

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

Printed: 12/04/2024
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 08/28/2024
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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based interview and record review, the facility failed to provide two of three residents, Resident 177 and Resident 248, with SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice). FINDINGS: Review of Resident 177, resident was admitted on [DATE] for Part A services, with diagnosis of Chronic Inflammatory Demyelinating Polyneuritis (a disease of the nervous system with progressive weakness and loss of sense and function of the legs and arms). SNF Beneficiary Protection Notification Review for Resident 177, indicated, Medicare Part A Skilled Services Episodes Start date:2/28/24. Last Covered day of Part A Service: 5/1/24. NOMNC was given 4/28/24. No issues. SNF ABN form not provided to resident. Per facility, CMS-10055 not needed, Resident 177 was placed on Part A for daily skilled PT,OT and ST. Resident 177 is still in the facility for custodial care. Review of Resident 248, resident was admitted on [DATE] for Part A services, with diagnosis of Ileus (a condition when the bowel does not work correctly). SNF Beneficiary Protection Notification Review for Resident 248, indicated: Medicare Part A Skilled Services Episode Start date: 3/18/24. Last covered day of Part A Service: 4/23/24. NOMNC given 4/9/24. SNF ABN form not provided to resident. Per facility,CMS-10055 not needed, Resident 248 was placed on Part A for skilled rehab. Resident 248 is still in the facility for custodial care. During an interview on 8/29/24 at 9:40 AM, with UM (Utilization Manager), per UM, form SNF ABN is for non-covered services, 90 % of admitted residents are discharged . SNF ABN form is provided when residents are under Medicare B. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 10:40 AM, with MDS RN (Minimum Data Set), per MDS RN, form SNF ABN is given when 100 skilled days is exhausted or when resident is readmitted without skilled need. Review of facility Policy and Procedure, Advanced Beneficiary Notices Policy, undated, indicated, Policy Explanation and Compliance Guidelines: 4. The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay before the facility provides: a. an item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary, or b. Custodial care. 5. The current CMS-approved version of the forms shall be used at the time of the issuance to the beneficiary .a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), Form CMS-10055.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49264 Based on interview and record review the facility failed to recognize and report an allegation of abuse for one out of six sampled residents (Resident 372) when Resident 372 reported to Social Worker (SW) 1 an allegation of verbal abuse by nursing staff and Physical Therapist (PT) 1, yet it was not reported to the facility administrator or other necessary agencies. This failure has the potential for allegations of abuse that may be substantiated to not be properly corrected and keep residents at risk for continued exposure to abuse. Findings: A review of facility policy and procedure (P & P), titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property, last revised August 2024, defined verbal abuse as the use of oral, written or gestured communication that willfully includes disparaging and derogatory terms to resident or their families . The P & P further indicated that reports of alleged abuse .are promptly and thoroughly investigated, and report all abuse allegations to the administrator/designee, California Department of Public Health, San Francisco Police Department if appropriate, ombudsman, and any other required agencies .immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. A review of Resident 372's face sheet (summary of resident's demographic and admitting information), dated 08/27/24, indicated that Resident 372 was admitted in 2024 with diagnoses including AFTERCARE FOLLOWING JOINT REPLACEMENT SURGERY and INJURY OF FEMORAL NERVE [part of the body that sends signals from the brain to the leg] . A review of Resident 372's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents), dated 08/02/2024, indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 15 out of 15 (scores of 0-7 suggest severe cognitive impairment, 9 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact). A review of a psychosocial note written by SW 1, dated 08/02/24, indicated that Resident 372 had strong communication and analytical skills. It further stated that Resident 372 ordered something online and was 'yelled at' by nursing that she was not allowed to have it. Resident 372 also reported that she was switched from her very good PT to [PT 1] . and she feels like it might be 'retaliation' and was allegedly told by PT 1 that she could be discharged any day because she is not making progress and that she should be 'thankful that you [Resident 372] have one good leg.' A review of a social services note by SW 2, dated 08/07/24, indicated that SW 2 discussed scheduling a care conference (a meeting involving resident's, family, and their care team to discuss how to meet a resident's needs) and that Resident 372 only wanted to meet with certain people due to issues arising with specific departments. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 10:40 AM with Resident 372, in their room, Resident 372 stated that PT 1 was verbally abusive to her and told her she should be very happy I'm only paralyzed in one leg. Resident 372 stated this occurred around 08/01/24 and she initially reported this to SW 1 on 08/02/24 but does not recall anything happening after that. During an interview on 08/26/24 at 2:27 PM with the Director of Social Services (DSS), the DSS stated that any abuse or allegation of abuse should be reported immediately to the police . the State [State Agencies], and Ombudsman [a person that advocates fair processes, provides advice/resources, and helps address complaints]. The DSS stated that it is important to report any allegation of abuse to keep the patient or resident safe in our community and outside . and ensure that it is properly investigated and resolved. During a telephone interview on 08/27/24 at 9:49 AM with SW 1, SW 1 stated that they recall that the Resident 372 was upset. SW 1 stated that they should report any kind of abuse anytime they suspect it. SW 1 stated they likely should have reported this as an allegation of abuse. During an interview on 08/27/24 at 3:06 PM with the Administrator. The Administrator stated they were not able to locate a report of alleged abuse or investigation of alleged abuse regarding Resident 372.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49264 Based on interview and record review the facility failed to recognize and investigate an allegation of abuse for one out of six sampled residents (Resident 372) when Resident 372 reported to Social Worker (SW) 1 an allegation of verbal abuse by nursing staff and Physical Therapist (PT) 1, yet it was not thoroughly investigated by the facility. This failure has the potential for allegations of abuse that may be substantiated to not be properly corrected and keep residents at risk for continued exposure to abuse. Findings: A review of facility policy and procedure (P & P), titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property, last revised August 2024, defined verbal abuse as the use of oral, written or gestured communication that willfully includes disparaging and derogatory terms to resident or their families . The P & P further indicated that reports of alleged abuse .are promptly and thoroughly investigated, and report all abuse allegations to the administrator/designee, California Department of Public Health, San Francisco Police Department if appropriate, ombudsman, and any other required agencies .immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. A review of Resident 372's face sheet (summary of resident's demographic and admitting information), dated 08/27/24, indicated that Resident 372 was admitted in 2024 with diagnoses including AFTERCARE FOLLOWING JOINT REPLACEMENT SURGERY and INJURY OF FEMORAL NERVE [part of the body that sends signals from the brain to the leg] . A review of Resident 372's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents), dated on 08/02/2024, indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 15 out of 15 (scores of 0-7 suggest severe cognitive impairment, 9 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact). A review of a psychosocial note written by SW 1, dated 08/02/24, indicated that Resident 372 had strong communication and analytical skills. It further stated that Resident 372 ordered something online and was 'yelled at' by nursing that she was not allowed to have it. Resident 372 also reported that she was switched from her very good PT to [PT 1] . and she feels like it might be 'retaliation' and was allegedly told by PT 1 that she could be discharged any day because she is not making progress and that she should be 'thankful that you [Resident 372] have one good leg.' A review of a social services note by SW 2, dated 08/07/24, indicated that SW 2 discussed scheduling a care conference (a meeting involving resident's, family, and their care team to discuss how to meet a resident's needs) and that Resident 372 only wanted to meet with certain people due to issues arising with specific departments. