STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555034	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Mateo Medical Center D/P Snf	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of three sampled residents (Resident 1) when Phenobarbital (a prescription medication primarily used to control certain types of seizures), Olmesartan Medoxomil (a prescription medication used alone or with other drugs to treat high blood pressure), Metoprolol (a prescription medication primarily used to treat high blood pressure, prevent chest pain, and manage heart failure), and Hydroxyzine (a prescription medication primarily used to treat itching, anxiety, and allergic reactions) were not given according to the doctor's orders from February to April 2026. This failure was likely to result in Resident 1 being put at risk for not attaining or maintaining his highest practicable level of physical, mental, functional, and psychosocial well-being.Review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated, Resident 1 was admitted to the facility with diagnoses including epilepsy (a long-term brain condition where a person has repeated seizures), hypertension (high blood pressure), and malignant neoplasm of brain (brain cancer). Review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/17/26 indicated, Resident 1 was cognitively intact. During an interview on 5/27/26 at 11:16 AM with Resident 1, Resident 1 stated that he occasionally did not take Phenobarbital, Olmesartan Medoxomil, Metoprolol, and Hydroxyzine on time from February to April in 2026 because he ran out of these four medications. Resident 1 was worried that missing his medication might affect his health. During a concurrent observation and interview on 5/28/26 at 12:50 PM with Registered Nurse (RN) 1 in the Director of Nursing (DON)'s office, RN 1 stated that each medication packet has blue indicator lines, and when the packets reach the blue line, nurses should request a refill. Resident 1's medication packets including Phenobarbital, Olmesartan Medoxomil, Metoprolol, and Hydroxyzine had all blue indicator lines and had enough medications. During a concurrent interview and record review on 5/28/26 at 1:29 PM with DON, Resident 1's doctor's orders titled, Order Details (OD) were reviewed. Resident 1's OD dated 9/5/23 indicated, Order Summary: PHENobarbital Oral Tablet 100 MG (Milligram, used for medication dosages) . Give 1 tablet by mouth two times a day for epilepsy . Resident 1's OD dated 2/23/25 indicated, Order Summary: Metoprolol . Oral Tablet 25 MG . Give 1 tablet by mouth two times a day for hypertension. Hold if SBP (systolic blood pressure, the maximum pressure in your arteries when your heart beats and pumps blood into your circulatory system) < 105 and HR (heart rate, the number of heart beats per minute) < 60 . Resident 1's OD dated 10/12/25 indicated, Order Summary: Olmesartan Medoxomil Oral Tablet 20 MG . Give 0.5 tablet by mouth one time a day for high blood pressure . Resident 1's two OD dated 3/22/26 and 3/23/26 indicated, Order Summary: hydrOXYzine . Oral Tablet 10 MG . Give 1 tablet by mouth three times a day for itchiness . During a concurrent interview and record review on 5/28/26 at 1:39 PM with Licensed Vocational Nurse (LVN) 1, Resident 1's MEDICATION ADMINISTRATION RECORD (MAR) dated from 3/1/26 to 3/31/26 and from 4/1/26 to 4/30/26, Weights and Vitals Summary dated 3/4/26, and Orders-Administration Note dated 4/9/26 were reviewed. LVN 1 verified that the initials XXXX (LVN 1's initial) on the MAR were hers. The MAR of March 2026 indicated, regarding the administration of Metoprolol, the blood pressure (BP) and pulse (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entries were marked with an X at 5 PM on 3/4/26. LVN 1 verified that Metoprolol was not given to Resident 1 at 5 PM on 3/4/26, and that the reason it was not given was chart code number 4, indicating Vitals (Known as vital signs, measurements of the body's most basic functions such as BP and pulse) Outside of Parameters for Administration. But Resident 1's Weights and Vitals Summary dated 3/4/26 indicated, there was no BP and pulse at 5 PM. LVN 1 stated she might have missed entering the BP and pulse on 3/4/26 at 5 PM on the MAR for Metoprolol. Resident 1's MAR indicated, regarding the administration of Olmesartan Medoxomil on 4/9/26 at 9 AM, it was recorded with chart code number 9, indicating Other / See Progress Notes. Resident 1's Orders-Administration Note dated 4/9/26 at 11:06 AM indicated, . Olmesartan Medoxomil . on order . LVN 1 stated that Olmesartan Medoxomil was not available from the pharmacy at that time, even though it had been ordered for refill earlier. LVN 1 stated that the pharmacy did not deliver the medication on time. During a concurrent interview and record review on 5/28/26 at 2:16 PM with LVN 2, Resident 1's MAR dated from 2/1/26 to 2/28/26 was reviewed. LVN 2 verified that the