STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056449	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Francisco Post Acute	5767 Mission Street San Francisco, CA 94112

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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 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. 44477 Based on observation, interview and record review, the facility failed to implement pain care plan for 1 of 14 sampled residents (Resident 38) when there was no evidence of pain assessment. This failure had the potential for not meeting Resident 38's nursing needs and goals to attain the resident's highest practicable well-being. Findings: Review of Resident 38's clinical record indicated, Resident 38 was admitted to the facility with diagnoses including displaced intertrochanteric fracture of left femur (broken left thigh bone), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and hyperlipidemia (high cholesterol). Review of Resident 38's Minimum Data Set (MDS, resident assessment tool) dated 10/2/24 indicated, Resident 38 was cognitively intact. During a concurrent observation and interview on 12/8/24 at 12:09 p.m., with Resident 38 in front of his room in hallway, he pointed to his abdomen while speaking in Chinese when asked if he had a pain. During a concurrent interview and record review on 12/8/24 at 12:11 p.m., with Registered Nurse (RN) 1, RN 1 stated, she gave Colace (a stool softener) and Miralax powder (an osmotic laxative, a medication that draws water into the stool to soften it and make it easier to pass) to Resident 38 for his abdominal discomfort. But she did not show the evidence of pain assessment of Resident 38 when asked. During a concurrent interview and record review on 12/9/24 at 2:42 p.m., with RN 1, RN 1 still did not show the evidence of pain assessment of Resident 38 when asked again. During an interview on 12/9/24 at 2:44 p.m., with Director of Nursing (DON), DON stated, every shift needs to assess pain when asked. Review of Resident 38's pain care plan initiated on 6/28/23 indicated, . Assess pain every shift and as indicated . (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/10/24 at 2:39 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 38's medication administration record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated December 2024 was reviewed. LVN 1 verified, there was no pain assessment until the night shift on 12/9/24. LVN 1 stated, the facility has 3 shifts which are day, evening, and night shift. LVN 1 stated, Every shift and as needed when asked about the facility's policy and procedure (P&P) regarding pain assessment. Review of the facility's P&P titled, Pain Assessment and Management dated October 2022 indicated, . Assessing Pain . 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level . Review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered dated March 2022 indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is . implemented for each resident .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44477 Based on observation, interview and record review, the facility failed to meet professional standards of quality when the facility did not follow doctor's order regarding oxygen for one of 2 sampled residents (Resident 8). This failure could potentially result in negative outcomes for Resident 8. Findings: Review of Resident 8's clinical record indicated, Resident 8 was admitted to the facility with diagnoses including spinal stenosis (the spaces inside the bones of the spine get too small), acute respiratory failure with hypoxia (a serious medical condition that occurs when there is not enough oxygen in the body's tissues), chronic obstructive pulmonary disease (COPD, a lung disease that makes breathing hard), and hypertension (high blood pressure). Review of Resident 8's Minimum Data Set (MDS, resident assessment tool) dated 11/16/24 indicated, Resident 8 was cognitively moderately impaired. Review of Resident 8's H&P (history and physical, a formal assessment of a resident that includes a review of their medical history, a physical exam, and a summary of any tests) dated 11/14/24 indicated, . with history of CHF (congestive heart failure, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), COPD . She used to use home O2 as needed for shortness of breath . she was given . Lasix (diuretic that can treat fluid retention called edema and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions) and duonebs (a combination of two medicines called bronchodilators to treat COPD. It works by opening your airways and reducing inflammation in your lungs to help you breathe) on admission with significant improvement and remained stable on room air . During an observation on 12/8/24 at 10:26 a.m., in Resident 8's room, Resident 8 was on oxygen (O2) at 3.5 liters per minute (LPM or L/min, a unit that expresses flow rate) via nasal cannula (a medical device that provides supplemental oxygen to a resident through their nose). Resident 8 did not have shortness of breath (SOB). During a concurrent observation and interview on 12/8/24 at 10:42 a.m., with Registered Nurse (RN) 1 in Resident 8's room, Resident 8 was still on O2 at 3.5 liters per minute. RN 1 stated, the doctor's order was 1-2 liters per minute as needed when asked, then she decreased oxygen from 3.5 to 3 liters per minute. During a concurrent interview and record review on 12/8/24 at 10:45 a.m., with RN 1, the doctor's order titled, Order