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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056298	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
We Care Skilled Nursing - Fremont	2100 Parkside Drive Fremont, CA 94536

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview, record review and observation, facility failed to be comply with Federal, State, and Local Laws and Professional Standards for one of three sample selected residents (Resident 1) when resident 1 had unusual occurrence (Fall), skin laceration and hospitalization and the facility did not follow the state regulation (22 CCR S 72541) to report the incident to the California Department of Public Health (CDPH). This deficient practice has the potential to result in negative outcomes for residents including actual harm, serious injury, a decline in quality of life, and putting residents at high risk of similar, potentially more severe, future incidents.A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility with multiple diagnosis including muscle weakness.A review of SBAR (a structured communication framework widely used in healthcare to provide a clear, concise, and organized method for conveying critical information between professionals) dated 11/5/25, indicated .At 03:16 pm resident had unwitnessed fall. LN (Licensed Nurse) was near the resident's room during shift change, both nurses heard loud noise and rushed to room. Resident found flat lying on her back on floor next to table. upon assessment resident alert and oriented x1. active bleeding noted to back of head. laceration approximately 2 cm with moderate bleeding. called 911 3:32 pm. paramedics arrived- 3:34 pm .During an interview on 12/9/25 at 9:30 a.m., with the Director of Nursing (DON), DON stated Resident 1 fell and had a skin laceration on her head, was sent to the hospital for evaluation and hospital sent Resident 1 back to the facility the next day. Furthermore, DON stated the facility did not report this incident to the CDPH because it was not a significant injury involved with the incident.A review of the facility's policy and procedure Unusual Occurrence Reporting revised December 2007, indicated .As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors.

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