

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER All Saint's Maubert		STREET ADDRESS, CITY, STATE, ZIP CODE 15731 Maubert 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to have a director of nursing for more than 5 months. This failure placed all residents at risk of substandard nursing care due to absence of leadership, oversight and accountability. During an interview on 8/18/25, at 10:08 a.m., with a different Facility's Director of Nursing (FDON), FDON stated they were not the facility's designated director of nursing and had assisted in collaboration with the Assistant Director of Nursing (ADON) with duties which needed a registered nurse. During a concurrent interview and record review on 8/19/25, at 10:01 a.m., with Human Resources, FDON's acceptance letter to another facility, untitled, dated 4/4/25, was reviewed. HR stated the letter indicated FDON was hired as the director of nursing at another facility. HR stated FDON was hired full time at another facility. HR stated there was no plan to hire a director of nursing for the facility and to have the ADON assigned as the director of nursing. During an internet search of the facility careers page performed on 8/19/25, at 10:30 a.m., the search indicated the facility did not have a job posting for a director of nursing. During an interview on 8/19/25, at 11:40 a.m., with Administrator (ADM), the ADM stated the facility did not have a director of nursing. The ADM stated they had been attempting to hire a director of nursing but was unable to find a suitable candidate. During an interview on 8/22/25, at 11:25 a.m., with the FDON, the FDON stated they did not have oversight or responsibility over the licensed nurses at the facility. FDON stated they were hired as the full time director of nursing at a different facility. During a review of a facility document handwritten by the ADM, untitled, undated, the document was a list of director of nursing coverage from the 9/3/23 to 8/22/25. The document indicated the facility did not have a director of nursing starting from 3/15/2025.		

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 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. Based on observation, staff interview, and record review, the facility failed to store food in accordance with professional standards for safety when food items were stored less than six inches above the floor. These failures had the potential for contamination of food resulting in food borne illness for the 10 residents who lived at the facility. During an observation 8/18/25, at 3:09 p.m., central supply was observed with tube feeding formulas stored less than six inches above the floor. During an interview on 8/21/25, at 10:39 a.m., with Registered Dietician (RD), RD stated food stored less than six inches above the floor was a risk for contamination from pests, could have altered the food temperature and had the potential to cause resident sickness. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated 2001, the P&P indicated, Food in designated dry storage areas are kept at least six (6) inches off the floor.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement comprehensive care plans for three sampled residents (Resident 2, Resident 15, Resident 16) when: Resident 2, 15, and 16's care plans did not address the use of psychotropic medications such as lorazepam (antianxiety) and sertraline (antidepressant), Modafinil (stimulant) for behavioral manifestations. Psychotropic medications are drugs used to treat mental illness. These deficient practices had the potential to result in the residents not receiving appropriate care, monitoring, and treatment. During a review of Resident 2's order summary dated 8/3/25, the order summary indicated the physician prescribed bupropion 100 mg Give 1 tablet via NG-Tube one time a day for depression manifested by (m/b) feeling sad; buspirone 10 mg Give 1 tablet via NG-Tube two times a day for anxiety m/b inability to relax; A review of Resident 2's order summary dated 8/12/25 indicated the physician prescribed lorazepam 1 mg Give 1 tablet via NG-Tube every 8 hours as needed for anxiety m/b restlessness, inability to relax. During a review of Resident 15's order summary dated 8/7/25, the order summary indicated the physician prescribed mirtazapine 7.5 mg Give 1 tablet via PEG-Tube at bedtime for depression m/b feelings of hopelessness; sertraline 50 mg Give 1 tablet via PEG-Tube for depression m/b persistent sadness in response to prognosis; lorazepam 0.5 mg Give 1 tablet via PEG-tube every 12 hours as needed for anxiety m/b inability to relax. During a review of Resident 16's order summary dated 8/16/25, the order summary indicated the physician prescribed modafinil (drug used to treat sleep disorders) 100 mg Give 1 tablet via PEG-tube one time a day for sleep cycle. During a review of Resident 2, 15, and 16's care plans and concurrent interview on 8/21/25 at around 12 p.m. the Assistant Director of Nursing (ADON) searched the electronic health records for the care plans to address the use of psychotropic medications and behavior manifestations for these residents. ADON stated they did not have care plans to address the residents' target behaviors, and she would update them now. