STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055280	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Gardens Post Acute	1355 Ellis Street San Francisco, CA 94115

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on Interviews and record reviews, the facility failed to ensure the allegation of resident-to-resident abuse was promptly reported to the State Agency (SA, which is the California Department of Public Health, CDPH) in accordance with the facility ' s policy and procedure for four of 4 sampled residents (Resident 1, Resident 2 Resident 3, and Resident 4). Failure to promptly report allegation of abuse had the potential for further abuse to happen and thereby increasing the chances of harm to the residents. Findings: During a review of Admission Record, dated [DATE], indicated, Resident 1, admitted to facility on [DATE], with diagnoses including: Seizures (involuntary body jerking), Adult failure to thrive, Dementia (loss of memory). Resident discharged on [DATE]. Review of Admission record, dated, [DATE], indicated, Resident 2, admitted to facility on [DATE] with diagnoses including: Compression Fracture Lumbar, Cirrhosis of Liver (damaged liver from various causes) , Malignant Neoplasm of Larynx (Cancer of the voice box). Patient expired [DATE]. During a review of facility Investigation Summary, dated, [DATE], indicated, on [DATE] at 2125, CNA reported to LN that Resident 2 told him that his roommate alleged splashed liquid in his face. LN separated residents .Resident 2, alert and oriented, interviewed by LN, per resident, was about to go sleep, when other resident who was sitting in his bed, opened the curtain and splashed liquid in my face. It feels like water from a cup .Resident 1 was transferred to another room. Per resident 1, I don ' t know what happened, I did not do anything. I ' m sorry about that. Resident 1is confused at baseline. Assessment done for both residents . Resident 2 was happy when resident 1 was transferred to another room. MD notified, RP notified for both. Local police notified, Ombudsman notified, CDPH notified, SOC faxed . During an interview on [DATE] at 2;14 PM, with Scial Worker Designee (SW), per SW, she remembers the incident, these two were roommates, resident 1 is a wanderer, he has Dementia. Resident 1 splashed water on roommate ' s face, it was in the evening. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 is alert and oriented, he stated, that his roommate opened the curtain and splashed liquid in his face most likely water from his table. They were separated, resident 1was moved to another room and resident 2 was satisfied and thank staff for the prompt action. During a review of nurses notes for monitoring, for ,d+[DATE]/- [DATE], resident 1, no signs of distress, was in bed all night .confused, walking in hallway wanted to smoke . confused walking in the hallway looking for relative. Refused nicotine patch application but consented when wife arrived . During an interview on [DATE] at 2:33 PM , with Registered Nurse (RN), PM nurse supervisor, per RN, resident 1, got up and threw water to resident 2. Resident 1 was transferred to another room, and resident 2 like that. There was no issue after that. SOC was completed, left voicemail message with CDPH and Ombudsman. both patients monitoring done, DSD gave inservice to staff on abuse. Mr Papkov was on Hospice and expired [DATE]. During a review of Interdisciplinary Note (IDT) note, dated [DATE], indicated, at 2125 CNA notified LN that resident that Resident 2 told him that his roommate alleged splashed liquid in his face. LN separated residents .Resident 2, alert and oriented, interviewed by LN, per resident, was about to go sleep, when other resident who was sitting in his bed, opened the curtain and splashed liquid in my face. It feels like water from a cup .Resident 1 was transferred to another room. Per resident 1, I don ' t know what happened, I did not do anything. I ' m sorry about that. Resident 1is confused at baseline. Assessment done for both residents . Resident 2 was happy when resident 1 was transferred to another room. MD notified; RP notified for both. Local police notified with reference number, Ombudsman notified. At 2152 CDPH notified and spoke with [NAME], after 15 minutes [NAME] from CDPH called the facility and informed the LN that they can send the SOC 341 tomorrow morning after 8 PM if having trouble faxing it.At 740 AM,DON faxed the SOC to CDPH, at 0805 , DON called CDPH phone number to verify if the SOC was received, went straight to voicemail, VM was left awaiting response. During an interview on [DATE] at 5 PM, with Director of Nursing (DON), per DON, the RN called the CDPH number to notify about the alleged abuse and faxed the SOC. The faxed machine on [DATE] was not printing receipts, but able to fax out as indicated in the fax machine window message. No confirmation of transmittal