STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555914	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
We Care Skilled Nursing Facility	21863 Vallejo Street Hayward, CA 94541

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36593 Based on interview, record review, and facility policy review, the facility failed to ensure one (Resident 1) of three sampled residents was free from unnecessary drugs when facility's interdisciplinary team (IDT) did not re-evaluate use of Seroquel (an antipsychotic medication) at the time of admission and/ or within two weeks for its appropriateness and indication for use to consider whether or not the medication could be reduced, tapered, or discontinued. Interdisciplinary team is a group of healthcare professionals who work together to treat a patient condition. This failure had the potential for Resident 1 to receive unnecessary medications and placed her at risk to suffer adverse effects from the medication. Findings: During a review of Resident 1's Admission Record (AR), dated 12/23/24, the AR indicated, Resident 1 was admitted from acute care hospital on 8/22/24. During a review of Resident 1's Admission-Minimum Data Set (MDS- Resident Assessment and care guide tool) dated 8/26/24, the MDS indicated Resident 1 had no potential indicators of psychosis e.g., hallucinations (perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). MDS indicated Resident 1 had no physical or verbal behavioral symptoms directed towards others e.g., verbal/vocal symptoms like screaming or disruptive sounds, hitting, kicking, pushing, scratching, or grabbing at others. MDS indicated Resident 1's diagnosis included chronic obstructive pulmonary disease with acute exacerbation (COPD-a worsening group of lung diseases that block airflow and make it difficult to breathe). During a review of Resident 1's Order Summary Report dated 8/22/24, indicated the physician prescribed Resident 1 Seroquel oral tablet 25 mg give one tablet by mouth at bedtime for mood disorder manifested by yelling and hitting for 14 days. Further review of Resident 1's Order Summary Reports dated 9/3/24 and 9/18/24, indicated physician continued prescribing Resident 1 Seroquel oral tablet 25 mg, to give one tablet by mouth at bedtime for mood disorder manifested by yelling and screaming. During a review of Resident 1's Medication Administration Record (MAR), dated 8/23/24 to 8/31/24 and 9/1/24 to 9/18/24, the MARs indicated Resident 1 was administered Seroquel 25 mg give one tablet by mouth at bedtime for yelling, hitting and screaming. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555914	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/23/24 at 11:17 a.m. with Certified Nursing Assistant (CNA) 1, CNA1 stated CNA1 cared for Resident 1 four days a week. CNA1 stated Resident 1 had behavior of calling out for help from time to time. CNA1 stated when Resident 1 was asked what she needed, Resident 1 said nothing. During an interview on 12/27/24 at 11:29 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 was prescribed Seroquel from Resident 1 stay at the hospital. LVN 1 stated Resident 1 had COPD, was on oxygen therapy. LVN 1 stated Resident 1 had anxiety behavior when she had problem with breathing and inability to relax; she would call out for help. During an interview on 12/27/24 at 11:37 a.m. Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 1 was nice and cooperative. LVN 2 stated Resident 1 sometimes had anxiety and called out for help. During a review of Resident 1's Consultant Pharmacist's Medication Regimen Review (MRR), dated 8/27/24, the MRR indicated, Resident 1 had an order for Seroquel 25 mg at bedtime for 14 days. If the drug is to be continued beyond its initial 14-day period, you may wish to ask if the dose could be reduced to 12.5 mg at bedtime . mood disorder is not a usual diagnosis for an antipsychotic, If continued beyond 14 days please clarify diagnosis . During a concurrent interview and record review on 12/31/24 at 10:16 a.m. with the Director of Nursing (DON), Resident 1's progress notes, care plan use of antipsychotic, MRR dated 8/27/24 and facility's policy and procedure (P&P) titled, Antipsychotic Medication Use were reviewed. The DON stated facility did not reevaluate Resident 1's use of Seroquel medication at the time of admission or within two weeks of her admission to the facility, to consider reduction or discontinuation. The DON stated she was unable to find documentation if facility followed up on pharmacist's recommendations made on 8/27/24. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, revised July 2022, the P&P indicated, Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will re-evaluate the use of the antipsychotic medication at the time of admission and / or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, discontinued.