. RTM stated he did not believe documenting the time suctioning was performed was necessary as long as RTs and/or RNs were providing respiratory care. RTM stated he verified that suctioning was being provided to residents with tracheostomies by communicating with RTs and/or RNs verbally and through resident care reports. RTM stated he was unsure why Resident 1 did not have a physician's order for tracheostomy suctioning while other residents did. RTM further stated he did not know why Resident 1's Care Plan directed suctioning to be performed as ordered by the physician. RTM stated Resident 1's Care Plan should have been followed because it reflected the physician's orders. RTM stated if the suctioning care plan was not followed, Resident 1 was at risk of infection. During an interview on 6/23/26 at 12:23 p.m., with the Infection Preventionist (IP), IP stated that suctioning tracheostomies required a physician's order because the procedure was considered invasive. IP stated if suctioning was required every two hours, staff were expected to follow the schedule strictly and document the time it was performed, because without documentation the facility would not have known whether Resident 1 was being suctioned in a timely manner. IP further stated if suctioning was not performed timely according to the physician's order and the care plan, Resident 1 was at risk for infection because secretions could have accumulated and grown bacteria in the mouth, tracheostomy, and lungs. IP stated Resident 1 also could have experienced respiratory arrest (when breathing stops) if suctioning was not performed as ordered. During a phone interview on 6/23/26 at 1:36 p.m., with RT 1, RT 1 stated tracheostomy suctioning should be performed as clinically indicated and should not be delayed when necessary. RT 1 furthermore stated excessive tracheostomy suctioning may increase the risk of tracheal bleeding. During a record review of the facility's undated P&P, titled, Suctioning, the P&P indicated Pre-procedure assessment.1. Verify provider order and patient identity. Assess and document. a. breath sounds b. Respiratory effort and rate c. SpO2 (saturation of peripheral oxygen, is an estimate of the percentage of hemoglobin in your red blood cells that are carrying oxygen) level. e. Amount, color, consistency of secretions. 9. Documentation Requirements. Indication for suctioning. Type of suction. Description of secretions. any complications and interventions. 2. During a record review of Resident 2's AR dated 6/23/26, AR indicated Resident 2 was admitted in May 2026 with diagnoses including respiratory failure, tracheostomy status, ventilator (a medical machine that mechanically moves breathable air into and out of the lungs to deliver oxygen and remove carbon dioxide) dependence and pneumonia (an infection that inflames the air sacs in one or both lungs). During an observation on 6/22/26 at 2:10 p.m., with Resident 2, Resident 2 was sleeping in bed while connected to the ventilator. Resident 2's emergency respiratory supplies maintained at bedside did not include a manual resuscitator bag. An unlabeled manual resuscitator bag was observed immediately outside the shared room's bathroom door, stored without a protective covering on top of a portable oxygen cylinder, with the attached tubing in contact with the floor. During an interview on 6/22/26 at 2:14 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the manual resuscitator bag belonged to Resident 2. LVN 1 stated it should not have been next to the bathroom door and should have been kept inside Resident 2's emergency supplies. LVN 1 stated the manual resuscitator bag had already been exposed to dirt and should have been replaced. LVN 1 further stated the manual resuscitator bag should have been stored in a protective bag to prevent risk of infection. During an interview on 6/22/26 at 4:08 p.m., with the Respiratory Therapist Manager (RTM), RTM stated, Resident 2 routinely likes to bring and use the manual resuscitator bag when goes to the bathroom. RTM stated the same manual resuscitator bag remained designated for emergency use if Resident 2 experienced respiratory distress (serious medical emergency where the body struggles to get enough oxygen). RTM stated the manual resuscitator bag should have been stored properly in a protective bag to prevent risk of contamination and infection and should have been readily accessible for Resident 2 in case of respiratory emergency. During a record review of the facility's undated P&P, titled, Departmental (Respiratory Therapy) -Prevention of Infection, the P&P indicated The purpose of (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this procedure is to guide prevention of infection associated with respiratory tasks and equipment, including ventilators, among residents and staff. Transport respiratory therapy equipment to designated soiled utility area for decontamination. keep oxygen cannula and tubing used as needed in a plastic bag when not in use.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, the facility failed to ensure accurate and complete clinical documentation for one of three sampled residents (Resident 1), when the licensed nurse documented that medications were administered to Resident 1 on 6/16/26 at 5:00 a.m., the medications administration were not documented on Resident 1's Medication Administration Record (MAR- It is the official clinical record log that nurses and caregivers use to document what prescribed medication a patient receives, the dosage, the time it was administered, and the route).This deficient practice resulted in Resident 1's inaccurate and incomplete clinical record, which could affect Resident 1's ongoing clinical assessment, treatment decisions, and continuity of care.During a record review of Resident 1's admission Record (AR), dated 6/23/26, AR indicated Resident 1 was originally admitted to the facility in March 2015, with diagnoses including traumatic brain injury (TBI, a disruption in normal brain function caused by an outside physical force), post traumatic seizures (abnormal electrical disturbances in the brain caused by a TBI), gastrostomy status (a surgical opening into the stomach used for long-term nutritional support) and persistent vegetative state (a severe neurological condition where an individual has completely lost cognitive function and awareness of their environment, yet retains basic, involuntary autonomic functions like breathing, heartbeat, and regular sleep-wake cycles).During a record review of Resident 1's Progress Notes dated 6/16/26, the Progress Notes documented by the PM shift (7:00 p.m.