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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055331 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/19/2024 |
| NAME OF PROVIDER OR SUPPLIER San Rafael Healthcare & Wellness Center, LP | | STREET ADDRESS, CITY, STATE, ZIP CODE 1601 5th Avenue San Rafael, CA 94901 | |
| 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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322</p> <p>Based on interview and record review, the facility failed to manage the dialysis (use of a machine to clean the blood when the kidneys are no longer able to do this) care of one of two sampled residents (Resident 1) when facility staff did not obtain a physician's order for Resident 1's dialysis, did not include his dialysis schedule in his care plan, did not transport Resident 1 to his scheduled dialysis appointments or transported Resident 1 late to his appointments, did not document Resident 1's missed appointments, did not notify Resident 1's physician about his missed appointments, and did not document the reason the appointments were missed. These failures had the potential to result in negative health outcomes for Resident 1 when his caregivers may not have readily available all the information they need regarding his dialysis care and potentially left his doctor unaware of how many dialysis appointments he is missing.</p> <p>Finding:</p> <p>During an interview on 7/1/24 at 1:03 p.m., an anonymous complainant stated the facility had been having issues with transporting Resident 1 to his dialysis appointments. The anonymous complainant stated the issues had been either the drivers arrived late to pick up Resident 1 or they did not come at all. The anonymous complainant stated the transportation issues resulted in Resident 1 missing his appointments or the sessions were cut short. The anonymous complainant stated Resident 1 was supposed to get 3.5 hours (210 minutes) of dialysis from 2:45 p.m. to 6:15 p.m. on Mondays, Wednesdays, and Fridays, and two hours of dialysis from 2:30 p.m. to 4:30 p.m. on Thursdays. The anonymous complainant stated Resident 1 never got the full 3.5 hours of dialysis and he had missed his appointments on 6/10/24, 6/17/24, 6/21/24 and 6/24/24.</p> <p>During an interview on 7/2/24 at 11:29 a.m., when queried, Resident 1 stated he had been late to his dialysis appointment last week.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 055331 |
| | | If continuation sheet Page 1 of 4 |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a record review on 7/2/24 at 12:12 p.m., Resident 1's face sheet indicated an admitted [DATE] and multiple medical diagnoses including end stage renal (related to the kidneys) disease and dependence on renal dialysis. Review of Resident 1's active physician orders for his current admission revealed no order for dialysis except one order for an extra dialysis day on 6/25/24 at 10:30 a.m. Review of Resident 1's dialysis care plan, dated 6/4/24, did not include his dialysis schedule and indicated, Resident receives dialysis 3 [times per] week. Review of Resident 1's physician note dated 6/10/24 indicated Resident 1 just returned from several days in the hospital after having chest pain, and his Dialysis schedule (is) now M/W/Th/Fri (Monday, Wednesday, Thursday, Friday). Review of Resident 1's progress notes revealed no documentation on 6/10/24, 6/17/24, or 6/21/24 regarding his missed dialysis appointments or any notes indicating the resident was late for dialysis. Review of Resident 1's nurse progress note dated 6/24/24 at 3:35 p.m., indicated that Resident 1 refused to go to his dialysis appointment due to loose bowel movements. The note further indicated the nurse had informed Resident 1's nurse practitioner and the nurse at the dialysis center.</p> <p>During a record review on 8/16/24 at 4 p.m., documentation of Resident 1's dialysis sessions obtained from the dialysis center indicated Resident 1 had missed appointments on 6/10/24, 6/17/24, 6/21/24, and 6/24/24. Under Comments section for 6/10/24, a note was entered, Reschedule tomorrow. For 6/17/24 a note was entered, called facility pt (patient) was not picked up by the transportation. Social worker trying to set up a ride for tomorrow [sic]. For 6/21/24, a note was entered, pt reschedule [sic] for tomorrow d/t (due to) transportation issue. For 6/24/24, a note was entered, pt refused to come in d/t diarrhea, requested to reschedule tomorrow. Review of Resident 1's document Hemodialysis Flowsheet dated 6/26/24 indicated under Pre Dialysis Comments section, Pt arrived late, treatment shortened by 15 min(utes) [due to] transportation issues. Review of Resident 1's document Hemodialysis Flowsheet dated 6/28/24 indicated under Post Dialysis Comments section, Pt came in late due to transportation.</p> <p>Continuing the record review on 8/16/24 at 4 p.m., documentation of the duration of Resident 1's dialysis sessions indicated the session on 6/11/24 was 154 minutes (56 minutes short), 6/12/24 was 172 minutes (38 minutes short), 6/14/24 was 148 minutes (62 minutes short), 6/19/24 was 177 minutes (33 minutes short), 6/25/24 was 179 minutes (31 minutes short), and 6/28/24 was 136 minutes (74 minutes short). Resident 1 had no dialysis documented on 6/18/24 or 6/22/24.</p> <p>During an interview on 8/19/24 at 2:08 p.m., Social Services Director (SSD) stated her role in arranging transportation for residents' appointments. SSD stated Resident 1's insurance company arranged all transportation for his appointments, unless there was less than three days' notice, in which case she arranged the transportation. When asked Resident 1's dialysis schedule, SSD stated the schedule was with Resident 1 at the dialysis clinic in his dialysis binder, and stated that off the top of her head, it was Monday, Wednesday, Friday at 2:30 p.m., and Thursdays at 2:15 p.m. When asked if Resident 1's dialysis schedule was in the electronic medical record, SSD stated she was not sure. SSD stated Resident 1's insurance company would have the schedule and pick-up times. SSD called Resident 1's insurance company and was placed on hold.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a record review and concurrent interview on 8/19/24 at 2:35 p.m., MDS (minimum data set, an assessment tool) Nurse reviewed Resident 1's care plan for dialysis, dated 6/4/24, and verified the care plan indicated Resident 1 received dialysis three times per week. MDS Nurse verified the care plan was incorrect and stated Resident 1 received dialysis four times per week. MDS Nurse stated it needed to be updated. When asked who was responsible for updating the care plan when there were schedule changes, MDS Nurse stated, I am. MDS Nurse reviewed Resident 1's physician orders and verified Resident 1 did not have an order for his dialysis other than the order for the extra day on 6/25/24. MDS Nurse stated a physician order was needed for dialysis. MDS Nurse stated it was important to have an order because then Resident 1's schedule would show up on his medication administration record and the nurses would know his schedule and to have his meals ready. MDS Nurse reviewed Resident 1's June 2024 progress notes at length and stated she could find no documentation of the missed dialysis appointments on 6/17/24 and 6/21/24, the reason the appointments were missed, or that the physician was notified of the missed dialysis appointments. MDS Nurse verified the reason for the missed appointment should be documented, and the nurse should notify the physician of the missed appointment and document it. When asked if the documentation about the missed appointments would be in Resident 1's dialysis binder, MDS Nurse stated she did not think it would be because it was just for communication between the facility and the dialysis center when Resident 1 goes out (for dialysis). When asked what documents were contained in the dialysis binder, MDS Nurse stated it was the Pre and Post Dialysis Assessment Forms and provided a blank copy. The form included a space to enter the time the resident left for dialysis and the time they returned. Copies of Resident 1's Pre and Post Dialysis Assessment Forms for several dates in June 2024 were requested.</p> <p>During a record review and concurrent interview on 8/19/24 at 3 p.m., SSD provided two sticky notes on which SSD had written Resident 1's dialysis appointment times and his pickup times that she got from Resident 1's insurance company. The sticky notes indicated Resident 1's dialysis appointments in June 2024 until 7/10/24 were Monday, Wednesday, Friday from 2:15 p.m. to 5:45 p.m. (210 minutes) and Thursdays from 2 p.m. to 5:30 p.m. When asked how Resident 1's insurance company got the appointment times, SSD stated she obtained the appointment times from the dialysis clinic and then she provided the appointment times to the insurance company. When queried, SSD stated she did not recall the reason Resident 1 missed his appointments on 6/17/24 and 6/21/24 but stated Resident 1 cancelled his dialysis appointments all the time because he was not feeling well. SSD stated she rescheduled the 6/21/24 appointment and showed me a text on her phone that she sent to a private transportation company requesting a ride to dialysis for 6/22/24 for Resident 1.</p> <p>Review of an email communication from Administrator received on 8/20/24 at 4:23 p.m., indicated they did not have Resident 1's Pre and Post Dialysis Assessment Forms for the dates requested, as they may have been misplaced in transition.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a phone interview on 8/22/24 at 10:41 a.m. with Director of Nursing (DON), Medical Records, MDS Nurse, and SSD, when queried, DON stated the nurse should write a detailed progress note whenever a resident missed a dialysis appointment. DON stated they were going to in-service the nurses about that. SSD verified she should have documented the rescheduled appointments and the arrangements made for transportation. When asked if she expected the nurses to notify the doctor of a missed dialysis appointment, DON stated, Technically, yes. When queried, DON stated Resident 1 should have a physician order for dialysis and that was an oversight when he came back from the hospital (at the beginning of June). DON stated Resident 1 has an order now. When asked about the Pre and Post Dialysis Assessment Forms, DON stated Resident 1's dialysis binder with all of his assessments got lost during one of Resident 1's hospitalizations. Medical Records verified they did not have a system for periodically scanning the assessments into the electronic medical record, and stated the assessments were part of the medical record.</p> <p>Review of facility policy Dialysis Management, last revised 1/25/24, indicated, The facility will arrange transportation to and from the dialysis provider . All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record.</p> | | |