

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

Printed: 10/09/2026
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 07/03/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed, for Residents 3, 4, 6 and 7, to ensure the scheduled (controlled medication, narcotic) medication record system was complete (all documents available) and accurate (numbers match). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration), and destruction logs. The facility did not have complete records. The facility did not have accurate records. These failures resulted in the potential for undetected loss and diversion. In addition, these failures resulted in the potential for avoidable medication errors. Findings: During an interview, on 8/18/25 at 9:50 a.m., the Medical Record Director (MRD) was requested to describe the scheduled medication accountability process. MRD's description included pharmacy Shipping Manifests were kept for 3-5 years and scheduled drug records were kept for 7-10 years. She stated the above records were kept onsite. She was asked to provide the pharmacy Shipping Manifests from 9/1/2022 - 12/31/22. During an interview, on 8/18/25 at 10:10 a.m., the Director of Nursing (DON) was requested to describe the scheduled medication accountability process. DON's description included the pharmacy delivered scheduled medication with a Shipping Manifest and a CDR. The receiving nurse confirmed the prescription details and signed the Shipping Manifest. The manifest was filed in medical records. The prescription was placed in the medication cart, and the CDR was filed in the cart's binder. She stated that when a scheduled medication was discontinued, and there were doses remaining, the medication and CDR were given to DON. DON and pharmacist destroyed the medication. DON and the pharmacist documented the destruction. During a concurrent interview and record review, on 8/18/25 at 12:35 p.m., the MRD identified pharmacy Shipping Manifests for prescriptions:-4329204 Resident 1 9/22/22 Hydrococone (narcotic pain reliever) /APAP (acetaminophen, pain reliever) 5/325 mg (milligram) tablet-4540388 Resident 2 9/30/22 Hydrococone/APAP 10/325 mg tablet-4470131 Resident 3 10/11/22 Oxycodone (narcotic pain reliever) 5 mg tablet-4701798 Resident 3 11/7/22 Oxycodone 5 mg tablet-4717751 Resident 4 11/10/22 Hydrocodone/APAP 10/325 mg tablet-4650367 Resident 5 10/26/22 Hydrococone/APAP 5/325 mg tablet-4846631 Resident 6 12/13/22 Hydrococone/APAP 5/325 mg tablet-4876197 Resident 8 12/20/22 Hydrococone/APAP 5/325 mg tablet She was requested to provide the CDRs for the identified prescriptions. During an observation, on 8/19/25 at 9:10 a.m., on TCU (nursing unit), medications were observed being administered using medication cart 1. During a concurrent interview and record review, on 8/20/25 at 1:15 p.m., MRD identified pharmacy Shipping Manifests for 4470131.01 Resident 3, 4717751 Resident 4, and 4846631 Resident 6. MRD stated that the corresponding CDRs could not be located. During an interview, on 8/20/25 at 2:20 p.m., the DON was requested to provide the Consultant Pharmacist reports from 6/2022-6/2023. During a concurrent (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
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview and record review on 8/21/25 at 11:15 a.m., DON identified CDR 4821618.01 for Resident 7. DON was requested to compare the Oxycodone 5 mg tablet removed and the MAR. DON identified that the CDR documented doses were removed on 1/11/23 1300, 1/25/23 1430, 1/31/23 1632, 2/1/23 1600 and 2/4/24 0238. The doses identified were not documented in Resident 7's MAR. Continuing the interview, DON was aware the facility was unable to provide the CDRs for 4470131.01 Resident 3 Oxycodone 5 mg #10, 4717751 Resident 4 Hydrocodone/APAP 10/325 #16 and 4846631 Resident 6 Hydrocodone/APAP 5/325 #30. Continuing the interview, DON identified the Executive Quarterly Summary of Consultant Pharmacist's Medication Regimen Review (6/22-6/23). She reviewed the documents and stated there was no documentation of scheduled medication accountability problems. During an administrative record review, of the facilities Policy and Procedure for Ordering and Receiving Controlled Medications showed, Procedures, 1. The director of nursing and the consultant pharmacist monitors for compliance with federal and state laws and regulations in the handling of controlled medications. 