

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 05/16/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31922</p> <p>Based on observation, interview, and record review, four problems were identified regarding the facility's fall prevention program:</p> <ol style="list-style-type: none"> 1. The facility did not regularly conduct a thorough investigation regarding the primary causes of falls for Resident 1. 2. The facility did not conduct a fall risk assessment for two of Resident 1's falls. 3. The facility continued using a tab alarm (an alarm that clips onto a resident's clothing) to alert staff for unassisted transfers for Resident 1 who has a history of unclipping the tab alarm from her clothing. The facility did not evaluate if a tab alarm was appropriate for Resident1 in decreasing her fall risks. 4. Staff did not consistently implement interventions within Resident 1 's care plans to minimize fall risks for Resident 1 (application of tab alarm or activation of bed alarm). <p>These failures resulted in four falls for Resident 1, one of two sample residents within four months (April to August 2024). On 08/05/2024, Resident 1 fell and fractured all five of her right toes.</p> <p>Findings:</p> <p>Review of Resident 1's medical records titled MINIMUM DATA SET (MDS, a standardized resident assessment tool), dated 02/11/2025, indicated Resident 1:</p> <ol style="list-style-type: none"> 1. Had memory problems and was moderately impaired in decision making and problem solving. 2. Needed substantial/maximal assistance with toileting and chair/bed to chair transfers. 3. Had no voluntary control over bowel and bladder functions. <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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's medical records titled Event Report, dated 08/08/2024, indicated Resident 1 had multiple diagnoses including: dementia (a progressive decline in mental abilities, impacting memory, thinking, and behavior); Parkinson's disease (a progressive brain and spinal cord disorder affecting movement, causing tremors, stiffness, and slow movement, as well as non-movement symptoms like sleep problems and mood changes); depression (a mental health condition with display of persistent low mood, loss of interest, and low energy) ; anxiety (feelings of uneasiness, worry, or dread, often accompanied by increased heart rate, sweating, and tension); osteoarthritis (progressive break down of joint tissues over time); extrapyramidal and movement disorder (a drug-induced movement disorders causing involuntary movements, muscle contractions, and other motor problems).</p> <p>Review of Resident 1's medical record titled Morse Fall Scale (a fall risk assessment tool), dated 04/26/2024, indicated she was assessed as at high risk for falls.</p> <p>Review of Resident 1's medical record titled Care Plan History, dated 03/01/2024, indicated .Resident has bed alarm when on bed/ tab alarm when up on wheelchair; at risk for fall .</p> <p>Review of Resident 1's medical record titled Event Report, dated 04/05/2024, indicated .(Resident 1) SLIDE FROM HER WHEELCHAIR DOWN TO THE FLOOR. FALL IS UNWITNESSED. WHILE ON BED, BED . (ALARM) IS ON AND TAB ALARM IS ATTACHED-SO . WILL NOT FORGET TO PUT ON WHILE ON . (wheelchair).</p> <p>During an observation of Resident 1 on 04/28/2025 at 12:17 PM with the Assistant Director of Nursing (ADON), Resident 1 was seated in her wheelchair out in the hallway. Resident 1 was able to unclip her tab alarm unassisted.</p> <p>During a concurrent interview and record review on 04/28/2025 at 12:36 PM, the Director of Nursing (DON) stated after a fall, she expected staff to conduct a huddle (meeting) to discuss the fall, identify potential causes of the fall, and formulate interventions. The DON stated these huddles were documented in their IDT (interdisciplinary= a group of health care professionals with various areas of expertise who work together in providing resident care) notes. The DON reviewed the IDT note for the 04/05/2024 fall. After reviewing the IDT note, the DON stated the IDT charting was unclear regarding if:</p> <ol style="list-style-type: none"> 1. A tab alarm was applied by staff while Resident 1 was in her wheelchair. 2. The tab alarm was removed by Resident 1. The DON stated Resident 1 has a history of removing her tab alarms. 3. The tab alarm malfunctioned. <p>The DON stated the tab alarm may not have been applied prior to the fall on 04/05/2024 as one of the interventions(s) documented was attachment of the tab alarm while in bed so staff will not forget to put tab alarm on while on wheelchair.</p> <p>The DON was asked:</p> <ol style="list-style-type: none"> 1. For documented evidence staff were reminded to apply Resident 1's tab alarm when she was in her wheelchair. The DON was unable to provide the requested document. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 04/28/2025 at 12:36 PM, after reviewing the IDT note for the 08/05/2024 fall, the DON stated the IDT notes failed to identify if the bed alarm was activated or was not functioning properly. The DON stated staff at the Quality department may have more information regarding this fall. The DON stated she will ask the department to send over more information.</p> <p>Review of a document titled FRAMEWORK FOR ROOT CAUSE ANALYSIS AND CORRECTIVE ACTIONS, dated 08/05/2024, indicated staff did a root cause analysis of the fall on 08/05/2024 and concluded . Bed alarm was not utilized .</p> <p>During an interview on 04/28/2025 at 3:48 PM, the Clinical Quality Analyst (CQA) stated she only conducted a root cause analysis on Resident 1's fall dated 08/05/2024. The CQA stated she did not conduct a root cause analysis on Resident 1's other falls on 04/05/2024, 04/21/2024, and 07/04/2024.</p> <p>Review of the facility's policy titled Fall Prevention and Management, revised on January 2025, indicated . PURPOSE .Appropriate interventions used to reduce falls and fall-related injuries A fall risk assessment . will be conducted by the registered nurse and documented in the medical record . After a fall .</p> <p>During a concurrent record review and interview on 05/14/2025 at 1:00 PM, the ADON was asked to provide documented evidence fall risk assessments were conducted after Resident 1's falls on 04/05/2024, 04/21/2024, 07/04/2024, and 08/05/2024. The ADON searched Resident 1's medical records and was unable to provide documented evidence a fall risk assessment was conducted after Resident 1 fell on [DATE] and 07/04/2024.</p> <p>During an interview on 05/15/2025 at 1:50 PM, the DON stated her expectation was staff should conduct a fall risk assessment after each fall within 72 hours. The DON also stated falls regardless of injuries are treated as unusual occurrences and should be thoroughly investigated to determine root cause(s) and appropriate intervention(s) implemented to reduce fall risks.</p>		