

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER The Avenues Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2043 19th Avenue San Francisco, CA 94116	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of 25 sampled residents (Resident 92 and Resident 7) were treated with dignity and respect when Certified Nursing Assistants (CNA 1 and CNA 2) were standing over residents while assisting them to eat.</p> <p>This failure resulted in the potential for Resident 92 and Resident 7 to feel disrespected and the potential to affect the resident's psychosocial (mental, emotional, social, and spiritual effects) well-being.</p> <p>Findings:</p> <p>1. Review of Resident 92's admission record indicated, Resident 92 was admitted on [DATE] with diagnoses including type 2 diabetes mellitus (high blood sugar), kidney disease, dementia (a progressive state of decline in mental abilities) without behavioral disturbance, and history of falling.</p> <p>Review of Resident 92's Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment dated [DATE], indicated, severe cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment. The functional abilities section of the MDS indicated, Resident 92 was dependent with eating, meaning total assistance is required for resident to complete the activity.</p> <p>During dining observation on 3/18/25 at 12:58 PM, in Resident 92's room, Resident 92 was lying in bed with eyes closed while CNA 1 called for help to reposition him. CNA 1 set up the lunch tray on the overbed table and started to assist Resident 92 with his meals. CNA 1 was on Resident 92's left side and remained standing while assisting him to eat.</p> <p>During an interview on 3/18/25 at 1:27 PM, CNA 1 stated she was supposed to sit in front and within eye level when feeding resident.</p> <p>During an interview on 3/20/25 at 2:43 PM, with the Assistant Director of Nursing (ADON), ADON stated, [CNAs] should be sitting in front of the resident for dignity and respect.</p> <p>During an interview on 3/21/25 at 1:50 PM, the Director of Staff Development (DSD) stated, CNAs need to sit down in front of the resident when assisting to eat to show respect.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy and procedure titled, Assisting the Impaired Resident with In-Room Meals, revised 9/2023, indicated, .Preparation .9.If resident is served his or her meal in bed, use wedges and pillows to achieve a nearly upright position . Steps in Procedure . 3. If you are going to be seated during the feeding, position a chair where it will be convenient for you and the resident .</p> <p>2. During a review of Resident 7 admission record, it indicated she was admitted in July 2024 with diagnoses of hemiplegia (paralysis or weakness of one side of the body) and hemiparesis (a partial or incomplete paralysis (paresis) affecting one side of the body), type 2 diabetes mellitus (A long-term condition in which the body has trouble controlling blood sugar and using it for energy), and dysphagia (difficulty swallowing) among others. Her minimum data set (MDS - a standardized assessment tool used to evaluate the health of nursing home residents) brief interview for mental status (BIMS- evaluates cognitive impairment and can help with dementia diagnosis) score was 1 indicating severe cognitive impairment.</p> <p>During a concurrent observation and interview on 03/18/25 at 01:04 PM in Resident 7's room observed CNA 2, feeding Resident 7 her lunch while CNA 2 was standing at Resident 7's bedside. The CNA 2 stated, I'm part time and she (Resident 7) only speaks Chinese. Observed both Resident 7 and the CNA are understanding each other with their Chinese dialect.</p> <p>During a concurrent observation and interview with CNA 2 on 3/18/25 at 1:05 PM, the CNA 2 stated, oh yes, they told us to sit while feeding. I left my chair outside pointing out the door. CNA 2 never tried to get her chair and continued to feed the resident while standing until Resident 7 finished eating her lunch.</p> <p>During a review of the facility's policy and procedure titled Resident Rights with revised date December 2016, it indicated Policy Statement: Employees shall treat all residents with kindness, respect, and dignity.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe self-administration of medications for one of 25 sampled residents (Resident 78) when:</p> <p>a. Multiple prescription medications were left at Resident 78's overbed table.</p> <p>b. The interdisciplinary team (IDT- a group of professionals from different disciplines who work together to achieve a common goal) did not determine if the prescription medications left on the overbed table may be self-administered by Resident 78.</p> <p>These failures resulted in the potential for medication error and may place residents on self-administration of medication at risk for adverse health reactions which could negatively impact the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>Review of Resident 78's admission record indicated, Resident 78 was admitted on [DATE] with diagnoses including type 1 diabetes mellitus (high blood sugar), end stage kidney disease, and dependence on renal dialysis (person relies on dialysis machines and procedures to filter their blood and remove waste products, as their kidneys are no longer functioning properly).</p> <p>Review of Resident 78's Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment dated [DATE], indicated, no cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment. The functional abilities section of the MDS indicated, Resident 78 had no impairment with range of motion (the distance and direction a joint can move) on both upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. The functional abilities section also indicated, Resident 78 required setup or clean-up assistance with eating, oral hygiene, and dressing.</p> <p>During an observation on 3/18/25 at 9:34 AM, in Resident 78's room, an unlabeled transparent medicine cup with multiple medication tablets inside, a box of prescription fluticasone nasal spray (a nasal spray that treats allergy symptoms like sneezing, itching and a runny or stuffy nose), one bottle of lubricating eye drops, and one bottle of saline nasal spray (used for nasal irrigation and provide lasting moisturization for dry nose) on the overbed table next to Resident 78 was observed in plain sight.</p> <p>During an interview on 3/18/25 at 9:39 AM, Resident 78 stated the fluticasone nasal spray was prescribed by a doctor to be used once a day. Resident 78 stated, she takes her medications after she eats so, the nurses leave the medications on her overbed table to be taken at a later time.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/18/25 at 9:53 AM, in Resident 78's room, Licensed Vocational Nurse (LVN) 2 acknowledged the medications he left on Resident 78's overbed table and identified them as the following: hydralazine (used to treat high blood pressure), amlodipine (used to treat high blood pressure and chest pain), Eliquis (a blood thinner used to treat and prevent blood clots and stroke), valsartan (used to treat high blood pressure and heart failure), and amiodarone (used to treat life-threatening heart rhythm problems).