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, undated, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three residents (Resident 2, Resident 15, Resident 16) of three sampled residents were free of unnecessary drugs, when they were receiving psychotropic medications without being monitored for their target behaviors. These failures had the potential for residents to receive unnecessary medications and suffer adverse medication side effects. Definitions: Lorazepam - an anti-anxiety medication to reduce tension or anxiety. Its adverse consequences include increased risk of confusion sedation, and falls Bupropion is an antidepressant medication for depression. Its adverse consequences include agitation or anxiety, trouble sleeping, and suicidal thoughts Buspirone - an anti-anxiety medication for short-term relief of anxiety symptoms. Its adverse consequences include nervousness or restlessness, and trouble sleeping or nightmares. Modafinil - is a stimulant drug that promotes alertness, wakefulness, and cognitive function. Its adverse consequences include anxiety and nervousness, confusion, depression, and suicidal thoughts. NG (Naso gastric) tube - a thin, flexible tube inserted through the nose and into the stomach. It is used for various medical purposes such as feeding. PEG (percutaneous endoscopic gastrostomy) tube - a feeding tube placed directly into the stomach through the abdominal wall. 1. During a review of Resident 2's admission record, the admission record indicated Resident 2 was admitted on [DATE] and her diagnoses included anxiety disorder and post-traumatic stress disorder, and depression. During a review of the physician orders dated 8/12/25, the physician orders indicated Resident 2 was prescribed Lorazepam 1 mg one tablet every 8 hours as needed for anxiety m/b restlessness, inability to relax A review of the Medication Administration Record (MAR) for August 2025 indicated Resident 2 was administered Lorazepam one tablet via NG-Tube for anxiety. Further review indicated there was no monitoring of the target behavior. During a review of the physician orders dated 8/3/25, the physician order indicated Resident 2 was prescribed Bupropion 100 mg one tablet via NG-Tube one time a day for depression manifested by feeling sad. A review of the Medication Administration Record (MAR) for August 2025 indicated Resident 2 was administered Bupropion one tablet via NG-Tube for depression. Further review indicated there was no monitoring of the target behavior. During a review of the physician orders dated 8/3/25, the physician orders indicated Resident 2 was prescribed Buspirone 10 mg one tablet via NG- tube two times a day for anxiety manifested by inability to relax A review of the Medication Administration Record (MAR) for August 2025 indicated Resident 2 was being administered Buspirone one tablet via NG-Tube anxiety manifested by inability to relax. Further review indicated there was no monitoring of the target behavior. During a concurrent interview and record review on 8/21/25 at 10:45 a.m. with Assistant Director of Nursing (ADON), the Medication Regimen Review (MRR) dated 7/25/25, indicated behavior monitoring and side effect monitoring was recommended by the consultant pharmacist. Resident 2's physician orders and MAR and the care plans were reviewed, ADON stated they have orders for side effects monitoring for Resident 2 and they were monitoring that, but they did not add the orders for behavior monitoring and behaviors were not being monitored and documented. She stated they missed it. ADON stated Resident 2 was still getting the Lorazepam and it would end on 8/27/25. She stated monitoring was important just to make sure Resident 15 was still not experiencing that behavior. 