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49264 Based on interview and record review, the facility failed to accurately assess hearing for one out of two sampled residents (Resident 356) when Resident 356 was assessed as not having hearing aids when they used hearing aids on admission to the facility. This failure has the potential for Resident 356's needs to not be met due to their communication and hearing needs not being accurately assessed. Findings: A review of Resident 356's face sheet (summary of resident's demographic and admitting information), dated 08/27/24, indicated that Resident 356 was admitted in 2024 with diagnoses including DISPLACED FRACTURE OF MEDIAL CONDYLE OF RIGHT FEMUR . (a break in the right upper leg bone). A review of Resident 356's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents) dated on 08/03/2024 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 13 out of 15 (scores of 0-7 suggests severe cognitive impairment, 9 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact). A review of Resident 356's care plan, dated 07/29/24, indicated that a focus of The resident has a communication problem r/t [related to] Hearing deficit. The interventions to this focus problem area included Apply bilateral [both sides] hearing aid while awake for communication. During a concurrent observation and interview on 08/21/24 at 2:27 PM with Resident 356 in their room, Resident 356 was observed pointing to their left ear. Resident 356 stated that she could best hear in her left ear because her right-sided hearing aid was broken. Resident 356 stated she thinks someone jammed a battery accidentally when changing the batteries. She further stated it occurred about ten days prior. During a concurrent observation and interview on 08/26/24 at 11:01 AM with RN 3 in Resident 356's room, RN 3 was observed asking Resident 356 about their hearing aids. RN 3 stated that she was not aware that Resident 356 had only been wearing one hearing aid. During a concurrent interview and record review on 08/28/24 at 2:18 PM with MDS Nurse 1, Resident 356's MDS, dated [DATE], was reviewed. The MDS indicated that Resident 356's Ability to hear (with hearing aid or hearing appliances if normally used) was assessed as Adequate - no difficulty in normal conversation, social interaction . The MDS further indicated that Resident 356's Hearing aid or other hearing appliance used was assessed as No. MDS Nurse 1 stated that it should have been assessed as a yes if the resident does wear hearing aids. MDS Nurse 1 further stated that this is an inaccurate assessment of the Resident's hearing.		

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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 develop and implement comprehensive care plans that included measurable objectives and specific interventions for 1 of 35 sampled residents (Resident 327) when: 1. Care plan was not developed to address urinary tract infection (UTI, a common infection that occurs when bacteria enter the urinary tract and cause inflammation). 2. Fall care plan interventions were not implemented. These failures had the potential for not meeting Resident 327's nursing needs and goals to attain the resident's highest practicable well-being. Findings: 1. Review of Resident 327's clinical record indicated, Resident 327 was admitted to the facility with diagnoses including dementia (memory loss), anxiety disorder (a condition that causes excessive fear, worry, and uneasiness that can interfere with daily life), and urinary tract infection (UTI). Review of Resident 327's Minimum Data Set (MDS, resident assessment tool) dated 4/17/24 indicated, . Cognitive Patterns (the mental processes that people use to perceive, interpret, and process information from their surroundings) . resident is rarely/never understood . Review of Resident 327's order, dated 6/30/24 indicated, . Sulfamethoxazole-Trimethoprim (Antibiotic, a drug used to treat infections caused by bacteria and other microorganisms) Oral Tablet 800-160 MG (milligram) . Give 1 table by mouth every 12 hours for Bacterial Infection -UTI for 5 Days until finished . Review of Resident 327's Medication Administration Record (MAR) of June 2024 and July 2024 indicated, the resident had Sulfamethoxazole-Trimethoprim from 9 PM on 6/30/24 to 9 AM on 7/5/24. Review of Resident 327's Progress Notes dated 7/5/24 indicated, . Chief Complaint UTI . She was sent to ER (emergency room) on 6/28/24 for report of facial droop (a loss of facial movement or muscle function on one or both sides of the face) slurred speech (a condition that makes it hard to speak due to issues with the muscles used for speech) . and found to have UTI . During a concurrent interview and record review on 8/23/24 at 2:19 PM with Registered Nurse (RN) 2, Resident 327's care plans were reviewed. RN 2 stated, I don't see it when asked if there was a care plan for Resident 327's UTI. During an interview on 8/23/24 at 2:20 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 verified, Resident 327 had UTI before. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24 at 11:12 AM with RN 2, RN 2 stated, I do not see anything on the care plan when asked about care plan for Resident 327's UTI. RN 2 acknowledged, They should have had a care plan for UTI when asked. 2. During an observation on 8/26/24 at 9:43 AM in the activity room, Resident 327 did not have an injury. During an interview on 8/26/24 at 9:50 AM with LVN 3, LVN 3 stated, Resident 327 was confused due to dementia. LVN 3 verified, Resident 327 did not have injuries from the recent falls. During a concurrent interview and record review on 8/26/24 at 10:08 AM with Registered Nurse (RN) 2, Resident 327's fall score (a medical assessment that estimates a resident's risk of falling), dated 5/7/24 was reviewed. The fall score indicated, . Score: 14 Score 10 or higher indicated the resident is at high risk of fall. RN 2 verified, Resident 327's fall score was 14 on 5/7/24 and the score of 14 meant the resident was at high risk of fall. During a concurrent interview and record review on 8/26/24 at 11:45 AM with RN 2, Resident 327's fall care plan was reviewed. The fall care plan indicated, . Risk for Falls r/t (related to) 1. Poor balance, 2. poor safety awareness . dementia 3. Unsteady gait . Date Initiated: 05/07/2024 . Then, updated fall care plan, dated 7/10/24 indicated, . Interventions . Rounding every 2-hour . RN 2 stated, I do not see the specific 2-hour monitoring . when asked about the evidence of it. RN 2 verified, Resident 327 fell on [DATE], 6/13/24, 6/18/24, 6/21/24, 6/24/24, 6/30/24, and 8/21/24 when asked. During an interview on 8/26/24 at 1:28 PM with RN 2, RN 2 stated, I couldn't find the order, when asked about the evidence of fall care plan intervention regarding . Rounding every 2-hour . for Resident 327. RN 2 stated, It should be documented. But I couldn't find it when asked if every 2-hour rounding should have been documented per Resident 327's fall care plan. During a concurrent interview and record review on 8/26/24 at 1:55 PM with Licensed Vocational Nurse (LVN) 3, Resident 327's fall care plan, dated 6/21/24 was reviewed. The fall care plan indicated, . Interventions . Video monitoring . LVN 3 stated, No when asked if there was evidence of documentation regarding video monitoring. During an interview on 8/27/24 at 11:35 AM with RN 2, RN 2 verified, there was no evidence of documentation of video monitoring. Review of the facility's policy and procedure (P&P) titled, Fall Prevention Policy revised in August 2024 indicated, . 