

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER San Mateo Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 222 West 39th Avenue San Mateo, CA 94403	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of sexual abuse between Resident 116 and Resident 223, 2 of 8 sample residents with allegations of abuse. Failure to thoroughly investigate an allegation of abuse did not ensure other residents were protected from abuse. Findings: Review of a facility's document titled Re: Five (5) Days Summary of Investigation, dated 05/30/2025, indicated .On 05/27/2025; .(Resident 223) told the receptionist on duty .that his male friend . (Resident 116) went to his room to visit him. However, this time on his visit, .(Resident 116) showed his private part(penis) and asked .(Resident 223) to touch it. On 06/26/2025 at 09:00 AM the Director of Nursing (DON) was asked to provide all documents regarding the facility's investigation into this allegation. Review of the documents requested, not titled and not dated, indicated the facility interviewed and assessed both Residents 116 and Resident 223. There was also a statement made by Activity Staff 1 (AS 1) who witnessed the alleged incident. Review of the AS 1's statement, dated 05/27/2025, indicated I went to do my rounds in the morning 5/27/2025 and I went to .(Resident 223's room) .as I walked in the room I saw .(Resident 116) inside .(Resident 116) attempted to pull his zipper down, I immediately told .(Resident 116) 'you are not supposed to be in his room.' Then .(Resident 116) left and went outside. I didn't see his .(genitals) exposed or out for that matter. On 07/02/2025 at 10:37 AM, the Administrator and the DON were interviewed about how they would conduct a thorough investigation into allegations of abuse. The Administrator stated we interview .staff and interview the other license nurses .DON .go look at the resident. we interview the previous shift go back 3 days .(if we have to,) we go further. We interview family, we check the environment in the resident room. If . (residents are) not interviewable then we interview staff or family. When asked what the facility would do if a resident was not interviewable and had no family. Both the DON and Administrator stated it sounds reasonable staff would then conduct body checks for defensive bruising, bruising/trauma around the private areas. Additionally, during these investigations, staff could assess these non-interviewable residents for changes in behavior: crying for no reason, insomnia, change in appetite, social withdrawal etc. The DON and Administrator were made aware, there was no evidence other residents in the area were assessed and/or interviewed during this investigation. Review of the facility's policy titled Abuse Prevention and Management, revised on 05/30/2024, indicated .Reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. When the Administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect, abuse facilitated or enabled by technology, exploitation or injuries of an unknown source, or suspicion of a crime, the Administrator or designated representative, will initiate an investigation immediately. 6. Immediate Actions .The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation or suspected crime. i. Witnesses include but are not limited to the resident, witnesses to the incident, other residents under the care of the staff member involved, roommates, family, visitors, etc. Review of the facility's abuse policy indicated there was no language directing staff how to conduct a thorough investigation when a resident was not interviewable and/or has no family member/responsible party.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe environment free from potentially serious accident hazards for all residents when its policies and procedures were not implemented for the following practices:1. The facility failed to ensure hot water in 6 of 8 residents' bathroom sinks were at a comfortable and safe temperature level.This deficient practice placed the residents (Residents 165, 187, and 259) at increased risk for scalding.An Immediate Jeopardy (IJ, a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) was declared at the [NAME] campus on 6/23/25 at 5:27 PM in the presence of the Administrator, Director of Nursing (DON), Regional Quality Management Consultants (RQMC), Assistant Chief Clinical Officer (ACCO), and [NAME] President of Operations (VPO) for the following deficient practice:Hot water temperatures were found to be between 121.6 F to 136.7 F in 6 of 8 sample rooms as evidenced by:a. room [ROOM NUMBER] = 132.2 Fb. room [ROOM NUMBER] = 136.0 Fc. room [ROOM NUMBER] = 136.7 Fd. room [ROOM NUMBER] = 121.6 Fe. room [ROOM NUMBER] = 131.9 Ff. room [ROOM NUMBER] = 130.5 F.On 6/24/25 at 10:38 AM, the facility submitted an unacceptable IJ Removal Plan (action to correct the deficient practices).On 6/24/25 at 2:36 PM, the facility submitted an unacceptable IJ Removal Plan #2.On 6/24/25 at 4:23 PM, the facility submitted an acceptable IJ Removal Plan #3.On 6/25/25 at 