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	03/21/2024

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on observation, interview and record review, the facility failed to ensure dignity and respect were maintained for one sampled (Resident 255) and two random residents (Residents 165 and 162) when: 1. Staff stood over Resident 255 and Resident 165 to assist with meals. 2. Facility failed to provide access to communication with staff in a language that is clear and understandable to the resident when a language translation service was not available for use by Resident 162. These deficient practices would not allow for social interaction and had the potential to lower Resident 255 and Resident 165's self-esteem and had the potential for Resident 162 to feel frustrated for being unable to communicate with staff and relaying her needs and concerns and had the potential for the other residents with limited proficiency in English to not have access to communication with persons inside and outside the facility. Findings: 1. Resident 255 was admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning -thinking, remembering, and reasoning -to such an extent that it interferes with a person's daily life and activities) and anxiety (a feeling of fear, dread, and uneasiness). During a concurrent observation and interview on 3/11/24 at 10:50 AM, Certified Nursing Assistant (CNA) 5 was at Resident 255's bedside, standing while assisting resident with feeding. CNA 5 stated, It's better for me when I'm standing while feeding because when I sit down, it feels weird. During an interview on 3/11/24 at 10:56 AM, Licensed Vocational Nurse (LVN) 5 acknowledged that staff was standing over while assisting Resident 255 with feeding and said, staff should sit at the resident's eye level when feeding to make resident feel more comfortable. Resident 165 was admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff) of left elbow. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 165's Minimum Data Set (MDS - an assessment tool) dated 1/4/24 indicated, Resident 165's cognitive skills was severely impaired, and was dependent (resident does none of the effort to complete the activity) with eating. During a concurrent observation and interview on 3/15/24 at 1:57 PM, CNA 6 was at Resident 165's bedside, standing while assisting resident with feeding. CNA 6 stated, I usually stand because it's easier for me. During an interview on 3/15/24 at 2:03 PM, LVN 3 acknowledged that staff was standing over while assisting Resident 165 with feeding and said, staff is supposed to be sitting down while feeding, at eye level for the resident to feel comfortable while eating. 2. Resident 162 was admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning -thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and anxiety (a feeling of fear, dread, and uneasiness). Review of Resident 162's MDS dated [DATE] indicated that the resident's preferred language is Cantonese and needs or wants an interpreter to communicate with a doctor or health care staff. Review of Resident 162's care plan indicated, The resident has a communication problem r/t (related to) Language barrier. Resident speaks Cantonese, decreased ability to make self understood and to understand others .Communication: Resident prefers to communicate in Cantonese .Date Initiated: 10/19/22 . During an observation on 3/19/24 at 10:12 AM, Resident 162 was in the hallway talking in her own language to LVN 2. LVN 2 was unable to understand what the resident was saying, hence, had to call other staff to interpret. During an interview on 3/19/24 at 10:26 AM, LVN 13 stated, I try my best to accommodate by pointing at things, facial expression, body language, or booklets that has pictures. If lucky, staff that speaks the same dialect/language. LVN 13 added, We don't have an interpreter to call. During an interview on 3/19/24 at 10:55 AM, LVN 2 said, Resident 162's language is Cantonese, and resident does not speak and understand English. LVN 2 communicates with the resident through hand gestures, language board with pictures where the resident can point, or through facial expressions. LVN 2 stated, I ask another staff to translate, or I call the family member. We don't have an interpreter to call. I pull out my phone and do Google translate. During an interview on 3/19/24 at 11:30 AM, Registered Nurse Supervisor (RNS) said that for communication, residents have a language book, but the easiest is to call the family or staff that can speak the language. RNS stated, We try to do hand gestures, try to anticipate what the resident needs. I don't know how else. When queried about facility's language line interpreter service, RNS stated, We don't have that. RNS further stated, We have a lot of residents who don't speak English, who speak different languages like Spanish, Polish, Chinese, Korean, and Japanese. There's no staff who speaks Korean or Japanese. RNS said, It's very hard to address the need of the resident because you cannot evaluate what their needs are. The residents will suffer because their needs are not met. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/10/24 at 12:06 PM, the Social Services Director (SSD) said, the facility has staff that speak most of the languages to accommodate residents' needs, picture boards, and staff can use Google translate. Staff can use the San [NAME] Medical Center line interpreter but it takes a little longer. For immediate medical concern, where accurate translation is needed, SSD stated, Quickest method is to call staff. During an interview on 3/19/24 at 3:47 PM, CNA 1 was not aware that the facility has a language line and stated, I have not been trained regarding the use of the language line. During an interview on 3/20/24 at 8:55 AM, CNA 7 said that she takes care of Hispanic and Chinese residents who don't speak English. CNA 7 stated, I ask a staff who can speak the language to interpret/translate in front of me. I ask the nurse to call the family so they will have direct communication. CNA 7 further stated, We don't have that language line. We use the phone (Google translate) if no one is available. Review of facility policy titled, Translation or Interpretation Services with revision date of 12/1/13 indicated, . Policy: The Facility provides assistance to residents with Limited English Proficiency .through translation and interpretation services. Procedure .IV. Facility Staff will orally inform the resident in a language they can understand of their right to obtain competent oral translation services free of charge .IX. Family members and friends are not to be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident .X. Translation and interpretation are provided in a way that is culturally relevant and appropriate to the Limited English Proficiency individual .

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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** 38066 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan (CP) for each resident that included measurable objectives and specific interventions for 2 of 38 sampled residents (Residents 111and 66) when: 1. No individualized person-centered CP was developed to address Resident 111's pressure ulcer (PU). 2. No individualized person-centered CP was developed for the use of Lorazepam (medication used to treat anxiety) for Resident 66. This failure had the potential for not meeting the residents' nursing needs and goals to attain their highest practicable well-being. Findings: 1. Resident 111 was readmitted on [DATE] with diagnoses including diabetes (abnormally high sugar level in the blood), congestive heart failure (a serious condition where the heart doesn't pump blood as efficiently as it should) and malnutrition. Review of Resident 111's Weekly Skin/Wound Assessment (WSWA) dated 3/13/24 indicated, Resident 111 had the following skin impairments: a. An initial assessment of a Stage 3 PU on the left buttock measuring 1.0-centimeter (cm) x (by) 0.2 cm x 0. 1 cm, with an onset date of 3/6/24 and was in house acquired ([NAME]). b. Stage 3 PU on the left heel measuring 0.7 cm x 1.0 cm x 0.1 cm, with an onset date of 2/6/24 and was [NAME]. Review of Resident 111's Order Review History Report dated 2/20/24 through 3/20/24 indicated, .Left Heel: Cleanse with wound cleanser. Apply Ag (alginate) wound gel to wound base; cover with foam dressing .start date: 2/7/24 . Review of Resident 111's Care Plan (CP) indicated, .Focus: Risk for Impaired Skin Integrity .Healing Wound Left Heel Stage 3 PI (pressure injury) .Utilize pillows or foam wedges .Utilize pressure relieving devices . date initiated: 2/19/24 . During an interview on 3/19/24 at 10:47 AM, Licensed Vocational Nurse (LVN) 1 said, Resident 111 had Stage 3 pressure ulcers on the left heel with a wound onset date of 2/6/24 and on the left buttock with a wound onset date of 3/6/24. (continued on next page)