4. Appropriate interventions . will be implemented for residents/patients at risk for falls as identified by Nursing, and the IDT (interdisciplinary team, a group of healthcare professionals from different fields who work together to provide the best care for a patient) . 7. Video monitoring may be considered as an intervention for patients/residents at risk for falling . Review of the facility's P&P titled, Care Plan Policy revised in March 2024 indicated, . The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview, and record review, the facility failed to update care plans for three of 35 sampled residents (Resident 327, 187, and 264) when: 1. Fall care plan was not updated for Resident 187 after her falls on 2/15/24, 3/23/24, and 8/2/24. 2. Fall care plan was not updated for Resident 327 after her falls on 6/30/24, and 8/21/24. 3. Care plan for pain was not updated for Resident 264. These failures had the potential to put the residents at risk of not receiving appropriate cares. Findings: 1. Review of Resident 187's clinical record indicated, Resident 187 was admitted to the facility with diagnoses including dementia (memory loss), hypertension (high blood pressure), and atrial fibrillation (Afib, an irregular and often rapid heart rate that commonly causes poor blood flow and can increase the risk of stroke). Review of Resident 187's Minimum Data Set (MDS, resident assessment tool), dated 2/8/24 indicated, her memory was severely impaired. During an interview on 8/27/24 at 2:02 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, Resident 187 was confused due to dementia. Review of Resident 187's Nurse Note (NN), dated 2/15/24 indicated, . 02/15/2024 7:25 AM Fall was not witnessed. Fall occurred in the hallway . found lying on the floor . Possible missed the chair. [NAME] was in front of the res. (resident) . No injury noted . Review of Resident 187's NN, dated 3/23/24 indicated, At 0700 (7:00 AM), CNA (Certified Nursing Assistant) found resident sitting on floor in her room . No s/s (signs and symptoms, abnormalities that can indicate a medical condition) of head injury . Review of Resident 187's IDT (interdisciplinary team, a group of healthcare professionals from different fields who work together to provide the best care for a patient) Meeting Note, dated 8/2/24 indicated, Resident sustained (maintained) a witnessed fall. Resident was sitting in wheelchair . Resident was kicking against legs of table hard enough to tip wheelchair back, resident fell backwards, remaining in seated position in the wheelchair . No sustained injuries . During an observation on 8/27/24 at 2:03 PM in the activity room, Resident 187 did not have an injury. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/27/24 at 2:17 PM with Registered Nurse (RN) 2, Resident 187's fall care plan was reviewed. The fall care plan indicated, there was no updated fall care plan for Resident 187 after her falls on 2/15/24, 3/23/24, and 8/2/24. RN 2 stated, I don't see a specific care plan for fall . when asked. RN 2 stated, No. I don't see anything for this year . when asked again if there is evidence of updated fall care plan after Resident 187's actual falls on 2/15/24, 3/23/24, and 8/2/24. 2. Review of Resident 327's clinical record indicated, Resident 327 was admitted to the facility with diagnoses including dementia (memory loss), anxiety disorder (a condition that causes excessive fear, worry, and uneasiness that can interfere with daily life), and urinary tract infection (UTI, a common infection that occurs when bacteria enter the urinary tract and cause inflammation). Review of Resident 327's Minimum Data Set (MDS, resident assessment tool) dated 4/17/24 indicated, . Cognitive Patterns (the mental processes that people use to perceive, interpret, and process information from their surroundings) . resident is rarely/never understood . Review of Resident 327's Nurse Note (NN), dated 6/30/24 indicated, @1830 (at 6:30 PM) . resident fell while trying to get from the bed . Resident had small bump at right back of her head . Review of Resident 327's NN, dated 8/21/24 indicated, Resident had a witnessed fall @ (at) 8:15 AM . no injury noted . During an observation on 8/26/24 at 9:43 AM in the activity room, Resident 327 did not have an injury. During an interview on 8/26/24 at 9:50 AM with LVN 3, LVN 3 stated, Resident 327 was confused due to dementia. LVN 3 verified, Resident 327 did not have injuries from the recent falls. During a concurrent interview and record review on 8/26/24 at 11:45 AM with Registered Nurse (RN) 2, Resident 327's electronic medical record was reviewed. RN 2 verified, Resident 327 fell on [DATE], 6/13/24, 6/18/24, 6/21/24, 6/30/24, and 8/21/24 when asked. During a concurrent interview and record review on 8/26/24 at 1:55 PM with Licensed Vocational Nurse (LVN) 3, Resident 327's fall care plan was reviewed. LVN 3 stated, It's concerning when asked how she would feel if her mother was a resident at the facility and had multiple falls like Resident 327 and if Resident 327's fall care plan was effective to prevent falls. LVN 3 stated, Video monitoring. q2hour (every 2 hour) rounding. One- to-one safety monitor when asked what the most effective intervention for Resident 327 would be to prevent falls. LVN 3 stated, Yes when asked if Resident 327 is needed for one-to-one safety monitoring since Resident 327 had falls multiple times. During a concurrent interview and record review on 8/26/24 at 2:05 PM with RN 2 and LVN 3, Resident 327's fall care plan was reviewed. RN 2 and LVN 3 stated, there was no evidence of updated fall care plan after Resident 327's falls on 6/30/24 and 8/21/24 when asked. (continued on next page)		

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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	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure (P&P) titled, Fall Prevention Policy revised in August 2024 indicated, . The Jewish Home & Rehab Center ensures . that each patient/resident receives adequate supervision . All patients/residents shall be assessed for fall risk . change of condition, after a fall . All patients/residents identified as at risk for falls shall have an individual care plan that includes interventions to prevent falls from occurring and considers the individual's ADL (Activities of Daily Living, the self-care tasks that a person does daily to maintain independence and care for themselves) ability . Review of the facility's policy and procedure (P&P) titled, Care Plan Policy revised in March 2024 indicated, . 4. Comprehensive care plans. a. The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . 5. A comprehensive care plan must be . c. Reviewed and revised by the interdisciplinary team (IDT, a group of healthcare professionals from different fields who work together to provide the best care for a patient) after each assessment . 43913 3. Review of Resident 264, resident admitted [DATE], with a diagnosis of Diabetes Mellitus (high sugar level), Cancer of the Lung, Osteoporosis (a disease that weakens the bones that they break easily). Resident re- admitted on [DATE] with diagnosis of Fracture of right Femur(a break of the right hip) needing surgery. During an interview on 8/20/24 at 10AM, with CNA3, per CNA 3, resident is alert but sometimes refused to talk to people she does not know. She had a fall last week, just came back and she is getting therapy. She complains of pain of the right hip, nurse gives pain pill. She was independent with walking, so she feels sad now she is in a wheelchair. Family comes to visit. During a concurrent interview and chart review on 8/23/24 at 9:30AM, with RN2, per RN2, resident had a fall on 8/11/24, sustained right hip fracture, was transferred to acute and has surgery on 8/12/24. IDT(Interdisciplinary) meeting done. Per IDT notes on 8/16/24, the resident is referred to PT/OT, recommendations for Vitamin D+Calcuim . will be on 2- hour rounding, educate to use call light, care plan is updated. Continue with fall interventions. Review of Fall care plan updated and revised 8/16/24. Post fall evaluation done 8/15/24. Review of Pain Care plan initiated 5/23/24. No updated interventions and goals for the fall on 8/11/24. During an interview on 8/22/24 at 3PM, with PT (Physical Therapist), per PT 1, patient is walking about 15 ft with the walker. Able to tolerate 6/10 pain level. Patient will get back to baseline. During an interview on 8/27/24 at 10AM,with LVN4, per LVN 4, care plans are updated when there is a change of condition, assessments due, re- admissions and when there is a need. Updating a care plan is adding new interventions and change dates. (continued on next page)		

