STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056272	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Health Care	1477 Grove Street San Francisco, CA 94117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41545 Based on observation, interview, and record review, the facility failed to ensure urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was covered with a privacy bag for one of 6 residents with indwelling catheters (Resident 25). This failure had the potential to affect Resident 25's psychosocial (mental, emotional, social, and spiritual effects) well-being. Findings: During the initial tour on 2/24/25 at 7:10 AM in resident's room, Resident 25 was sleeping in bed. A partially filled urinary catheter drainage bag was observed hanging on the side rail by the left side of the foot of the bed exposing its contents. The urinary catheter drainage bag had no cover and a reddish-brown discoloration on the front of the bag was observed. The drainage bag was unlabeled and undated. A reddish-brown fluid was also observed in the tube attached to the urinary catheter drainage bag. During a concurrent observation and interview on 2/24/27 at 7:18 AM with Certified Nursing Assistant (CNA) 3, Resident 25's urinary catheter drainage bag was uncovered, undated, and unlabeled. CNA 3 acknowledged and stated, there was no date on the drainage bag and should have been placed inside a dignity bag. During an interview on 2/26/25 at 1:43 PM, Registered Nurse (RN) 1 stated, resident's urinary catheter drainage bag needs to have a cover for privacy.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to ensure baseline care plan was developed within 48 hours of admission for one of 22 sampled residents (Resident 204). This failure had the potential to result in inadequate care and services rendered to the residents. Findings: Review of Resident 204's admission record indicated, was admitted on [DATE] with diagnoses including heart failure, acquired absence of left leg below knee, kidney disease, and dependence on renal dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so). During an interview on 2/24/25 at 7:41 AM with Resident 204, Resident 204 stated he has a catheter on his right upper chest used for dialysis. Resident 204 stated that he was not able to go to dialysis on Saturday (2/22/25) because transportation needed to be arranged. During an interview on 2/24/25 at 8:42 AM, Registered Nurse Supervisor (RNS) stated, Resident 204 has a central venous catheter (CVC - a tube inserted into a major vein in the chest, neck, or groin for emergency dialysis or temporary access) on his right upper chest for his dialysis. RNS also stated that no special precautions are followed for Resident 204's care. During a concurrent interview and record review on 2/25/25 at 2:26 PM, with Licensed Vocational Nurse (LVN) 1, Resident 204's care plan was reviewed and was unable to find a care plan addressing Resident 204's dialysis and CVC care. LVN 1 also reviewed Resident 204's baseline care plan and stated, not completed yet. LVN 1 added that the baseline care plan is completed 3 days on admission. During an interview on 2/25/25 at 2:44 PM, RNS stated, No dialysis care plan right now. Nursing section is not complete yet. RNS also stated, there is no deadline for the baseline care plan to be completed and that it depends on family or resident preferences.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on observation, interview, and record review, the facility failed to develop a plan of care for one of 22 sampled residents (Resident 25) who fell and fractured his hip. This failure resulted in Resident 25 not receiving the necessary care and treatment such as physical and occupational therapy. Additionally, this resulted in miscommunication between the staff and Resident 25 regarding aftercare and weight bearing activities. Findings: During an observation on 2/24/25 at 7:10 AM in resident's room, Resident 25 was sleeping in bed. A blue fall mat was observed on the floor, situated between the beds of Resident 25 (bed A) and his roommate (bed B). Review of Resident 25's admission record indicated, Resident 25 was readmitted to the facility on [DATE] with diagnosis including fracture of unspecified part of neck of right femur (refers to a broken bone in the neck of the right thigh bone, where the exact location of the fracture within the neck is not specified), presence of right artificial hip joint (indicates a hip replacement surgery where the damaged or diseased parts of the right hip joint have been replaced with artificial components, typically made of metal, ceramic, and/or plastic), difficulty walking, and unspecified fall. During an interview on 2/24/25 at 10:51 AM with Resident 25, Resident 25 stated, he was recently hospitalized due to a fall that required him to undergo hip surgery. Resident 25 stated, he tripped on the [pointing to] fall mat between him and his roommate, fell and hit his right hip onto the floor. Resident 25 stated he's on non-weight bearing on his lower extremities and has not been out of bed since he came back to the facility. Additionally, Resident stated he was not evaluated by a physical therapist (PT) and occupational therapist. Review of Resident 25's Change in Condition Evaluation, dated 2/15/25, indicated, CNA (Certified Nursing Assistant) . finding resident on floor of resident room on bottom. Resident alert and oriented x4. Resident verbalized he landed on his right hip, did not head strike .bruise forming on right hip . Resident feels soreness on right hip. When getting resident back to bed, his legs buckled and was unable to walk. MDs (Medical Doctor) notified .Waiting for order from MD for x-ray for hip. Review of Resident 25's Licensed Nurse's Notes, dated 2/15/25, indicated, .Resident endorses 10/10 pain when moving, 4/10 still. Pain, sharp localized to hip, bruise is forming. MDs notified . Sending to [Name of acute hospital] to rule out fracture . Review of Resident 25's undated care plan titled, The resident is on high risk of fall and risk for the further multiple injuries related to following factors: Decline in functional status, Incontinence (loss of bladder control), Pacemakers (an electronic device to regulate the heart's rhythm), Unsteady Gait, Use cardiovascular meds/diuretics, Use of cane/walker/crutch, indicated interventions including Assess cause, pattern of falls, and activities .Keep environment free from obstruction . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's Post Fall Assessment, dated 2/15/25, indicated, Resident 25 was getting out of bed and tripping under his feet. Review of Resident 25's General Acute Care Hospital (GACH) Discharge Summary, dated 2/19/25, indicated, a discharge diagnosis of femoral neck fracture (a break in the bone [femur] that connects the hip joint [acetabulum] to the upper thigh [femoral head]) and requires SNF (skilled nursing facility) for rehab . The Discharge Summary indicated, .