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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 3/19/24 at 2:44 PM with LVN 2, Resident 111's care plans were reviewed. LVN 2 acknowledged that there was no CP for newly identified Stage 3 PU on the left buttock. LVN 2 said, the CP for the left heel Stage 3 PU was not specific, and stated, Doesn't specify the interventions (doesn't reflect the physician's order for the care of the PU). 2. Resident 66 was admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning -thinking, remembering, and reasoning -to such an extent that it interferes with a person's daily life and activities), anxiety, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident 66's Order Summary Report for March 2024 indicated, Resident 66 had an order of Lorazepam with a start date of 3/11/24. During a concurrent interview and record review on 3/13/24 at 12:20 PM with LVN 6, Resident 66's care plans were reviewed. LVN 6 confirmed that the order for Resident 66's use of Lorazepam had a start date of 3/11/24. LVN 6 acknowledged that there was no care plan for Resident 66's antianxiety medication, and stated, I don't see it. Review of facility policy titled, Comprehensive Person-Centered Care Planning revised on November 2018 indicated, .Procedure .IV. Comprehensive Care Plan .c. The comprehensive care plan will be periodically reviewed and revised by IDT after each assessment which means after each MDS assessment as required, except discharge assessments. In addition, the comprehensive care plan will also be reviwed and revised at the following times: i. Onset of new problems .v. Other times as appropriate or necessary .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on observation, interviews and record reviews, facility did not ensure hospice services and interventions were addressed for three of five residents (Resident 155, Resident A, Resident B) when: 1. No coordination for plan of communication with facility and hospice agency regarding changes in Resident A's condition and death, and the staff were not trained on the protocol of who is the responsible provider for each specific function, to notify family,MD and Hospice. 2. The care plan did not include specific interventions of coordination of care between facility and hospice agency for Resident 155 and Resident B. These failure resulted in family not notified of change in condition and death of Resident A, and had the potential to result in not providing the needed treatment care and services for Resident 155 and Resident B. Findings: 1. During a review of Resident A's Admission Record, dated [DATE], indicated, resident admitted on [DATE] original date. admitted to Palliative Care on [DATE] with the diagnosis of Hypertensive heart(complications of high blood pressure) and chronic kidney disease (a longstanding disease of the kidneys leading to renal failure). During record review on [DATE] at 1:45 PM with (Resident Care Coordinator) RCC 2, Resident A's careplan, latest (interdisciplinary Team) IDT notes on [DATE] about pressure ulcer and skin issues were reviewed. Progress notes dated, [DATE], was reviewed, indicated, last BM [DATE], Hospice nurse assessed resident, abdomen soft and not distended. Digital rectal stimulation performed by Hospice nurse and no signs of fecal impaction noted. No stomach pain or discomfort. Resident eat ,d+[DATE]% of meals and no nausea or vomiting noted. VS within normal limits. Plan of care ongoing. During a review of Hospice document, Discipline Communication Form, dated [DATE], entered by RN, indicated, Patient was confirmed expired (time of death) TOD, 7:15 PM, family notified spoke with Chariza. Mortuary notified body to be picked up at 10 PM to give family time with their mom. During a review of facility progress notes, dated [DATE] at 20:16 PM, indicated, Social Services Director (SSD) and Social Services Coordinator (SSC) greeted family upon arrival to the facility after resident expired. SSD ensured that Hospice was in the facility supporting and a mortuary location was located. SSD and SSC will continue to support until mortuary arrives to retrieve the body. During a review of Hospice document, Discipline Communication Form dated [DATE] by Licensed Vocational Nurse (LVN), Indicated, patient asleep, obtunded, hard to arouse to loud and shaking .Tachypneic 28 min on 3L/M. she is calm and .noted no informed LVN .to give morphine. Bedbound and still . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 2 PM, with Resident Care Coordinator (RCC) 2, per RCC 2, no progress notes on day of death, no notification of MD. No notification of family. No notification of Hospice by facility staff. I dont see any chartings on the progress notes on the day of death. During an interview on [DATE] at 11 AM, with Social Worker (SW) 3, SW 3 stated, I know the patient, I was on Covid leave when she passed. Hospice is the one taking charge of patient's medical needs and staff assist them. Means of communication is thru the daughter even before transition to Hospice on [DATE]. During an interview on [DATE] at 2PM, with SSD, SSD stated, there is no protocol who will call the family or MD, when a Hospice patient expires. During an interview on [DATE] at 9 AM, with RCC4, RCC 4 stated, When a hospice patient dies, we call the Hospice and they call the family and MD. The facility Registered Nurse (RN) can pronounce patient expiration. 2. During a review of Resident 155's Admission record, dated [DATE], indicated, resident admitted to facility on [DATE] with diagnoses including: Degenerative Disease of Nervous System (cells of the nervous system stop working or die), Encounter for Palliative Care(a specialized medical care focused on relieving the symptoms of a serious illness) on readmission on[DATE]. During a review of Resident 155's facility care plan, initiated [DATE], indicated, admitted under the care of Hospice agency with diagnosis of Arteriosclerotic heart Disease((a medical condition when the arteries thickened or hardened) No interventions to indicate facility coordination with hospice for care of Resident 155. During an interview on [DATE] at 11 AM, with Licensed Vocational Nurse(LVN) 10, per LVN 10, Resident 155 is on Hospice, Hospice nurse comes and visit, they have a binder where they chart their visit. I don't see a care plan for Hospice in our chart. During an interview on [DATE] at 11:30 AM, with RCC 4, per RCC 4, the Hospice has the binder where they have their plan of care and visit notes entry. Care plan does not include hospice services, only name of Hospice agency and contact number. During an interview on [DATE] at 2:57 PM, with SSD, SSD stated, with hospice patients, SW (social worker) involved with quarterly, annual, change of condition, discharge and return or readmission assessments. With immediate family concern I am involved. More involved with Chinese patients. 38066 3. Resident B was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), diabetes (group of diseases that result in too much sugar in the blood), and dementia (general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Resident B was admitted to hospice care on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 8:45 AM with SW 1, Resident B's care plans were reviewed. SW 1 acknowledged that there was no care plan for hospice care for Resident B, and stated, No facility care plan for hospice. Review of facility policy titled, End of Life Care dated ,d+[DATE], indicated, .VI. Coordination with Hospice .A. If hospice care is involved the resident's Care Plan will reflect Hospice interventions .B. Social Services and Nursing staff will coordinate with the Hospice team to ensure that the resident's needs are addressed . Review of facility policy titled, Hospice Care of Residents dated [DATE], indicated, .III. If the resident and/or surrogate decision maker decides to utilize hospice care, the Attending Physician will be contacted to make a final determination . B. The Hospice and Facility will collaborate on a Care Plan for the resident .C. Facility and Hospice staff will collaborate on a regular basis concerning the resident's care . Review of facility policy titled, Death of a Resident dated [DATE], indicated, .Purpose: To ensure the facility responds appropriately to the death of a resident . I. Pronouncement of Death .A. Only a licensed Physician may declare a resident dead . I. The licensed nurse will report the resident's symptoms to the attending Physician so the Attending Physician can make an official determination of death .B. Licensed nurse will document the symptoms of the resident's status (e.g., no breath sounds, no blood pressure, no pulse, color) . I. All information pertaining to a resident's symptoms will be recorded on the nurses notes .IV. Anticipated Death- DNR or NO code .A.The licensed Nurse will notify Attending Physician regarding resident's change in condition .B. The Resident will be declared dead only by the licensed physician .C. The licensed nurse or attending physician will notify the family/surrogate of the resident's death as soon as possible .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on observation, interview, and record review, the facility failed to prevent the development of a preventable pressure ulcer (PU) for one of three sampled residents (Residents 111) when staff did not perform an accurate body check that reflected and identified Resident 111's skin condition. This deficient practice resulted in the development of Stage III PU for Resident 111. Definition/Stages for Pressure Ulcer/Pressure Injury (also called a bed sore, is an injury to skin and underlying tissue resulting from prolonged pressure on the skin. Stage I: Intact skin with a localized area of non-blanchable redness (non-blanchable: redness persists and does not fade or turn white after removal of fingertip pressure). Stage II: Partial-thickness loss of skin with exposed upper skin layer. The wound bed is pink. May also present as an intact or ruptured blister. Fat tissue and deeper tissues (muscle, tendons, bone) are not visible. Stage III: Full-thickness tissue loss. Subcutaneous fat (fat under the skin) may be visible, but bone, tendon (connects muscles to bones) or muscle is not exposed. Slough (dead tissue) may be present but does not conceal the depth of tissue loss. Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin or blood-filled blister (bubble on the skin containing fluid) due to damage of underlying soft tissue from pressure and/or shear (a mechanical force that acts on an area of skin in a direction parallel to the body's surface). Findings: Review of Resident 111's clinical record indicated, resident was readmitted on [DATE] with diagnoses including diabetes (abnormally high sugar level in the blood), congestive heart failure (a serious condition where the heart doesn't pump blood as efficiently as it should) and malnutrition. The facility assessed Resident 111 as moderate risk for developing pressure ulcers. Review of Resident 111's Minimum Data Set (MDS - an assessment tool) dated 2/26/24, indicated, Resident 111 was dependent with bed mobility (resident does none of the effort to complete the activity) and was always incontinent with bladder and bowel functions (unable to control the excretion of urine or the contents of the bowels). Resident 111 had no pressure injuries on readmission. Review of Resident 111's Weekly Skin/Wound Assessment (WSWA) dated 2/4/24 indicated, a right lower arm skin tear with an onset date of 2/3/24. The WSWA did not mention other skin impairments. Review of Resident 111's WSWA dated 2/5/24 indicated, scattered discoloration on anterior (front) and posterior (back) of bilateral (both) lower legs, with an onset date of 2/3/24. The WSWA did not mention other skin impairments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 111's WSWA dated 2/7/24 indicated the following skin impairments: 1. Stage III pressure ulcers on the sacrum (a triangle-shaped bone at the base of the lower back) and on the upper back. Both had an onset date of 11/21/23 and were present on admission. 2. An initial wound assessment of a Stage III PU on the left heel, with a measurement of 0.8 centimeter (cm) x (by) 1.8 cm x 0.1 cm. The wound had an onset date of 2/6/24 and was in-house acquired ([NAME]-facility acquired). Review of Resident 111's WSWA dated 2/14/24 indicated, a bruise on the left lower extremity (the part of the body that includes the hip, thigh, knee, leg, ankle, and foot) with an onset date of 2/14/24. There were no new skin impairments identified. Review of Resident 111's WSWA dated 2/19/24 indicated the following new skin impairments: 1. Discoloration on right lower arm with an onset date of 2/3/24. 2. Stage III PU on the sacrum, with an onset date of 2/7/24 and was [NAME]. No wound measurement was indicated. 3. Stage III PU on the upper back, with an onset date of 2/7/24 and was [NAME]. No wound measurement was indicated. Resident 111's WSWA dated 2/23/24 indicated, pressure injuries to left heel, sacrum and upper back have all healed. There were no new skin impairments identified. Review of 111's WSWA dated 3/1/24 indicated, skin tear to right lower arm has healed. There were no new skin impairments identified. Review of 111's WSWA dated 3/11/24 indicated, .no new skin issues noted . During an interview on 3/19/24 at 10:47 AM, Licensed Vocational Nurse (LVN) 1 said, Resident 111 had Stage III pressure ulcers on the left heel with a wound onset date of 2/6/24 and on the left buttock with a wound onset date of 3/6/24. Both pressure ulcers were in-house acquired. During a concurrent interview and record review on 3/19/24 at 2:44 PM with LVN 2, Resident 111's WSWA dated 3/13/24 was reviewed. The WSWA indicated, Resident 111 had the following new skin impairments: 1. An initial assessment of a Stage III PU on the left buttock measuring 1.0 cm x 0.2 cm x 0.1 cm, with an onset date of 3/6/24 and was [NAME]. 2. Stage III PU on the left heel measuring 0.7 cm x 1.0 cm x 0.1 cm, with an onset date of 2/6/24 and was [NAME]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During the same concurrent interview and record review, Resident 111's Progress Notes (PN) was also reviewed. The PN dated 2/3/24 through 3/13/24 did not indicate licensed nurse was notified of a change in skin condition on the left buttock and left heel. LVN 2 said, the Certified Nurse Assistant (CNA) will report unusual skin conditions like redness, rash, skin tear, and wounds. The licensed nurses will then assess and report to the physician. LVN 2 stated, Stage 3 pressure ulcers could have been prevented if the previous pressure ulcer stages (Stages 1 and 2) were reported, or unusual skin conditions were reported by staff (CNA). I don't see anything reported because the initial assessment was at Stage 3 already. The PN did not indicate the physician was notified of the identified skin impairments. During an interview on 3/19/24 at 3:44 PM, CNA 1 said, skin conditions that should be reported to the nurse are rash, redness, and wounds. CNA 1 stated, Something that looks different or unusual in the skin, the nurse must be made aware. If not reported, it may worsen. During a concurrent wound care observation at Resident 111's bedside and interview on 3/20/24 at 10:10 AM, with the Wound Care Physician (WCP) and LVN 1, LVN 1 explained that he will do wound treatment on Resident 111's left heel and left buttock. WCP said, the left heel was a DTI and the left buttock was a Stage 2 PU. LVN 1 said, the left buttock PU was at Stage III when initially reported. Review of Resident 111's Interdisciplinary Team Progress Notes (IDTPN) dated 1/11/24 through 3/14/24 indicated, no IDTPN on 2/6/24 when the Stage III PU on the left heel was identified. There was no IDTPN on 3/6/24 when the Stage III PU on the left buttock was identified. Review of Resident 111's Care Plan (CP) revised on 7/28/23, indicated the following: .The resident has potential impairment to skin integrity (rashes, skin tear, pressure injury development) . Goal: The resident will have intact skin, free of redness, blisters, or discoloration by/through review date . revised on 2/28/24. Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown. Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage .date initiated: 11/16/21. Review of facility policy titled Skin Integrity Management revised on 10/26/23 with an effective date of 11/14/23 indicated, .Policy: The facility will identify, evaluate, and intervene to prevent and/or heal pressure ulcers and any other skin integrity conditions. Purpose: A plan of care will be developed for residents who are at risk for development of skin integrity conditions, and to provide guidelines for the treatment of skin integrity conditions to facilitate healing. The policy did not indicate the process/procedure for risk assessment, skin inspection (monitoring, reporting), interventions (maintenance of skin integrity, wound care, education, and evaluation of plan of care), and documentation (skin integrity, wound assessment, interventions, and progress towards outcome focused goals). (continued on next page)

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	03/21/2024

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San Mateo Medical Center D/P Snf	222 West 39th Avenue San Mateo, CA 94403

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy titled Pressure Injury Prevention revised on 3/30/23 with an effective date of 4/10/23 indicated, .Policy: A plan of care will be developed for residents who have risk factors or are at risk for development of a pressure injury. Purpose: To prevent the development of pressure injury in residents identified at risk. The policy did not indicate the process/procedure for risk assessment, skin inspection (monitoring, reporting), interventions (maintenance of skin integrity, wound care, education, and evaluation of plan of care), and documentation (skin integrity, wound assessment, interventions, and progress towards outcome focused goals).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43913 Based on observation, interview and record review, the facility failed to post complete nurse staffing data daily from 3/11/24 to 3/15/24. Findings: During an observation on 3/11/24, on the initial tour, the nurse staffing posted for 3/11/14, indicated, name of facility, date, number of employees all shift, census. No total number and actual hours worked by each categories. During an observation on 3/12/24, the nurse staffing posted indicated, name of facility, date, number of employees all shifts, census. No actual number of hours worked by each categories. During an interview on 3/12/24 at 11AM, with Administrator, per Administrator there is a staffing person doing the posting, as a D/P SNF not obliged to comply with the DHPPD. (Direct Care Service Hours Per Patient Day). During an observation on 3/13/24, the nurse staffing posted indicated the same data. This posting remained till 3/15/24. During an interview with Administrator on 3/15/24 at 2:45 PM, showed him the posting dated 3/13/24. Administrator pulled posting and left. During an interview on 3/19/24 at 10:28 AM with Staffing Coordinator (SC), per SC staffing is posted at midnight. SC prepares the data for posting, leaves to NOC shift supervisor, NOC supervisor at midnight will change the posting to the next day. It was not the right posting for last week. per SC. A review of facility Policy and Procedure, Nursing Department, Staffing, Scheduling and Posting, dated 7/2018, indicated, Nurse Staffing Postings: A. The facility will post the following information on a daily basis: 1. Facility name 2. The current date 3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. Registered Nurses b. Licensed Practical Nurses or Licensed Vocational Nurses (as defined under State law) c. Certified Nurses Aides (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Resident Census B. Posting Requirements 1. The facility will post the nurse staffing data specified above, on a daily basis at the beginning of each shift .

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	555034	A. Building B. Wing	03/21/2024

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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. 49264 Based on observation, interview, and record review, the facility failed to keep an accurate reconciliation (recordkeeping) for a controlled substance (a chemical or medication regulated by the federal government due to high risk for abuse or dependence) when one out of six sampled narcotic records (a logbook used to keep track of controlled substances used/discarded and still available in supply) had an inaccurate count of medication. This failure has the potential to result in medication diversion (the transfer of a controlled substance from lawful to unlawful use). Findings: A review of a policy titled CONTROLLED MEDICATIONS, undated, indicated that When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration, Amount administered, Signature of the nurse administering the dose, completed after the medication is actually administered. A review of a Resident 233's medication administration record, dated March 2024, indicated 2mg (milligrams) of Hydromorphone (a controlled substance and potent pain killer) is to be given every four hours as needed for severe pain. The administration record also indicated that Resident 233's Hydromorphone was administered at 9:00 AM on 03/12/24. During an interview on 03/12/24 at 12:02 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated I gave two today already when referring to how many tablets of Hydromorphone LVN 2 gave Resident 233. During a concurrent observation and interview on 03/12/24 at 12:03 PM with LVN 2, Resident 233's supply of Hydromorphone was observed to contain 24 tablets. LVN 2 stated that she counts 24 tablets as well. During a concurrent interview and record review on 03/12/24 at 12:07 PM with LVN 2, page 135 of the Individual Narcotic Record was reviewed. Page 135 indicated that the record was for Resident 233's Hydromorphone tablets-each tablet containing 2mg. It further indicated that there should be 26 remaining tablets. LVN 2 stated yes when asked if the documented number of tablets in the narcotic record and actual number of tablets available are not the same. During an interview on 03/13/24 at 11:35 AM with the Director of Nursing (DON), the DON stated that when a controlled substance is given, the LVN should document [make a record of] immediately after the medication is given.

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	555034	A. Building B. Wing	03/21/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on interview, and record review, the facility failed to ensure the pharmacy consultant's recommendation for the use of psychotropic medication was acted upon for one of three sampled residents (Resident 255). This failure had the potential for Resident 255 to receive unnecessary psychotropic medications, be exposed to adverse health consequences from the medications, which could negatively impact the resident's mental, physical, and psychosocial well-being. Findings: Resident 255 was admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning -thinking, remembering, and reasoning -to such an extent that it interferes with a person's daily life and activities) and anxiety (a feeling of fear, dread, and uneasiness). Review of Resident 255's Order Summary Report for the month of March 2024 indicated, .Lorazepam (medication used to treat anxiety) Oral Tablet 0.5 mg (milligram) Give 1 tablet by mouth every 4 hours as needed for anxiety .Start Date 11/25/23 . Review of Resident 255's Consultant Pharmacist's Medication Regiment Review (MRR) dated 12/30/23 indicated, .Patient is on Lorazepam PRN (as needed) .the use of PRN psychotropics (other than antipsychotics) should be limited to 14 days except in rare cases where therapeutic benefit outweighs risk. Please evaluate if PRN psychotropic can be discontinued. If patient must continue on PRN .require orders to be written for a maximum of 14 days with no refills . During a concurrent interview and record review on 3/13/24 at 2:12 PM, with Licensed Vocational Nurse (LVN) 5, Resident 255's physician's orders was reviewed. LVN 5 said, Resident 255 had an order for Lorazepam 0.5 mg 1 tablet every 4 hours as needed for anxiety with a start date of 11/25/23 and was discontinued on 3/1/24. During an interview on 3/13/24 at 3:38 PM with the Pharmacist (PHM), PHM said, MRR is done monthly, and all medications are reviewed. Identified irregularities are communicated to the nurse and the physician. PHM acknowledged that there was no response in January 2024 from the physician, for recommendations in MRR on 12/30/23. Review of facility policy titled, Drug Regimen Review with revision date of December 2016 indicated, .Policy . II. Facility must ensure that the attending physician documents in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record .

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	555034	A. Building B. Wing	03/21/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49264 Based on observation, interview, and record review, the facility failed to follow physician's order of parameters regarding a pain medication for one of two sampled residents (Resident 233) when Resident 233 received an excessive dose of Hydromorphone (a potent pain medication). This failure has the potential to result in an adverse reaction (a harmful and unexpected effect of a medication) such as respiratory depression (slow breathing resulting in poor oxygen intake) Findings: A review of a policy titled Medication - Administration, last revised January 2012, indicated that If the PRN medication [Pro re nata, medication that is only given as needed for a specific reason or situation] is for complaint of pain, the Nurse will document the pain score prior to giving the medication . In addition, the policy indicated that Nursing Staff will keep in mind the seven 'rights' of medication [seven checks used to reduce risk of medication administration error] when administering medication . 'rights' of medication are: . the right amount [or dose of a medication]. During a concurrent observation and interview on 03/12/24 at 12:03 PM with Licensed Vocational Nurse (LVN) 2, Resident 233's supply of Hydromorphone was observed to contain 24 tablets. LVN 2 stated that she counts 24 tablets as well. During a concurrent interview and record review on 03/12/24 at 12:07 PM with LVN 2, page 135 of the Individual Narcotic Record (the controlled substance logbook) was reviewed. Page 135 indicated that the record was for Resident 233's Hydromorphone tablets-each tablet containing 2mg. It further indicated that there should be 26 remaining tablets. LVN 2 stated yes when asked if the documented number of tablets in the narcotic record and actual number of tablets available are not the same. During a concurrent interview and record review on 03/12/24 at 3:46 PM with LVN 2, Resident 233's Hydromorphone administration record, started in February 2024, was reviewed. The Hydromorphone administration record indicated that 2 mg (milligrams) of Hydromorphone is to be given every four hours as needed for severe pain. The administration record also indicated that Resident 233's pain level was scored as a 7 (see score interpretation in next paragraph) when Hydromorphone was administered at 9:00 AM on 03/12/24. LVN 2 stated she gave Resident 233 two tablets today. LVN 2 stated that I thought it [the physician order] said two tabs [tablets]. During a concurrent interview and record review on 03/12/24 at 3:54 PM with LVN 2, Resident 233's pain assessment order, started in January 2024, was reviewed. The pain assessment order indicated that a nurse should assess for pain every shift and chart [document] intensity of pain using 1-10 numeric pain scale. 0= no pain, 1-4= mild pain, 5-7= moderate pain, 8-9= severe pain, 10= excruciating pain. LVN 2 verified that they documented Resident 233's pain as a 7 when they administered the Hydromorphone. LVN 2 stated that a pain level of 7 is not considered severe according to the pain assessment order, 8 to 9 is severe pain. LVN 2 stated no when asked if Resident 233 should have received the Hydromorphone for a pain level of 7. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 03/13/24 at 11:13 AM with the Director of Nursing (DON), Resident 233's orders and medication administration record, dated March 1, 2024 to March 31, 2024, was reviewed. The record indicated both the pain assessment order started in January 2024 and the administration record for Hydromorphone. The DON stated that she [LVN 2] gave the pain meds [medication] outside the parameters [specifications of a physician's order]. Furthermore, the DON stated that she [LVN 2] gave the wrong dose . she gave two instead of one [tablet] when asked about Resident 233's Hydromorphone.

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	555034	A. Building B. Wing	03/21/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on interview and record review, the facility failed to ensure three of three sampled residents (Residents 66, 118, and 255) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) when: 1. For Resident 66, consent was not obtained for the use of Mirtazapine (medication used to treat depression). 2. For Resident 118, consents were not obtained for the use of Aripiprazole (medication used to treat depression and Tourette syndrome [a nervous system disorder involving repetitive movements or unwanted sounds]), Haloperidol (medication used to control symptoms of Tourette syndrome), and Buspirone (medication used to treat anxiety [[a feeling of fear, dread, and uneasiness]). 3. For Resident 255, consents were not obtained for the use of Lorazepam (medication used to treat anxiety) and Trazodone (medication used to treat depression), and order for Lorazepam PRN (as needed) did not have a stop date. These deficient practices had the potential for Residents 66, 118, and 255 to receive unnecessary psychotropic medications, be exposed to adverse health consequences from the medications, which could negatively impact the resident's mental, physical, and psychosocial well-being. Findings: 1. Resident 66 was admitted on [DATE] with diagnoses including dementia (the loss of cognitive functioning -thinking, remembering, and reasoning -to such an extent that it interferes with a person's daily life and activities), anxiety, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident 66's Order Summary Report for March 2024 indicated, .Mirtazapine Oral Tablet 15 mg (milligram) Give 1 tablet by mouth at bedtime on even days for depression .Start date: 11/10/23 . Review of Resident 66's Medication Administration Record for February 2024 indicated, .Mirtazapine Oral Tablet 15 mg . was administered on even days at 9:00 PM. Review of Resident 66's Medication Administration Record for March 2024 indicated, .Mirtazapine Oral Tablet 15 mg . was administered on even days at 9:00 PM from 3/1/24 through 3/13/24. During a concurrent interview and record review on 3/13/24 at 12:02 PM with Licensed Vocational Nurse (LVN) 6, Resident 66's consents for psychotropic medications were reviewed. LVN 6 said, consent for Remeron (brand name for Mirtazapine) was for 7.5 mg 1 tablet daily, and Resident 66's current order is for 15 mg 1 tablet once a day. LVN 6 stated, The consent should be changed to reflect the current order. I went through it all, I don't see it. None. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/24 at 3:55 PM with the Pharmacist (PHM), PHM stated, If dosage is increased, we need another consent. 2. Resident 118 was admitted on [DATE] with diagnoses including Tourette's syndrome, major depressive disorder and anxiety disorder. Review of Resident 118's Order Summary Report for March 2024 indicated, .Aripiprazole Tablet 5 mg .Start date: 10/13/23 .Buspirone HCl Oral Tablet 7.5 mg .Start date: 9/6/23 .Haloperidol Oral Tablet 5 mg .Start date: 2/15/24 . During an interview on 3/13/24 at 2:58 PM with Licensed Vocational Nurse (LVN) 6, LVN 6 checked if consents for Resident 118's use of psychotropic medications were obtained. LVN 6 said, there were no consents obtained for the use of Aripiprazole, Buspirone, and Haldol. LVN 6 stated, I don't see any consents for any of them (for the three medications). I don't see it. During an interview on 3/13/24 at 3:12 PM with Resident Care Coordinator (RCC) 3, RCC 3 said, Licensed Nurse is responsible for obtaining the consents. 3. Resident 255 was admitted on [DATE] with diagnoses including dementia and anxiety. Review of Resident 255's Order Summary Report for the month of March 2024 indicated, .Lorazepam (medication used to treat anxiety) Oral Tablet 0.5 mg (milligram) Give 1 tablet by mouth two times a day for agitation .Start Date: 12/14/23 .Trazodone HCl Oral Tablet 50 mg . During an interview on 3/13/24 at 2:12 PM, LVN 5 checked if consents for Resident 255's use of psychotropic medications were obtained. LVN 5 said, there were no consents obtained for the use of Trazodone and routine order of Lorazepam. Review of Resident 255's Order Summary Report for the month of March 2024 indicated, .Lorazepam Oral Tablet 0.5 mg Give 1 tablet by mouth every 4 hours as needed for anxiety .Start Date 11/25/23 . The order did not have an end date. During an interview on 3/13/24 at 2:12 PM, LVN 5 said, Resident 255 had an order for Lorazepam 0.5 mg 1 tablet every 4 hours as needed for anxiety with a start date of 11/25/23 and was discontinued on 3/1/24. Review of Resident 255's Medication Administration Record for February 2024 indicated, .Lorazepam Oral Tablet 0.5 mg Give 1 tablet by mouth every 4 hours as needed for anxiety Start date: 11/25/23 D/C (discontinue) date: 3/1/24 . was administered on 2/25/24. Review of Resident 255's Consultant Pharmacist's Medication Regiment Review (MRR) dated 12/30/23 indicated, .Patient is on Lorazepam PRN (as needed) .the use of PRN psychotropics (other than antipsychotics) should be limited to 14 days except in rare cases where therapeutic benefit outweighs risk. Please evaluate if PRN psychotropic can be discontinued. If patient must continue on PRN .require orders to be written for a maximum of 14 days with no refills . During an interview on 3/13/24 at 3:38 PM with the Pharmacist (PHM), for psychotropic medications, PHM said, PRN medications are recommended for 14 days and should be renewed after. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled, Behavior/Psychoactive Drug Management with revision date of November 2018 indicated, .Procedure .II. Interventions .C. Whenever an order is obtained for psychoactive medication(s), the Licensed nurse verifies with the Attending Physician/Prescriber that informed consent has been obtained. The Licensed Nurse documents this verification of the order on NP-67-FormC-Verification of Informed Consent .III. Evaluation .D. Documentation Requirements .vi. Any Psychoactive Medication ordered on a prn basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reason(s) for the continued usage, and write the order for the medication; not to exceed the 14-day time frame .

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	555034	A. Building B. Wing	03/21/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49264 Based on observation, interview and record review, the facility failed to ensure medications were not expired and stored properly when: 1. One out of six sampled medication carts had two prescription eye drops that were found to be expired or not labeled after opening, 2. Multiple medications were found to be stored in the garage without temperature control. This failure has the potential to result in medications being administered to residents that are expired, ineffective, or potentially hazardous to the resident. Findings: 1. During a concurrent observation and interview on [DATE] at 3:23 PM with Licensed Vocational Nurse (LVN) 3 at the Unit 3 nurse's station, an opened Latanoprost Ophthalmic solution (eye drops used to lower pressure in the eyes) was observed inside the medication cart drawer. The ophthalmic solution had an open date of [DATE] and an expiration date of [DATE]. LVN 3 stated that the medication was expired and should have been discarded. During a concurrent observation and interview on [DATE] at 3:25 PM with LVN 3 at the Unit 3 nurse's station, an opened Latanoprost Ophthalmic solution was observed inside the medication cart drawer. The ophthalmic solution had no open date or expiration date after opening. LVN 3 stated that medication could be expired and should have been discarded. 44477 2. During a concurrent observation and interview on [DATE] at 11:35 AM with Infection Preventionist (IP) 1 in the garage storage, there were bottles of Hydrogen Peroxide 3% (an antiseptic to help prevent infection in minor cuts, scrapes, or burns), Milk of Magnesia (a laxative, a medicine that relieves constipation), ClearLax (a laxative), and Stomach Relief (Bismuth Subsalicylate, a medicine to treat occasional upset stomach, heartburn, and nausea) on the shelves. IP 1 acknowledged, they were over-the-counter drugs (medicines that can be bought without doctor's prescriptions). During a concurrent observation and interview on [DATE] at 11:44 AM with Central Supply Coordinator (CSC) in the garage storage, CSC stated, We are actually moving most of med (medication) stuff into the med room in the unit . They are supposed to be going up to each nursing station when asked about bottles of Hydrogen Peroxide 3%, Milk of Magnesia, ClearLax, and Stomach Relief (Bismuth Subsalicylate) on the shelves. CSC stated, No. Not at all, when asked if it is safe to store the over-the-counter drugs in the garage storage. CSC stated, I agree, when asked if the over-the-counter drugs should be in the medication room in the nursing station. (continued on next page)

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	03/21/2024

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:31 AM with IP 1 in the garage storage, there was no thermometer. IP 1 also could not find a thermometer in the garage storage when asked if he could see the thermometer. During a concurrent observation and interview on [DATE] at 9:35 AM with Environmental Services (EVS) staff 1 in the garage storage, EVS 1 stated, I don't think so, when asked if he could see a thermometer in the garage storage. EVS 1 stated, No when asked if there is a thermometer in the garage storage. EVS 1 stated, No when asked if there was a log to monitor the temperature in the garage storage. During an interview on [DATE] at 10:35 AM with CSC, he acknowledged, there was no thermometer and no temperature log in the garage storage. During an Interview on [DATE] at 11:37 AM with Pharmacist (PHM) via phone, PHM verified, bottles of Hydrogen Peroxide 3%, Milk of Magnesia, ClearLax, and Stomach Relief (Bismuth Subsalicylate) were over-the-counter drugs. PHM stated, she did not know they stored over-the-counter drugs in the garage storage. PHM stated, they were supposed to have thermometer in the garage storage because the over-the-counter drugs should be stored at room temperature, and temperature logs should be in place and documented every day. She stated, the over-the-counter drugs should be in the controlled temperature. Review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 2019 indicated, . J. Medications requiring storage at room temperature are kept at temperatures ranging from 15 C (59 F) to 30 C (86 F) . N. Outdated . or deteriorated medications . are immediately removed from stock, disposed of according to procedure for medication disposal . O. Medication storage areas are kept . and free of . extreme temperatures . Review of the facility's P&P titled, Storage of Medications: General, dated [DATE] indicated, . P. Any medications that are not used, expired, or otherwise un-usable shall be returned to the pharmacy . or, when permitted, dispose of the medication in an approved manner (e.g., special bins designated for medication disposal) .

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	555034	A. Building B. Wing	03/21/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40478 Based on observation, interview, and record review the facility failed to serve food and substitutes according to residents' preferences when: Residents with food preferences such as Jook and soups were not honored. This failure has the potential to deny the basic rights of 31 residents in a census of 264 residents to receive the services and care necessary to achieve or maintain their quality of life. Findings: During a concurrent observation and interview with cook1 on 3/12/24 at 10:45 AM in the kitchen, observed him cooking pasta in a large skillet. He stated, today, we will serve meatballs, pasta, and spinach. During tray line observation, interview, and record review on 3/12/24 between 11:15 AM to 2:30 PM in the kitchen, observed some Residents' meal tickets indicated, likes Jook (porridge or Congee) and/or soup. During an interview with kitchen aide1, inquired, what is Jook? Kitchen aide1 stated, Jook is rice soup. There is no jook or soup today. During tray line observed several residents' meal tickets indicated, likes Jook. Some residents' meal tickets indicate likes soup, some chicken noodle soup, congee, some likes hamburger or burger. Resident 90's meal ticket indicated Likes Hamburger, Dislike pasta. No hamburger was served when the menu was meatballs. Per the Consultant Registered Dietician (CRD), the meatballs were made from scratch. During a review of the facility's meal tickets for lunch on 3/12/24, the following residents had these likes, some indicated add on their meal tickets: Likes: Jook - Residents: 154, 130, 218, 162, 47, 190, 209, 98, 163, and one unnumbered resident in room [ROOM NUMBER]. Residents with likes soup on their meal tickets are Residents: 2, 72, 5, 88 (pureed soup), 32, 205, 98, 255, 162, 44, 165, 18, 111, 168, and 107. The following residents with specific order of chicken noodle soup are Residents 122, 195, 132, and 153. Resident 248's meal ticket indicated, likes Chinese foods. During an interview with the cook of the day (Cook2) on 3/13/24 at 11:09 in the kitchen, he stated, we had no Jook, usually like a side soup, rice soup. If it is on the menu like tonight, there's soup. You are right. It was not on the tray line yesterday. During an interview with the Dietary Manager (DM) on 3/13/24 at 11:35 AM in the kitchen by the preparation table, the DM stated, about the Jook, we talked about that yesterday. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Dietary Profile and Resident Preference Interview, Operation Manual, Dietary with revised date, April 21, 2022, the purpose indicated, to ensure that residents are properly evaluated for dietary needs on an ongoing basis. Policy. The Dietary Manager will complete a dietary profile for residents to reflect current nutritional needs and Food Preferences Procedure: I. The DM will meet with the resident within 72 hours of admission and readmission to introduce the following: A. Responsibilities of the dietary department. B. Review attending Physician's order for diet. II. The DM will complete a dietary profile for residents within 72 hours of admission to capture and update information regarding nutritional needs and preferences. III. Resident Preferences will be reflected in the medical record and tray-card and updated in a timely manner.

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	555034	A. Building B. Wing	03/21/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40478 Based on observation, interview, and record review the facility failed to provide meals according to the facility's serving hour schedule when: During mealtimes observation, the meal cart was observed arriving late on the second floor for breakfast and lunch. This failure to follow the 14-hour rule for mealtimes especially at breakfast time have the potential to deny the residents patient centered care that will affect their psychosocial well-being and health outcome. Findings: During a concurrent observation and interview on 3/11/24 at 10:15 AM, observed staff passing out trays into residents' room on the second floor. One HFEN Surveyor stated, they are just serving breakfast. During an interview with a certified nursing assistant (CNA5) on 3/11/24 at 10:26 AM on the second floor, she stated, yes, every day, the meal cart is always late. Breakfast just came in. During an interview with the Dietary Manager (DM) at 11 AM in the kitchen, the DM stated, the meal cart starts to go out at . Breakfast is served between 7 - 9AM, lunch at 11:30 -1:30 PM and dinner at 5-7 PM. During a concurrent observation and interview with the facility's Consultant and the Registered Dietitian Consultant (RDC) on 3/11/24 at around 11:15 AM in the kitchen, the RDC and the Consultant were informed that the breakfast was served late today. Observed both were quiet. During a concurrent interview and observation on 3/12/24 around 10:30 AM in the kitchen, the RDC stated, yesterday we have two staff on leave. Today, we have enough staff. During the kitchen tray line on 3/12/24 at 1:30 PM kitchen aide 1 stated we have a total of eleven carts to fill. Observed the last meal cart left the kitchen at 2:30 PM. Observed the Consultant was not present on 3/12/24. During a concurrent observation and interview on 3/13/24 around 10:15 AM at the kitchen entrance, observed the Consultant arrived entering the back door to the conference room. The Consultant stated with a smile, so, the meals were delivered earlier yesterday? The Consultant was not wearing a mask. The Consultant was informed, yesterday the last tray cart left the kitchen at 2:30 PM. During an interview with the RDC on 3/13/24 at 11:21 AM in the kitchen, the RDC stated, we are staffed today. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 3/15/24 at around 12:45 PM in the hallway, observed Resident 107 ambulating towards his room holding on to the railings. When asked if he had eaten his lunch, Resident 107 stated, not yet everyone is waiting. Observed some residents sitting in their wheelchairs in front of the nurses' station. Observed Resident 131 standing by his door daily waiting for his lunch tray, but no complaints. Always smiling. During an interview with two resident complaints investigation on 3/13/24 at 11:45 AM, Resident 239 stated, they serve frozen foods here. Interview with Resident 6 at 2:30 PM in his room who stated, they serve me cold eggs in the morning. It needs to be re-heated. During an interview with the DM on 3/13/24 at 2:35 PM in the first-floor dining area by the piano, the DM stated Resident 6 gets an early tray. I visited him this morning. I will visit him again. I just started in this job last week. During an interview with the Dietary Supervisor on 3/13/24 at 2:45 PM in the first-floor dining area by the piano, the DS stated, I control, manage, and control the employees to make sure it comes out efficient and correctly . During a review of the facility's kitchen serving hours schedule, it indicated: Breakfast 7:00 - 9:00 AM Lunch 11:30 AM - 1:30 PM Dinner 5:00 PM - 7:00 PM During a review of the facility's policy and procedure titled, Dietary Profile and Resident Preference Interview, Operation Manual, with revised date, April 21, 2022, the purpose indicated, to ensure that residents are properly evaluated for dietary needs on an ongoing basis. Policy- The Dietary Manager will complete a dietary profile for residents to reflect current nutritional needs and Food Preferences Procedure: I. The DM will meet with the resident within 72 hours of admission and readmission to introduce the following: A. Responsibilities of the dietary department. B. Review attending Physician's order for diet. C. Schedule mealtimes and locations. The regulation requires there must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

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	555034	A. Building B. Wing	03/21/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40478 Based on observation, interview and record review, the facility failed to ensure food safety requirements in accordance with professional standards for food service when: 1. Serving plastic bowls, large plastic food containers and baking pans were not dried appropriately. 2. Plate warmers were not cleaned. 3. Serving trays were stacked and stored on a dusty cart outside of the kitchen door. 4. The kitchen staff still uses the hand sanitizer in the kitchen. 5. Bowls of cream of rice and bowls of oatmeal in the refrigerator were undated. 6. Two packs of grapes in the refrigerator were overripe, and some of them were mushy. The failure to store, serve, hand sanitize and distribute food in an unsafe and sanitary manner had the potential to put residents at risk for foodborne illness leading to severe illness and even death for 262 residents who consumed food by mouth. Findings: 1.During a concurrent observation, interview, and record review in the kitchen with the facility's Consultant, the Regional Registered Dietician (RD) on 3/11/24 at around 10:30 AM, observed on the rack by the entrance door multiple stacks of small plastic bowls that are still moist and wet to touched. The next rack with piles of stacked big plastic food containers that are wet, and the next rack with baking pans that are stacked and were moist and wet. The Consultant stated, they are wet, and he called for a kitchen staff and directed them to wash it again. According to the 2022 Federal Food Code, after cleaning and sanitizing, equipment and utensils are to be air-dried before storing. According to the annex, wet nesting occurs when dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. During a review of the facility's policy and procedure titled P-DS48 Pot and Pan Cleaning with revised date 6/22/2023, it indicated, after cleaning the pots and pans . 9. Invert the pots and pans and place them on a drying rack or counter. Place small items in a dish rack to dry. 10. Allow the items to air dry. Do not use a towel. 11. When items are dry, store them in the proper storage area. (continued on next page)

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	03/21/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During observation and interview, with the Regional RD on 3/12/24 around 11 AM in the kitchen, observed three plate warmers that are not cleaned. The RD stated they were cleaned . Upon looking inside, the inside floor of the plate warmer was dirty with dust, pebbles, straws, stained papers, and other dried stuff. The RD also took some pictures of the inside of the plate warmer. During observation and interview with the regional RD on 3/14/24 at around 11:40 AM in the garage after checking the garbage bins and compost bins, observed one male staff doing some work on a metal table. The RD stated, he is cleaning the plate warmer. During a request for the facility's policy and procedure for the maintenance of plate warmer, received the policy and procedure titled: Lowerator -Operation and Cleaning. Operational Manual Dietary services, Revised date October 1, 2014. No policy and procedure for plate warmer maintenance. Review of the facility's policy and procedure for Dish Machine Operation and Cleaning with revised date October 01, 2014, the purpose indicates: To establish guidelines for the use and cleaning of dish machine. During a review of the facility's policy and procedure titled: Cleaning & Disinfection of Resident Care Equipment Infection Control Manual with revised date January 01, 2012. The purpose indicated, to ensure that the cleaning and disinfection of environmental surfaces is in accordance with Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines. 3. During observation and interview with the Regional RD on 3/14/24 at around 11:10 AM, observed multiple serving trays were stored and stacked outside the kitchen on a dusty cart. The RD stated, they are clean . Surrounding the stacked trays were opened packets of salt and pepper. The topmost trays with flat brown cartoon. The top of the flat cartoon on top of the stacked trays next to the door sat the box of hair caps. In the afternoon, observed the cart with stacked trays is gone near the entrance of the kitchen door. Observed a dusty floor where the cart was located. During a review of the facility's policy and procedure titled: Cleaning & Disinfection of Resident Care Equipment Infection Control Manual with revised date January 01, 2012. The purpose indicated, to ensure that the cleaning and disinfection of environmental surfaces is in accordance with Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines. 4. During a concurrent observation and interview with the kitchen manager (KM) and the Regional RD on 3/11/24 at 10 AM, observed a Purell hand sanitizer dispenser at the entrance to the kitchen, and above the hand washing sink inside the kitchen. During an interview with the regional RD, she stated that hand sanitizer dispenser has nothing in it. We are not using it. Informed the RD and the KM the hand sanitizer dispenser had sanitizer in it, and it is working. During an observation in the afternoon of 3/11/24, observed the hand sanitizer dispenser above the hand washing sink was removed from its mount. (continued on next page)

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	555034	A. Building B. Wing	03/21/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 3/13/24 around 11 AM outside the emergency storage room by the kitchen entrance, observed the hand sanitizer by the entrance door. Interview with the RD who stated it will be taken out. There should be no sanitizer. During observation in the afternoon of 3/13/24, the hand sanitizer at the entrance door to the kitchen was gone. During a review of an article titled Safe Food Handling in the Changing Long Term Care Environment (michigan.gov) indicates avoid cross contamination through safe food handling. All employees associated with handling of food must wash their hands. Alcohol based sanitizer is not a replacement for washing hands. During a review of the facility's operation manual-dietary services titled: Dietary Department-Infection Control for Dietary Employees with revised date, November 9, 2016. The purpose was, to ensure that the dietary department is maintained in a sanitary condition in order to prevent food contamination and growth of disease producing organisms and toxins. 44477 5. During a concurrent observation and interview on 3/11/24 at 10:52 AM with Director of Food and Nutrition Services (DoFNS), and Clinical Services Manager (CSM) in the kitchen, there were 63 bowls of cream of rice on one tray and 40 bowls of oatmeal on two trays without dates on them (Total two items) in the refrigerator. DoFNS stated, the two items should have been dated with prep dates and used by dates. 6. During a concurrent observation and interview on 3/11/24 at 11:07 AM with DoFNS and CSM in the kitchen, there were one pack of mushy and overripe grapes with received date of 2/27/24, and the other pack of overripe grapes with received date of 2/24/24 in the refrigerator. DoFNS acknowledged, they were overripe, and some of them were mushy. CSM acknowledged, the grapes were overripe, and some of them were mushy. CSM also acknowledged, the received dates were 2/24/24 (16 days old) and 2/27/24 (13 days old) for respective grape packs. CSM stated, Discard when overripe when asked about the facility's policy regarding fruit. CSM stated, We would not have served it to anybody when asked. Review of the facility's Standard Operating Procedures titled, Date Marking Ready-to-eat, Potentially Hazardous Foods (Standard Operating Procedures), dated April 2022 indicated, Instructions . 3. Label all ready-to-eat, potentially hazardous foods that are prepared on-site and held for more than 24 hours. 4. Label any processed, ready-to-eat, or potentially hazardous foods when opened with a use-by date and following the department shelf-life charts . 6. Serve or discard refrigerated, ready-to-eat, potentially hazardous foods within 7 days or by the date/time stamp . 2. Foods that are not date marked or that exceed the 7-day time-period will be discarded . Review of the facility's Shelf Life Chart for Produce titled, Produce Refrigerated Storage Life of Foods, undated indicated, . Whole Raw Fruit . Discard When over ripe .

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	03/21/2024

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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44477 Based on observation, interview, and record review, the facility failed to ensure a refuse (solid waste not carried by water through the sewage system) container were disposed in a proper manner with the lid. This failure had the potential to promote development and spread of communicable diseases and infections that could jeopardize the health of the residents in the facility. Findings: During a concurrent observation and interview on 3/12/24 at 10:05 AM with Director of Food and Nutrition Services (DoFNS), and Clinical Services Manager (CSM) in the kitchen, a blue colored recycle container near flat top griddle was half-open and almost full of empty chocolate pudding cans with small pudding residue. CSM stated, Close when asked what to do with the lid of the blue colored recycle container. DoFNS disagreed, then stated, the lid of the container can be closed at the end of the day. During an interview on 3/13/24 at 2:23 PM with Infection Preventionist (IP) 2, and IP 3, when showed the pictures of the half-opened blue colored recycle container in the kitchen, IP 2 stated, the half-opened blue colored recycle container could contaminate food when it was near the food preparation area, and IP 3 was also in agreement. During a concurrent interview and record review on 3/13/24 at 4:41 PM with IP 2 and IP 3, the facility's policy and procedure (P&P) titled, Infection Control In Food And Nutrition Services, dated December 2020 was reviewed. The P&P indicated, . Food and Nutrition Services (FNS) maintains an active Infection Control program which includes proper safety procedures, safe food preparation, and proper sanitation techniques. These procedures must be followed at all times . H. Waste Disposal 1. All wet waste is disposed of into garbage disposal. Other waste will be disposed of in plastic liners within double-lined containers . with close-fitting covers . Both IP 2 and IP 3 verified, this P&P was applicable for the half-opened blue colored recycle container in the kitchen. Review of U.S. Food and Drug Administration's 2022 Food Code indicated, . Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled . Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions . and may be a possible source of contamination of food, equipment, and utensils . All containers must be maintained in good repair . in order to store garbage and refuse under sanitary conditions as well as to prevent the breeding of flies . Refuse, recyclables, and returnable items, such as beverage cans and bottles, usually contain a residue of the original contents. Spillage from these containers soils receptacles and storage areas and becomes an attractant for insects, rodents, and other pests . Waste materials and empty product containers are unclean and can be an attractant to insects and rodents .

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	555034	A. Building B. Wing	03/21/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview, and record review, the facility failed to maintain infection control program and practices designed to help prevent the development and transmission of diseases and infections when: 1. There was unopened Biohazard Spill Kit (a cleaning supply to remove the biohazard and disinfect the area) with expiration date of [DATE] in the garage storage. 2. The facility did not implement the correct cleaning and disinfecting practices of a glucometer (a machine used to test a resident's blood sugar at the bedside) after obtaining a blood glucose (sugar) for one of two sampled residents (Resident 133). These failures had the potential for spread of infection or bloodborne pathogens (bacteria or viruses in blood that can spread disease) to residents and staff. Findings: 1. During a concurrent observation and interview on [DATE] at 11:30 AM with Infection Preventionist (IP) 1 in the garage storage, there was an unopened Biohazard Spill Kit indicated, . Expiration: [DATE] . IP 1 acknowledged, it was expired 4 years ago when asked. IP 1 stated, We need to throw it out . It should have been tossed out, when asked. During an interview on [DATE] at 2:09 PM with IP 1, IP 1 stated, No when asked if the Biohazard Spill Kit, which had expired on [DATE], was effective for disinfection. During an interview on [DATE] at 10:25 AM with IP 1, IP 1 stated, there was no policy regarding expiration dates for supplies. IP 1 stated, the facility's policy and procedure (P&P) titled, Medication Storage dated 2019, could be applied instead for cleaning supplies such as Biohazard Spill Kit. Review of the facility's P&P titled, Medication Storage dated 2019 indicated, . N. Outdated . or deteriorated medications . are immediately removed from stock, disposed of according to procedure for medication disposal (see Section IE: DISPOSAL OF MEDICATIONS AND MEDICAITON-RELATED SUPPLIES) . 49264 2. During a concurrent observation and interview on [DATE] at 11:44 AM with License Vocational Nurse (LVN) 4 outside of Resident 133's room, LVN 4 was observed cleaning a glucometer with a wet wipe after obtaining Resident 133's blood glucose. LVN 4 stated that she used a green non-bleach Clorox wipe to clean the glucometer. The green non-bleach Clorox wipe has an Environmental Protection Agency (EPA) registration number of ,d+[DATE] . (continued on next page)

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	03/21/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 10:05 AM with the IP 1, a glucometer manufacturer manual titled ARKAY Technical Brief, revised [DATE], was reviewed. The manual listed five types of cleaning and disinfecting wipes approved for use with the facility's glucometer. IP 1 stated that staff should use the Super Sani-Cloth Germicidal Wipes with the EPA registration number of ,d+[DATE] after each use of the glucometer. If that is not available, IP 1 stated that the Clorox Germicidal Wipes with an EPA registration number of ,d+[DATE] should be used. IP 1 stated that the green non-bleach Clorox wipes with EPA number of ,d+[DATE] should not be used on the Glucometer. During a concurrent interview and record review on [DATE] at 1:43 PM with IP 1, a policy titled Cleaning & Disinfection of Resident Care Equipment, last revised [DATE], was reviewed. The policy stated that Critical items consist of items that carry a high risk of infection if contaminated with any microorganism [bacteria or virus]. The policy also stated that Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturer's instructions. IP 1 stated that glucometers are considered critical items for cleaning and disinfection.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 43913 Based on observation, interviews and record review, the facility did not ensure staff were trained on infection control practices for oral suctioning, when eight residents have orders for suctioning PRN, nurses unable to tell protocol on change of tubes and cleaning the canister. This failure could result in break in infection control practice that could spread infection among residents. Findings: During an observation on 3/11/24, observed resident's bedside table with a suction machine with a suction tip, not dated, with all other personal hygiene items including oral care items. During an interview on 3/11/24 at 2:45PM, with Certified Nursing Assistant (CNA) 2 , CNA 2 stated, resident is bedbound, total care, bedside table is like that, son's preference, I have not seen any nurse use this machine, son comes in the evening and use it per report to us. During an interview on 3/11/24 at 2:45 PM with Licensed Vocational Nurse (LVN) 3, per LVN 3 its' son's preference, he is the RP (responsible party) There is an order for suctioning . Have not seen him do it, it is care planned. The staff is not allowed to clean her bedside table, he comes every night, bring food and feed resident. Per LVN 3, does not change or clean the suction machine. I don't use it, don't know who changes the suction tip or was changed or cleaned last During an interview on 3/12/24 at 2 PM, with Resident Care Coordinator (RCC) 3, per RCC 3, we are aware of the suction machine in her room, as care planned it's the son's preference. He comes to visit at night, we tried to clean it but son does not like it. Tried to have care conference with him but he does not answer. Other family member cannot make decision. During an interview on 3/19/24 at 1PM, with Infection Preventionist (IP), per IP use of suction machine is Licensed nurse responsible for cleaning and changing the tube. We don't have specific policies and procedures for suctioning. During an interview on 3/20/24 at 11 AM, with LVN 7, LVN 7 stated, never used the suction machine on her. If I use it now, I will document on nurses' progress notes and endorse to next shift. I will look at facility protocol on changing of tubing. During an interview on 3/20/24 at 11:10AM, with LVN 8, LVN 8 , stated, I have never used the suction machine, labeling and dating is important to know when to change next, will look at policy . During an interview of 3/20/24 at 11:30 AM, with LVN 9, LVN 9 , stated,I used the suction machine before, change the tubing every 24 hours by NOC shift, empty the canister every shift. Don't know of the policy, I know from school. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24 at 11:40AM, with LVN 11, LVN 11 stated, never used the suction machine in my shift, work full time here, it should be charted in Medication Administration Record (MAR) if used, change canister and tubing. I will follow up on the policy. No policy and procedure for oral suctioning orders found.