2:43 PM, the IJ was removed after the survey team validated onsite the IJ Removal Plan was implemented through observation, interview, and record review.2a. The facility failed to ensure safe smoking practices were followed when Resident 208 ignited her lighter inside the room while roommate (Resident 195) was actively receiving continuous supplemental oxygen.2b. The facility failed to implement their smoking policy and procedures (P&P) when it allowed five (5) of 14 residents (Resident 208, Resident 2, Resident 138, Resident 139, and Resident 81) who smoked in the facility to keep in possession of their own lighters and cigarettes inside the resident care area.These deficient practices posed an increased risk for combustion and/or fire, serious injury and/or death to residents, staff, and visitors.On 6/26/25 at 5:10 PM, an IJ was declared at the [NAME] campus in the presence of the Administrator, DON, RQMC, ACCO, and VPO for the following deficient practices:a. Without being prompted, Resident 208 ignited her lighter in the room while roommate (Resident 195) was actively receiving continuous oxygen at 2L(liters)/minute via nasal cannula. In addition, Resident 208 was in possession of three lighters and one opened pack of cigarettes.b. Resident and Staff interviews indicated, Resident 2, Resident 138, Resident 139, and Resident 81 were in possession of their own lighters and cigarettes.c. The facility failed to implement its smoking policy when it allowed Residents to keep in possession of their own lighters and cigarettes.On 6/27/25 at 11:13 AM, the facility submitted an unacceptable IJ Removal Plan.On 6/27/25 at 2:04 PM, the facility submitted an acceptable IJ Removal Plan #2.On 6/27/25 at 4:10 PM, the IJ was removed after the survey team reviewed and verified onsite the implementation of the IJ Removal Plan through observation, interview, and record review.3. The facility failed to ensure that one out of two sampled residents (Resident 898) receive adequate supervision to prevent elopement. This deficient practice resulted in Resident 898 eloping on 6/17/25 and putting Resident 898 at risk for serious injury or death.4. The facility failed to consistently implement effective interventions to prevent Resident 234 from elopement. This deficient practice resulted in Resident 234 eloping on 06/15/2025 and putting Resident 234 at risk for serious injury or death. Findings:</p> <p>1. During an initial tour observation on 6/23/25 at 11:43 AM, in Residents' 195 and 208's room, while hand was held under running water in the bathroom sink faucet with hot and cold handles, the hot water was hot to touch. The bathroom was shared with Residents 1 and 214.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an initial tour observation on 6/23/25 at 11:57 AM, in Residents' 165 and 187's room, while hand was held under running water in the bathroom sink faucet with hot and cold handles, the hot water was hot to touch.</p> <p>During an initial tour observation on 6/23/25 at 1:05 PM, in Residents' 271 and 188's room, while hand was held under running water in the bathroom sink faucet with hot and cold handles, the hot water was hot to touch. The bathroom was shared with Resident 151.</p> <p>Resident 165 was admitted on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by a combination of symptoms like hallucinations and delusions and mood disorder symptoms like depression or mania), cataract (a medical condition in which the lens of the eye becomes progressively opaque resulting in blurred vision), and glaucoma (a condition on increased pressure within the eyeball, causing gradual loss of sight). Resident 165's Minimum Data Set (MDS - an assessment tool), dated 5/14/25 indicated, vision and cognition were severely impaired. Resident 165's care plan for activities of daily living (ADL) indicated, .Date Initiated: 3/30/22 .Toilet Use: The resident is able to: ambulate to the bathroom (BR) on her own familiar to the location of the BR in her room and back .</p> <p>Resident 187 was admitted on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), peripheral vascular disease (PVD - a slow and progressive circulation disorder affecting blood vessels in the arms and legs), and cognitive communication deficit (difficulties in communication arising from impairments in cognitive processes, rather than primary language or speech problems). Resident 187's MDS dated [DATE] indicated, cognition was moderately impaired, and resident can walk independently. Resident 187's ADL care plan indicated, .Toilet Use: The resident is able to transfer self to the BR .Revised on: 8/29/24 .</p> <p>Resident 259 was admitted on [DATE] with diagnoses that included cognitive communication deficit, Alzheimer's disease (a progressive brain disorder that gradually destroys memory and thinking skills, ultimately impacting the ability to carry out even simple tasks), and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Resident 259's MDS dated [DATE] indicated, impaired vision, moderate cognitive impairment, can walk independently, and independent with ADLs.</p> <p>During an observation on 6/23/25 at 3:40 PM, with the MS, the hot water in the residents' bathroom sink faucet was turned on and ran for 10-15 seconds, then MS tested the hot water using the facility's thermometer. The hot water temperature for each of the following residents' rooms were room [ROOM NUMBER] = 132.2 &deg;F, room [ROOM NUMBER] = 136.0 &deg;F, room [ROOM NUMBER] = 136.7 &deg;F, room [ROOM NUMBER] = 121.6 &deg;F, room [ROOM NUMBER] = 131.9 &deg;F, and room [ROOM NUMBER] = 130.5 &deg;F.</p> <p>During an interview on 6/23/25 at 4:00 PM, the MS said that random bathroom water temperature check was done each day. MS stated, Anything over 120 &deg;F is too hot.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of facility's undated policy titled Water Temperatures indicated, .The Facility ensures water is maintained at temperatures suitable to meet residents' needs. Tap water in the Facility is maintained within a temperature range to prevent scalding of residents. Procedure: I. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas are set to temperatures of no more than 120 &deg;F (49 &deg;C) .</p> <p>2a. The list of smokers provided by the facility dated 6/23/25 indicated, there were 14 residents who smoke in the facility (Resident 208, 2, 138, 139, 81, 116, 57, 140, 5, 241, 263, 285, 58, and 182).</p> <p>During an observation on 6/26/25 at 10:27 AM, a &ldquo;No Smoking Oxygen In Use sign was posted by the door of Resident 208 and Resident 195&rsquo;s room. Resident 208&rsquo;s roommate (Resident 195) was observed lying in bed receiving oxygen at two (2) liters per minute via a nasal cannula (NC, thin flexible tube with small prongs inserted into the nostrils).</p> <p>During an interview on 6/26/25 at 10:28 AM, Resident 208 stated the facility allowed her to smoke in the designated smoking area with staff supervision during smoking hours. When asked where she keeps her smoking materials, Resident 208 stated, &ldquo;15 cigarettes are in the locked box in the utility room. [Staff Name] from Activities keeps them. But I keep [five] 5 cigarettes with me.&rdquo; Resident 208 added, &ldquo;I have a collector&rsquo;s item lighter that I keep.&rdquo;</p> <p>During concurrent observation and interview on 6/26/25 at 10:32 AM, in Resident 208&rsquo;s room, without being prompted, Resident 208 opened the left bedside drawer and took out two (2) objects. Resident 208 showed a brown, pen shaped object with a skull design on one end and a silver, square shaped object with engraved letters on one side. Resident 208 identified the two objects as lighters and stated that she keeps these &ldquo;two collector&rsquo;s item lighters&rdquo; in her possession. After showing the two lighters, Resident 208 suddenly removed the skull shaped part and without being prompted, ignited the lighter which sparked and produced a small yellow/orange flame. Furthermore, Resident 208&rsquo;s roommate (Resident 195) was on the other bed actively receiving oxygen at 2 liters per minute via a nasal cannula.</p> <p>Review of Resident 195&rsquo;s &ldquo;Order Review History Report&rdquo; for 6/1/25 to 6/30/25, indicated an order to administer &ldquo;Oxygen 2L/min (liters per minute) via NC continuous to keep O2 Sat (oxygen saturation, amount of oxygen that&rsquo;s circulating the blood) at/above 92 % (percent, a unit of proportion) for low oxygen every shift related to chronic respiratory failure (occurs when the lungs can't adequately oxygenate the blood or remove carbon dioxide, leading to long-term breathing difficulties) with hypoxia (low levels of oxygen in your body tissues).</p> <p>During a follow up interview on 6/26/25 at 10:42 AM, Resident 208 stated that she was informed of the &ldquo;rules for smoking&rdquo; six months ago.</p> <p>During an observation on 6/26/25 at 10:46 AM, in resident&rsquo;s room, Resident 208 showed the brown and silver colored (collector&rsquo;s item) lighters and without being prompted, Resident 208 ignited again the pen shaped lighter which immediately sparked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Further observation and interview on 6/26/25 at 10:48 AM, in Resident 208's room, Resident 208 stated that she keeps some cigarettes and a disposable lighter in her possession because staff are not available at times to provide their smoking materials. During concurrent observation, Resident 208 took something out from the side of her wheelchair next to her bed and showed an opened cigarette pack. Resident 208 then opened the cigarette pack and showed the contents which included a few cigarettes sticks and a pink disposable lighter that had the last four letters of Resident 208's name.</p> <p>Review of Resident 208's admission record indicated, was admitted on [DATE] with diagnoses including nicotine dependence (an addiction to tobacco products caused by the drug nicotine), mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), 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 left artificial hip joint (indicates a hip replacement surgery where the damaged or diseased parts of the left hip joint have been replaced with artificial components, typically made of metal, ceramic, and/or plastic), and muscle weakness.