</p> <p>During concurrent interview on 3/18/25 at 9:53 AM, LVN 2 stated that Resident 78 like to take meds (medication/drug) after breakfast. LVN 2 stated, Normally should stay and encourage to take it right away. I should not leave it at the bedside.</p> <p>Review of Resident 78's Self-Administration of Medication V3 assessment dated [DATE], indicated, .1. Resident is alert, oriented and with no cognitive impairment and is able to follow direction consistently .able to read the label .able to follow medication direction properly .aware of the indication of the medication .can remove medication from the container .administer own injection safely and use inhaler without any difficulty . can verbalize to staff the need for safe storage of medication .agrees to terms and policies of self-administration of medication .</p> <p>Review of Resident 78's care plan for self-administration of medication, created date and revision date of 2/11/25, indicated, Resident would prefer to self-administer Insulin (a natural hormone that turns food into energy and manages your blood sugar level) Lispro (a synthetic, rapid acting insulin used to treat type 1 or type 2 diabetes for the control of high blood sugar) and Insulin Glargine (a long-acting, synthetic insulin analog used to treat type 1 and type 2 diabetes) depending on her mood and the nurse working with her. Medication is kept at the medication cart, nurse will prepare/aspirate medication for resident. Per IDT (interdisciplinary team) members and primary physician resident is safe to self administer above medications . Interventions .MD ordered to self-administer the following medications: Insulin Lispro and Insulin Glargine .</p> <p>During concurrent interview and record review, on 3/20/25 at 1:19 PM, with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 78's active orders, assessment, and care plan for self-administration of medication. The active orders for Resident 78 dated 3/1/25 to 3/20/25, indicated, no self-administration of medication was ordered. The ADON stated, there was no order on 2/11/25 for self-administration. Opened a care plan only. The ADON further stated that the IDT opened an assessment and asked the doctor if Resident 78 can self-administer her insulin. During further interview and record review, the ADON stated, I don't see any progress notes form MD (medical doctor) regarding self-admin. The Self-Administration of Medication V3 assessment dated [DATE], indicated, no mention of specific medications that Resident 78 can self-administer. The ADON stated, Resident 78's self-admin assessment on 2/1/25 did not specify which medications can be self-admin. The ADON also stated that the care plan for self-administration of medications was only specific to insulin Lispro and Glargine. The ADON added, the Flonase should be included in the care plan for self-admin and update for any meds. On the same interview, the ADON stated, [they're] not supposed to leave meds at the bedside. Make sure resident takes it. Should be aware if there are other residents in the room.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545</p> <p>Based on observation, interview, and record review, the facility failed to identify and provide needed care and treatment for two of 25 sampled residents (Resident 32 and Resident 78) when:</p> <ol style="list-style-type: none"> 1. The facility failed to follow physician's order to obtain monthly measurements of mid upper arm circumference (MUAC, a tool used to assess nutritional status and help identify people at risk for malnutrition or weight loss, allowing for early intervention) for Resident 32 and Resident 78 who were refusing monthly weights. This failure had the potential to result in Resident 32 and Resident 78 to experience unplanned and undesirable weight loss. 2. The facility failed to implement interventions to monitor Resident 78's injection sites for bruising (skin discoloration from damaged, leaking blood vessels underneath your skin). Additionally, a change in condition was not completed for Resident 78's bruising on the right lower abdomen. This failure had the potential for uneven insulin (a hormone that is injected into the body to help regulate blood sugar levels) absorption and the potential to negatively affect Resident 78's physical and psychosocial well-being. <p>Findings:</p> <p>1a. Review of Resident 32's admission record indicated, was readmitted on [DATE] with diagnoses including hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die) affecting right dominant side, vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), type 2 diabetes mellitus (high blood sugar), and psychotic disorder with delusions (a mental health condition characterized by persistent and false beliefs (delusions) that are not based on reality).</p> <p>Review of Resident 32's Minimum Data Set (MDS, a federally mandated patient assessment tool) assessment dated [DATE], indicated, severe cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment. The Behavior assessment section of the MDS indicated Resident 32 rejected care 4 to 6 days during the last 7 days.</p> <p>Review of Resident 32's nutrition care plan, revised on 12/4/24, indicated, .Refuses to be weighed monthly . Interventions .9/20/23 MUAC 10.5 cm (centimeters - a unit of measurement). Recommend to continue to obtain MUAC measurements (RD [Registered Dietitian] trained RNAs on proper procedures; nurses provided copy of procedures) every month to trend. Nov MUAC 11 cm .Notify MD and responsible party/surrogate decision maker for significant weight change .</p> <p>Review of Resident 32's Dietary Profile (Quarterly/Annual) dated 2/19/25, indicated, Last wt. (weight) taken on 5/6/24: 121.8 # (pounds). Pt (patient) refuses wts (weights) .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/25 at 9:36 AM, Registered Nurse Supervisor (RNS) 2 stated, the Restorative Nursing Assistant (RNA - a healthcare professional, often a Certified Nursing Assistant (CNA) with additional training, who focuses on helping residents regain or maintain their functional abilities and independence through restorative programs) obtains the MUAC of residents.</p> <p>During a concurrent interview and record review on 3/21/25 at 9:33 AM with RNS 2, Resident 32's Weights and Vitals Summary in PCC (Point Click Care - facility's electronic health record [EHR]) was reviewed. Resident 32's Weights and Vitals Summary dated from 1/1/24 to 3/21/25 indicated, no weights were recorded since 5/6/24. RNS 2 stated, [Resident 32] had been refusing. [Resident 32] has order for MUAC every month due to resident refusal. During further review, RNS 2 was unable to find documentation of Resident 32's MUAC in the EHR.</p> <p>Review of Resident 32's Order Summary Report dated 3/21/25, indicated, an order date of 9/21/23 for Obtain MUAC (mid upper arm circumference) every month to trend due to resident history of refusing weights. Nurses provided with copy of proper procedures.</p> <p>During an interview on 3/21/25 at 9:40 AM, Licensed Vocational Nurse (LVN) 3 stated, MUAC is recorded in the MAR (Medication Administration Record). Done by nurses. I have not done it.