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 10:45 AM, with NM 2(Nurse manager), per NM 2, the goal date is changed when indicated in the chart, due to renew 11/19/24. Confirmed that pain care plan is not due for update. Review of facility Policy and Procedure, Care Plan Policy, dated 3/24, indicated, 5.A comprehensive care plan must be .c. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 44477 Based on interview and record review, the facility failed to implement their fall policy and procedure for three of 6 sampled residents (Resident 187, 327, and 356) when: 1. There was no evidence of post fall interdisciplinary team (IDT, a group of healthcare professionals from different fields who work together to provide the best care for a patient) meeting for Resident 187. 2. There were no consent for video monitoring and evidence of post fall IDT meeting for Resident 327. 3. There was no post fall assessment and completed IDT meeting note for Resident 356. These failures could potentially result in negative outcomes for Resident 187, 327, and 356. Findings: 1. Review of Resident 187's clinical record indicated, Resident 187 was admitted to the facility with diagnoses including dementia (memory loss), hypertension (high blood pressure), and atrial fibrillation (Afib, an irregular and often rapid heart rate that commonly causes poor blood flow and can increase the risk of stroke). Review of Resident 187's Minimum Data Set (MDS, resident assessment tool), dated 2/8/24 indicated, her memory was severely impaired. During an interview on 8/27/24 at 2:02 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, Resident 187 was confused due to dementia. Review of Resident 187's Nurse Note (NN), dated 2/15/24 indicated, . 02/15/2024 7:25 AM Fall was not witnessed. Fall occurred in the hallway . found lying on the floor . Possible missed the chair. [NAME] was in front of the res. (resident) . No injury noted . Review of Resident 187's NN, dated 3/23/24 indicated, At 0700 (7:00 AM), CNA (Certified Nursing Assistant) found resident sitting on floor in her room . No s/s (signs and symptoms, abnormalities that can indicate a medical condition) of head injury . During an observation on 8/27/24 at 2:03 PM in the activity room, Resident 187 did not have an injury. During a concurrent interview and record review on 8/27/24 at 2:17 PM with Registered Nurse (RN) 2, Resident 187's IDT Meeting Notes were reviewed. RN 2 stated, there was no evidence of IDT meeting after Resident 187's fall on 2/15/24, and 3/23/24 when asked. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 327's clinical record indicated, Resident 327 was admitted to the facility with diagnoses including dementia (memory loss), anxiety disorder (a condition that causes excessive fear, worry, and uneasiness that can interfere with daily life), and urinary tract infection (UTI, a common infection that occurs when bacteria enter the urinary tract and cause inflammation). Review of Resident 327's Minimum Data Set (MDS, resident assessment tool) dated 4/17/24 indicated, . Cognitive Patterns (the mental processes that people use to perceive, interpret, and process information from their surroundings) . resident is rarely/never understood . During a concurrent interview and record review on 8/26/24 at 1:33 PM with RN 2, Resident 327's fall care plan, dated 6/21/24 was reviewed. The fall care plan indicated, . Video monitoring . RN 2 stated, I don't see anything related to the consent of video monitoring in the progress notes, as verbal consent from the family when asked about the consent. Review of Resident 327's Nurse Note (NN), dated 8/21/24 indicated, Resident had a witnessed fall @ (at) 8:15 AM . no injury noted . During an interview on 8/26/24 at 2:37 PM with Nurse Manager (NM) 1, NM 1 stated, There should be IDT meeting note for every fall when asked about IDT meeting after falls. During an interview on 8/27/24 at 9:10 AM with Director of Nursing (DON), DON stated, consent for video monitoring is needed per the facility's policy and procedure (P&P) of fall when asked. During a concurrent interview and record review on 8/27/24 at 1:35 PM with RN 2, RN 2 stated, the latest IDT meeting note regarding fall for Resident 327 was on 7/19/24 when asked about evidence of IDT meeting after Resident 327's fall on 8/21/24. RN 2 stated, For August, No IDT note unfortunately . when asked again. RN 2 stated, IDT meeting should be held after each fall when asked about the facility's P&P of fall. Record Review of P&P titled, Fall Prevention Policy revised in August 2024 indicated, . 4. Appropriate interventions . will be implemented for residents/patients at risk for falls as identified by Nursing, and the IDT 7. Video monitoring may be considered as an intervention for patients/residents at risk for falling. If video monitoring is determined appropriate for the patient/resident, obtain consent for the monitoring from the patient/resident or responsible party and note the consent in the clinical notes. a. Document consent for video monitoring in the clinical notes . 1. A resident/patient who triggers the fall assessment as high risk will be reviewed by the IDT . 3. Review by Shift IDT: a. Cause of fall is discussed b. Root cause is analyzed and documented c. Recommendations for interventions are documented d. Care plan updated and documented e. IDT Participants presence is documented . 49264 3. A review of Resident 356's face sheet (summary of resident's demographic and admitting information), dated 08/27/24, indicated that Resident 356 was admitted in 2024 with diagnoses including DISPLACED FRACTURE OF MEDIAL CONDYLE OF RIGHT FEMUR . (a break in the right upper leg bone) and HISTORY OF FALLING. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 356's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents) dated on 08/03/2024 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 13 out of 15 (scores of 0-7 suggests severe cognitive impairment, 9 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact). During an interview on 08/21/24 at 1:28 PM with Resident 356, Resident 356 stated that she fell in her room a few weeks ago while a Physical Therapist (PT) was assisting them from the edge of the bed to the wheelchair. Resident 356 further stated that it was a controlled fall . I landed on my back. During a concurrent interview and record review on 08/26/24 at 10:49 AM with Registered Nurse (RN) 3, Resident 356's electronic medical record was reviewed. RN 3 stated that she does not see a post-fall assessment for Resident 356. RN 3 stated she does not recall if Resident 356 has fallen at the facility but confirmed that if Resident 356 did fall in the facility, a post-fall assessment should be completed. RN 3 further stated that she only sees one fall assessment for Resident 356 that was completed as part of their admission. During an interview on 08/26/24 at 11:05 AM with PT 1, PT 1 stated she recalls helping Resident 356 during a therapy session on August 5th. PT 1 stated that during a transfer (physical move) from the edge of the bed to a wheelchair, Resident 356 had an assisted fall to the ground. During a concurrent interview and record review on 08/27/24 at 11:24 AM with Nurse Manager (NM) 2, Resident 356's electronic medical record was reviewed. NM 2 stated that she does not see a post-fall assessment done. During a concurrent interview and record review on 08/27/24 at 11:24 AM with Nurse Manager (NM) 2, Resident 356's Interdisciplinary Team Meeting (IDT, a collaborative group of people involved in a resident's care) note, dated 08/08/24 was reviewed. The IDT note indicated that after Resident 356's fall, Fall safety precautions at all times enforced all shift. Family and staff fully aware. NM 1 stated that this was the only documentation by the IDT of the fall on August 5th, 2024. During a concurrent interview and record review on 08/27/24 at 11:24 AM with Nurse Manager (NM) 2, facility Policy and Procedure (P & P) titled, Fall Prevention Policy, last revised August 2024 was reviewed. The P & P indicated that the IDT should ensure that Cause of fall is discussed . Root cause is analyzed and documented .recommendations for interventions are documented . Care plan updated and documented .IDT participants presence is documented. NM 2 stated that these details were not documented in the IDT note for Resident 356's fall on August 5th, 2024.