2. During a review of Resident 15's admission record, the admission record indicated Resident 15 was admitted on [DATE] and originally admitted on [DATE] and her diagnoses included mental disorder, not otherwise specified. During a review of the physician orders dated 8/7/25, the physician orders indicated Resident 15 was prescribed Lorazepam 0.5 mg one tablet via PEG- tube every 12 hours as needed for anxiety m/b inability to relax. A review of the MAR for August 2025 indicated Resident 15 was administered Lorazepam one tablet via PEG-Tube for anxiety. Further review indicated there was no monitoring of the target behavior. During a concurrent interview and record review on 8/21/25 at 10:57 a.m. ADON, the Medication Regimen Review (MRR) dated 8/1/25 and 8/13/25 indicated (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior monitoring and side effect monitoring was recommended by the consultant pharmacist. Resident 15's physician orders and MAR and the care plans were reviewed, ADON stated they have orders for side effects monitoring for Resident 15 and they were monitoring that, but they did not add the orders for behavior monitoring and target behaviors were not being monitored and documented. She stated they missed it. ADON stated Resident was getting the PRN Lorazepam as she still needed it. ADON stated monitoring behavior was important to make sure Resident 15 was not feeling anxious and then they would stop the medication or if they got worse they would be increasing the medication. ADON stated the first order for the Lorazepam for Resident 15 was supposed to end today, but there was a new order pending the medical doctor (MD)'s signature. 3. During a review of the physician orders dated 8/16/25, the physician orders indicated Resident 16 was prescribed Modafinil 100mg one tablet via PEG- tube one time a day for sleep cycle.A review of the MAR for August 2025 indicated Resident 16 was being administered Modafinil one tablet via PEG-Tube for sleep cycle. Further review indicated there was no monitoring of the target behavior.During a concurrent interview and record review on 8//21/25 at 11:59 a.m. with ADON, the Medication Regimen Review (MRR) dated 7/25/25 indicated behavior monitoring and side effect monitoring was recommended by the consultant pharmacist. Resident 16's physician orders and MAR and the care plans were reviewed, ADON stated they have orders for side effects monitoring for Resident 16 and they were monitoring that, but they did not add the orders for behavior monitoring and behaviors were not being monitored and documented. ADON stated the medication was for sleep cycle for Resident 16. She stated monitoring behavior was important to see if the medication was effective, and if Resident was restless during the day or the opposite, not sleeping, keeping awake. ADON confirmed there was no behavior monitoring for the three residents in their physician orders and MARs. ADON stated there were also no care plans for the target behaviors for Residents 2, 15, and 16 and she would update them now. During an interview on 8/22/25 at 2:26 p.m. with ADON, ADON stated it was important to monitor to see if the residents were still manifesting those behaviors, as they might not need the medication anymore and then they might take them off.During a review of the facility's policy and procedure (P&P) titled Behavioral Assessment, Intervention, and Monitoring, undated, the P&P indicated, .The facility complies with regulatory requirements related to the use of psychotropic medications.The nursing staff identify, document, and inform the physician about specific details regarding changes in an individual's.behavior.including.behavioral symptoms.Circumstances that warrant a behavioral assessment of a resident include: a resident admitted to the facility on psychotropic medication that was started without a clear, documented indication.;new or worsening change in status or condition; an irregularity identified in the medication regiment review.monitoring of efficacy.plans (if applicable) for gradual dose reduction.The IDT monitors for and documents any new, worsening, or improved symptoms in the resident's behavior.interventions are adjusted based on the impact on behavior and other symptoms.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication error rate of less than five percent when four errors were observed in 33 medication pass opportunities for four out of five sampled residents (Resident 9, Resident 10, Resident 17) resulting in 12.12% medication error rate. The errors were: Three residents were not identified using the required minimum of two resident identifiers prior to administering medications to each of them. For Resident 9, no physician or pharmacy clarification was done for a medication, fludrocortisone acetate tablet (a medication that increases blood volume and blood pressure) that had a Hold parameter on the bubble pack and had no parameters on the physician order for Resident 9. These failures had the potential to compromise patient safety and medication accuracy which could result in adverse effects to the residents. During a med pass observation on 8/19/25, between 8:15 a.m. and 10:24 a.m., Licensed Vocational Nurse (LVN) 1 did not utilize the required minimum of two resident identifiers when administering medications to three residents (Resident 10, Resident 16, Resident 17). During an interview on 8/19/25 at 4:27 p.m., with LVN 1, LVN 1 acknowledged that she did not verify the identity of the residents. She stated she knows the residents, but she needed to check their ID (identification) band and photo. During an interview with LVN 1 on 8/20/25 at 3:10 p.m. LVN 1 stated verifying the identity of residents prior to administering medications is important as it is part of the five rights to make sure she gives medications to the right patient. During a review of the facility's policy and procedure (P&P), titled Administering Medications, dated April 2019, the P&P indicated, .The individual administering the medication verifies the resident's identity before giving the resident his/her medications. Methods of identifying the residents include checking identification band; checking photograph attached to medical record; and if necessary, verifying resident identification with other facility personnel. During an observation on 8/19/25 at around 9:48 a.m. LVN 1 prepared four medications that included Fludrocortisone 0.1mg tablet for Resident 9 and gave each medication (med) to him separately via his PEG tube. The label on the bubble pack for Fludrocortisone indicated, Fludrocortisone Acetate Oral Tablet 0.1 mg Give 1 tablet via PEG-Tube twice daily for blood pressure management - Hold for blood pressure (BP) less than 100 and Heart Rate (HR) less than 55. During Medication Reconciliation [the process of comparing a patient's medication pass observations with the medical doctor (MD)'s orders (given incorrectly/omitted? MD's specifications for use such as timing, hold parameters for BP etc., manufacturer's specifications regarding preparation/administration, and accepted professional standards of practice] on 8/19/25 at 4:53 p.m. record it in the computer, but she wrote it down on paper. She stated she did not hold fludrocortisone acetate per the direction on the bubble pack to hold for BP less than 100 and HR less than 55 as the doctor's orders did not give any parameters. When asked, LVN 1 stated fludrocortisone acetate was for BP management as indicated on the order, but not sure if it was specifically for hypotension or hypertension for Resident 9. A review of the order summary report for active medications for August 2025 indicated, Fludrocortisone Acetate oral tablet 0.1 mg Give 1 tablet via PEG tube two times a day for blood pressure management, order date 6/10/25. During a telephone interview and record review on 8/20/25 at 10:55 a.m. with PharMerica Pharmacist (PP), PP stated the medication typically is ordered for low blood pressure. PP stated fludrocortisone acetate for Resident 9 was ordered for BP management and she believed it was for low pressure, and the parameters to hold for BP less than 100 and HR less than 55 did not make sense. She stated the original order had parameters and she did not see any note clarification from the doctor, and it should have been clarified with the doctor. During an interview on 8/20/25 at 3:03 p.m. LVN 1 stated the physician order for fludrocortisone acetate for Resident 9 initially had the BP and HR parameters, but the MD removed the parameters. She stated however, the bubble pack still had parameters. LVN 1 stated she should have clarified with the MD and put a sticker on the bubble pack. She stated that the direction not matching the order might cause confusion for the nurses and they might hold the medication. During concurrent interview and record (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review on 8/21/25 at 12:13 p.m. with the Assistant Director of Nursing (ADON), ADON stated the fludrocortisone acetate was ordered for low blood pressure for Resident 9 and the nurse should have notified the pharmacy to update the label on the bubble pack. ADON further stated they have a sticker they should have placed on the bubble pack instructions to indicate no parameters on the current order. When asked, ADON stated the medications were held for about four days on different times in July 2025. At 12:40 p.m. when asked, ADON stated she could not find any care plan for fludrocortisone acetate in Resident 9's chart. She stated the care plan was important, to know if the medication was working for the patient and what their goals and interventions were. During a concurrent interview and record review on 8/22/25 at 2:20 p.m. with ADON, ADON stated the MAR for Resident 9's fludrocortisone acetate with days with chart codes of 4 (Vital signs outside of parameter) or 5 (Hold/See nurse notes) were days that the medication was held. A review of the MAR dated July 2025 indicated, 7/1/25 (9 a.m. and 8 p.m.), 7/2/25 (9 a.m. and 8 p.m.); 7/5/25 (8p.m), 7/6/25 (8pm), 7/7/25 (9.m.), 7/8/25 (9 a.m.). During a review of the facility's policy and procedure (P&P), titled Medication Administration General Guidelines, undated, the P&P indicated, .Prior to administration, the medication and dosage schedule on the resident's MAR (Medication Administration Record) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions,.Apply a direction change sticker to label if directions have changed from the current label.