- 7:00 a.m.) licensed nurse indicated Medications administration at 0500 (5:00 a.m.) per orders.During a phone interview on 6/22/26 at 3:46 p.m., with Registered Nurse (RN) 1, RN 1 stated she was assigned to Resident 1's respiratory care on 6/16/26. RN 1 stated another licensed nurse was assigned to administer Resident 1's medications. RN 1 furthermore stated the licensed nurse had confirmed and reported to RN 1 that Resident 1's medications were administered at 5:00 a.m.During a concurrent interview and record review on 6/23/26 at 11:25 a.m., with the Director of Nursing (DON), Resident 1's MAR dated 6/1/26 through 6/30/26 and the Progress Note dated 6/16/26, were reviewed. DON confirmed that Resident 1's MAR did not reflect the medications administered on 6/16/26 at 5:00 a.m., DON stated there were two possible medications administered by the licensed nurse: valproic acid (an anti-seizure medication) and propranolol (a medication for high blood pressure). DON stated these medications were scheduled for administration at 6:00 a.m., and the licensed nurse was permitted to administer medications up to one hour before the scheduled time. DON stated they were unsure why the licensed nurse did not document the medications administered to Resident 1. DON stated the medications given should have been documented on the MAR. DON further stated that this practice could have negatively impacted adherence to the five rights of medication administration, including verifying the right patient, the right medication, the right route, the right dose, and the right time, which compromised Resident 1's safety.During a record review of the facility's undated P&P, titled, Administering Medications, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame.21. As required of indicated for a medication, the individual administering the medication records in the resident's medical record.a. the date and time the medication was administered.b. the dosage.c. the route of administration.g. the signature and title of the person administering the drug.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff adhered to its infection control policies for one of three sampled residents (Resident 3) when housekeeper (HK 1) entered and cleaned Resident 3's room without wearing the required isolation gown (protective barrier to prevent the transfer of germs between patients and staff) while Resident 3 was on contact isolation precautions (safety measure to wear gloves and gown when in contact with an infected resident, surfaces or equipment) for MRSA (methicillin-resistant staphylococcus aureus, bacteria that does not respond to antibiotics) associated wounds to the left foot and left leg, increasing the risk of cross-contamination and transmission of healthcare-associated infections. This failure exposed residents and staff to potential cross-contamination and increased risk of transmission of infectious organisms. Findings: During a review of Resident 3's admission Record, indicated Resident 3 was admitted in the facility on 11/18/24, with diagnoses of Tracheostomy (a surgically created hole in the neck that leads directly into the windpipe, usually holding a tube open to breathe). During a review of Resident 3's doctor's order dated 3/20/25, under Order Summary Report indicated Resident 3 was on contact precautions related to MRSA related to wound on the left foot and leg. During an observation on 6/22/26 at 1:48 p.m., a Contact Precautions signage was posted on the outside of Resident 3's room door. Resident 3 was in the room, in her bed, her bed was right next to the door. The HK 1 was inside Resident 3's room, wearing a pair of gloves and using a moist towel to wipe an unoccupied bed which was located near the window in that room, without wearing an isolation gown. HK 1 walked past Resident 3's privacy curtain and bed multiple times, to get in and out of the room to get cleaning supplies, continued wiping the unoccupied bed, climbed up a ladder with gloved hands, removed used privacy curtains, stepped out of the room to discard used towels. During an interview on 6/22/26 at 2:02 p.m., with HK 1, HK 1 stated when cleaning surfaces in a Contact Precautions room, they were required to wear a gown and gloves. HK 1 stated they should use this applies even when the bed is unoccupied because germs can get on their clothes and may be spread to other residents. During an interview on 6/23/26 at 12:12 p.m., with the Infection Preventionist (IP), IP stated housekeepers were required to wear an isolation gown and gloves when cleaning the surfaces/environment in a room where residents' were on Contact Precautions, even when not every bed in the room was occupied, because the whole environment in the room was considered contaminated (something has been made dirty or unsafe because something harmful has been added to it) and microorganisms (germs, tiny living things that are too small to be seen with the naked eye) could remain on surfaces for days, creating a risk of spreading them to other residents causing fever or cough. The IP stated since Resident 3 had tracheostomy and a wound on her leg, it placed Resident 3 at higher risk for acquiring further infections if staff did not follow infection control practices. During a review of the facility's Policy and Procedure (P&P) titled, Contact Precautions, dated 2001, the P&P indicated, Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.		