

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

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Jewish Home & Rehab Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 302 Silver Avenue San Francisco, CA 94112	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview and record review, the facility failed to implement pressure ulcer care plan for one of 3 sampled residents (Resident 1) when Certified Nursing Assistant (CNA) 1 did not reposition Resident 1 every 2 hours on 5/1/24. This failure had the potential to delay the healing of the pressure ulcer for Resident 1. Findings: Review of Resident 1's clinical record indicated, Resident 1 was admitted to the facility with diagnoses including nephritis (inflammation of the kidneys), renal and perinephric abscess (a pocket of pus in the kidney and perinephric space, surrounding the kidneys), dementia (memory loss), and pressure ulcer (same as bedsore, an injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time). Review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 4/15/24 indicated, Resident 1 was cognitively moderately impaired. During an interview on 4/24/24 at 2:27 PM with Ombudsman (a person who assists residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) by phone, Ombudsman stated, CNAs did not really know what Resident 1's care plans were, such as position change. During an observation on 5/1/24 at 11:47 AM with Resident 1 in her room on the first floor of [NAME] building (F1), Resident 1 was lying on her back in the bed and there was a position change schedule at bedside. The position change schedule titled, Reposition Every 2 Hours and As needed Unless Contraindicated indicated, 8 am- supine 10 am- right side lying 12nn (noon)-left side lying . During an interview on 5/1/24 at 12:15 PM with CNA 1 in hallway in F1, CNA 1 stated, Resident 1 had a small pressure ulcer on the coccyx when asked. She stated, Every 2 hours, we have to position her when asked about the facility's policy of position change. CNA 1 stated, 9 AM when asked when she last changed Resident 1's position. She stated, I was busy when asked why Resident 1's position was not changed every 2 hours per the position change schedule at Resident 1's bedside. (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: 055169	Facility ID: 055169 If continuation sheet Page 1 of 4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 12:21 PM with CNA 1 in hallway in F1, CNA 1 stated, No, I do not ask. Sorry, when asked if she had asked the night shift CNA what time Resident 1's last change of position was during their shift endorsement. CNA 1 stated, their shift endorsement time was around 7 AM, and Resident 1 was sleeping at that time, so she did not want to bother Resident 1 around 7 AM. She stated, she cleaned Resident 1 around 8 AM, then changed Resident 1's position at 9 AM. CNA 1 stated, 9 AM was the only time she changed Resident 1's position. During a concurrent interview and record review on 6/25/24 at 10:35 AM with Nurse Manager (NM) 1, Resident 1's pressure ulcer care plan, initiated on 2/25/24 was reviewed. The care plan indicated, . Reposition q (every) 2 hours and PRN (Pro re nata, as needed) . NM 1 verified, the CNA should have followed the care plan. Review of the facility's policy and procedure (P&P) titled, Wound and Skin Management dated 11/2023 indicated, . c. Assure patients are turned and repositioned every 2 hours in bed . Review of the facility's P&P titled, Care Plan Policy dated 3/2024 indicated, . a. The facility must develop and implement a comprehensive person-centered care plan for each resident .		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview, and record review, the facility failed to ensure one of 3 Certified Nursing Assistants (CNA) 1 was competent when CNA 1 did not know Resident 1 had dementia and urinary tract infection (UTI, a collective term that describes any infection involving any part of the urinary tract, namely the kidneys, ureters, bladder and urethra). This failure had the potential to result in Resident 1 not receiving appropriate treatments and services. Findings: Review of Resident 1's clinical record indicated, Resident 1 was admitted to the facility with diagnoses including nephritis (inflammation of the kidneys), renal and perinephric abscess (a pocket of pus in the kidney and perinephric space, surrounding the kidneys), dementia (memory loss), and pressure ulcer (same as bedsore, an injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time). Review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 4/15/24 indicated, Resident 1 was cognitively moderately impaired. During a concurrent observation and interview on 5/1/24 at 11:45 AM with CNA 1 in the nursing unit of [NAME] 1 (F1), there was an enhanced barrier precaution (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) signage at the door of Resident 1's room. CNA 1 stated, Resident 1 had C-diff (Clostridium difficile, bacteria that cause an infection of the colon, the longest part of the large intestine) when asked. During an interview on 5/1/24 at 12:11 PM with CNA 1 in hallway in F1, CNA 1 stated, I forgot. Let me ask . when asked again if Resident 1 had C-diff. Then she went to the nursing station to ask Registered Nurse (RN) 1, and came back at 12:13 PM to answer. CNA 1 stated, She (Resident 1) has bacteria in urine . No C-diff . CNA 1 acknowledged she was wrong regarding Resident 1's enhanced barrier precaution. She stated, I am float . I thought another patient . During an interview on 5/1/24 at 12:19 PM with CNA 1 in hallway in F1, CNA 1 stated, No when asked if Resident 1 has dementia. Then CNA 1 stated, Hold on a second, then she went to the nursing station to ask Nurse Manager (NM) 1. CNA 1 came back at 12:20 PM to answer the question. CNA 1 stated, I asked my charge nurse. She (Resident 1) is confused, and she has dementia. She stated, I am sorry. I forgot. I am just floating . when asked what she does to take care of residents with dementia. She stated, . I always forgot . She stated, No when asked if she had taken some notes during the shift endorsement since she stated that she always forgets. Then she stated, Everyone (other CNAs) is like that . (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 12:49 PM with RN 1, RN 1 verified because Resident 1 had UTI with ESBL (extended spectrum beta-lactamase. It's an enzyme found in some strains of bacteria. ESBL-producing bacteria can't be killed by many of the antibiotics that doctors use to treat infections), the resident was put on the enhanced barrier precaution, not because of C-diff. RN 1 acknowledged, CNA 1 asked her about Resident 1, and CNA 1 did not know that Resident 1 had dementia and was on the enhanced barrier precaution due to UTI. Review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 4/2024 indicated, . Jewish Home aims to prevent the spread of multi-drug resistant organisms (MDRO) within the facility . MDROs fall under the category of Healthcare Associated Infections (HAI). MDROs are common bacteria that have developed resistance to multiple types of antibiotics . MDROs can contaminate the immediate environment of residents who may need assistance with indwelling medical devices, wounds, and frequent soiling . Review of the facility's P&P titled, Competencies for Nursing Staff dated 12/2023 indicated, . It is the policy of the Jewish Home & Rehab Center (JHRC) to ensure nursing staff are competent to perform their jobs .		