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to adequately monitor and document the necessity of a physical restraint for one out of one resident (Resident 16), when staff did not monitor and document their specific reason for the restraint as ordered by their doctor for four days. This failure had the potential to result in isolation, depression and the unnecessary restraint of Residents 16. During a review of Resident 16's admission Record, printed 8/20/25, the record indicated Resident 16 was admitted to the facility in August 2025 with a diagnosis of Tracheostomy Status (an incision in the windpipe made to relieve an obstruction to breathing). During an observation on 8/18/25, at 12:35 p.m. Resident 16 was observed lying in bed with a soft wrist restraint (a medical device that limits a patient's arm movement by securing their wrist to the frame of the bed) on their left hand. During a concurrent interview and record review on 8/19/25, at 4:32 p.m., with Assistant Director of Nursing (ADON), Resident 16's Doctors' Orders, dated 8/16/25, Progress Notes, dated 8/16/25 to 8/19/25, and Medication Administration Record, dated 8/16/25 to 8/19/25 were reviewed. ADON stated Resident 16's reason for a left wrist restraint was their history of pulling out their tracheostomy tube (a tube inserted into a tracheostomy to help with breathing). A review of Resident 16's doctor's order, dated 8/16/25, indicated May apply soft wrist restraint on the left hand as clinically indicated to prevent the resident from pulling out medical tubes and devices ordered to ensure safety and to help achieve optimum health outcome. ADON stated Resident 16 did not have monitoring of pulling out medical tubes documented in their medication administration record or progress notes. During an interview on 8/21/25, at 1:51 p.m., with ADON, ADON stated ongoing monitoring of Resident 16 for pulling out their medical tube was important to make sure their restraint was necessary. ADON stated unnecessary restraints can lead to depression and isolation. During a review of Resident 16's Medication Administration Record, dated 8/16/25 through 8/19/25, the Record indicated, resident 16 had the left wrist restraint applied on 8/16/25 through 8/19/25. During a review of the facility's policy and procedure (P&P) titled, Use of Restraint, revised April 21, 2022, the P&P indicated, When the use of restraints is indicated. the ongoing re-evaluation for the need for restraints will be documented.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR - mental health assessment tool) for one of one sampled resident (Resident 8) was completed and coded accurately. This failure placed Resident 8 at risk to not receiving care and services appropriate to his needs. During a review of Resident 8's admission Record undated, the admission record indicated Resident 8 was admitted on [DATE] and has diagnosis of paranoid schizophrenia, a severe mental disorder characterized by hallucinations (sensory experiences like hearing voices) and delusions (fixed false beliefs), particularly involve persecution or being threatened. During a concurrent interview and record review on 8/22/25 at 9:10 a.m. with Minimum Data Set (MDS) Resource (R) stated Resident 8's PASRR Level I screening result indicated Resident 8 had a positive PASRR I and required a PASRR II evaluation. His PASRR Level II letter from Department of Health Care Services (DHCS) indicated, . Unable to Complete Level II Evaluation for Serious Mental Illness (SMI). MDSR stated the PASRR II was not completed because Resident 8 was discharged from another facility and transferred here. She stated they needed to resubmit another one. During an interview on 8/22/25 at 9:10 a.m. with MDS Coordinator (MDSC), MDSC stated upon Resident's admission, the admission department and the business office coordinate the PASRR and were supposed to send it to her for the MDS assessment, but she did not get one for Resident 8. She stated she would follow up with the admission to see if they initiated one. During an interview and record review on 8/22/25 at around 2:42 p.m. with Assistant Director of Nursing (ADON), ADON stated Resident 8 came from another nursing facility and the PASRR II was not completed. She stated they needed to reschedule another one for Resident 8 here, but it was not done. ADON stated PASRR II screening was important as they needed to evaluate to see if Resident still needed to be medicated so that he would not experience any behavioral issues or to harm himself or others. During a review of the facility's policy and procedure (P&P) titled, PASRR (Pre-admission Screening & Resident Review), undated, the P&P indicated, to ensure each patient in the facility is screened for a mental disorder or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 