</p> <p>51664</p> <p>1b. During a review of Resident 78's MDS assessment dated [DATE], indicated, Resident 78 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, indicating no cognitive impairment.</p> <p>During a review of Resident 78's nutrition care plan, revised on 11/30/23, indicated, The resident has nutritional problem or potential nutritional problem or at risk for dehydration r/t ESRD (End Stage Renal Disease) on dialysis, DM1 (often refuses insulin), . Interventions .Weigh resident as ordered: Resident refuses to be weighed at facility . 9/22/23: MUAC 10 cm. Recommend to continue to obtain MUAC measurements (RD to train nurses on proper procedures; nurses provided copy of procedures) every month to trend. 10/31/23: agreeable to WC (wheelchair) weight this month 10/2023: 115 lb (pounds) 11/30/23: MUAC 10 cm .</p> <p>During a review of Resident 78's Dietary Progress Notes (written records that document a resident's health status, treatment progress, and changes in their condition over time), dated 09/22/2023, indicated, no new nutritional concerns .history of refusing being weighed .recommend to continue asking to take resident's weight, but in the case of refusal, continue obtaining MUAC every month during monthly facility weigh-ins .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 3/21/25 at 10:12 AM with Registered Nurse (RN) 2, Resident 78's Weights and Vitals Summary, dated from 10/3/23 to 2/20/25 was reviewed. Resident 78's Weights and Vitals Summary, indicated, no weights were recorded for the year of 2024. During further review, Resident 78's Physician Order dated 9/24/23, indicated, Obtain MUAC (mid upper arm circumference) every month to trend due to resident history of refusing weights. Nurses provided with a copy of proper procedures . RN 2 stated, patients need frequent weights, I think it might be monthly .She (Resident 78) has a history of refusing weights. If they (residents) refuse weights, medications, MUAC we (licensed nurses) document the refusal and then let the doctors know. RN 2 verified there were no monthly weights and no monthly MUAC recorded for Resident 78 in the year of 2024. RN 2 stated she did not see documentation of Resident 78 refusing weights nor refusing MUAC for the year of 2024.</p> <p>During a concurrent interview and record review on 3/21/25 at 10:40 AM, with RNS 2, Resident 78's Physician's Order, dated 9/24/23 was reviewed. RNS 2 stated, MUAC should be done every month to make sure she isn't losing weight, and the measurements should be documented in the Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). RNS 2 also stated, Resident 78 would normally refuse weight taking and the alternative is to offer monthly MUAC instead to make sure she isn't losing weight. During further interview, RNS 2 stated, only one MUAC was done since order placed .nurses have to complete these measurements . nurses have to document these measurements in the MAR or document Resident 78's refusal every month. During further review, RNS 2 confirmed he did not find any nurse's documentation on Resident 78 's refusal of monthly MUAC for the year of 2024. RNS 2 also reviewed Resident 78's Weights and Vitals Summary, dated from 10/3/23 to 2/20/25, and confirmed no weights were recorded for the year of 2024.</p> <p>During an interview on 3/21/25 at 2:48 PM, Resident 78 stated, I don't recall staff educating me on the importance of being weighed or measuring my upper arm. I get weighed at the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) clinic every time I go to [Name of dialysis center]. Why do I need to be weighed here?</p> <p>During an interview on 3/21/25 at 1:29 PM, the Director of Nursing (DON) stated, Yes, we missed that one. No documentation of [Resident 78's] refusal of MUAC. The DON further stated, MUAC should have been completed and documented monthly as ordered by the Physician to monitor Resident 78's health status.</p> <p>During a concurrent interview and record review on 3/21/25 at 2:11 PM, the DON reviewed Resident 78's Dietary Progress Notes dated 9/22/23 and stated that MUAC should have been completed and documented monthly if Resident 78 refused to be weighed according to the Registered Dietitian's recommendation and Physician's Order.</p> <p>A review of the facility's policy and procedure titled, Weight Assessment and Intervention, revised 9/2008, indicated, The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Weight Assessment - 1. The nursing staff will measure weights on admission and weekly for at least two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49373</p> <p>Based on observation, interview, and record review, the facility failed to ensure the accountability of controlled medications (medications with high potential for abuse and addiction), appropriate preparation and accurate administration of medications when:</p> <ol style="list-style-type: none"> 1. The Controlled Drug Records (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) for five of seven sampled residents (Residents 105, 119, 81,30 and 36) did not reconcile with the Medication Administration Records (MAR). This failure resulted in inaccurate accountability and the potential for abuse and diversion of controlled medications. 2. Nursing staff did not administer correct prescribed medication to one of five residents (Resident 28). 3. Nursing staff did not observe Resident 432 take her medication after leaving one of eight prescribed scheduled medication on the bedside table. 4. Nursing staff did not clean the shared pill cutter in between medication preparations. <p>These failures resulted to medications not given according to the prescriber's orders and/or facility's policy and had the potential for residents not receiving the full therapeutic effects of the medications and increasing the risk for allergic reactions.</p> <p>Findings:</p> <p>1a. Review of Resident 105's Physician's Order, dated 6/14/24, indicated, oxycodone (a controlled narcotic medication for pain) 5 mg (milligram, unit of measurement), Give 0.5 tablet (2.5 mg) by mouth every 6 hours as needed for moderate pain.</p> <p>During a concurrent interview and record review on 3/18/25 at 11:31 AM with Registered Nurse Supervisor (RNS) 3, Resident 105's oxycodone 5 mg CDR and February 2025 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet on 2/9/25 at 1:00 AM but did not document the administration on the MAR. RNS 3 verified that one tablet of Resident 105's oxycodone 5 mg was unaccounted for on the February 2025 MAR.</p> <p>1b. Review of Resident 119's Physician's Order, dated 2/4/25, indicated, lorazepam (a controlled medication for anxiety) 0.5 mg, Give 0.25 mg by G-tube every 12 hours as needed for Agitation.</p> <p>During a concurrent interview and record review on 3/18/25 at 11:46 AM with RNS3, Resident 119's lorazepam 0.5 mg CDR and February 2025 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet on 2/12/2025 at 3:00 PM but did not document the administration on the MAR. RNS 3 verified that one tablet of Resident 119's lorazepam 0.5 mg was unaccounted for on the February 2025 MAR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1c. Review of Resident 81's Physician's Order, dated 4/29/22, indicated, oxycodone 5 mg, Give 1 tablet by mouth every 6 hours as needed for pain management.