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49264 Based on observation, interview and record review, the facility failed to ensure that a resident's assistive hearing device was functioning in one of two sampled residents (Resident 356) when Resident 356 reported that their hearing aid had been broken for multiple days and clinical staff were not aware of it. This failure has the potential to result in the residents' needs not being met due to a reduction in their ability to hear and communicate. Findings: A review of Resident 356's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents) dated on 08/03/2024 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 13 out of 15 (scores of 0-7 suggests severe cognitive impairment, 9 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact). During a concurrent observation and interview on 08/21/24 at 2:27 PM with Resident 356 in their room, Resident 356 was observed pointing to their left ear. Resident 356 stated that she could best hear in her left ear because her right-sided hearing aid was broken. Resident 356 stated she thinks someone jammed a battery accidentally when changing the batteries. She further stated it occurred about ten days prior. A review of Resident 356's care plan, dated 07/29/24, indicated a focus of The resident has a communication problem r/t [related to] Hearing deficit. The interventions to this focus problem area included Apply bilateral [both sides] hearing aid while awake for communication. During an interview on 08/26/24 at 10:38 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated that Resident 356 has a hearing aid . only in one ear, that they are aware of. During an interview on 08/26/24 at 10:44 AM with Registered Nurse (RN) 3, RN 3 stated that Resident 356 has bilateral hearing aids. RN 3 stated they will usually know that a hearing aid is broken when a resident tells them. During a concurrent observation and interview on 08/26/24 at 11:01 AM with RN 3 in Resident 356's room, RN 3 was observed asking Resident 356 about their hearing aids. RN 3 stated that she was not aware that Resident 356 had only been wearing one hearing aid. During an interview on 08/27/24 at 11:42 AM with Nurse Manager (NM) 2, NM 2 stated that she was recently made aware that one of Resident 356's hearing aids were broken. NM 2 stated she expects nursing staff to check hearing aid function daily for residents when they speak to residents and they may notice a problem hearing. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy and procedure (P & P), titled Hearing Enhancement - Care of Hearing Aids, last revised August 2024, indicated that For Cognitively Able Residents staff should Perform daily cleaning and inspection of hearing aid .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40454 Based on observation, interview and record review, the facility failed to ensure safety to prevent fall related injuries to one of one sampled resident (Resident 250) when a volunteer transported Resident 250 using a wheelchair. The facility failure resulted to Resident 250 to sustain a laceration (a tear on the skin) to the forehead, a fracture (a break in the bone) on the second cervical (neck) spinal bone (C2 dens fracture), and a fracture along the ulnar base of the first proximal phalanx of the left hand (a finger on the left hand). Findings: Review of Resident 250's admission record indicated, was admitted on [DATE] with diagnoses including repeated falls, history of multiple fracture of the left ribs, fracture of the left clavicle (collarbone, bones that connects the arm to the body), and supranuclear ophthalmoplegia (a medical condition that involves the gradual deterioration of the brain, loss of balance, slowing of movements, and cognitive [includes thinking, reasoning, and remembering] impairment). Review of the Minimum Data Set (MDS, a standard assessment tool) dated 7/26/24, Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive functioning. 0-7 severely impaired [never/rarely make decisions], 8-12 moderately impaired [decisions poor, supervision required], 13-15 little to no cognitive impairment, intact cognition [Decisions consistent/reasonable]) score of 10 indicated moderate cognitive impairment. Under functional abilities, Resident 250 was non ambulatory (unable to walk). Review of the physical therapy progress notes dated 8/5/24, indicated, Resident 250's impairments included balance deficits (inability to maintain posture), safety awareness deficits, and strength impairment (weakness). During a review of the Post fall evaluation dated 8/19/24, indicated Resident 250 had a fall occurred in the hallway. Resident 250 was sleepy and was leaning forward while sitting in his chair. Resident hit his head first and suffered a laceration in the middle of his forehead and significant bleeding from both nostrils (nose). During an observation and interview on 8/20/24, at 12:20 PM in resident's room , Resident 250 was sitting up in wheelchair, with a cast (a medical device that holds broken bones in place while it heals) to the left hand and wrist area, and dry gauze dressing to the forehead. Resident 250 did not respond when spoken to. Resident 250's visitor, stated (Resident 250) had a fall episode the day before and had to go to the emergency room . Resident 250's visitor further stated the, (Resident 250) was downstairs on the first floor lobby (of the facility) when he rolled out of his wheelchair and hit his head. He just fell couple of days ago. I can't take care of him at home. He has to stay here (at the facility). What do I do? (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24, at 11:40 AM, CNA 3 stated, You have to know the patient (resident). If they are leaning forward when on the wheelchair, you stop pushing the wheelchair, check the resident if they are okay. Help them to sit up. During an interview on 8/23/24, at 10:13 AM, Licensed Vocational Nurse (LVN) 5, stated, When a resident in a wheelchair, sleeping and leaning forward, the resident may fall out of the wheelchair. You make sure the resident is positioned upright and not dragging their feet. During an interview and concurrent record review on 8/23/24, at 1:43 PM, Nurse Manager 3 stated, on 4/19/24, at 10:30 AM, a volunteer was pushing Resident 250 on a wheelchair going to the gym. NM 3 stated, He was sleepy, he doesn't have a footrest, he fell forward from the wheelchair. The volunteer doesn't know what to do. They are not trained. NM 3 reviewed the care plan addressing fall for Resident 250 and stated, (Resident 250) has a sitter now. The sitter (escort and companion for a resident) schedule is Monday through Sunday, on all shifts. NM 3 acknowledged the care plan did not address resident's safety during transport using a wheelchair and stated, I should have added to give instructions to volunteers. NM 3 stated that the involved volunteer to Resident 250's fall incident was not available. Review of the Emergency Department (ED) after visit summary dated 8/19/24, indicated Resident 250 sustained three centimeters (unit of measurement) laceration (a tear on the skin) over the forehead repaired with stitches and x-ray results revealed Resident 250 had C2 dens fracture and a fracture on a finger of the left hand. During an interview on 8/27/24, at 11:19 AM, the Director of Nursing stated, the volunteers need additional training on safety when pushing the resident's wheelchair and to make sure the resident always has footrest. Review of the Policy and Procedure titled, Fall Prevention Policy dated 8/2024, indicated,(Facility) ensures that the patient's/residents environment remains as free of accident hazards as is possible and that each patient/resident receives adequate supervision and assistive devices to prevent accident and mitigate injuries from falls while improving mobility and maintaining or enhancing quality of life .Residents/patients determined to be at high risk for falls on the fall risk assessment form will have low and moderate fall risk in place in addition to the high risk fall interventions implemented. High risk interventions include .reposition patient/resident as appropriate .Wheelchair Safety Anti-Tip Devices (device attached to a wheelchair to prevent tipping backwards) .(Facility) will make every effort to minimize the risk for fall of residents/patients by preventing their wheelchair from tipping .		