6) received good grooming when Resident 6 had long thick nails and facial hair. The failure placed Resident 6 at risk for having skin irritations and infections, and compromising his physical health, and not preserving his dignity. During a review of Resident 6's undated admission record, the admission record indicated Resident 6 was readmitted on [DATE] and originally admitted on [DATE] with multiple diagnoses that included anoxic brain damage (condition where the brain is deprived of oxygen for a prolonged period, leading to damage or death of brain cells), dependent on a respirator and tracheostomy (a surgically created hole in the windpipe that provides alternative airway for breathing. During a review of Resident 6's Minimum Data Set (MDS- an assessment tool to guide care) dated 8/8/25, the MDS for activities of daily living (ADL) indicated Resident 6 was dependent on staff (Helper does ALL the effort or required the assistance of two or more helpers) for hygiene. During an observation on 8/19/25 at 2:25 p.m. and concurrent interview with Certified Nursing Assistant (CNA) 1, CNA 1 confirmed Resident 6's toenails needed trimming. She stated she was new and her first time working with Resident 6. During an interview on 8/20/25 at 3:14 p.m. with Licensed Vocational Nurse (LVN) 1 stated the nurses cut the nails for non- diabetic residents, and diabetic residents are referred to the podiatrist. She stated the podiatrist would now come in to see Resident 6. LVN 1 stated nail care is important to prevent the resident from having fungus and self-inflicting germs or bacteria that might live in the nails. During an interview on 8/20/25 at 4:52 p.m. with LVN 1, LVN 1 stated Resident 6 was not diabetic. She stated she did not know Resident 6's toenails were long and how long they had been like that. During an observation on 8/21/25 at 3 p.m. there were no CNAs on the floor. Per the Respiratory Therapist Nurse (RTN), the CNAs were in the other building having an in-service. During a concurrent observation and interview on 8/21/25 at 3:10 p.m. with LVN 2, Resident 6 was lying in bed, open eyes and awake. Resident 6 with gray facial hair above his lips and below the nose, around the cheeks and chin, unshaven and appeared unkempt. LVN 2 confirmed Resident 6 needed shaving and did not look good. She stated the CNA was supposed to shave the patient. LVN 2 stated she had come into the room to take care of Resident 6 but had not noticed Resident 6's facial hair as she would have assigned it to the CNA. LVN 2 stated some residents like to have mustache. When asked if they had asked Resident 9's Responsible Party (RP) for Resident's preference, LVN 2 stated she would check. During an interview on 8/21/25 at 4:29 p.m. with Assistant Director of Nursing (ADON), ADON stated that it was not okay for Resident 6's nails to be long. Upon reviewing Resident 6's chart, ADON stated Resident 6 was not diabetic, but his toenails were mycotic and needed referral to the podiatrist. ADON also acknowledged the facial hair on Resident 6 and stated the expectation was for their CNAs to groom the patients. During a concurrent interview and record review on 8/22/25 at 9:33 a.m. with Social Services Director (SSD), SSD stated she sends referrals to the podiatrist within 24 - 48 hrs. when she is notified by nursing. SSD stated they might not have told her Resident 6 needed the podiatrist. She stated the podiatrist had just told her they wanted to see Resident 6 and he was not on the list before. SSD stated Resident 6 had just been added to the list on 8/19/25 and the podiatrist sent her an email on 8/20/25 with the list. During a review of the facility's policy and procedure titled, Assistance with Activities of Daily Living (ADLs) for Dependent Residents, undated, the P&P indicated, .Staff will provide ADL care for dependent residents as follows: Bathing & hygiene. Dressing & Grooming. A review of the facility's P&P titled, Grooming, undated, indicated, It is the policy of the facility to ensure that all residents receive assistance with personal hygiene and grooming in accordance with individual need and preferences. Residents will be maintained in a clean, comfortable, and dignified manner at all times. Daily Grooming Care. Beards/mustaches groomed per resident preference. Nails trimmed and cleaned regularly, considering medical needs. A review of the facility's P&P titled, Foot Care, dated (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555879	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER All Saint's Maubert		STREET ADDRESS, CITY, STATE, ZIP CODE 15731 Maubert 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 2023, indicated, Residents are provided with foot care and treatment in accordance with professional standards of practice. Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals.		