</p> <p>Review of Resident 208's Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment, dated 5/26/25, indicated no cognitive impairment. Under the Active Diagnoses section of the MDS assessment indicated, Resident 208's active diagnoses included nicotine dependence, psychotic disorder (a group of serious mental illnesses characterized by psychosis, a condition where a person has difficulty distinguishing between what is real and what is not), and mild cognitive impairment.</p> <p>Review of Resident 208's "Smoking and Safety" assessment dated [DATE], indicated, "Resident is not consistent with following smoking times. Spoke with resident again and reiterated rules and regulations of smoking protocol." Resident 208's "Smoking and Safety" assessment did not indicate Resident 208 was safe to have smoking materials in her possession. Furthermore, the assessment did not address the "Smoking Care Planning" section.</p> <p>Review of Resident 208's smoking care plan revised on 12/2/24 indicated, individualized plan for safe use and storage of smoking materials was not addressed.</p> <p>Further review of Resident 208's clinical record indicated, Resident 208 acknowledged and signed a copy of the facility's "Smoking Policy" on 3/5/25.</p> <p>Review of the facility's policy and procedures titled "Oxygen Therapy", revised 11/2017, indicated, "Oxygen is administered under safe and sanitary conditions to meet resident needs &hellip; II. A. No smoking signs will be prominently displayed wherever oxygen is being stored or administered. B. Smoking is not allowed near where the oxygen is being stored or administered &hellip;";</p> <p>2b. During an observation on 6/26/25 at 11:40 AM, in Resident 548 and Resident 2's room, CNA 4 was attending to Resident 548 who was sitting on the bed receiving oxygen at 2 L/min via a nasal cannula. Resident 548's roommate (Resident 2) was not in bed. During further observation, Resident 2 had an oxygen concentrator attached to an oxygen tubing next to her bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/26/25 at 11:41 AM, CNA 4 stated Resident 2 was out for an appointment and confirmed that Resident 2 uses the oxygen concentrator next to her bed whenever she's in bed/room. CNA 4 also confirmed Resident 2 was an active smoker in the facility. CNA 4 stated that Resident 2 usually goes out to smoke with supervision and always keeps her smoking materials in her pocket.</p> <p>Review of Resident 54's Order Review History Report for 6/1/25 to 6/30/25, indicated an order to administer Oxygen at 2L/min via nasal cannula to keep O2 Sat at/above 92% continuous for COPD (Chronic Obstructive Pulmonary Disease, a group of lung diseases that block airflow and make it difficult to breathe) / CHF (Congestive Heart Failure, a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>Review of Resident 2's admission record indicated, was admitted on [DATE] with diagnoses including asthma (a chronic respiratory disease that affects the airways in the lungs, causing them to become inflamed and narrowed, making it difficult to breathe), heart failure, and seizure disorder (abnormal electrical activity in your brain).</p> <p>Review of Resident 2's Order Review History Report for 6/1/25 to 6/30/25, indicated an order to administer Oxygen at 2L/min via nasal cannula for mild SOB (shortness of breath) as needed.</p> <p>During concurrent observation and interview on 6/26/25 at 11:43 AM, Resident 81 was lying in bed, alert and oriented. Resident 81 stated he smokes in front of the building and keeps his cigarettes and lighter with him in the room. Resident 81 further stated, "I don't give it to the nurse. I want it with me. It's easier."</p> <p>During an observation on 6/26/25 at 11:44 AM, Resident 138 was sitting in his wheelchair outside his room watching on a computer tablet. Resident 138 agreed for interview and went inside his room.</p> <p>During concurrent observation and interview at 11:45 AM, in the resident's room, Resident 138's bedside (top) drawer was unlocked and slightly opened. Resident 138 stated he keeps the lighter and cigarettes in his possession and was saying, "here, there", while pointing to his pocket and to the unlocked bedside (top) drawer. Resident 138 refused to open and check the bedside drawer.</p> <p>During an interview on 6/26/25 at 11:47 AM, Certified Nursing Assistant (CNA) 3 stated, Resident 138 had a lighter and cigarettes kept in his pocket and bedside drawer. CNA 3 also stated that residents' smoking materials were stored in the Activities Department. CNA 3 further stated that residents should not keep smoking materials in the room for safety reasons.</p> <p>During an interview on 6/26/25 at 11:48 AM, CNA 5 stated, residents should not keep cigarettes or lighters in their rooms and that she would report to the nurse immediately when she finds them in a resident's room.