</p> <p>During a concurrent interview and record review on 3/18/25 at 1:07 PM with the Assistant Director of Nursing (ADON), Resident 81's oxycodone 5 mg CDR, December 2024 MAR and February 2025 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet on 12/30/24 at 11:33 AM and one tablet on 2/16/2025 at 12:00 AM but did not document the administrations on the MAR. The ADON verified that two tablets of Resident 81's oxycodone 5 mg was unaccounted for on the December 2024 MAR and February 2025 MAR.</p> <p>1d. Review of Resident 30's Physician's Order, dated 3/18/22, indicated, oxycodone 5 mg, Give 1 tablet by mouth every 4 hours as needed for left shoulder pain, right leg pain.</p> <p>During a concurrent interview and record review on 3/18/25 at 2:46 PM with RNS2, Resident 30's oxycodone 5 mg CDR and March 2025 MAR were reviewed. The CDR indicated the nursing staff did not sign out one tablet on 3/17/25 at 6:34 PM but documented the administration on the MAR. RNS2 verified that one tablet of Resident 30's oxycodone 5 mg was unaccounted for on CDR.</p> <p>1e. Review of Resident 36's Physician's Order, dated 3/18/25, indicated, oxycodone 5 mg, give 1 tablet by mouth every 6 hours as needed for moderate pain (pain scale of 4-6) and give 2 tablets by mouth every 6 hours as needed for severe pain (8-10).</p> <p>During a concurrent interview and record review on 3/18/25 at 2:50 PM with RNS2, Resident 81's oxycodone 5 mg CDR, June 2024 MAR and August 2024 MAR were reviewed. The CDR indicated the nursing staff signed out two tablets on 8/21/24 at 11:40 PM, one tablet on 6/12/24 at 10 AM and one tablet on 6/11/24 at 4:25 PM but did not document the administrations on the MAR. The RNS 2 verified that four tablets of Resident 36's oxycodone 5 mg was unaccounted for on the June 2024 MAR and August 2024 MAR.</p> <p>During an interview on 3/21/25 at 2:18 PM, the Director of Nursing (DON) stated she is aware of the five residents with concerns on narcotic accountability. The DON stated the CDR and MAR should match. The DON further stated, it's important to be sure the controlled drug was given to the resident and there's no drug diversion by staff.</p> <p>Review of the facility's policy and procedure titled, Preparation and General Guidelines IIA5: Controlled Medications, dated 8/2014, indicated, .When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration .Amount administered . Signature of the nurse administering the dose .</p> <p>2. Review of Resident 28's Physician's Order, dated 3/5/25, indicated, guaifenesin (medication that helps loosen phlegm)100 mg/5 ml (milliliter, unit of measurement), Give 10 ml by mouth every 6 hours as needed for cough.</p> <p>During a medication pass observation on 3/19/25 at 9:29 AM, Licensed Vocational Nurse (LVN) 1 prepared 10 ml of Geri-Tussin DM (a brand of medication that contains dextromethorphan [relieves cough] and guaifenesin) in a medication cup, then brought it to Resident 28 and administered it with water.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/19/25 at 10:40 AM with LVN1, a medication bottle labeled, Geri-Tussin DM was stored in the medication cart 2. LVN1 verified Geri-Tussin DM 10ml was administered instead of the prescribed PRN (as needed) order guaifenesin 10ml to Resident 28.</p> <p>During an interview on 3/21/25 at 2:29 PM, the DON acknowledged Resident 28 was administered with a wrong medication. The DON stated the expectation is to have no medication errors when giving medications to residents.</p> <p>Review of the facility's policy and procedure titled, Preparation and General Guidelines IIA2: Medication Administration . dated 10/2017, indicated, .Medications are administered in accordance with written orders of the attending physician .</p> <p>3. Review of Resident 432's Physician's Order, dated 3/6/25, indicated, polyethylene glycol powder (ClearLax, medication that relieves constipation), Give 17 gram [g, unit of measurement] by mouth one time a day for constipation.</p> <p>During an observation on 3/19/25 at 8:53 AM, LVN1 measured one capful (17g) of ClearLax powder into an empty plastic cup, then filled the cup with water from a jug and stirred it.</p> <p>During an observation on 3/19/25 at 9:14 AM, LVN1 provides Resident 432 a full cup of clear liquid (ClearLax water cup) with straw to take with vitamin D capsule. Resident 432 took the vitamin D with sips of ClearLax water and LVN1 left two-thirds (2/3) full of ClearLax water cup on the bedside table.</p> <p>During an observation on 3/19/25 at 9:27 AM, a 2/3 full of ClearLax water cup was seen on Resident 432's bedside table.</p> <p>During an observation on 3/19/25 at 9:33 AM, a 2/3 full of ClearLax water cup was seen on Resident 432's bedside table.</p> <p>During an observation on 3/19/25 at 9:49 AM, a less than 2/3 full of ClearLax water cup was seen on Resident 432's bedside table.</p> <p>During an interview on 3/19/25 at 10:35 AM, LVN1 verified Resident 28 didn't finish taking the ClearLax water cup when she was in the resident's room. LVN1 stated the licensed nurse has to wait for Resident 28 to finish taking the medication (pertaining to ClearLax water cup) before leaving the room.</p> <p>During an interview on 3/21/25 at 2:29 PM, the DON stated the licensed nurse should not leave any medications at bedside and supposed to observe resident taking the medication before leaving the room, when asked if it's acceptable to leave medication at the bedside without the resident taking it.</p> <p>Review of the facility's policy and procedure titled, Preparation and General Guidelines, dated 10/2017, indicated, .Medication Administration .The resident is always observed after administration to ensure that the dose was completely ingested .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a continuous medication preparation observation on 3/19/25 from 8:53 AM to 8:59 AM, LVN1 used a shared pill cutter to split Resident 432's 100 mg docusate sodium (medication that relieves constipation) tablet into two, then used the same pill cutter to split Resident 432's 500 mg metformin (medication to treat type 2 diabetes [condition with high blood sugar level]) tablet into two. Each time, LVN1 did not clean the pill cutter before or after use.</p> <p>During an interview on 3/19/25 at 10:29 AM, LVN1 acknowledged the shared pill cutter needs to be cleaned between each medication preparation use.</p> <p>During an interview on 3/21/25 at 2:29 PM, the DON stated using a shared pill cutter without wiping it before and after each medication use can lead to potential drug interactions. The DON further stated the residents are exposed to medication residue left on the pill cutter which potentially cause an allergic reaction.</p> <p>Review of the facility's policy and procedure titled, Cleaning and Disinfecting Non-Critical Resident-Care Items dated 6/2011, indicated, Reusable (shared) items used in resident care are cleaned and disinfected or sterilized between residents.