3. The pharmacy or the nursing care center prepares an individual resident controlled substance record/receipt/log for each controlled substance medication prescribed for a resident. During an administrative record review, of the Facilities Executive Quarterly Summary of Consultant Pharmacist's Medication Regimen Review (6/22-6/23) did not show documentation of scheduled medication accountability problems.		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a state- licensed Nursing Home Administrator was overseeing facility operations when the unlicensed Operations Manager (OM) had assumed the role of administrator for more than 11 months. This failure resulted in residents, staff and facility operations being supervised and directed by unqualified administrative leadership for more than 11 months. During a record review of state nursing home administrator licensing database titled, Licensing and Certification License Verification Page, the database indicated OM did not have a nursing home administrator license. During a review of state nursing home database titled, ELMS, the database indicated ADM 2 was the reported administrator of the facility from 11/4/2020 to 3/13/2023. Administrator 3 (ADM 3) was listed as the administrator from 3/14/2023 to 5/10/2024. OM was not listed as a former administrator of the facility. During a record review of two facility financial self-report to the state agency both titled, Long Term Care Facility Integrated Disclosure and Medi-Cal Cost Report, one report dated 12/31/2021 and the second report dated 12/31/2022, the report dated 12/31/2021 indicated OM was reported as the facility administrator from 12/15/21-12/31/2021 and ADM 2 was the facility administrator until 12/14/21. The report dated 12/31/2022 indicated OM was reported as the facility administrator from 1/1/22 to 11/2/22, and ADM 3 started as the facility administrator on 11/3/22. During a record review of facility resident council form titled, Department Responses to Issues, dated 10/1/22, the form indicated OM had signed as the Administrator. During a record review of facility grievance form titled, Concern Form (Front), dated 3/24/22, Resident 9 had a grievance about the facility environment. The form indicated a meeting regarding the grievance was attended by: [OM] (Administrator), [director of nursing] (DON), [social services director] (SSD) and [maintenance manager]. ADM 2 was not listed as the attendees. During a record review of facility grievance form titled, Concern Form (Front), dated 4/26/22, Resident 10, had a concern about contractors entering their room without announcement. The form indicated OM was the administrator assigned to investigate Resident 10's grievance. The form indicated a meeting was attended by OM with OM listed as (Administrator). During a record review of a facility contract titled [Contractor] Inpatient Services Agreement, dated 9/22/22, the contract indicated OM had signed the contract on 9/22/22 as the administrator. During a concurrent interview and record review on 7/3/26, at 11:00 a.m., with the Director of Nursing (DON), a facility document titled, [Facility], dated 7/3/26, was reviewed. The document indicated OM was the facility administrator from [DATE] - [DATE]. DON stated OM was the facility's administrator from [DATE] - [DATE] and ADM 3 was the next administrator. During a review of state health and safety code titled, California Code, Health and Safety Code 1416.6, the code indicated it shall be a misdemeanor for any person to act or serve in the capacity of a nursing home administrator, unless he or she is the holder of an active nursing home administrator's license. A person who is acting as an administrator shall notify the program in writing within five days of acting in this capacity and provide factual information and specific circumstances necessitating the use of an acting administrator. No person shall act as an administrator for more than 10 days unless arrangements have been made for part-time supervision of his or her activities by a nursing home administrator who holds a license or provisional license under this chapter. Supervision shall include at least 8 hours per week of direct onsite supervision by the licensed administrator. The program shall be notified in writing of the nature of this arrangement. No person shall act as an administrator for more than two months without the written approval of the program. During a review of state regulation titled, Title 22, Chapter 3. Skilled Nursing Facilities, (continued on next page)		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	72007 Administrator, the regulation defined an administrator as a person licensed as a nursing home administrator by the California Board of Examiners of Nursing Home Administrators.		