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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. 26917 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below five percent (5%). During the medication pass on 8/20/24 and 8/21/24, four medication errors were observed out of twenty-six opportunities for three out of six residents, resulting in an error rate of 15%. This failure had the potential to result in harm in the health and safety of residents. Findings: 1. A review of the manufacturer insert for Flovent indicated to properly administer the Flovent HFA 220 ug inhaler, it is essential to follow the manufacturer's instructions. Begin by shaking the inhaler vigorously for five seconds to ensure that the medication is well-mixed. Hold the inhaler with the mouthpiece facing downwards, and exhale deeply through the mouth to empty the lungs as much as possible. While inhaling deeply, press the top of the canister all the way down to release the medication. After inhaling, hold your breath for up to 10 seconds, or as long as you comfortably can, allowing the medication to settle in your lungs. Once you have held your breath, resume normal breathing to restore regular respiratory function. By carefully following these steps, you can ensure that the medication is administered effectively and reaches the lungs, providing the intended therapeutic effect. During an observation on 08/20/24 at 10:15 AM, LVN 1 administered the Flovent HFA 220 ug inhaler to Resident 102. However, the administration technique appeared to be inadequate as Resident 102 did not receive the full dose of the medication. The nurse neglected to shake the inhaler for five seconds before placing the mouthpiece into the resident's mouth, which is an essential step to ensure proper mixing of the medication. LVN 1 failed to instruct Resident 102 to inhale deeply and hold their breath while administering the medication. Consequently, most of the mist was observed coming out of the resident's mouth, indicating that the medication was not effectively delivered into their lungs. During an interview on 8/20/24 at 10:15 AM LVN 1 stated and acknowledged that Resident 102 did not receive the full dose of the administered medication, as a significant portion was visibly observed exiting the resident's mouth. Additionally, LVN 1 admitted to not shaking the inhaler before administration, which is an essential step in ensuring proper medication mixing and dosing. Although LVN 1 correctly placed the mouthpiece of the inhaler into Resident 102's mouth, LVN 1 failed to instruct Resident 102 to inhale deeply and hold their breath while administering the medication. Consequently, most of the mist was observed coming out of the resident's mouth, indicating that the medication was not effectively delivered into their lungs. Proper instruction and technique are crucial to ensure the effective administration of inhaled medications and should be emphasized in future administrations. (continued on next page)		

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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.			
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the hospital policy, Specific Medication Administration Procedures - Eyedrop Administration, Section 8.5, dated 06/2015, the purpose is to ensure the safe, accurate, and effective administration of ophthalmic solutions into the eye. To achieve this, the policy outlines specific steps for administration. Firstly, put on gloves and gently pull down the patient's lower eyelid with a gloved finger, creating a pouch. Instruct the resident to look upward, exposing the pouch for proper administration. Hold the inverted medication bottle securely between the thumb and index finger, taking care not to touch the dropper tip to maintain sterility of the eyedrop. Apply gentle pressure to dispense the prescribed number of drops into the pouch near the outer corner of the eye, ensuring the dropper does not touch the eye or any other surface. By adhering to this hospital policy, healthcare providers can administer ophthalmic solutions accurately and safely while minimizing the risk of adverse events or complications. During an observation on 08/20/24 at 10:15 AM, LVN 1 administered one drop of Systane in both eyes to Resident 102; however, while administering the eyedrops, the tip of the dropper came into contact with the eyelashes of both eyes. Systane is a brand of eye drops used to relieve dry, irritated eyes. It helps to keep the eyes moist, protect them from injury and infection, and reduce symptoms like burning, itching, and redness. This contact between the dropper and eyelashes deviates from the recommended technique for maintaining sterility during eyedrop administration. To ensure safety and minimize the risk of contamination, it is essential for healthcare providers to avoid touching the tip of the dropper to any surface, including eyelashes, when administering ophthalmic solutions. During an interview conducted on 08/20/24 at 10:15 AM, LVN 1 acknowledged that during the administration of Systane eyedrops to Resident 102, the tip of the eyedrop bottle had indeed made contact with the resident's eyelashes. This admission confirms the deviation from recommended practices for maintaining sterility during eyedrop administration, highlighting the importance of adhering to proper techniques to ensure the safe and effective delivery of ophthalmic solutions. 3. During an observation on 08/20/24 at 12:23 PM, LVN 2 administered one drop of Systane in both eyes of Resident 217. However, the LVN 2 did not wear gloves during the administration process, which raises concerns about maintaining appropriate infection control standards. Moreover, the tip of the dropper bottle touched the eyelashes of both eyes, which deviates from the recommended technique for ensuring sterility during eyedrop administration. To maintain safety and minimize the risk of contamination, healthcare providers should wear gloves and avoid contact between the dropper tip and any surface, including eyelashes, when administering ophthalmic solutions. During an interview on 8/20/24 at 12:30 PM, LVN 2 confirmed that she did not wear gloves while administering one drop of Systane in both eyes of Resident 217. She further acknowledged that she encountered difficulties during the process, which led to the tip of the eyedrop bottle touching the eyelashes of both eyes. LVN 2's statement corroborates the observed deviation from recommended practices for maintaining sterility during eyedrop administration. Healthcare providers should emphasize the importance of adhering to proper infection control standards, such as wearing gloves and avoiding contact between the dropper tip and any surface, including eyelashes, to ensure the safe and effective administration of ophthalmic solutions. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 8/21/24, at 9:15 AM, Registered Nurse 2 administered Olopatadine 0.2% eyedrops to Resident 428. However, while administering the drops, the tip of the dropper bottle touched the patient's eyelashes and was placed very closely to the eye. This resulted in Resident 428 repeatedly blinking their eyes, and it was evident that their eyelashes made contact with the tip of the bottle. Maintaining proper technique during eyedrop administration is crucial to avoid potential contamination and ensure the safety of patients. In this case, the nurse should be reminded of the importance of adhering to recommended practices and taking necessary precautions to prevent contact between the dropper tip and the patient's eyelashes or any other surface. During an interview conducted on 8/21/24, at 9:20 AM, Registered Nurse 2 acknowledged that she had held the tip of the Olopatadine 0.2% eyedrop bottle too close to Resident 428's eyes during administration. RN 2 also admitted that she noticed Resident 428 was blinking excessively during the process. Recognizing these issues, RN 2 expressed her intention to improve her technique in the future to prevent similar incidents from occurring again, demonstrating a willingness to learn from her experience and prioritize patient safety.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41337 Based on observation, interview and record review the facility failed to maintain a sanitary kitchen when: 1. A rodent dropping was found under the cooking line (area in the kitchen where multiple pieces of cooking equipment are in a line), this area had a build-up of food, black grime and trash. 