</p> <p>During an interview on 6/26/25 at 11:54 AM, Resident 139 stated she smokes and vapes occasionally, and that she keeps her cigarettes and lighter in her fanny pack at all times. Resident 139 also stated, she is aware of the facility's smoking policy which includes safe storage of smoking materials.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the facility's undated "Smoking Policy" acknowledgement form indicated, "8. All residents that smoke will have their smoking materials (lighter, cigarettes, e-cigs [electronic cigarettes], etc.) kept in a safe place at Nursing Stations . 10. No resident is allowed to keep any smoking materials in their room . 14. Residents whether it is traditional tobacco cigarettes, pipes, cigars, or electronic (e-cigarettes) cigarettes are governed by this policy."</p> <p>(continued on next page)</p>

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During an interview on 07/02/2025 at 2:18 PM with the Director of Nursing (DON), Resident 898 had a wander guard (a special bracelet worn by residents at risk for wandering and elopement, that alerts facility staff when resident leaves a safe area defined by the facility) in place prior to the elopement. During concurrent observation and interview on 07/02/2025 at 10:09 AM with Resident 898, Resident 898 was unable to remember the elopement. Resident 898 was also unable to correctly state the day of the week or current city. Resident 898 had difficulty stating names of siblings. Resident 898 was wearing both an identification wrist band on the right wrist and a wander guard wrist band on the left wrist. During a review of Progress Note entitled Communication with Physician and dated 06/17/2025 at 18:26 for Resident 898, the situation described was, Resident eloped from the facility. The background described is, Resident has a history of elopement and wandering. A recommendation that was made was, Send resident to [emergency room] ER if or when he returns to the facility to be evaluated. During an interview on 07/03/25 at 10:54 AM with the DON, Resident 898 was admitted to the facility on [DATE] for dementia and worsening mental status. Resident 898 was evaluated for elopement risk on 06/02/2025 and was determined to be at risk for elopement with a score of 6 out of 10. Resident 898 was evaluated again for elopement risk on 06/17/2025 and was determined to be at risk for elopement with a score of 6 out of 10, with no change in the elopement risk score. The higher the elopement risk score the higher the risk for elopement. The DON stated the facility has cameras in the hallway, but the facility was unable to identify Resident 898 on any of the camera recordings on the day of the elopement 06/17/2025. During a record review of Elopement Evaluations dated 06/02/2025 and 06/17/2025 did not reveal a specific total score for each evaluation. Both documents note, Score value of 1 or higher indicates Risk of Elopement. Elopement Evaluation for 06/02/2025 at 21:26 has 6 marked questions as yes answers from a total of 10 questions. Elopement Evaluation for 06/17/2025 at 17:40 has 3 marked questions yes answers from a total of 10 questions. The questions answered yes for the Elopement Evaluation for 06/02/2025 include the following: Does the Resident have a history of elopement or an attempted elopement while at home; Does the resident have a history of elopement or attempted leaving the facility without informing staff; Has the Resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door; Does the Resident wander?; Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.; and, Is the Resident's wandering behavior likely to affect the safety or well-being of self/others. The questions answered yes for the Elopement Evaluation for 06/17/2025 include the following: Does the resident have a history of elopement or attempted leaving the facility without informing staff; Does the Resident wander?; and, Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.). During a record review of the Medication Administration Record (MAR) for June 2025 shows 3 separate orders for, Check placement of wander guard . with different stop and start dates. The order to Check placement of wander guard every shift is it in place, Yes or No? with start date of 06/10/2025 to 06/12/2025 is marked as completed for 2 days in June, 06/10/2025 and 06/11/2025. The order to, Check placement of wander guard on left wrist every shift is it in place, Yes or No? with start date of 06/14/2025 and no stop date is marked as completed for Day, Evening, and Night shifts from 06/15/2025 to 06/30/2025, and marked as completed for Evening and Night shift for 06/14/2025. The order to, Check placement of wander guard every shift for wanderer is it in place, Yes or No? with start date 06/02/2025 and end date of 06/10/2025 is marked completed for Day, Evening, and Night shifts for 06/03/2025 to 06/09/2025 and marked completed for Night shift only for 06/02/2025. During an interview on 07/03/25 at 1:38 PM with ADON 2, Resident 898's reason for admission to the facility was because Resident 898's caregiver was in the hospital. Resident 898 was found wandering around the vicinity of the caregiver's hospital and identified by police. Resident 898 was evaluated by Hospital 1 and later transferred to the facility</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER San Mateo Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 222 West 39th Avenue San Mateo, CA 94403	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident 234's records, titled RESIDENT INFORMATION, printed on 07/01/2025, indicated she had multiple diagnoses including: alcohol abuse (an impaired ability to stop/control alcohol use despite adverse consequences), .alcohol -induced persisting amnesic disorder (severe memory loss associated with chronic alcohol abuse), abnormal walking pattern, anxiety disorder (a mental disorder associated with excessive worry, fear, or nervousness that interferes with daily life), delusional disorder (a mental disorder when one cannot tell what is real from what is imaginary), and history of falls. During an interview on 07/01/2025 at 11:40 AM, CNA 1 stated she has cared for Resident 234 for 2-3 years. CNA 1 stated Resident 234 was very .forgetful, she is always trying to find her husband, constantly asking staff how to get a hold of her husband. She doesn't remember her husband passed away two years ago. CNA 1 stated Resident 234 has a history of trying to get out (elope). To keep her from elopement, CNA 1 stated she tries to distract (Resident 234) to activity (and Resident 234) wears a wanderguard. Wanderguard: a bracelet type device that activates an audible alarm when a resident is approaching an exit. Review of Resident 234's record titled Elopement, dated 07/10/2024, indicated Resident 234 eloped from the facility At .(1:15 PM, nurses were) alerted by staff that .(Resident 234) was seen exiting the facility .staff did a search of the facility and unable to locate her.[NAME] .(police department was) . contacted and a missing persons report filed. The document indicated Resident 234 was found 2 hours and 35 minutes later approximately 1 mile away from the facility. During a concurrent interview and record review on 06/26/2025 at 10:18 AM with LVN 1, review of the facility's daily log communication between shifts on the facility's computer (not titled), indicated Resident 234 Eloped on 06/15 at around 7:30 pm, went out on the street. LVN 1 was asked to search Resident 234's record for any documentation regarding this elopement. LVN 1 was unable to find any documentation in Resident 234's medical records regarding this elopement. During an interview on 07/02/2025 at 10:09 AM, CNA 2 stated Resident 234 was a high elopement risk because she .wanders around the facility she very active . We really need to keep an eye on her. she always says I need to go home. Things like that. We always keep an eye on her. CNA 2 stated on 06/15/2025, she does not . remember the exact time around break time so I was at the break room eating .(when)one of my co-workers called me that she saw .(Resident 234) outside so I ran out of the break room .ran out of the building .and we saw.(Resident 234) across . the road . On 07/01/2025 at 3:20 PM, the Registered Nurse Supervisor (RNS1) and the Director of Nursing (DON) were interviewed regarding Resident 234's elopement on 06/15/2025. The RNS 1 and the DON searched Resident 234's records and confirmed there was no documentation regarding the elopement. The DON stated her expectations were staff would initiate a change of condition charting, notify the responsible party, physician, ombudsman and CDPH (California Department of Public Health). The DON stated she expected staff to conduct an investigation to identify potential weakness in the facility's so the facility could put interventions in place to prevent Resident 234 from elopement. Review of the facility's policy titled Wandering and Elopement, Revised on 01/31/2023, indicate .Elopement - A behavior that may lead to the resident leaving the facility unsupervised and/or without permission. When the resident who eloped returns to the Facility, the Licensed Nurse should: i. Assess the resident for possible injuries, changes of condition and vital signs. ii. Notify the Attending Physician of the return of the resident and the result of the exam; and iii. Notify the resident's responsible party of the return of the resident and the result of the exam. iv. Upon return the Licensed Nurse will implement immediate interventions to prevent further elopement of the resident and update the plan of care. b. The Interdisciplinary Team as part of the investigation will conduct a post elopement meeting to determine if alternate prevention measures can be put in place (activities, rehab, etc.) and if necessary, determine if the resident can safely remain in the facility. c. If the resident cannot be safely kept in the facility the Interdisciplinary team will discuss with the physician and responsible party/surrogate decision maker, the transfer of the resident to a safe environment.</p>		