

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Central Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>31524</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a Level I Pre-Admission Screening and Resident Review (PASARR) accurately reflected the presence of diagnosed mental illnesses for 1 (Resident #7) of 3 residents reviewed for PASARR requirements. Specifically, Resident #7 had a Level I PASARR completed upon readmission to the facility that did not reflect all their mental health diagnoses.</p> <p>Findings included:</p> <p>An undated facility policy titled, Admission Criteria, indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.</p> <p>Resident #7's Admission Record indicated the facility originally admitted the resident on 10/03/2020 and most recently admitted the resident on 05/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of delusional disorders and schizophrenia.</p> <p>Resident #7's Care Plan Report included a focus area, initiated on 02/14/2023, that indicated the resident had a mood problem related to schizophrenia.</p> <p>A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2024, revealed that at the time of the assessment, Resident #7 had active diagnoses that included psychotic disorder and schizophrenia.</p> <p>Resident #7's Level I PASSAR, completed by a local hospital on 05/03/2024, revealed Section III- Serious Mental Illness, question 10 was answered no to indicate the resident did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. As a result, the resident's Level I PASARR was Negative, and a Level II Evaluation was not required.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Central Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/19/2025 at 9:04 AM, the Director of Nursing (DON) stated the Admissions Director and the Marketer were responsible for reviewing PASARRs completed by a hospital at the time of each resident's admission. The DON further stated he expected the admissions team to ensure all pertinent diagnoses were included on PASARRs. The DON stated Resident #7 had diagnoses of schizophrenia and delusional disorder, which were considered serious mental illnesses. The DON further stated Resident #7's Level I PASARR dated 05/03/2024 was inaccurate because it did not reflect the resident's mental health diagnoses.</p> <p>During an interview on 02/20/2025 at 9:08 AM, the Admissions Director stated he received Level I PASARRs from the hospital for new admissions, and he reviewed them for accuracy. The Admissions Director further stated he would have reviewed Resident #7's most recent PASARR dated 05/03/2024 for accuracy and was not sure how the resident's mental health diagnoses were missed. The Admissions Director stated Resident #7's 05/03/2024 Level I PASARR was not accurate, because it did not reflect the resident's mental health diagnoses.</p> <p>During an interview on 02/20/2025 at 10:40 AM, the Administrator stated Level I PASARRs were completed at the hospital prior to each resident's admission. The Administrator further stated Resident #7 went to the hospital in May 2024, and their PASARR was completed by the hospital. The Administrator stated Resident #7's Level I PASARR completed on 05/03/2024 was inaccurate because it did not include their mental health diagnoses, and the admitting staff should have caught the inaccuracy and completed a new Level I PASARR for Resident #7.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Central Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of less than 5 percent (%). Specifically, the facility had 2 errors out of 30 opportunities, resulting in a medication error rate of 6.67 %, affecting 1 (Resident #39) of 6 residents observed during medication administration.</p> <p>Findings included:</p> <p>A facility policy titled Medication Administration, revised 04/2019, indicated, 10. The individual administering the medication verifies the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>An Admission Record revealed the facility admitted Resident #39 on 07/19/2024. According to the Admission Record, Resident #39 had a medical history that included a diagnosis of unspecified bipolar disorder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition.</p> <p>Resident #39's Care Plan Report included a focus area, initiated 10/10/2024, that indicated the resident was at risk for complications related to a sinus infection. An intervention dated 10/10/2024 directed staff to administer medication per physician's orders. The Care Plan Report also included a focus area, initiated 02/18/2025, that indicated the resident had a behavior problem manifested by angry outbursts. An intervention dated 02/18/2025 directed staff to administer medications as ordered.</p> <p>Resident #39's Order Summary Report contained an active order dated 02/01/2025 for Debrox otic solution 6.5 % with instructions to instill 10 drops into both ears twice a week on Wednesdays and Saturdays for ear wax removal. The Order Summary Report also contained an order dated 01/21/2025 for lurasidone hydrochloride (an antipsychotic medication) 20 milligrams (mg) with instructions to give 40 mg (equivalent to two tablets) each morning for bipolar disorder.