2. Multiple areas in the kitchen on the floor under equipment, there was old food, trash and black grime. 3. The ice machine had a black grime build-up on the area above the ice grates where water flows to fill up the grates. 4. Utensils were stored with a build-up of old food. 5. The refrigerator utilized to store food for activities was food crumbs and spills and expired foods. 6. Multiple floor drains in the kitchen had a build-up of old food and grime. 7. The dating system in the walk-in refrigerator was not accurate and readable. These failures had the potential to cause foodborne illness in 332 out of 338 medically compromised residents who receive food from the kitchen. Findings: 1. During an observation, on the meat preparation side of the kitchen, on [DATE], at 10:40 AM, on the floor under the tilting skillet (cooking equipment that allows the user to prepare a variety of foods in large batches), there was a build-up of food, trash and a rodent dropping was found. On the floor under the cooking line in this same area, there was a scattered build-up of old food, crumbs, grease and black grime. During an interview with the Technician 2 from [company name] pest control on [DATE], at 3:40 pm, he stated if food is left out, it can attract rodents. T2 verified that the rodent dropping found at 10:40am was mouse dropping. He stated that due to the size of the dropping (larger than usual) it was probably a breeder mouse. He stated that there is an exterior door that goes to the outside that is automatic and stays open for a certain amount of time and this could be how the mice are entering the kitchen. During an interview with the Infection Preventionist 1 (IP1), on [DATE], at 10:03 AM, IP1 agreed that salmonella is a concern because the mouse could contaminate the food. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Registered Dietitian 1 (RD1) and the Director of Dining Services (DDS), on [DATE], at 12:31 pm. The DDS stated that the floors under the equipment should be maintained clean and there should not be any rodent droppings. During a review of the policy titled Sanitation and Infection Prevention/Control, dated [DATE], indicated, the Food and Nutrition Services department shall be free of all rodents and insects. During a review of the FDA Federal Food Code, dated 2022, ,d+[DATE].111 indicated, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (B) Routinely inspecting the PREMISES for evidence of pests; . (D) Eliminating harborage conditions. In addition, Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. 2. During an observation in the kitchen, on [DATE], at 3:05pm, the floor underneath the coffee cart near the handwashing sink had black grime and trash. During an observation in the kitchen on [DATE], at 3:27 pm, there was a build-up of food under the tilting skillet and under the flat top grill and two ovens. During an observation in the kitchen, on [DATE], at 9:48 am, on the floor under the under the counter fridge #14 and #15, there was a build-up of food crumbs. During an observation in the kitchen, on [DATE], at 10:23 am, the floor under the stainless steel counters in the vegetable preparation area had a build-up of black grime and food crumbs. During an interview on [DATE], at 3:03 pm, with the Technician (T1) from [company name], T1 stated they come every 60 days to deep clean the cooking equipment. He stated that [DATE]th was the last time he was at the facility to do a deep clean. He stated they are not currently contracted to do deep cleaning of the floors. During an interview with the Director of Dining Services (DDS) on [DATE], at 3:22 pm, The DDS stated that she thought they were doing the deep cleaning of the floors, and she was not aware that they were not contracted to do regular deep cleaning of the floors under equipment. She stated that her staff cleans the floor daily but does not clean the floor under the equipment because its harder to clean. During an interview with the Director of Dining Services (DDS) on [DATE], at 12:33 pm, DDS stated that the floors under equipment should be kept clean and free of any debris. During a review of the facility policy titled Sanitation and Infection Prevention/Control, dated [DATE], indicated nonfood contact surfaces of utensils and equipment must be . maintain in good condition. In addition, nonfood contact surfaces of equipment . shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the FDA Federal Food Code, dated 2022, ,d+[DATE].11 indicated (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. 3. During an observation and concurrent interview with the Director of Dining Services (DDS) on [DATE], at 3:34 pm, the ice machine had a black grime build-up on the area above the ice grates where water flows to fill up the grates. The shield that covers the ice grates was covered in black grime. The top portion of the ice bin also had a build-up of black grime. DDS stated that they contract with a company to come every 6 months to clean the ice machine. She stated after finding this build-up she is going to need to do frequent checks of the internal cleanliness of the ice machine. During an observation on [DATE], at 3:36 pm, Director of Dining Services (DDS) stated that the ice machine is used for water pitchers and to keep food cold. During an interview with the Director of Dining Services (DDS) on [DATE], at 12:33 pm, FSD stated the interior part of the ice machine where the ice is made should be kept clean with no build-up of any kind. During a review of the FDA Federal Food Code, dated 2022, ,d+[DATE].11 indicated, ,d+[DATE].11 (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, . EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. In addition, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. 4. During an observation in the kitchen and concurrent interview with the Director of Dining Services (DDS) on [DATE], at 10:23 am, there were two vegetable peelers stored ready for use in a drawer that were coated in food grime. Per the DDS, all the utensils should be stored clean and shouldn't have any build-up of old food. In another drawer there was a mandolin (utensil for slicing) and a vegetable slicer were crusted with old food and stored ready for use. During an interview with the DDS on [DATE], at 12:33 pm, the DDS stated utensils should be stored free of food debris. During a review of the FDA Federal Food Code, dated 2022, ,d+[DATE].11 indicated, (A) Equipment food-contact surfaces and utensils shall be cleaned: .(5) At any time during the operation when contamination may have occurred. In addition, Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an observation in the kitchen on [DATE], at 3:05 pm, the refrigerator next to the handwashing sink that was used to store food for activities had a half gallon of expired milk, puree challah with no date, and a block of yellow cheese that was expired. During an interview with the Director of Dining Services (DDS) on [DATE], at 12:33 pm, DDS stated, all expired foods should be discarded. During a review of the facility policy titled, Production, Purchasing, Storage, dated [DATE], indicated all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. In addition, Use manufacturer's expiration date for products. 6. During an observation in the kitchen on [DATE], at 3:05 pm, the floor sink under the handwashing sink where water drains had a build-up of old food and black grime. During an observation on [DATE] at 3:23 pm, the floor sink on the dairy side of the kitchen had a build-up of food and black grime. During an interview with the Director of Nutrition Services (DNS) on [DATE], at 12:33 pm, DNS stated the floor drains should be maintained clean. During a review of the FDA Federal Food Code, dated 2022, ,d+[DATE].11 indicated (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. 7. During an observation and concurrent interview with the Director of Dining Services (DDS) and the Registered Dietitian 1 (RD1) in the Walk-in refrigerator, on [DATE], at 10:04 am, there was a large bowl of salad dressing with no label or date. There was a fruit salad that was not dated, and a bag of shredded carrots with a use by date of [DATE]. RD 1 stated that even though the sticker on the carrots with the date says use by, it should have read opened on. The DDS stated that they would need to in-service staff on how to use the dating gun correctly. During an interview with the Director of Dining Services (DDS) on [DATE], at 12:33 pm, DDS stated anything that has been opened should have a use by date, or received by date and prepared foods should have a use by date or expiration date. During a review of the facility policy titled, Production, Purchasing, Storage, dated [DATE], indicated all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. In addition, Use manufacturer's expiration date for products.