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>49373</p> <p>Based on interview and record review, the facility failed to ensure one of five residents reviewed (Resident 28) was free from unnecessary medication when Resident 28 has no evidence of monitoring for bleeding for the use of heparin (anticoagulant-commonly known as a blood thinner, a medication that prevents blood clots from forming in the heart and blood vessels).</p> <p>This failure had the potential to result in undetected medication adverse effects, such as bleeding.</p> <p>Findings:</p> <p>Review of Resident 28's Admission Record, indicated, Resident 28 was readmitted in the facility on 2/5/25, with diagnoses including fracture (a break or crack in a bone) of left femur (thigh bone) and hemorrhage (bleeding) of anus and rectum (sections of the digestive tract).</p> <p>Review of Resident 28's Physician's Order, dated 2/10/25, indicated, heparin injection 5000 unit/ml (milliliter, unit of measurement), Inject 1 ml subcutaneously (into fatty tissue, just under the skin) two times per day for DVT (Deep Vein Thrombosis, a blood clot that forms in a deep vein, usually in the leg, which can cause swelling, pain, and redness) prophylaxis (preventative treatment) for 30 days.</p> <p>During a concurrent interview and record review on 3/21/25 at 12:17 PM, with the Assistant Director of Nursing (ADON), Resident 28's electronic medical record was reviewed. The record indicated there was no evidence of monitoring for bleeding for Resident 28. The ADON stated Resident 28 was on heparin and not monitored for bleeding. The ADON further stated, Resident 28 should have been monitored for signs and symptoms of bleeding.</p> <p>Review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for Heparin, dated 1/5/24, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated, most common adverse reactions of Heparin are: hemorrhage . injection site irritation, general hypersensitivity (allergic) reactions .</p> <p>Review of facility's policy and procedure (P&P), titled, Anticoagulation-Clinical Protocol, revised on 11/18, indicated, .Monitoring and Follow-Up .The staff and physician will monitor for possible complications in individuals who are being anticoagulated (prevent blood from clotting) and will manage related problems .</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49373</p> <p>Based on interview and record review, the facility failed to ensure two of five residents reviewed (Residents 32 and 121) were free from unnecessary antipsychotic (drug that affects brain activities associated with mental process and behavior) medications when:</p> <ol style="list-style-type: none"> 1. There was no evidence of non-pharmacological interventions and PRN (as needed) Seroquel (quetiapine, an antipsychotic medication) was ordered for more than 14 days for Resident 32; 2. There was no evidence of specific behavioral monitoring for Seroquel use for Resident 121. <p>These failures had the potential to result in unnecessary use of medications that could cause somnolence (sleepiness), dry mouth and dizziness.</p> <p>1. Review of Resident 32's Admission Record, indicated, Resident 32 was readmitted in the facility on 8/30/23 with diagnoses including vascular dementia (a progressive state of decline in mental abilities), psychotic disorder (mental illnesses characterized by a significant loss of contact with reality) with delusion (false belief) and mood disorder.</p> <p>During a concurrent interview and record review on 3/21/25 at 1:18 PM with the Assistant Director of Nursing (ADON), Resident 32's electronic medical record was reviewed. The record indicated there was no evidence of non-pharmacological intervention for Resident 32. The ADON stated there should be one, when asked if monitoring is required for non-pharmacological interventions for the resident on PRN Seroquel.</p> <p>During a concurrent interview and record review on 3/21/25 at 1:23 PM with the ADON, Resident 32's electronic medical record was reviewed. The record indicated a physician's order, dated 2/26/25, for Seroquel 25 mg (milligram- unit of measurement) to be given to the resident, Give 1 tablet by mouth every 24 hours as needed for Dementia related behavioral disturbance M/B (manifested by) physical aggression. The ADON stated the PRN Seroquel should have been discontinued after 14 days, however, the medication was not discontinued and remained an active order for 23 days.</p> <p>Review of the facility's policy and procedure (P&P), titled, Psychotropic Medication Use, dated 6/2021, indicated, .Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use .</p> <p>Review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, indicated, .Antipsychotic PRN orders are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication .</p> <ol style="list-style-type: none"> 2. Review of Resident 121's Admission Record, indicated Resident 121 was admitted on [DATE] with diagnoses including dementia, psychotic disturbance and mood disturbance. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 121's Physician's Order, dated 1/27/25, indicated, quetiapine 25 mg to be given to the resident, Give 0.5 tablet (12.5 mg) by mouth in the evening for delirium.</p> <p>During a concurrent interview and record review on 3/21/25 at 12:49 PM with the ADON, Resident 121's electronic medical record was reviewed. The record indicated there was no evidence of behavioral monitoring for Resident 121's use of quetiapine. The ADON stated, the resident's behaviors were not monitored for quetiapine. The ADON further stated, We know if the medication is working and to note an increase or decrease in number of resident's episodes when asked regarding the importance of behavioral monitoring for quetiapine.</p> <p>Review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, indicated .Facility staff should monitor resident's behavior . using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for BPSD (Behavioral and Psychological Symptoms of Dementia). Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/ (or) intensity of episodes and the resident's response to staff intervention .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49373</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications (drug or medicine, used to diagnose, cure, treat, or prevent disease) and biologicals were properly stored when:</p> <ol style="list-style-type: none"> 1.The temperature in one of two sampled medication storage rooms did not follow the manufacturer's labeling for proper medication storage. 2.One of two sampled medication storage room refrigerator contained an open and undated multi dose vial (a small bottle of medication that contains more than one dose). 3.Three expired lidocaine (medication that reduces pain) 5% patches were stored in one of three medication carts for Resident 105, readily available for use. <p>These failures had the potential for medications to be ineffective, unsafe for unknown usage timelines and expired that can harm residents.