Details was reviewed. The order details indicated, . CONTINUOUS O2 @ 1-2 LPM VIA NASAL CANNULA PER CONCENTRATOR/TANK TO KEEP O2 SAT (oxygen saturation level, a measurement of how much oxygen the blood is carrying as a percentage) >90% as needed for SOB/COPD . RN 1 did not answer when asked about O2 Sat of Resident 8 in her shift. She acknowledged, O2 was not administered as the doctor's order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/8/24 at 11:52 a.m., with Director of Nursing (DON), Resident 8's O2 Sats were reviewed. The O2 Sats indicated, 95% at room air on 12/8/24 at 5:42 a.m., and 96% at 3 liters per minute on 12/8/24 at 10:51 a.m. DON did not answer why Resident 8 was on O2 at this time when asked. During a concurrent interview and record review on 12/10/24 at 1:43 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 8's clinical records were reviewed. LVN 1 stated, There is none unfortunately why they increased it when asked why they applied O2 at 3.5 liters per minute to Resident 8 on 12/8/24 after O2 Sat 95% at room air on 12/8/24 at 5:42 a.m. During an interview on 12/12/24 at 9:47 a.m., with DON, DON acknowledged, O2 at 3.5 liters per minute was a bit of high amount for COPD (For residents with COPD, high oxygen levels is generally considered not recommended and can be harmful, as the target oxygen saturation level for most COPD residents should be between 88% and 92% to avoid complications like oxygen-induced hypercapnia- a condition that occurs when supplemental oxygen increases blood carbon dioxide (CO2) levels in residents with COPD or other conditions that cause chronic hypercapnia), and RN 1 should have followed the doctor's order. Review of Resident 8's care plan indicated, . Monitor oxygen saturation via pulse oximetry (a painless, noninvasive test used to measure the oxygen saturation of the blood) . Review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered dated March 2022 indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is . implemented for each resident . Review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated 2001 indicated, . 1. Verify that there is a physician's order for this procedure. Review the physician's order .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 44477 Based on observation, interview and record review, the facility failed to ensure communication services were provided for one of 6 sampled residents (Resident 38) who spoke in his native language when there were no interpreter services for Resident 38 on Sunday (12/8/24). This failure has the potential for Resident 38 not to understand and carry out activities of daily living (ADL) to attain the resident's highest practicable well-being. Findings: Review of Resident 38's clinical record indicated, Resident 38 was admitted to the facility with diagnoses including displaced intertrochanteric fracture of left femur (broken left thigh bone), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and hyperlipidemia (high cholesterol). Review of Resident 38's Minimum Data Set (MDS, resident assessment tool) dated 10/2/24 indicated, Resident 38 was cognitively intact. During an interview on 12/8/24 at 11:58 a.m., with Son of Resident 38 via phone, Son stated, Resident 38 speaks Cantonese, Mandarin, and Chinese and does not speak English well. Son stated, Resident 38 had abdominal discomfort. During a concurrent observation and interview on 12/8/24 at 12:09 p.m., with Resident 38 in front of his room in hallway, he pointed to his abdomen while speaking in Chinese when asked if he had a pain. During a concurrent interview and record review on 12/8/24 at 12:11 p.m., with Registered Nurse (RN) 1, RN 1 stated, they are using Chinese-speaking staff or a Chinese-translated book when asked how they can communicate with Resident 38. RN 1 stated, the Chinese speaking staff was off today (Sunday) and she did not know where the book was when asked if interpreter service was available for Resident 38 today which was Sunday. During an interview on 12/9/24 at 2:06 p.m., with Business Office Manager (BOM), BOM stated, Resident 38 speaks Cantonese, and she helps translate when Resident 38 uses Cantonese. BOM stated, Resident 38's abdominal discomfort was due to bowel movements. BOM stated, she works from Monday to Friday. BOM stated, she did not know when asked whether staff use interpreter services on Sundays or nights for Resident 38. During a concurrent interview and record review on 12/9/24 at 2:15 p.m., with RN 1 and BOM, CHINESE COMMUNICATION BINDER was reviewed. The binder indicated, images of health issues, home assist/items, food, utensil, appliances, etc. RN 1 acknowledged, she did not use the binder because she did not know where it was. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/24 at 2:21 p.m., with Resident 38, with translation assistance from BOM, Resident 38 stated, he did not like the new binder titled, CHINESE COMMUNICATION BINDER because he was not used to it and the binder had so many pages. Resident 38 stated, he prefers the old binder because that was simple. During an interview on 12/12/24 at 9:45 a.m., with Director of Nursing (DON), DON stated, they should use another Chinese-speaking CNA, binder, or Google interpreter services when asked what to do with Chinese speaking residents on Sundays or at night. DON stated, it is important for residents to communicate in their own language. Review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, dated March 2021 indicated, . 