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26917 Based on observation, interview, and document reviews it was found that the facilities' Quality Assessment Performance Improvement (QAPI) program was ineffective. Despite its purpose to proactively identify and prevent medication administration errors, it fell short. This was evident during a medication pass observation conducted during the survey, which revealed multiple medication errors related to eye drops (See F759). Findings: The hospital policy, Specific Medication Administration Procedures - Eyedrop Administration, Section 8.5, aims to ensure the safe and accurate administration of ophthalmic solutions by outlining specific steps, such as wearing gloves, creating a pouch with the lower eyelid, and carefully dispensing drops without touching the dropper to any surface. However, during an observation on 08/20/24, Licensed Vocational Nurse (LVN) 1 administered Systane eye drops to Resident 102 but allowed the dropper tip to touch the resident's eyelashes, which is a deviation from the recommended sterile technique. Systane is used to relieve dry, irritated eyes, and maintaining dropper sterility is crucial to prevent contamination. LVN 1 later acknowledged the mistake during an interview, underscoring the importance of adhering to proper procedures to ensure the safe and effective administration of eye medications to residents like Resident 102. During an observation on 08/20/24 at 12:23 PM, Licensed Vocational Nurse (LVN) 2 administered Systane eye drops to Resident 217 without wearing gloves, raising concerns about infection control. Additionally, the dropper tip touched the resident's eyelashes, which deviates from the recommended sterile technique. In an interview at 12:30 PM, LVN 2 confirmed that she did not wear gloves and acknowledged that the dropper tip touched the eyelashes due to difficulties during the procedure. This incident highlights the importance of adhering to proper infection control standards, such as wearing gloves and avoiding contact between the dropper tip and any surface, including eyelashes, to ensure safe and effective administration of ophthalmic solutions for residents like Resident 217. During an observation on 8/21/24 at 9:15 AM, Registered Nurse (RN) 2 administered Opatadine 0.2% eyedrops to Resident 428. During the procedure, the tip of the dropper bottle touched the resident's eyelashes and was placed very close to the eye, causing the resident to blink repeatedly. This contact between the dropper tip and the eyelashes raised concerns about potential contamination and improper technique. In an interview at 9:20 AM, RN 2 acknowledged that she had held the dropper too close to Resident 428's eyes and noticed the excessive blinking. She expressed her intention to improve her technique in the future, demonstrating a commitment to learning from the incident and prioritizing patient safety. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 3:30 PM an interview was conducted with two members of the Quality Committee: the Assistant Director of Nursing, the Director of Nursing, and the Administrator. During this interview, it was noted that they had not identified any issues related to medication pass observations. Furthermore, they did not have any ongoing performance improvement projects specifically aimed at addressing medication errors. However, the Quality Committee members acknowledged the need for improvements in the medication administration process. They expressed concern over the survey results, which indicated a medication error rate of 15%. This statistic underscores the urgency of their commitment to enhancing the current procedures.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview, and record review, the facility failed to maintain infection control program and practices designed to help prevent the development and transmission of diseases and infections when: 1. Certified Nursing Assistant (CNA) 1 did not perform hand hygiene between Resident 327 and Resident 289 in the dining room in G ([NAME] Building) 2. 2. The facility failed to maintain 6 out of 6 wash machines per manufacturer's recommendation. These failures had the potential for spread of infection to residents and staff. Findings: 1. During an observation on 8/21/24 at 1:58 PM in the dining room in G2, CNA 1 assisted Resident 327, then cleaned Resident 327's table with a towel. Then CNA 1 went directly to Resident 289's table, then assisted Resident 289 without performing hand hygiene. During an interview on 8/21/24 at 2:03 PM with CNA 1 in the dining room in G2, CNA 1 acknowledged he did not perform hand hygiene between Resident 327 and Resident 289 when asked. CNA 1 stated, Infection when asked why he needed to perform hand hygiene. During an interview on 8/22/24 at 9:48 AM with Nurse Manager (NM) 1, NM 1 stated, Of course! I think so when asked if hand hygiene should be performed between two residents in the dining room. During an interview on 8/28/24 at 10:15 AM with infection preventionist (IP), IP acknowledged hand hygiene should be done between two residents when asked. Review of the facility's policy and procedure titled, Hand Hygiene revised in May 2024 indicated, . Jewish Home & Rehab Center considers hand hygiene the primary means to prevent the spread of infections . for the following situations: . I. After contact with a resident's intact skin . O. Before and after . handling food; P. Before and after assisting a resident with meals . 43913 2. During an interview with AS, Laundry person 1, per AS, the washing machines are maintained quarterly by the company they were purchased these from. They come and do all the checks on these machines, including the chemical machines. Observation on 8/27/24 at 11 AM, 5 washing machines running. During an interview on 8/27/24 at 11:15 AM, with EVS (Environmental Services) Manager, per EVS manager, the company they were purchased the machines from comes quarterly on their schedule, we don't call them they just show up for maintenance. The last billing was done 2/27/24, last routine maintenance check. Per the oompany they were purchased from the contract has terminated. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the contract, Planned Maintenance Program Proposal, dated 3/22/23, 1. Maintenance agreement . Owner may herebycontract with our company for purposes of performing maintenance procedures recommended by the manufacturer of Owner's laundry equipment for a period of (1) year from the date of agreement. Owner signed 7/26/23. Review of facility Policy and Procedure, Linens- Laundry Services, dated 04/24, indicated, Processing Laundry Including the Use of Laundry Equipment and Detergents in the Facility.Laundry Equipment(e.g. Washing machines ,dryers) is used and maintained according to the manufacturer's IFU(Instructions for use) to prevent microbial contamination of the system.		

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 08/28/2024
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 41337 The facility failed to maintain equipment in safe operating condition when reach-in refrigerator #7 had condensation inside the refrigerator that was dripping on food. This had the potential to contaminate food and cause food-borne illness to 332 out of 338 medically compromised residents who receive food from the kitchen. Findings: During the initial tour of the kitchen and concurrent interview with the Director of Dining Services (DDS) on August 20, 2024 at 3:14 pm, the reach-in refrigerator #7 on the dairy side of the kitchen had condensation dripping from the ceiling of the fridge onto food. The DDS stated that the hinge of the door needs to be realigned to prevent the condensation from forming. She stated the surveyor that observed earlier discovered it. During a review of the facility policy titled Safety and Equipment Maintenance, dated January 2024, indicated, proper maintenance of the physical plant and all equipment in the department is the responsibility of the Director in cooperation with the Maintenance department. During a review of the FDA Federal Food Code, dated 2022, 4-501.11 indicated, (A) EQUIPMENT shall be maintained in a state of repair and condition. In addition, Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures.		