#R FNF (right femoral neck fracture) s/p R hemi .WBAT (weight bearing as tolerated) RLE (right lower extremity), posterior hip precautions .discharge back to SNF for PT . Review of Resident 25's Plan of Care Note, dated 2/19/2025, indicated, Late Entry Note Text: Patient is back from the hospital status post arthroplasty for right femoral neck . # Mechanical ground level fall .-we will start PT/OT (physical therapy/occupational therapy) . During a concurrent interview and record review on 2/26/25 at 10:02 AM with Registered Nurse Supervisor (RNS), Resident 25's Order Summary Report was reviewed. The Order Summary Report did not indicate Resident 25 has an order for WBAT and PT referral. The RNS stated there was no documentation that an order was carried for WBAT and PT referral. Furthermore, RNS was unable to find documentation that an IDT (interdisciplinary team - team of individuals with different areas of expertise) meeting occurred to discuss and assess the cause of the fall and update Resident 25's plan of care related to the recent fall and right femoral fracture. RNS stated, I could not see a care plan for fracture. Additionally, RNS stated that Resident 25 had been in bed since readmitted to the facility. During a follow-up interview on 2/27/25 at 9:37 AM, Resident 25 stated, PT/OT were not aware he had a fall and fractured his right hip that is why he was not seen since he was readmitted on [DATE]. During an interview on 2/27/25 at 1:05 PM, Physical Therapist (PT) stated, Resident 25 had history of falls but was not aware of the recent fall with fracture until 2/26/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43913 Based on observation, interview and record review, the facility failed to develop a coordinated plan of care and communication process with the Hospice agency, when there was no care plan to address what services Hospice will provide and for facility when to notify Hospice for one (Resident 61) of two sampled residents. This failure had the potential to result in hospice residents being at risk for gaps in their hospice services. Findings: Review of Resident 61's Admission record dated 6/15/21, indicated admitted to SNF under Hospice Services on 1/31/25 with End Stage diagnosis of Dementia (decline in cognition including memory). Review of Order Summary Report, dated 2/27/25, indicated, Admit to facility under Hospice Service for comfortable care. DNR, Comfortable-Focus Treatment. No artificial nutrition. During an interview on 2/24/25 at 11:30 AM, with MDS Coordinator (MDSC, MDS - minimum data set, a standardized tool used to plan resident care) , MDSC stated the Hospice residents each have a binder which contains the name of hospice agency and their plan of care, names of hospice staff who will visit and notes of their visits. MDSC also stated the facility has their own care plan for each Hospice resident. During a concurrent interview and record review on 2/25/25 at 12:00 PM, with Director of Social Service (DSS), DSS stated the Hospice agency makes their care plan in their binder. Review of chart, care plan indicated, Comfort Altered Pain Related to Dementia: no mention of Hospice, no interventions as to communication between Hospice and facility. DSS acknowledged, Moving forward, will document in care plan what Hospice will do and how facility will coordinate with Hospice for the care management and comfort of the hospice patients. During an Interview on 2/25/25 at 3:00 PM, with Director of Nursing (DON), DON stated Hospice communicates with facility staff. The hospice nurse, whoever comes, will talk to the nurse on duty of any changes for plan of care or any new orders. During an interview on 2/26/25 at 9:30 AM, with Registered Nurse (RN) 4, RN 4 stated when there is change in the needs of the patient, such as medication, the facility calls the Hospice nurse and Hospice nurse will order medication and have it delivered to facility. If the Hospice nurse is visiting and there is a change of medication, Hospice nurse will inform [the facility staff] and document in their binder. Review of facility Policy and Procedure Policy on Collaboration with Hospice Providers, (undated), indicates: Conclusion . The facility will . Participate in regular interdisciplinary team meetings with hospice providers, Document all collaboration efforts, including meeting records and care plan updates, Ensure clear communication between facility staff and hospice providers.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41545

Based on observation, interview, and record review, the facility failed to identify environmental hazards, implement interventions, and maintain assistive device (refers to any item including wheelchair and walker, that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety) in good working condition for two of 22 sampled residents (Resident 25 and Resident 73) when:

1. A fall mat was placed on the floor between Resident 25 in bed A and his roommate in bed B obstructing the path and safe passage. As a result, Resident 25 tripped, fell on to the floor and sustained a right hip fracture requiring surgical repair. Resident 25 was readmitted to the facility status post (s/p-a medical or clinical shorthand that refers to a state after an intervention) right hip hemiarthroplasty (a surgical procedure that replaces the femoral head (ball) of the right hip joint with an artificial implant).

2. A missing arm rest padding on Resident 73's wheelchair was not reported and replaced to ensure safe use. As a result, Resident 73 slid her right arm on the metal part of the wheelchair, hit her head on the window and sustained a large hematoma (a closed wound where blood collects and fills a space inside your body) on the forehead requiring two hospital transfers on two different occasions.

Findings:

1. During the initial tour on 2/24/25 at 7:10 AM in resident's room, Resident 25 was sleeping in bed. A blue fall mat was observed on the floor, situated between the beds of Resident 25 (bed A) and his roommate (bed B).

Review of Resident 25's admission record indicated, was readmitted to the facility on [DATE] with diagnosis including fracture of unspecified part of neck of right femur (refers to a broken bone in the neck of the right thigh bone, where the exact location of the fracture within the neck is not specified), presence of right artificial hip joint (indicates a hip replacement surgery where the damaged or diseased parts of the right hip joint have been replaced with artificial components, typically made of metal, ceramic, and/or plastic), difficulty walking, and unspecified fall.