</p> <p>1.During a concurrent observation and interview on 3/18/25 at 11:51 AM with the Assistant Director of Nursing (ADON), the thermometer in the medication storage room [ROOM NUMBER] indicated a temperature of 78 degrees () Fahrenheit (F, a temperature scale), and the fan was on . The ADON stated, to regulate the temperature, when asked regarding the purpose of the fan and added, the room is hot.</p> <p>During an observation on 3/18/25 at 12:04 PM, the thermometer in the medication storage room [ROOM NUMBER] indicated a temperature of 79 F to 80 F and the fan was on.</p> <p>During a concurrent observation and interview on 3/21/25 at 2:39 PM with the Director of Nursing (DON), the thermometer in the medication storage room [ROOM NUMBER] indicated a temperature of 81 F, and the fan was on. The DON stated, It's warm here.</p> <p>During an observation on 3/18/25 at 2:43 PM in the medication storage room [ROOM NUMBER], the DON opened the Intravenous (IV, method of administering medication within the vein) Emergency kit (E-kit, a container of medical supplies and medications for emergency use) and one vial of vancomycin (an antibiotic, medication to treat infection) 1 gram (g, a unit of measurement) for injection was removed.</p> <p>During a concurrent interview and record review on 3/21/25 at 2:46 PM with the DON, the manufacturer's label for vancomycin 1 gram/vial for injection was reviewed. The manufacturer's label for vancomycin indicated, . Store at .68 (degrees) to 77 F . The DON acknowledged the medication storage room's temperature exceeded the manufacturer's labeling. The DON stated the potential harm of medications not being stored at the correct temperature is the medication may become not effective.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility provided document, titled, Temperature Log for Refrigerator and Freezer (TLRF), dated 1/2025, 2/2025 and 3/2025, indicated the room temperatures in the medication storage room [ROOM NUMBER] were monitored and recorded from 1/1/2025-3/18/2025. The TLRF further indicated the temperatures exceeded 77 F on 20 out of 31 days in January 2025, 16 out of 28 days in February 2025 and 17 out of 18 days in March 2025, totaling to 53 days.</p> <p>Review of the facility provided document, titled, Pharmacy Consultant Report (PCR), dated 9/2024, 12/2024 and 2/2025, indicated the temperature on 9/2024 and 12/2024 in the medication storage room [ROOM NUMBER] was warm with the administrator had plans in place to address the concern. The PCR further indicated the temperature on 2/2025 of medication storage room [ROOM NUMBER] needs improvement.</p> <p>Review of facility's policy and procedure (P&P), titled, Medication Storage in the Facility, dated 4/2008, indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations.</p> <p>2. During a concurrent observation and interview on 3/18/25 at 11:59 AM with the ADON, the medication storage room [ROOM NUMBER], medication refrigerator contained an opened and undated multi dose vial for Tuberculin Purified Protein Derivative (TPPD, used to detect tuberculosis [serious lung infection]). The ADON stated the multi dose vial should have a label when it was opened to know when it will be discarded.</p> <p>During an interview on 3/21/25 at 2:18 PM, the DON acknowledged she was aware of one opened and undated TPPD multi dose vial. The DON stated when licensed nurse opens the multi dose vial, it should be labeled with date.</p> <p>Review of the Drug Label Information (detailed description of a medication that is available to clinicians) for TPPD, dated 8/20/24, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated, Vials in use more than 30 days should be discarded (to get rid of) .</p> <p>Review of facility's policy and procedure (P&P), titled, Preparation and General Guidelines, dated 4/2008, indicated, .Vials and Ampules of Injectable Medications .The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose).</p> <p>3. During a concurrent observation and interview on 3/18/25 at 11:15 AM with Registered Nurse Supervisor (RNS) 1, a clear plastic bag was found inside the medication cart 3. The bag had a label with Resident 105's name, the medication's name (lidocaine 5% patch), and an expiration date of 10/2020. Three lidocaine 5% patches were found in the bag with an expiration date of 10/2020 and one patch was cut open . RNS 1 acknowledged the lidocaine 5% patches were expired and verified the patches were in the medication cart and available for use. RNS 1 stated, these medications should be discarded.</p> <p>During an interview on 3/18/25 at 11:21 AM, RNS 1 stated expired medications from the facility were supposed to be discarded. RNS 1 further stated she was unaware, three lidocaine 5% patches with an expiration date of 10/2020 were in the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/25 at 2:18 PM, the DON acknowledged she was aware of the three expired lidocaine 5% patches found in the medication cart 3. The DON stated the expectations for expired medications are the staff should remove them from the medication cart and should be discarded like discontinued medications.</p> <p>Review of facility's policy and procedure (P&P), titled, Medication Storage in The Facility, dated 4/2008, indicated, .Outdated (expired), contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists .</p>		

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NAME OF PROVIDER OR SUPPLIER The Avenues Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2043 19th Avenue San Francisco, CA 94116	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>40478</p> <p>Based on observation, interview and record review, the facility failed to ensure food preferences for two out of 133 residents (Residents 36 and Resident 68) were honored when:</p> <ol style="list-style-type: none"> 1. Resident 36 was served hard carrots with order of SOFT VEGETABLES. Texture: Mechanical Soft. 2. Resident 68 was plated the regular menu of fried rice, mixed veggies, and pork slices, when his meal ticket indicated, Serve Chow Mein with chicken OR potstickers. <p>This failure had the potential for residents not receiving their food preferences that will result to poor appetite, and missing the nutritive value of their food leading to weight loss and/or malnutrition.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During concurrent observation and interview on 3/20/25 between 11:45 AM to 1:00 PM in the kitchen tray line, observed Resident 36 was served the regular menu of fried rice, mixed veggies (peas, carrots, corn and beans), and sliced pork. Review of Resident 36 meal ticket indicates: Texture - Mechanical soft; Special Diets ~ Thin Liquids; Notes - SOFT VEGETABLES. Interview with the Cook, Registered Dietitian (RD) and the Dietary Manager (DM) if the mixed veggies are soft, the DM requested for a sample of the mixed veggies on a plate and took a metal ladle to test the softness/hardness of the vegetables. Observed the 1-inch carrot did not give in to slicing with a metal ladle. It was hard. The cook removed the veggies on Resident 36's plate and turned around to replace it with diced, soft carrots which was on hand, part of their substitute menu. 2. During a concurrent observation and interview on 3/20/25 between 11:45 AM to 1:00 PM in the kitchen tray line, observed Resident 68 was plated the regular menu of fried rice, mixed veggies (peas, carrots, corn and beans), and sliced pork. Review of Resident 68's meal ticket indicates: Texture - Regular RG7; Notes: Serve Chow Mien with chicken OR potsticker. After the cook plated Resident 68 with the regular menu, he was asked: Resident 68 wants Chow Mien or potsticker. There is chow mien available as substitute menu but was not served on Resident 68's plate. The cook stated, this resident doesn't want chow mien now. The RD stated, I will check. Observed the RD left and came back stating, according to the nurse the resident doesn't want chow mien, but he still wants potstickers. <p>During a review of the facility's policy and procedure titled Resident Rights with revised date December 2016, it indicated Policy Statement: Employees shall treat all residents with kindness, respect and dignity.