1. The resident's individual needs and preferences are accommodated to the extent possible .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44477 Based on interview, and record review, the facility failed to ensure Resident 25 was free from unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic [a type of psychiatric medication which are available on prescription to treat psychosis]; (ii) Anti-depressant [prescription medicines to treat depression]; (iii) Anti-anxiety [drugs used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress]; and (iv) Hypnotic [a class of drugs that induce or prolong sleep in people with sleep disorders and are intended to improve the overall quality of sleep]) when: 1.There was no evidence of non-pharmacological intervention for Aripiprazole (antipsychotic), Bupropion (antidepressant), Lorazepam (antianxiety), and Mirtazapine (antidepressant) for Resident 25 2. There was no targeted behavior of Lorazepam for Resident 25. 3. There was no evidence of specific behavioral monitoring for Lorazepam for Resident 25. 4. There is no specific indication for Mirtazepine for Resident 25. These failures could result in unnecessary use of, ineffective and/or lack of monitoring or interventions for psychotropic medications that could negatively affect the residents' highest practicable mental, physical and psychosocial well-being. Findings: Review of Resident 25's clinical record indicated, Resident 25 was admitted to the facility with diagnoses including low back pain, depression (mental health condition that involves a low mood or loss of interest in activities for a prolonged period of time), and PTSD (Post Traumatic Stress Disorder, an anxiety problem after seeing or having a traumatic event). Review of Resident 25's Minimum Data Set (MDS, resident assessment tool) dated 11/6/24 indicated, Resident 25 was cognitively moderately impaired. Review of the document titled, Resident Matrix (a form used by the facility to list all current residents and to note pertinent care categories) dated 12/9/24 indicated, Resident 25 was on antianxiety, antidepressant, and antipsychotic medications. Review of Resident 25's doctors order titled, Order Details dated 11/4/24 indicated, . ARIPiprazole (an antipsychotic medication) Oral Tablet 20 MG (Milligram) . Give 1 tablet by mouth one time a day . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's doctors order titled, Order Details dated 11/4/24 indicated, . buPROPion (an antidepressant medication) . Oral Tablet Extended Release 24 Hour 300 MG . Give 1 tablet by mouth one time a day . Review of Resident 25's doctors order titled, Order Details dated 11/4/24 indicated, . Mirtazapine (an antidepressant medication) Oral Tablet 15 MG . Give 1 tablet by mouth at bedtime . Review of Resident 25's doctors order titled, Order Details dated 12/4/24 indicated, . LORazepam (an antianxiety medication) Tablet 0.5 MG . Give 1 tablet by mouth every 12 hours as needed for anxiety for 14 Days . During a concurrent interview and record review on 12/10/24 at 10:02 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, No when asked if there was the evidence of non-pharmacological intervention for Resident 25 regarding Aripiprazole, Bupropion, Lorazepam, and Mirtazapine. LVN 1 stated, Unfortunately we don't have a target behavior when asked if there were targeted behaviors for Resident 25 regarding Lorazepam. LVN 1 stated, No. There was not when asked if there was the evidence of behavioral monitoring for Lorazepam for Resident 25. LVN 1 stated, Not in the order when asked if there were the specific indications for Mirtazepine for Resident 25. Review of the facility's policy and procedure (P&P) titled, Psychotropic Medication dated December 2019 indicated, . The facility supports the goal for using psychotropic medications appropriately . 1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications . 3. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident .

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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. 50147 Based on observation, interview, and record review, the facility failed to follow disinfection protocols for reusable items which includes durable medical equipment (DME - equipment that is used for a medical purpose, is used in the home, and is expected to last at least three years) for three out of three residents (Residents 18, 29, and 41). This failure puts residents at risk for cross contamination and the possible spread of infection among residents. Findings: During a continuous observation on 12/8/24 from 8:55 a.m. to 9:25 a.m. on unit B, with Registered Nurse 1, (RN1) was observed taking Resident 29's blood pressure, then Resident 41's blood pressure, and finally Resident 18's blood pressure. Each time, RN1 did not disinfect the blood pressure cuff prior to taking the residents' blood pressures. During an interview on 12/09/24 at 1:50 p.m., with RN1, she was unclear about the facility's policy and procedure (P&P) regarding disinfecting resident care equipment, and offered no explanation. RN1 stated she would have to check with the Director of Nursing (DON) & check the P&P. During concurrent interview and record review on 12/10/24 at 2:30 p.m. with the Executive Assistant, the facility policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated July 2014, indicated 1. d. Reusable Items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). The Executive Assistant stated that DME includes bp cuffs