During an interview on 2/24/25 at 10:51 AM Resident 25 stated, he was recently hospitalized due to a fall that required him to undergo hip surgery. Resident 25 stated, he tripped on the [pointing to] fall mat between him and his roommate, fell and hit his right hip onto the floor. Resident 25 stated he's on non-weight bearing (NWB-a person should not put any weight on a specific limb, usually after an injury or surgery) on his lower extremities and has not been out of bed since he came back to the facility. Additionally, Resident stated he was not evaluated by a physical therapist (PT) and occupational therapist.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 25's undated care plan titled, The resident is on high risk of fall and risk for the further multiple injuries related to following factors: Decline in functional status, Incontinence, Pacemakers (a small implantable device used to control an irregular heart rhythm), Unsteady Gait, Use cardiovascular meds/diuretics, Use of cane/walker/crutch, indicated interventions including Assess cause, pattern of falls, and activities .Keep environment free from obstruction . Review of Resident 25's 3-Morse Fall Scale (a tool used to assess a patient's risk of falling), dated 1/12/25, indicated, Resident 25 had a high risk for falls. Review of Resident 25's Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment, dated 1/19/25, indicated, no cognitive impairment. Under the functional abilities and goals of MDS assessment indicated, Resident 25 required supervision with transfer and moderate assistance with ambulation using a walker. Review of Resident 25's Change in Condition Evaluation, dated 2/15/25, indicated, CNA (Certified Nursing Assistant) .finding resident on floor of resident room on bottom. Resident alert and oriented x4 (refers to someone who is alert and oriented to person, place, time and event). Resident verbalized he landed on his right hip, did not head strike .bruise forming on right hip . Resident feels soreness on right hip. When getting resident back to bed, his legs buckled and was unable to walk. MDs (Medical Doctor) notified .Waiting for order from MD for x-ray for hip. Review of Resident 25's Licensed Nurse's Notes, dated 2/15/25, indicated, .Resident endorses 10/10 pain (a pain scale of 0 to 10, where 0 is no pain and 10 is the worst pain imaginable) when moving, 4/10 still. Pain, sharp localized to hip, bruise is forming. MDs notified . Sending to [Name of acute hospital] to rule out fracture . Review of Resident 25's Plan of Care Note, dated 2/15/2025, indicated, Late Entry Note Text: Contact by our team regarding a recent fall, landed on right hip now having severe pain over right hip. Unable to move extremity . Orders placed to send out for further trauma evaluation and hip fx. (fracture) . # Mechanical ground level fall .we will start PT (physical therapy) / OT (occupational therapy) . Review of Resident 25's Post Fall Assessment, dated 2/15/25, indicated, Resident 25 was getting out of bed and tripping under his feet. Review of Resident 25's General Acute Care Hospital (GACH) Discharge Summary, dated 2/19/25, indicated, Resident 25 was brought in for right hip pain with obvious deformity s/p GLF (ground level fall) and was taken to the operating room on 2/16/25 for right hip hemiarthroplasty. The Discharge Summary indicated, a discharge diagnosis of femoral neck fracture (a break in the bone [femur] that connects the hip joint [acetabulum] to the upper thigh [femoral head]) and requires SNF (skilled nursing facility) for rehab . Further review of the Discharge Summary dated 2/19/25, indicated, .#R FNF (right femoral neck fracture) s/p R hemi .WBAT (weight bearing as tolerated) RLE (right lower extremity), posterior hip precautions .discharge back to SNF for PT . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 25's Plan of Care Note, dated 2/19/2025, indicated, Late Entry Note Text: Patient is back from the hospital status post arthroplasty for right femoral neck . # Mechanical ground level fall .-we will start PT/OT . During a concurrent interview and record review on 2/26/25 at 10:02 AM with Registered Nurse Supervisor (RNS), Resident 25's Order Summary Report was reviewed. The Order Summary Report did not indicate Resident 25 has an order for WBAT and PT referral. The RNS stated there was no documentation that an order was carried for WBAT and PT referral. Furthermore, RNS was unable to find documentation that an IDT (interdisciplinary team) meeting occurred to discuss and assess the cause of the fall and update Resident 25's plan of care related to the recent fall and right femoral fracture. RNS stated, I could not see a care plan for fracture. Additionally, RNS stated that Resident 25 had been in bed since readmitted to the facility. 2. Review of Resident 73's admission record indicated, was admitted to the facility on [DATE] with diagnosis including COVID-19 (Coronavirus disease 2019-is an infectious disease caused by the SARS-CoV-2 virus), Parkinson's disease (a progressive movement disorder of the nervous system) without dyskinesia (involuntary and uncontrolled movements, is a common side effect of Parkinson's medications), dementia (a progressive state of decline in mental abilities) without behavioral disturbance, and muscle weakness. Review of Resident 73's MDS assessment dated [DATE], under staff assessment for mental status indicated, memory problem and severely impaired cognitive skills for daily decision making. Under the functional abilities and goals of the MDS assessment indicated, Resident 73 has impaired upper and lower extremities, a manual wheelchair, and is totally dependent to staff with activities of daily living (ADL-routine tasks/activities), and wheelchair for mobility. During the initial tour on 2/24/25 at 6:54 AM, in Resident 73's room, Resident 73 was in bed asleep. Observed a fading yellow/green discoloration on Resident 73's right eye and side of the forehead. During a phone interview on 02/25/25 at 11:10 AM, Family Member 1 stated, he was notified on 1/5/25 that Resident 73 fell and hit her head on the windowsill. The son stated, Resident 73 had a bruise and swelling on the right side of the forehead. The son also stated that the swelling subsided, but the bruising is still present. Furthermore, the son stated Resident 73 might have slipped from the arm rest of her wheelchair that had a missing padding. Review of Resident 73's Change in Condition Evaluation, dated 1/5/25, indicated, At 11:50 AM, the CNA reported a forehead bruise on the patient. The nurse assessed a hematoma, redness, and scratches on both hands, with no other injuries or signs of shock . Physician ordered ice packs and ED (emergency department) transfer. Family was notified, and [Name] Ambulance transported the patient at 12:40 PM. At 6:20 PM, the patient returned after a CT scan (A computed tomography scan, formerly called computed axial tomography scan, is a medical imaging technique used to obtain detailed internal images of the body) (results pending). The hematoma had enlarged, partially covering the right eye . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/27/25 at 2:09 PM with Licensed Vocational Nurse (LVN) 1, Resident 73's clinical record was reviewed. The clinical record did not indicate Resident 73 had a fall on 1/5/25. LVN 1 stated, No fall incident this year. Change in Condition on 1/5/25 did not indicate fall incident. Review of Resident 73's fall assessment dated [DATE], indicated, high risk for fall. LVN reviewed all change in condition and progress notes including IDT meeting notes and was not able to find any documentation pertaining to a fall incident. LVN 1 stated, No notes regarding fall. I don't see it in the progress note. During an interview on 2/27/25 at 2:27 PM, Certified Nursing Assistant (CNA) 1 stated, Resident 73 did not have a fall on 1/5/25. CNA 1 stated, he left Resident 73, who was sitting on her wheelchair by the window, to get her lunch tray that was just outside the resident's room. But when CNA 1 came back with the lunch tray, he found Resident 73 leaning on her right side to the wall by the window. CNA 1 stated, he noticed there was no padding on the right arm rest of the wheelchair exposing the metal part. CNA 1 stated, Resident 73 slid her arm on the metal part of the right arm rest. CNA 1 further stated, he did not notice there was no padding on the arm rest when he transferred Resident 73 to the wheelchair. During further interview, CNA 1 stated, Resident 73 had a bump and red discoloration on the forehead and was transferred to the hospital via 911 for further evaluation and treatment. CNA 1 stated, Resident 73 came back in the evening with bluish/blackish discoloration on the forehead. Review of Resident 73's CT scan result dated 1/5/25, indicated, .fall with hematoma right eyebrow, r/o (rule out) ICH (intracerebral hemorrhage) . Impression: Large right periorbital soft tissue hematoma. No intraorbital (situated or occurring within the orbit, the bony cavity that contains the eyeball) hematoma, underlying fracture, or acute intracranial abnormality . Review of Resident 73's Plan of Care Note, dated 1/6/25, indicated, Patient is seen and examined, discussed in IDT meeting. Patient had a recent fall with headstrike, evaluated by [VDA-Vascular Disrupting Agents] and cleared from trauma standpoint. We will order labs in 2 to 3 days to monitor patient's duration status . Review of Resident 73's Licensed Nurse's Notes, dated 1/6/25, indicated, COC (change of condition) 1/3 R (right) side of head hit the edge of the window and sustained hematoma, swelling on the R side of forehead and around the R eye . Review of Resident 73's IDT Post Fall Notes, dated 1/12/25, indicated, Noted Text: **IDT Note for unwitnessed Fall on 1/5/2025 .At approximately 11:50 AM, the assigned CNA reported to the on-duty nurse that the patient had a bruise on the forehead while seated in a wheelchair. the on-duty nurse promptly assessed the patient and noted a large hematoma and bruise on the right side of the forehead, minor redness and scratches on the back of both hands, but no other injuries .Noted some forehead frowning upon touching the hematoma with no verbalization of pain. The nurse notified the physician, who ordered intermittent application of ice packs to the forehead and recommended transferring the patient to ED for further evaluation . Ambulance arrived at around 12:40 pm and transferred out to [Name of GACH]. At 6:20 PM, the patient returned after a CT scan with hematoma had enlarged, partially covering the right eye . RECOMMENDATION/IDT .a safety plan was established, including placing bilateral mattress next to the bed .low bed is positioned. Closed monitoring of the forehead hematoma for healing and possible complications . documenting all actions, and communications in the resident's medical record. Updating the care plan to incorporate enhanced fall precautions . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 73's Change in Condition Evaluation, dated 1/22/25, indicated, Np. (Nurse Practitioner) [Name] and this writer noticed that pt's hematoma on right periorbital (area around the eye socket) is boggy (efers to abnormal texture of tissues characterized by sponginess, usually because of high fluid content), darker purple color and more swollen compared to last week. Informed MD with results of CT scan at [Name of GACH] on 1/5/25. MD said monitor for now .Skin changes: skin scratches and hematoma with bruise . Review of Resident 73's Transfer to Hospital Summary, dated 1/22/25, indicated, Resident has been experiencing a hematoma on right lateral forehead since 1/5. NP [Name] was seen resident today and noted hematoma was previously though to be resolving, but then the sudden increase in swelling and color change is concerning for a potential deeper issue, such as clotting or bleeding. The resident exhibited facial grimacing when the hematoma was touched, indicating discomfort or pain .As per MD's orders, the resident was sent to [Name of GACH] .for further evaluation . Review of Resident 73's undated care plan titled, Altered skin integrity RT patient accidently head trauma while sitting on wheelchair as evidenced by Skin hematoma and bruise noted on the right forehead, minor skin scratches on the back of both hands on [1/5/25]. hematoma on her right periorbital is boggy, darker purple color and more swollen compared to last week on 1/22/25, indicated the following interventions: - Patient will be sent out to the hospital for further evaluation and treatment. - Skin hematoma will be free from s/s of pain, swelling, and skin breakdown thru next review. - Gentle handling during ADL care. - Have resident wear long sleeves clothes as the weather permits. - Head to toe assessment, neurological and pain assessment with no concerning manifestations. - Ice pads applied intermittently on forehead. - Inform responsible party (son) for presence of skin hematoma. - Notify MD for presence of skin hematoma. - Observe skin hematoma for s/s of pain, swelling, and skin breakdown. - Pt returned back form hospital at 18.20 pm with pending result for CT scan. - Safety measures are rendered including lower bed level, floor [NAME] next to the bed to safeguard against any further inadvertent injury. - Transfer out to Ed for further evaluation per MD order. - Use palm of the hand when holding and turning resident during care. - Use two-person assist for transfers and positioning as indicated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/28/25 at 8:49 AM, RNS stated, she never heard or not aware of the missing arm rest padding for Resident 73. RNS stated, anything broken should be taken out immediately from the floor and should not be used. RNS also stated that it should be reported to the maintenance and have it fixed or replaced. Review of the facility's Daily Maintenance Request Log, dated 12/9/24 through 2/25/25, indicated, no documentation of Resident 73's missing arm rest padding was reported. During an interview on 2/28/25, at 1:05 PM, Nursing Home Administrator (NHA) stated, they reviewed the Daily Maintenance Request Log and could not find any reports or documentation regarding the broken wheelchair that caused Resident 73's injury. Review of the facility's policy and procedure titled, [Name of Facility] Falls - Clinical Protocol, revised 7/9/19, indicated, Assessment and Recognition - 1. As part of the initial assessment, Interdisciplinary Team and the physician will help identify individuals with a history of falls and risk factors for subsequent falling . 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk . Cause Identification - 1. For an individual who has fallen, staff will attempt to define possible causes within 24 to 48 hours of the fall . c. When necessary, Licensed Staff or Interdisciplinary Team (IDT) will refer the resident to other disciplines such Rehabilitation Department .to rule out possible causes of fall . 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified . Treatment/Management - 1. Based on the preceding assessment, the staff or IDT and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling . Review of the facility's policy and procedure titled, Work Orders, Maintenance, revised April 2010, indicated, Maintenance work orders shall be completed in order to establish a priority of maintenance service . 2. It shall be the responsibility of the department directors to fill out and forward such work orders to the maintenance director.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31922 Based on observation, interview, and record review, for Residents 3, one of two residents with weight loss out of a total sample of 22 residents, the facility did not: 1. Provide 1:1 assistance/support during meals as ordered by the physician. 2. Monitor percentage of supplement eaten. 3. Offered alternatives/other interventions during poor meal intake. 4. Implement a meal monitoring system that could distinguish between 0-25% intake for residents at risk for poor intake. 5. Use meal intake data to investigate refusals, assess food preferences, and/or identify other issues. 6. Assess for food preferences. This resulted in a 24.4% weight loss for Resident 3 within a six months period. Findings: Review of Resident 3's medical record titled Minimum Data Set (MDS, a standardized resident assessment tool), dated 02/07/2025, indicated she sometimes understood others and had long and short-term memory problems. Her MDS indicated there were no rejection of care. Review of Resident 3's records titled Progress Notes, dated 02/18/2025, indicated . (responsible party) . re-confirmed .NO ARTIFICIAL MEANS OF NUTRITION, INCLUDING FEEDING TUBES. Review of Resident 3's MDS, dated [DATE] indicated her weight was 98 pounds. Review of Resident 3's MDS, dated [DATE] indicated her weight was 74 pounds. This was a 24 pounds weight loss or a 24.4 % weight loss. Review of Resident 3's records titled Nutrition Therapy (initial Assessment), dated 07/23/2024, indicated . Presents with severe .(weight) loss of 32 .(pounds) 24.6% x 3 months. BMI (Body mass index: used to determine a healthy body weight in relation to a specific height) at underweight status . protein . malnutrition . Remains on (nutritional) shake . Will follow .(plan of care) and monitor closely .Goal: maintain or gradual . (weight) gain, . (increase intake to greater than) 75%. Review of Resident 3's records titled Order Summary Report (physician orders), printed on 02/25/2025, indicated Resident 3 was to have Ensure Clear (a fat-free, fruit-flavored nutrition drink containing high-quality protein and essential nutrients) two times a day for weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and electronic record review with the RD (Registered Dietitian) on 02/25/2025 at 12:23 PM, the RD was asked to show how supplement intakes were documented in Resident 3's electronic records. The RD navigated to the supplement section in Resident 3's records. On the screen, there were check marks indicating when supplements were provided. The RD was asked if there were documentation of percentage of supplement consumed by Resident 3. The RD said she was not sure. The RD said she will look through Resident 3's records and provide the information if it was available. The RD agreed it would be difficult to objectively evaluate effective nutritional interventions if percentage supplement intakes were not documented. An email was sent on 02/25/2025 at 1:42 PM to the RD, DON (Director of Nursing) and MDS Coordinator requesting percentage of supplement consumed by Resident 3 in the last 30 days. As of exit on 02/28/2025, the requested document was not provided. Review of Resident 3's records titled Order Summary Report (physician orders), printed on 02/25/2025, indicated Resident 3 was to have Feeding Assistance: 1:1 with meals for assist with eating/feeding. During lunch observation on 02/24/2025 at 11:50 AM, a staff member brought Resident 3's lunch tray into her room and set up her tray for her. At 12:15 PM, Resident 3's lunch tray was removed and placed in a metal tray container. During an interview with Certified Nursing Assistant (CNA) 1on 02/24/2025 at 12:30 PM, he stated Resident 3 has a poor appetite and usually only eat around 20% of her meals. CNA 1 stated he provided set up only and did not assist Resident 3 with her meals because she could feed herself. During lunch observation on 02/26/2025 at 11:48 AM, a staff member brought Resident 3's lunch tray into her room and set up her tray for her. During intermittent observations at 12:05 PM and at 12:08 PM, no staff went into Resident 3's room to check in on her or to assist her. At 12:14 PM, Resident 3's tray was taken away and placed in a metal tray container. During an interview on 02/26/2025 at 12:19 PM CNA 1 stated he was the one who removed Resident 3's tray and he stated she ate her usual amount of 20%. CNA 1 was asked if he attempted to offer her any alternatives or assistance/support to increase her intake. CNA 1 stated no and added Unfortunately, I cannot communicate with her. She's Chinese speaking. Review of the facility's policy titled Offering Alternatives and Encouraging Intake Meals Policy, dated July 1, 2024, indicated .If a patient consumes less than 25% of their meal, nursing and dietary staff must intervene by offering nutritional alternatives, providing additional support, and encouraging intake to prevent malnutrition and weight loss. Review of Resident 3's records titled What percentage of the meal was eaten?, dated 01/27/2025 to 02/25/2025, indicated there were four main columns for staff to assess percentage of meal eaten: 0-25%, 26-50%, 51-75%, 76-100%. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/28/2025 at 9:37 AM, the Director of Nursing (DON) agreed their current method of meal percentage monitoring was not able to determine if a resident ate 0% or 20% or 25%. The DON agreed the ability to distinguish between these low intakes was critical to determine if staff should intervene and offer alternatives and/or assistance/support. The DON stated she expected her staff to intervene if a resident was experiencing inadequate intake during meals. The DON agreed . It makes sense to intervene even if a resident was on comfort measures or requested no aggressive nutritional interventions because residents are not static medically/psychologically and may change their mind at any time. There was no documented evidence the facility was using the meal percent monitoring as a tool to assess food preferences. For example, review of Resident 3's records titled What percentage of the meal was eaten?, dated 01/27/2025 to 02/25/2025, indicated she ate 51-100% of her food for 21 out of 87 meals (24%). For these meals there were no documented evidence staff analyzed if her higher intakes were correlated to specific food preferences. Additionally, review of the same document indicated for 41 out of 87 meals (47.1%), Resident 3 ate between 0-25%. There was no documented evidence these meals were assessed to see if they were related to things the kitchen could control (menu items, temperature, timing etc.) or related to other issues. During an interview on 02/25/2025 at 12:30 PM, the Registered Dietitian (RD) was asked to provide documented evidence the facility assessed Resident 3 for food preferences. The RD stated Resident 3 was unable to respond due to impaired thinking/reasoning and memory problems. The RD was asked to provide documented evidence the facility reached out to Resident 3's responsible parties and/or family members prior to 02/25/2025 to help with food preference assessment. The facility was unable to provide the requested documents. Review of Resident 3's records titled Care Plan Report, printed on 02/26/2025, indicated staff should . ENCOURAGE (Resident 3) TO EAT AT LEAST 75% OF MEALS.OFFER SUBSTITUTES FOR REFUSED FOODS/FLUID .Promote good .intake (eating by mouth).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Medication Error rate- 25.9% Based on observation, interviews and record review, the facility had a medication error rate of 25.9% when seven medication errors occurred out of 27 opportunities during the medication administration for four of seven residents (Residents 256, 72, 63 and 17). The failure had the potential to result in residents not receiving full therapeutic effects or causing side effects for the residents. FINDINGS: 1. During the medication administration observation on 2/24/25 at 8:03 AM, for Resident 17, Registered Nurse (RN) 3 was observed preparing and administering four oral medications. RN 3 crushed all 4 tablets, poured them in a medication cup, mixed with applesauce and administered to patient. Patient took the medication with applesauce. Per RN 3, patient takes medications with no problem. Review of Resident 17's Admission Record, admitted 0n 3/15/24 with diagnoses including: Dementia (memory loss) and Failure to Thrive (a decline characterized by weight loss, decreased appetite, poor nutrition, and inactivity). Review of Order Summary Report, dated 2/27/25, indicated, May crush medications or open capsules as indicated per pharmacy protocol. 