page was printed. During an iInterview on [DATE] at 5 PM, with RN, per RN, she called the CDPH number from the website, she has to search the number (unable to give that phone number), and spoke to two people from CDPH,and informed LN that they can send the SOC 341 tomorrow morning after 8 PM if having trouble faxing it. During a review of facility document, Care Plan, initiated [DATE] for both residents, updated, no issues. Interview on [DATE] at 3:23 Pm, with Director of Staff Development (DSD), /DSD, per DSD, Abuse inservices are given every month for all staff. It is given through powerpoint presentation in the conference room. During a review of voicemail messages in the CDPH office on [DATE] at 9AM with CDPH office staff, per office staff no voicemail message left on [DATE] or [DATE], to report abuse . SOC 341 was received in the office on [DATE] via fax. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Admission Record, dated, [DATE], indicated, Resident 3 admitted to facility on [DATE] with diagnoses including: Compression Fracture of Lumbar vertebra, (small breaks or cracks in the bones of the spinal column) Osteonecrosis (death of a bone tissue due to interruption of blood supply), Anxiety Disorder (uncontrollable feelings of fear). Patient discharged on [DATE]. During a review for Resident 3 ' s MDS- Cognitive Patterns, dated [DATE], indicated, Brief Interview for Mental Status (BIMS), score is 11, no cognitive impairment. During a review of Admission Record, dated, [DATE], indicated, Resident 4 admitted to facility on [DATE] with diagnoses including Intracranial(brain) injury without loss of consciousness s/p pedestrian injured in traffic accident, Hemiplegia (weakness in one side of body) Cervicalgia (formal way of calling neck pain or cervical pain). Patient discharged [DATE]. During a review for Resident 4 ' s MDS- Cognitive Patterns, dated [DATE], indicated, Brief Interview for Mental Status(BIMS), score is 12, no cognitive impairment. During a review of facility ' s Investigation Summary, dated, [DATE], indicated, On [DATE], Resident 3 came back from his appointment at 1550, upon returning to his room, resident 3 informed Administrator in Training (AIT), claiming that his former roommate allegedly stole his Identification card and $32.00 cash .Resident 4 was discharged on [DATE]. Ombudsman was notified via phone. CDPH was informed at 1710 via phone and spoke with [NAME]. Local police were notified. SOC 341 was faxed afterwards. RN called Resident 4 ' s listed number .not answering phone with multiple attempts. Facility not able to get a statement from resident 4 . facility investigation, spoke with the staff worked with resident 3, staff stated no awareness of said allegation, staff also were not notified by resident 3 he has some cash in his possession. Residents interviewed stated, no concerns about care rendered by staff . no mention in his inventory list that he signed that he has cash in possession . During a review on [DATE] at 4PM, of facility document, Inventory of Personal Items, signed by resident 3 on [DATE], no indication of ID or cash on the list. During a review of Interdisciplinary Team (IDT) note, dated [DATE], indicated, on [DATE], Resident 3 came back from his appointment at 1550, upon returning to his room, resident 3 informed Administrator in Training (AIT), claiming that his former roommate allegedly stole his Identification card and $32.00 cash .Resident 4 was discharged on [DATE]. DPOA for patient care was called at 1645 and was informed in regards to patient ' s complain. Ombudsman informed at 1700 via phone call and voicemail was left. CDPH was informed at 1710 via phone and spoke with an agent ([NAME]) and reported the alleged financial abuse. Local police were notified at 1720. PIMG was called at 1725 and was able to talk to PA (Physician Assistant). Ombudsman called back the facility at 1745, LN was able to talk to him in regards to alleged financial abuse . patient monitored for any emotional and psychological distress every shift. During an interview on [DATE] at 5PM, with Director of Nursing, per DON, he called CDPH office and talked to an agent named [NAME] as indicated in nurses notes and IDT notes dated [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3PM, with Director of Staff Development(DSD), per DSD, the inservice for Abuse is given monthly to all staff via powerpoint. Review of Inservice Lesson Plan dated [DATE], was provided and [DATE] to include, Inventory guidelines. Per DSD, no specific inservice for misappropriation, it ' s a part of the Abuse class. During an interview on [DATE] at 2:15PM, with Social Worker Designee (SW), per SW these residents were roommates, resident 3 was admitted first in that room. There was no complaints from both of them, but that [DATE], alleged financial abuse. The staff will list all personal belongings on admission, money is not in the list. Most patients will want to keep them if alert and oriented. Or we put in safe, patient has to agree to that. During an interview on [DATE] at 9:30 AM, with CDPH office staff, per office staff, no voicemail notification from facility on [DATE], no staff or agent at CDPH named [NAME]. No SOC 341 received via fax on [DATE]. Office received 5day summary on [DATE]. Facility provided transmission verification result with fax number [DATE] (not CDPH fax number). Review of facility Policy and Procedure, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, dated ,d+[DATE], indicated, 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .3. Immediately is defined as: a. Within two hours of an allegation involving abuse or result in serious injury .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to ensure baseline care plan was developed within 48 hours of admission for Resident 6 and a copy of the baseline care plan summary was provided to the resident and/or representative for three of 3 sampled residents (Resident 5, 6, and 7). A Baseline Care Plan (BCP) includes minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline, injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. The deficient practice resulted in Resident 5, 6, and 7, and/or RP not receiving information of the initial plan of care; and had the potential to result in inadequate care and services rendered to the residents. Findings: Review of Resident 5 ' s admission record indicated, admitted to facility on 4/11/24 with diagnoses including rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), kidney disease, pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident 5 ' s Minimum Data Set (MDS, a resident assessment tool) dated 4/15/24, indicated, no cognitive (thought process) impairment. Review of Resident 5 ' s Baseline Care Plan dated 4/11/24, indicated, na (not applicable) under section E. Baseline Care Plan Summary - Resident and/or Resident Representative (RR) participated in the Baseline Care Plan review with a printed/written summary provided . Printed Baseline Care Plan provided via: 2a. In person .2b. Fax .2c. Mail .2d. Email . Review of Resident 6 ' s admission record indicated, admitted to facility on 12/1/23 with diagnoses including cancer of the prostate, cervical disc degeneration (caused by decreased water content of the disc or desiccation which leads to tears in the outer ring or the annulus fibrosus), and glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of the eye). Review of Resident 6 ' s MDS dated [DATE], indicated no cognitive impairment. Review of Resident 6 ' s Baseline Care Plan dated 12/1/23, indicated, all sections were not completed within 48 hours. The baseline care plan indicated, Social Services section was completed on 12/4/23, Rehabilitative Services completed on 12/5/23, and Activity Preferences completed on 12/4/23. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review indicated, Resident 6 ' s Baseline Care Plan Summary dated 12/1/23, indicated, na (not applicable) under section E. Baseline Care Plan Summary - Resident and/or Resident Representative (RR) participated in the Baseline Care Plan review with a printed/written summary provided . Printed Baseline Care Plan provided via: 2a. In person .2b. Fax .2c. Mail .2d. Email . Review of Resident 7 ' s admission record indicated, admitted to facility on 4/23/24 with diagnoses including kidney disease, congestive heart failure (a long term condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and depression. Review of Resident 7 ' s Baseline Care Plan Summary dated 4/23/24, indicated, na (not applicable) under section E. Baseline Care Plan Summary - Resident and/or Resident Representative (RR) participated in the Baseline Care Plan review with a printed/written summary provided . Printed Baseline Care Plan provided via: 2a. In person .2b. Fax .2c. Mail .2d. Email . During interview and concurrent record review on 4/25/24 at 5:08 PM, the Director of Nursing (DON) reviewed Resident 5, Resident 6, and Resident 7 ' s Baseline Care Plan. The DON acknowledged and stated, Resident 6 ' s baseline care plan was not completed on time and that all sections should be completed within 48 hours. During further interview, the DON stated, na written on the Baseline Care Plan Summary means not reviewed and provided to the resident. Review of facility ' s policy and procedure titled, Care Plans - Baseline, revised December 2022, indicated, A baseline plan of care should be developed for each resident within forty-eight (48) hours of admission. 1. The baseline care plan should include instructions needed to provide effective, person-centered care of the resident, which may include the following: . d. Therapy services; e. Social Services . 4. The resident and/or representative should be provided a written summary of the baseline care plan as guided by the discussion noted above.