</p> <p>A concurrent observation and interview on 02/19/2025 at 7:41 AM revealed Registered Nurse (RN) #1 was preparing morning medications for Resident #39. As RN #1 prepared the resident's medications, it was noted she placed only one 20 mg tablet of lurasidone into the medication cup. RN #1 was stopped and asked to read the medication directions on the label and to review the physician's order on the resident's Medication Administration Record (MAR). The nurse then added a second tablet of lurasidone to the medication cup. During medication administration, RN #1 picked up the bottle of Debrox otic solution and placed the bottle into the resident's right nasal passage. The nurse was stopped before she instilled the drops into the resident's left nostril. RN #1 was interviewed immediately upon leaving Resident #39's room. She confirmed she had not read the label correctly for the lurasidone and had only placed one 20 mg tablet into the cup until reminded to read the medication label and orders. RN #1 stated she also made a mistake by instilling the resident's ear drops into the resident's nostril due to being nervous.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Central Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed on 02/19/2025 at 9:10 AM and stated that when a nurse gave medications, he expected the nurse to check and make sure the right dose was given to the right patient in the right room by the right route at the right time. The DON stated RN #1 should have read the label carefully for the lurasidone and given two tablets as ordered by the physician. The DON stated he would have expected the ear drops to be administered by the right route for Resident #39.</p> <p>A telephone interview was held with the Consultant Pharmacist (CP) on 02/20/2025 at 7:56 AM. The CP stated he expected nurses to double check medications before administering them to make sure the medications had been prepared correctly, which included making sure the right dose of the right medication was given to the right resident by the right route. The CP stated instilling ear drops into Resident #39's nose and preparing the wrong dose of lurasidone were considered medication errors.</p> <p>The DON was interviewed on 02/20/2025 at 10:00 AM and stated the nurse made medication errors when she gave the medication by the wrong route and did not give the correct dosage of lorasidone. He stated he expected nurses to give the right medication by the right route and expected the right dose to be given.</p> <p>The Administrator was interviewed on 02/20/2025 at 10:15 AM. The Administrator stated he expected the nurses to make sure they gave the right medication, the right dosage, by the right route, to the right resident. The Administrator stated that when RN #1 had not given the right dosage of medication to Resident #39 and administered the ear drops by the wrong route, medication errors were made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Central Gardens Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>22445</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) when providing care to 1 (Resident #155) of 1 resident requiring EBP observed during the provision of care. Specifically, staff failed to wear a gown during resident care that consisted of touching the resident and their feeding tube.</p> <p>Findings included:</p> <p>An Admission Record revealed the facility admitted Resident #155 on 02/08/2025. According to the Admission Record, Resident #155 had a medical history that included a diagnosis of gastrostomy (surgical procedure to create an opening in the abdominal wall into the stomach) status.</p> <p>Resident #155's Care Plan Report included a focus area, initiated on 02/08/2025, that indicated the resident required tube feeding related to dysphagia (difficulty swallowing). The Care Plan Report also included a focus area, initiated on 02/17/2025, that indicated the resident required EBP during high-contact resident-care activities due to the presence of an indwelling medical device (feeding tube).</p> <p>During a concurrent observation and interview on 02/17/2025 at 10:35 AM, Licensed Vocational Nurse (LVN) #2 entered Resident #155's room and donned a pair of gloves but no gown. While in the room providing care to the resident, LVN #2 was observed leaning over the resident's bed and body, touching the resident's body, and manipulating the resident's feeding tube. LVN #2 stated she should have donned a gown before going into the resident's room, due to the risk of spreading germs.</p> <p>The Infection Preventionist (IP) was interviewed on 02/19/2025 at 12:20 PM. The IP stated if a resident required EBP, and staff went into the resident's room and touched the resident and/or manipulated their feeding tube, she expected staff to wear both a gown and gloves to minimize the risk of spreading germs to other residents and to themselves.</p> <p>The Director of Nursing (DON) was interviewed on 02/20/2025 at 10:09 AM. The DON stated Resident #155 required EBP, and staff should have worn a gown when touching the resident and manipulating the resident's feeding tube.</p> <p>The Administrator was interviewed on 02/20/2025 at 10:13 AM. The Administrator stated staff had been trained to wear gowns when entering a resident's room to provide care if the resident required EBP.</p>