2. Review of Resident 256's Admission Record, admitted on [DATE] with diagnoses including: Cerebral Infarction (a condition where blood flow to the brain is interrupted causing brain tissue to die), Dysphagia(difficulty swallowing), Gastrostomy Status(where a thin flexible tube is inserted through the abdominal wall and into the stomach for feeding). Review of Order Summary Report for Resident 256, dated 2/28/25, indicated, Enteral Feed order every shift Diabetic Source feeding @ 90 ml/hr start at 1 pm stop at 9 am. May crush medications and open capsules as indicated per pharmacy protocol to give via GT. During the medication administration observation on 2/24/25 at 8:30 AM, for Resident 256, RN 3 was observed preparing 6 tablets for Gastrostomy administration. RN 3 crushed all 6 tablets and poured them into a cup of water. After GT placement check, RN 3, poured the mixed tablets with water into the syringe. RN 3 then flushed the tube with a cup of water. RN3 proceeded with giving a liquid antibiotic per GT. RN3 stated it takes a while to dilute the tablets, needs a little push at times. 3. During the medication administration observation on 2/25/25 at 11:30 AM for Resident 63, RN 3 stated, the PCC (Point Click Care - an electronic health record program) is down but I know his medication, will check the MAR(medication administration record) later. RN 3 was observed getting the eyedrop, Artificial Tears and 2 tissues, prepared and explained to the patient, dropped one dop to right eye, then wiped with tissue. Then dropped one drop to left eye and wiped the left eye. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Order Summary Report for Resident 63, dated 2/28/25, indicated, Artificial Tears, Instill 2 drops to left eye every 4 hours for dry eyes. Review of facility Policy and Procedure, Medication Administration-Preparation and General Guidelines, dated 6/15, indicated, B. Administration, 2. Medications are administered in accordance with written orders of the prescriber. A. Preparation, 5. The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medications, the medication and dosage schedule on the resident's MAR are compared with the medication label. 4. A review of Resident 72's Admission Record, indicated, admitted on [DATE] with diagnoses including: Organ-Limited Amyloidosis (abnormal protein deposits that can build up in organs and tissues causing damage and disease), Paroxysmal Atrial Fibrillation (a kind of irregular heartbeat that occurs intermittently and stops on its own.) During a concurrent observation and interview on 2/24/25 at 9:00 AM, with RN 3, for medication administration for resident 72, RN 3 stated, Resident 72 has an order for Vyndaquel (a medication to delay nerve damage caused by abnormal protein deposits in organs and tissues) 20 mg 4 capsules every day. RN 3 pulled out the box and stated, medication is not available, has been reordered. Last given on 2/19/25. This medication is not available in our Automatic Dispensing Unit (ADU - a computerized system used in healthcare settings to store, dispense, and track medications). During an initial interview on 2/24/25 at 7:00 AM, with Resident 72, Resident 72 stated he has not been given his cardiac medication, Vyndaquel 20 mg since last week. During an interview on 2/24/25 at 9:00 AM, with RN 3, RN 3 stated the medication was reordered; the pharmacy was notified but needed the Attending physician to order. MD gave order and was faxed to pharmacy but the pharmacy stated [the medication was] not available. No progress notes found on this issue. Review of Order Summary Report dated, 2/26/25, indicated, Tafamidis Meglumine (Cardiac - a medication used to treat cardiac amyloidosis - a rare condition caused by abnormal protein deposits in the heart) oral capsule 20 mg. Give 4 capsules by mouth one time a day for cardiac amyloidosis, start date 1/7/25. Review of MAR for February 2025, indicated, Tafamidis Meglumine Cardiac, on 2/20/25 to 2/25/25, code 9 = Other/see progress notes initialed by nurses. A review of progress notes did not indicated what code 9 meant. On 2/25/25, indicated Tamafidis is not available . Review of facility progress notes, by MD, dated 2/17/25,Follow ups: if additional 30 days supply of Tafamidis not delivered on 1/8/25, call [Hospital] Specialty Pharmacy at XXX-XXX-XXXX. Review of facility Policy and Procedure, medication Administration- General Guidelines, dated 6/15, indicates: D. Documentation (including electronic) 6.If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on reverse side of record. If a vital medication is not available, the physician is notified. Nursing documents the notification and physician response.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31922 Based on observation, interview and record review the facility failed to prepare, store, and serve food in a sanitary manner when these were observed in the kitchen and other areas: 1. One of the icemaker's dispensing spouts was dripping water. 2. The ice maker had two water filters and one of the water filters was not replaced. 3. The bottom of the kitchen hood was covered in a film of a greasy-looking substance. These failures had the potential to result in putting residents at risk for food borne illnesses. Findings: During initial kitchen observation on 02/24/2025 at 6:21 AM with Dietary Aide (DA), the following were observed and confirmed with the DA: 1. One of the icemaker's dispensing spouts was dripping water. 2. The icemaker had two water filters and one of the water filters was not replaced. 3. The bottom of the kitchen hood was covered in a film of a greasy-looking substance. The film was heavy enough there were at least 30+ spots on the hood where the substance were lumped into early droplets and ready to drip down. During an interview on 02/26/2025 at 9:52 AM with the Maintenance Manager (MM). the MM stated he changed both water filters for the kitchen's icemaker back in December 2024. Since there were no dates on the water filters, the facility was asked to provide documented evidence the water filters were changed back in December 2024. A review of the facility records titled Details for Order ., dated 12/11/2024, indicated one water filter was purchased for the icemaker. There was no evidence the second water filter was purchased and/or replaced back in December 2024. On 02/24/2025 at 10:58 AM, the Administrator (NHA) , the Director of Nursing (DON) and the Registered Dietitian (RD) were asked to provide their policies regarding icemaker water filter replacement, and maintenance of the icemaker regarding drips. On 02/26/2025 at 10:15 AM, the RD stated the facility do not have the requested policies. A review of the facility's policy titled HOODS, FILTERS, AND VENTS, dated 2023, indicated .Hoods must be cleaned every two weeks and must be free of dust and grease.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 31922 Based on observation, interview and record review the facility failed to dispose of kitchen refuse properly when two garbage containers within the kitchen did not have lids. This failure had the potential to result in flying insects contaminating food items, food prep areas and utensils. Findings: During initial kitchen observation on 02/24/2025 at 6:21 AM with Dietary Aide (DA), two garbage containers without lids were found in the kitchen and these observations confirmed with the DA. During an interview on 02/24/2025 at 10:57AM with the Registered Dietacian (RD), the RD agreed that there should be lids on all garbage containers in the kitchen. Review of the facility's policy titled MISCELLANEOUS AREAS GARBAGE AND TRASH, dated 2023, indicted .Adequate, clean, . areas must be provided for storage of garbage .All food wasted must be placed in a sealed leak-proof, non-absorbent, tightly closed containers .