initials OOOO (LVN 2's initial) on the MAR were his. The MAR indicated, regarding the administration of Phenobarbital at 9 AM on 2/28/26, it was recorded with chart code number 9, indicating Other / See Progress Notes. LVN 2 acknowledged that there was no nursing progress notes or Orders-Administration Note to explain the situation for the chart code number 9 when asked. But LVN 2 stated that he could not give Phenobarbital to Resident 1 because it was not available from the pharmacy on 2/28/26. LVN 2 stated that since the resident takes phenobarbital to prevent seizures, a seizure could occur if the medication is not taken on time when asked about the possible risks of not taking Phenobarbital on time. LVN 2 stated that delays in medication delivery from the pharmacy to the nursing unit are not an ongoing issue but rarely occur, probably about once every 3 to 4 months. During a concurrent interview and record review on 5/28/26 at 3:03 PM with LVN 3, Resident 1's MAR dated from 3/1/26 to 3/31/26 was reviewed. LVN 3 verified that the initials **** (LVN 3's initial) on the MAR were his. The MAR indicated, regarding the administration of Hydroxyzine on 3/23/26, it was given to Resident 1 at 9 AM and 1 PM by initial @@@@ (LVN 5's initial), then it was given to Resident 1 by LVN 3 at 5 PM and 9 PM. LVN 3 acknowledged that Hydroxyzine was given 4 times on 3/23/26 even though the doctor's orders indicated it should be given three times a day when asked. LVN 3 stated he did not know there were duplicate orders and he just followed the order on the MAR when asked why Hydroxyzine was given 4 times on 3/23/26. LVN 3 stated that Hydroxyzine was given for itchiness when asked. LVN 3 stated it could cause an overdose when asked about the possible risks associated with taking one more dose of Hydroxyzine without doctor's order. During a concurrent interview and record review on 5/28/26 at 3:19 PM with LVN 4, Resident 1's MAR dated from 3/1/26 to 3/31/26 and Orders-Administration Note dated 3/7/26 were reviewed. LVN 4 verified that the initials #### (LVN 4's initial) on the MAR were hers. The MAR indicated, regarding the administration of Olmesartan Medoxomil at 9 AM on 3/7/26, it was recorded with chart code number 9, indicating Other / See Progress Notes. Resident 1's Orders-Administration Note dated 3/7/26 indicated, Olmesartan Medoxomil . on order . LVN 4 stated that the medicine was not available from the pharmacy at that time, even though it had been ordered for refill earlier when asked. LVN 4 stated that medications could not be administered on time because delays occurred about once every 3-4 months during the process of delivering drugs from the pharmacy to the nursing unit. During an interview on 5/28/26 at 3:36 PM with LVN 5 via phone, regarding Resident 1, LVN 5 verified that the initials @@@@ (LVN 5's initial) on the MAR were hers. LVN 5 stated that she did not remember the incident about Hydroxyzine on 3/23/26. But LVN 5 verified that medications should be administered in accordance with the doctor's orders when asked. LVN 5 stated that Hydroxyzine should have been administered 3 times, not 4 times on 3/23/26 per doctor's order when asked. LVN 5 stated that there could be resistance to the medication when asked about the risks associated with taking one more dose without doctor's order. During a concurrent interview and record review on 5/28/26 at 4:13 PM with DON, Resident 1's MAR dated from 2/1/26 to 2/28/26 was reviewed. The MAR indicated, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the administration of Olmesartan Medoxomil at 9AM on 2/12/26, she verified that LVN 1 did not administer the medication and that no nursing notes explained why it was not given. During an interview on 5/28/26 at 4:20 PM with LVN 1 via phone, LVN 1 stated that she could not give Olmesartan Medoxomil to Resident 1 at 9 AM on 2/12/26 because the medication was not available from the pharmacy, and she forgot to document it on the nursing notes when asked. During a concurrent interview and record review on 5/28/26 at 4:28 PM with DON, Resident 1's MAR dated from 3/1/26 to 3/31/26 was reviewed. The MAR indicated, regarding the administration of Hydroxyzine at 1 PM on 3/22/26, it was recorded with chart code number 9, indicating Other / See Progress Notes. Resident 1's Order-Administration Note dated 3/22/26 indicated, . hydrOXYzine . medication not available . DON verified that Hydroxyzine was not administered at 1 PM on 3/22/26 by LVN 5 because the medication was not available from the pharmacy. DON acknowledged that the facility shared a pharmacy with ******* (hospital name), and that the pharmacy tends to be late in delivering medications to the facility, even when nurses had requested refills ahead of time. The facility's policy and procedure (P&P) titled, NP76 Medication - Administration dated 6/26/25 indicated, . All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner .