

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Ahmc Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Avenue Daly City, CA 94015	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>31922</p> <p>Based on observation, interview and record review, the facility did not thoroughly investigate a grievance regarding administration of tube feeding formula as ordered by the physician for Resident 1, one of three sample residents. The facility ' s investigation was not thorough because they failed to :</p> <ol style="list-style-type: none"> 1. Consider the maximum rate their tube feeding pump could run at (295 ml/hr, milliliter per hour, milliliter= unit of fluid measurement). 2. Identify an unclear tube feeding physician order. The tube feeding order directed staff to administer each feeding (325 ml) within an hour. Given the maximum rate of the pump, it was impossible to infuse the ordered amount with the pump alone within the time frame specified. 3. During the investigation, staff failed to measure the total amount of tube feeding within an enclosed bag and staff failed to measure tube feeding formula remaining in the bag lack after the third feeding. Without this information, it would be difficult to conclude if the ordered amount of tube feeding was being administered. 4. During the investigation, staff failed to uncover their tube feeding pumps had a plus/minus 10% error rate according to the pump manufacturer. <p>The lack of a thorough investigation resulted in the facility unilaterally declaring the grievance resolved without following up with the complainant.</p> <p>Findings:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 1 ' s RP on 04/23/2025 at 10:36 AM, the RP stated that she has looked at Resident 1 ' s tube feeding order, and it stated he should be receiving 325 ml of tube feeding to be infused within one hour at 6 AM, 11 AM, 4 PM and 8 PM. The RP stated she called the company providing the enclosed tube feeding bags and the company told her that they fill these bags to exactly 1000 ml of tube feeding solution. The RP stated if staff were administering the tube feeding correctly, the bag should be almost empty when they are done with the third tube feeding. There should only be 25 ml of formula after three episodes of feeding (325 ml X 3 sessions = 975 ml; 1000 ml -975 ml = 25 ml). The RP provided one photo dated 01/04/2025 which shows the bag with more than 25 ml of formula left after the third session. The RP alleged she noticed formula left inside these bags five months ago and has complained to facility regarding this issue. The RP alleged she also involved the ombudsman because facility staff refused to believe they were delivering less than the ordered amount of formula to Resident 1.</p> <p>Review of Resident 1 ' s records titled tube feeding order, printed on 04/23/2025, confirmed that Resident 1 should be receiving 325 ml (milliliter) of tube feeding at 6 AM, 11 AM, 4 PM and 8 PM.</p> <p>During a concurrent observation and interview on 04/24/2025 at 11:15 AM with the Unit Manager (UM) and Biomedical technician (BT, a staff responsible for calibrating and inspecting medical equipment), the UM confirmed documentation on Resident 1 ' s tube feeding bag indicated the first feeding session was started on 04/23/2025 at 8:00 PM (yesterday). The UM and BT reviewed Resident 1 ' s tube feeding orders and acknowledged only 25 ml should be remaining in the bag after the third feeding session (04/24/2025 at 11:00 AM) . After the third feeding, total content in the bag was measured to be 165 ml. This observation confirmed staff failed to administer 145 ml of formula to Resident 1 (165 ml - 25 ml= 145 ml) because, the entire content of a new enclosed tube feeding bag was measured and the UM confirmed these bags were filled to 1000 ml (as reported to the RP by the manufacturer).</p> <p>During an interview on 04/25/2025 at 11:00 AM, the BT stated after conducting calibration measurements on the tube feeding pumps from the unit and communicating with the tube feeding pump manufacturers, the Biomed tech concluded the pumps were functioning as intended. However, these pumps have a plus/minus 10% error rate. For example, if programmed to deliver 975 ml of solution, the pump could be delivering 877.5 ml to 1072.5 ml of solution. The BT confirmed the pumps could be delivering less than the programmed amount of tube feeding as observed on 04/24/2025.</p> <p>During an interview on 04/25/2025 at 11:43 AM the Registered Dietitian (RD) confirmed she was the one responsible for calculating tube feeding rates and amount to meet Resident 1 ' s nutritional needs. The RD stated she was not aware these tube feeding pumps had an error rate of plus/minus 10% and had the potential to deliver less than the programmed amount of tube feeding to a resident.</p> <p>During an interview on 04/29/2025 at 3:44 PM, the UM confirmed that Resident 1 ' s RP had been complaining about staff not giving the full amount of formula as ordered by the RD. The UM thought the issue was resolved as currently, the RP had not been complaining about this particular issue. The UM stated she was not aware the tube feeding pumps had a plus/minus error rate of 10% and had the potential to deliver less (or more) than the programmed amount of tube feeding formula. The UM was made aware if a thorough investigation had been conducted, she would have uncovered the plus/minus 10% error and provided the RP with an accurate explanation of why there were formula left after each third feeding session. The UM did not comment on this statement. During an interview on 05/06/2024 at 11:59 AM the UM was made aware the facility ' s tube feeding grievance investigation was not a thorough investigation because the facility ' s investigation did not uncover these issues:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. The order for the tube feeding was 325 ml to be infused within 1 hour. The maximum rate of the facility ' s tube feeding pumps was 295 ml/hr. There was no way for staff to fulfill this order using only their current tube feeding pumps. The UM agreed nurses administering tube feeding since 12/28/2024 to now should have questioned/clarified the order.</p> <p>2. Staff did not verify if these enclosed tube feeding bags were filled to 1000 ml. Because if these bags were filled to more than 1000 ml, this may account for the RP ' s continual observation/complain of excessive tube feeding formula left in the bag after the third feeding.</p> <p>3. Staff were not aware these tube feeding pumps had an error rate of plus minus 10%. It was only after this CDPH investigation that BT asked the tube feeding pump manufacturers about error rates. Staff were not aware if their tube feeding pumps were programmed by staff to deliver 325 ml for three feedings (total of 975 ml) that the actual amount delivered might be as low as 877.5 ml. this may account for RP ' s continual observation/complain of excessive tube feeding formula left in the bag after the third feeding.</p> <p>4. During the facility ' s investigation, staff did not measure to verify if the formular left in the bag after three feedings was 25 ml.</p> <p>Review of a document titled RESIDENT GRIEVANCE/COMPLAINT FORM, dated 01/09/2025, indicated the facility resolved this grievance: Administrative Follow-up/Resolution: Complainant Notified on March 2025 by RN .(manager) .Complete Resolution/Satisfied .</p> <p>During an Interview with the Ombudsman and RP on 05/06/2025 at 9:00 AM, they both stated the facility never followed up with them regarding this grievance, the problem continued and was never resolved. The Ombudsman stated that was why she escalated this issue to CDPH.</p> <p>The UM was asked on 05/06/2025 at 1:01 PM to provide documented evidence the facility met or notified the ombudsman and RP. The UM was asked to also provide documented evidence the ombudsman and RP agreed with the facility ' s findings/intervention regarding their grievance. The facility was unable to provide the requested information.</p> <p>Review of the facility ' s policy titled PATIENT COMPLAINTS AND GRIEVANCES, revised on January 2025, indicated .The party filing the grievance will be provided written notification of the outcome of the grievance review and investigation including:</p> <ol style="list-style-type: none"> The name of the hospital contact person The steps taken on behalf of the patient to investigate the grievance The results of the grievance process and The date of completion <p>.If a resolution cannot be completed within 7 calendar days, an acknowledgment letter will be provided to the complainant within 7 calendar days of receipt of the grievance, stating that a resolution letter will be sent within 30 calendar days. This communication will be managed by Risk Management.</p>		