</p> <p>Review of the facility's policy and procedure titled: Food Preferences dated 2023 indicated, Policy: Resident's food preferences will be adhered to within reason. Substitute for all foods disliked will be given from the appropriate food group. Procedure: Food preferences will be obtained as soon as possible through the initial resident screen . Updating of food preferences will be done as the resident's needs change and/or during the quarterly review.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40478</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure food safety requirements in accordance with professional standards for food service when:</p> <ol style="list-style-type: none"> 1. A dirty frying pan was found stacked in between clean frying pans under the food preparation counter. 2. Large metal pans and trays for serving were stacked wet under the food preparation counter. 3. A large can of mushroom was found dented among the undented canned products in the dry storage room. <p>The failure to store clean cooking utensils, wet serving trays and dented canned products has the potential to contaminate other clean cooking utensils and promote growth of food borne illnesses to 133 residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During observation and interview with the dietary manager (DM) on 3/18/25 at 10:40 AM in the kitchen, observed a stack of frying pans under the food preparation table. The DM stated these are cleaned frying pans. When checked one by one, the second pan from the top was found dirty with dried food debris on the surface (looks like scrambled egg remains) with scratches. The black surface of the frying pan shows silver underlining from too much usage. The sides of the pan with black, thick, dried matter. 2. During observation and interview on 3/18/25 at 10:40 AM in the kitchen observed a stack of large metal serving trays under the preparation table. Upon inspection by lifting each tray, some are moist inside and out, some are still wet and dripping when lifted. The DM stated, yes, they are still wet. 3. During observation and interview on 3/18/25 at 10:40 AM in the Registered Dietitian (RD) and the DM's office, the DM stated, this is also our dry storage room. Observed metal storage shelves with condiments, and cooking supplies behind the DM's desk. On the left side of the RD's desk is the storage rack for large, canned goods. Upon inspection of the canned goods, observed the third can inspected with dent on the top side of the can. The DM stated Oh, it should not be there. I am surprised . look, I have the dented cans here on my desk showing 2 or 3 canned goods with dents sitting on her desk. <p>During a review of the 2022 Federal Food Code, it indicates; after cleaning and sanitizing, equipment and utensils are to be air-dried before storing.</p> <p>According to annex, wet nesting occurs when dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of 2022 Food Code U.S Food and Drug Administration (FDA) indicated FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41545</p> <p>Based on observation, interview, and record review, the facility failed to implement its infection control program when:</p> <ol style="list-style-type: none"> 1. The urinal used by Resident 45 was stowed inside the trash bin at bedside. 2. During collection of soiled linen on the second floor, the janitor did not perform hand hygiene (the practice of cleaning hands to remove germs, dirt, and other contaminants) before and after glove use. 3. Nursing staff did not perform hand hygiene prior to medication preparation and administration for two of five residents (Resident 432 and Resident 28) and did not disinfect the blood pressure cuff (a device used to measure the force of blood against the artery walls) before and after use for one of one resident (Resident 432). 4. Nursing staff did not wear gloves during medication administration for one of five residents (Resident 433). <p>Failure to implement infection prevention practices may result in cross contamination of infection that may jeopardize the health and safety of the residents and staff.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 3/18/25 at 9:13 AM, in Resident 45's room, Resident 45 was sitting on his wheelchair next to his bed. One of two urinals labeled with resident's name was hanged and stored inside the trash bin. During concurrent interview, Resident 45 stated, he was actively using the urinal hanging inside the trash bin and does not want to put it on his overbed table. <p>During an interview on 3/18/25 at 9:22 AM, MDSC (MDS Coordinator) stated, urinals should not be in the garbage. It should be on the holder at bedside.</p> <p>During an interview on 3/21/25 at 1:50 PM, the Director of Staff Development (DSD) stated the resident's bed has a urinal holder by where they can easily access it and should not be in the trash bin for infection control.</p> <ol style="list-style-type: none"> 2. During an observation on 3/18/25 at 11:00 AM, on the second floor by the soiled linen room, a staff was transferring linens from a white bin labeled soiled linen to the gray bin. The staff removed his gloves, did not perform hand hygiene, and pushed the gray bin towards the end of the hallway. <p>During a concurrent observation and interview on 3/18/25 at 11:29 AM, in front of the shower room on the second floor, the staff took a pair of gloves from his back pocket and wore them without performing hand hygiene. The staff again transferred the linens from the white bin labeled soiled linen to the gray bin, removed his gloves, and did not perform hand hygiene. During interview, the staff identified himself as Janitor 1 and stated, he keeps the gloves in his pocket because no gloves in the hallway. Janitor 1 then stated he speaks limited English and will call his supervisor.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/25 at 11:45 AM, Housekeeping Supervisor (HS) stated, staff should perform hand hygiene before and after glove use especially the staff was handling soiled linens.</p> <p>During a phone interview on 3/21/25, at 1:08 PM, the Infection Preventionist (IP) stated, staff should perform hand hygiene before donning and after doffing of gloves.</p> <p>Review of facility's policy and procedure titled, Departmental (Environmental Services) - Laundry and Linen, revised 1/2014, indicated, .Standard Precautions . 2. Wash hands after handling soiled linen and before handling clean linen. 3. Consider all soiled linen to be potentially infectious and handle with standard precautions .</p> <p>Review of facility's policy and procedure titled, Hand Washing/Hand Hygiene, revised 6/2021, indicated, .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 5. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . f) Before donning sterile gloves . m) After removing gloves . 6. Hand hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>49373</p> <p>3. During a medication pass observation on 3/19/25 at 8:54 AM, Licensed Vocational Nurse (LVN) 1 was observed standing in front of medication cart 2 and not performing hand hygiene prior to preparing eight medications for Resident 432.</p> <p>During a medication pass observation on 3/19/25 at 9:05 AM, LVN 1 was observed not disinfecting the blood pressure cuff before and after checking Resident 432's blood pressure.</p> <p>During a medication pass observation on 3/19/25 at 9:18 AM, LVN 1 was observed not performing hand hygiene prior to administering eight medications for Resident 432.</p> <p>During a medication pass observation on 3/19/25 at 9:40 AM, LVN 1 was observed not performing hand hygiene prior to preparing and administering five medications for Resident 28.</p> <p>During an interview on 3/19/25 at 10:29 AM, LVN 1 acknowledged she did not perform hand hygiene prior to preparing and administering Resident 432 and Resident 28's medications. LVN 1 stated hand hygiene is needed prior to preparing and administering of medications to prevent infection. LVN 1 further stated failing to perform hand hygiene can transfer infections and can cause cross contamination.</p> <p>During an interview on 3/19/25 at 10:32 AM, LVN 1 acknowledged failing to disinfect the blood pressure cuff before and after use. LVN1 stated the blood pressure cuff needs to be disinfected between each resident's use.</p> <p>During an interview on 3/21/25 at 2:29 PM, the Director of Nursing (DON) stated hand hygiene is needed before entering and exiting resident's room and before preparing and administering medications for different residents. The DON further stated not performing hand hygiene can be a risk of infection especially during flu season and can cause cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/25 at 2:29 PM, with the DON, the DON stated shared blood pressure cuff needs to be cleaned before and after use. The DON acknowledged not cleaning blood pressure cuff before and after use is an infection control risk.</p> <p>Review of the facility's policy and procedure (P&P) titled, Hand Washing/ Hand Hygiene, revised on 6/2021, indicated, .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water .c) before preparing or handling medications .</p> <p>Review of the facility's policy and procedure titled, Cleaning and Disinfecting Non-Critical Resident-Care Items dated 6/2011, indicated, Reusable items used in resident care are cleaned and disinfected or sterilized between residents.</p> <p>4. During a medication pass observation on 3/19/25 at 10:26 AM, RN 1 administered Dulera (a brand of an oral inhalation medicine, used to control symptoms of asthma [a lung condition]) to Resident 433 without wearing gloves. RN1 held two cups, one containing water and the other one was empty. After administering the oral inhalation, RN1 held the empty cup with a bare hand as Resident 433 rinsed the mouth with water and spit into the cup.</p> <p>During an interview on 3/19/25 at 2:02 PM, RN 1 acknowledged not wearing gloves while administering Dulera oral inhalation. RN1 further acknowledged not wearing gloves when Resident 433 spit water into an empty cup and recognized wearing gloves was needed in the situation. RN1 stated wearing gloves is important when dealing with oral secretions and for infection control.</p> <p>During an interview on 3/21/25 at 2:29 PM, the DON stated not wearing gloves while handling oral secretions poses an infection control concern.</p> <p>Review of the facility's policy and procedure (P&P) titled, Personal Protective Equipment - Gloves, revised on 7/2009, indicated, .The use of disposable gloves is indicated: a. When it is likely that the employee's hands will come in contact with blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin while performing a procedure .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48700</p> <p>Based on observation, interview, and record review, the facility failed to ensure 47 of 48 residents' rooms met the required minimum of 80 square feet (sq ft) per resident.</p> <p>This failure has the potential affecting residents' comfort, privacy and overall quality of life.</p> <p>Findings:</p> <p>During an observation on 3/18/2025 starting at 10:00 AM, in the course of the initial tour of the facility conducted on the nursing units of the first, second, and third floors, all the rooms were occupied by two or three residents, with curtain to divide each bed.</p> <p>During an interview on 3/18/25 at 10:20 AM, with the Administrator stated the actual count is 48 rooms from first to third floor, but 47 rooms were less than 80 sq ft. room [ROOM NUMBER] has appropriate room size with 2 beds. There is no room [ROOM NUMBER]. He confirmed that all rooms were equipped for three residents except rooms 8, 25 and 41 which were for two residents.</p> <p>During an interview on 3/18/2025 at 10:26 AM with Resident 1 in Room10, Resident was asked how the space was in their room. Resident 1 stated, it's okay</p> <p>During an interview on 3/18/25 at 10:40AM, with Resident 28 in room [ROOM NUMBER]B, Resident was asked about her room through AI translator device. Resident 28 denied any issues with her room size.</p> <p>A review of facility-submitted documents, titled Client Accommodations Analysis and the The Room Size Waiver Request, dated 3/18/2025, completed by the Administrator, listed the rooms with less than 80sq ft per resident. The Administrator provided a copy of the letter dated March 18, 2025 addressed to the California Department of Public Health San Francisco District Office, requesting for a waiver for variance in room size, which indicated the following:</p> <p>Room # Occupancy Room Size (Sq Ft)</p> <p>1 3 74.86</p> <p>2 3 74.66</p> <p>3 3 73.33</p> <p>4 3 74.80</p> <p>5 3 74.80</p> <p>6 3 75.48</p> <p>7 3 74.80</p> <p>(continued on next page)</p>

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F 0912	8 2 76.72
Level of Harm - Potential for minimal harm	9 3 74.55
Residents Affected - Some	10 3 76.84
	11 3 75.48
	12 3 75.48
	14 3 77.22
	15 3 74.80
	16 3 75.16
	17 3 74.43
	18 3 74.43
	19 3 76.73
	21 3 75.85
	22 3 75.16
	23 3 75.16
	24 3 74.80
	25 2 74.80
	26 3 75.85
	27 3 78.20
	28 3 75.16
	29 3 74.80
	30 3 76.16
	31 3 74.80
	32 3 74.80
	33 3 74.12
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F 0912	34 3 76.16
Level of Harm - Potential for minimal harm	35 3 76.16
Residents Affected - Some	36 3 75.48
	37 3 76.53
	38 3 76.16
	39 3 77.21
	40 3 78.28
	41 2 76.16
	42 3 76.53
	43 3 76.84
	44 3 77.59
	45 3 78.58
	46 3 77.52
	47 3 75.48
	48 3 76.53
	49 3 76.53