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on observation, interview, and record review, the facility failed to provide specialized rehabilitative services (includes but is not limited to physical therapy, speech-language pathology, occupational therapy, or respiratory therapy and are provided or arranged for by the nursing home) for one of 22 sampled residents (Resident 25) that required physical therapy (PT-treatment that helps you improve how your body performs physical movements) and occupational therapy (OT-a healthcare profession that focuses on helping individuals improve their ability to perform everyday activities) status post (s/p-a medical or clinical shorthand that refers to a state after an intervention) right hip hemiarthroplasty (a surgical procedure that replaces the femoral head (ball) of the right hip joint with an artificial implant). This failure may result in further decline in condition for Resident 73 and the potential to negatively affect the ability to attain and maintain his highest practicable level of physical, mental, functional and psycho-social well-being. Findings: During the initial tour on 2/24/25 at 7:10 AM in resident's room, Resident 25 was sleeping in bed. A blue fall mat was observed on the floor, situated between the beds of Resident 25 (bed A) and his roommate (bed B). Review of Resident 25's admission record indicated, was readmitted to the facility on [DATE] with diagnosis including fracture of unspecified part of neck of right femur (refers to a broken bone in the neck of the right thigh bone, where the exact location of the fracture within the neck is not specified), presence of right artificial hip joint (indicates a hip replacement surgery where the damaged or diseased parts of the right hip joint have been replaced with artificial components, typically made of metal, ceramic, and/or plastic), difficulty walking, and unspecified fall. During an interview on 2/24/25 at 10:51 AM Resident 25 stated, he was recently hospitalized due to a fall that required him to undergo hip surgery. Resident 25 stated, he tripped on the [pointing to] fall mat between him and his roommate, fell and hit his right hip onto the floor. Resident 25 stated he's on non-weight bearing (cannot put any weight) on his lower extremities and has not been out of bed since he came back to the facility. Additionally, Resident stated he was not evaluated by a physical therapist (PT) and occupational therapist. Review of Resident 25's Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment, dated 1/19/25, indicated, no cognitive impairment. Under the functional abilities and goals of MDS assessment indicated, Resident 25 required supervision with transfer and moderate assistance with ambulation using a walker. Review of Resident 25's Plan of Care Note, dated 2/15/2025, indicated, Late Entry Note Text: Contact by our team regarding a recent fall, landed on right hip now having severe pain over right hip. Unable to move extremity . Orders placed to send out for further trauma evaluation and hip fx. (fracture) . # Mechanical ground level fall .we will start PT/OT (Occupational Therapy, a treatment to help develop, recover, improve, and maintain skills needed for daily living and work) . (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's General Acute Care Hospital (GACH) Discharge Summary, dated 2/19/25, indicated, a discharge diagnosis of femoral neck fracture (a break in the bone [femur] that connects the hip joint [acetabulum] to the upper thigh [femoral head]) and requires SNF (skilled nursing facility) for rehab . Further review of the Discharge Summary indicated, .#R FNF (right femoral neck fracture) s/p R hemi .WBAT (weight bearing as tolerated) RLE (right lower extremity), posterior hip precautions .discharge back to SNF for PT . Review of Resident 25's Plan of Care Note, dated 2/19/2025, indicated, Late Entry Note Text: Patient is back from the hospital status post arthroplasty for right femoral neck . # Mechanical ground level fall .-we will start PT/OT . During a concurrent interview and record review on 2/26/25 at 10:02 AM with Registered Nurse Supervisor (RNS), Resident 25's Order Summary Report was reviewed. The Order Summary Report did not indicate Resident 25 has an order for WBAT and PT referral. The RNS stated there was no documentation that an order was carried for WBAT and PT referral. Furthermore, RNS was unable to find documentation that an IDT (interdisciplinary team) meeting occurred to discuss and assess the cause of the fall and update Resident 25's plan of care related to the recent fall and right femoral fracture. RNS stated, I could not see a care plan for fracture. Additionally, RNS stated that Resident 25 had been in bed since readmitted to the facility. During a follow-up interview on 2/27/25 at 9:37 AM, Resident 25 stated, PT/OT were not aware he had a fall and fractured his right hip that is why he was not seen since he was readmitted on [DATE]. During an interview on 2/27/25 at 1:05 PM, Physical Therapist (PT) stated, Resident 25 had history of falls but was not aware of the recent fall with fracture until 2/26/25. Review of the facility's policy and procedure titled, [Name of Facility] Falls - Clinical Protocol, revised 7/9/19, indicated, Assessment and Recognition - 1. As part of the initial assessment, Interdisciplinary Team and the physician will help identify individuals with a history of falls and risk factors for subsequent falling . 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk . Cause Identification - 1. For an individual who has fallen, staff will attempt to define possible causes within 24 to 48 hours of the fall . c. When necessary, Licensed Staff or Interdisciplinary Team (IDT) will refer the resident to other disciplines such Rehabilitation Department .to rule out possible causes of fall . 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified . Treatment/Management - 1. Based on the preceding assessment, the staff or IDT and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .

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NAME OF PROVIDER OR SUPPLIER San Francisco Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1477 Grove Street San Francisco, CA 94117	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on observation, interview, and record review, the facility failed to implement its infection control program when enhanced barrier precautions (EBP) was not followed for four of 11 residents (Resident 62, Resident 204, Resident 25, Resident 256) with indwelling medical devices. This failure has the potential to result in cross contamination of infection which may jeopardize the health and safety of the residents and staff. Definition: Enhanced Barrier Precautions (EBP) - refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Indwelling medical devices - refers to a device that is inserted into the body and remains there for a period of time, such as central lines, urinary catheters, and feeding tubes. Additionally, there was no signage posted and personal protective equipment (PPE) cart set up by the resident's care area. Findings: 1. Review of Resident 62's admission record indicated, Resident 62 was admitted on [DATE] with diagnoses including stroke, heart failure, diabetes mellitus (high blood sugar), and gastrostomy status (presence of an artificial opening in the stomach (gastrostomy) used for nutritional support or gastric decompression - removing gas and fluid from the stomach), During an observation on 2/24/25 at 6:56 AM in Resident 62's room, Resident 62 was in bed asleep and was receiving enteral (a thin flexible tube inserted through the gastrointestinal tract for nutrition) feeding via an automated feeding pump. During further observation, an opened, unlabeled, and undated irrigation syringe (a medical device used to flush fluids or medications into specific areas of the body) inside its plastic packaging was hanging on the feeding pump pole. During an interview on 2/24/25 at 7:03 AM with Registered Nurse (RN) 2, RN 2 stated, the irrigation syringe should be dated and labeled with resident's name once opened. During further interview, RN 2 stated, Resident 62 is not on any precautions. Review of Resident 62's undated care plan indicated, infection control precaution was not addressed in the care plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 25's admission record indicated, was readmitted to the facility on [DATE] with diagnoses including fracture of unspecified part of neck of right femur (refers to a broken bone in the neck of the right thigh bone, where the exact location of the fracture within the neck is not specified), presence of right artificial hip joint (indicates a hip replacement surgery where the damaged or diseased parts of the right hip joint have been replaced with artificial components, typically made of metal, ceramic, and/or plastic), and neuromuscular dysfunction of bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). During an observation on 2/24/25 at 7:10 AM in resident's room, Resident 25 was in bed asleep. A partially filled urinary catheter drainage bag was observed hanging on the lowered partial side rail by the left side of the foot of the bed exposing its contents. The urinary catheter drainage bag had no cover and a reddish-brown discoloration on the front of the bag was observed. The drainage bag was unlabeled and undated. A reddish-brown fluid was also observed in the tube attached to the urinary catheter drainage bag. During a concurrent observation and interview on 2/24/27 at 7:18 AM with Certified Nursing Assistant (CNA) 3, CNA 3 acknowledged Resident 25's urinary catheter drainage bag was uncovered, undated, and unlabeled. CNA 3 stated, there was no date on the drainage bag and should have been placed inside a dignity bag. During an interview on 2/26/25 at 1:43 PM, RN 1 stated she follows contact precaution (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) when changing the dressing for Resident 25's suprapubic catheter (a medical device that drains urine from the bladder directly through the abdominal wall). Review of Resident 25's undated care plan titled, Resident has an suprapubic catheter DUE TO: Overactive urinary bladder/spasms. At risk for UTI Bleeding due to trauma to perennial area Urinary meatus or other parts of the genital area, indicated, infection control precaution was not addressed in the care plan. 3. Review of Resident 204's admission record indicated, was admitted on [DATE] with diagnoses including heart failure, acquired absence of left leg below knee, kidney disease, and dependence on renal dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so). During an observation and interview on 2/24/25 at 7:41 AM in resident's room, with Resident 204, Resident 204 was awake, still lying in bed. Resident 204 stated he has a catheter on his right upper chest used for dialysis. During an interview on 2/24/25 at 8:42 AM, Registered Nurse Supervisor (RNS) stated, Resident 204 has a central venous catheter (CVC - a tube inserted into a major vein in the chest, neck, or groin for emergency dialysis or temporary access) on his right upper chest for his dialysis. RNS also stated that no special precautions are followed for Resident 204's care. Review of Resident 204's Order Summary Report indicated, an order date of 2/22/25 for Daily Dialysis access site care: The patient has -CVA (Central Venous Access)- Assess for bleeding or infection every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 204's undated care plans indicated, CVA site care and infection control precautions were not addressed in the care plan. During the initial tour on 2/24/25 at 6:30 AM to 7:41 AM, there were no residents observed to be on EBP. Additionally, there were no signs posted and PPE cart set up near the resident care area or outside the resident's room. During an interview on 2/26/25 at 2:13 PM with the Infection Preventionist (IP), the IP stated all catheters, nasal cannulas, O2 tubing had to be changed and labeled. The IP also stated, residents with catheters, tube feedings, and wounds should be placed on EBP. Additionally, the IP stated a sign on the resident's door is posted with instructions on what PPE's to wear and a PPE cart is set up outside the resident's room. During further interview, the IP acknowledged that there was no signage for EBP posted and PPE cart set up for residents with catheters and tube feedings including Resident 62, Resident 204, Resident 25, Resident 256. 43913 4. During a concurrent observation and interview on 2/24/25 at 6:30 AM, Resident 256 was up in wheelchair, observed holding his Gastrostomy tube (GT) tubing, resident stated, don't worry about it when asked what he was doing. Resident stated they showed me how to do it, then disconnected his GT feeding himself, leaving the end of the feeding tube on his bed. During a concurrent observation and interview on 2/24/25 at 6:35 AM, with CNA 5, no sign or posting for EBP was observed on Resident 256's room. CNA 5 stated the posting was for residents with tube feeding and oxygen, when asked about a sign posted on another room. During and observation for medication pass 2/24/25 at 8:30 AM , with RN 3, RN 3 observed giving the GT medication using gloves only. Review of Resident 256's Admission Record, admitted on [DATE] with diagnoses including: Cerebral Infarction (a condition where blood flow to the brain is interrupted causing brain tissue to die), Dysphagia(difficulty swallowing), Gastrostomy Status(where a thin flexible tube is inserted through the abdominal wall and into the stomach for feeding). During an interview on 2/25/25 at 11 AM, with RNS, RNS stated residents with any tubing should have a signage for EBP (Enhanced Barrier Precaution) on the door.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 31922 Based on observation, interview and record review the facility failed to maintain an effective pest control program, when flying insects were seen in the facility. This failure had the potential to result in exposing residents to pest borne illnesses. Findings: During a concurrent observation and interview on 02/24/2025 at 1:00 PM, in Resident 93's room, with Resident 93's family member, Resident 93's family member stated you can see these insects here and pointed to a little flying insect resting on the wall approximately 8 feet above the floor. During a concurrent observation and interview on 02/25/2025 2:07 PM, with Kitchen Supervisor (KS) a flying insect was observed flying in the room while interviewing Resident 82. KS confirmed he saw the flying insect. During an interview on 02/26/2025 at 9:52 AM, the Maintenance Manager (MM) stated the facility was subcontracted with a pest control company as part of their pest management program. Review of the facility's policy titled Pest Control, revised on May 2008, indicated .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.