

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/15/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure one of the 26 sampled residents (Resident 97) bed/side rail was raised up while the resident was in bed. This failure resulted in Resident 97 falling out of bed and sustain a fracture (broken bone) through the right femur (thigh bone). During an observation on 8/11/25, at 10:04 AM, Resident 97 was asleep in bed. The right and left upper bed/side rails were raised. During an interview on 8/13/25, at 10:08 AM, Registered Nurse (RN) 4 stated that the bed/side rails were raised up when Resident 97 is in bed for positioning. RN 4 further stated Resident 97 leans to one side. A review of the facility's Informed Consent for Bedrail Use - Facility verification Form indicated the consent was obtained on 6/29/23. A review of the care plan with a start date of 6/30/23, indicated Resident 97 was at risk for fall or injury. The care plan interventions to address fall or injury included having the bed / side rails up when the resident is in bed and to anticipate resident's needs. A review of the Minimum Data Set (a standard assessment tool) dated 3/13/25, indicated diagnoses for Resident 97 included dementia (decline in memory or other thinking skills), diabetes (abnormally high blood sugar level) and hypertension (abnormally high blood pressure). Brief Interview of Mental Status (BIMS, a brief memory test to help determine cognitive function including memory recall and decision-making ability) indicated moderately impaired cognition (decisions poor, supervision required). Functional status indicated Resident 97 was dependent (helper does all the effort. Resident does none to complete the activity) with all activities of daily living including bed mobility (the ability to turn and reposition in bed) and transfer (ability to transfer in and out of bed). A review of the Interdisciplinary Team (IDT, a group of professionals who work together to provide resident care) notes dated 4/24/25, indicated Resident 97 fell out of bed during ADL care. The IDT notes indicated that the two Certified Nurse Assistants (CNA 1 and CNA 2) did not put the side rail up when they left the resident's bedside. A review of the facility investigation dated 4/24/25, indicated CNA 1 stated that while (with CNA 2) were in the bathroom, they heard a thump and saw the resident on the floor. The facility investigation further indicated CNA 1 and CNA 2 transferred Resident 97 from the floor to bed and continued providing care. A review of the facility investigation indicated on 4/24/25, Resident 97 complained of pain and was transferred to the emergency department (ED). The facility investigation further indicated that on 4/25/25, staff observed Resident 97 was grimacing (a facial expression to non-verbally communicate pain) when moving their legs. More grimacing was observed when the right hip was touched. The Xray (a test that produces pictures of the inside of the body) result indicated a non-displaced impacted fracture (when the bone is broken but the bone fragments remain aligned) through the right femur and osteopenia (fragile bones). During an interview on 8/13/25, at 12:12 PM, the Director of Nursing stated that the CNA's should have put the side rail up before they left the resident. The DON stated that there was no other incident that occurred after the fall incident. The DON further stated that the two CNAs have terminated their employment. A review of the facility Policy and Procedure titled Major neurocognitive disorder (formerly known as dementia) - Patient Care with a revised date 5/2025, indicated, . Purpose: To ensure patients/residents who are diagnosed with Major neurocognitive disorder or have an established diagnosis of Major neurocognitive disorder, are (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	managed according to acceptable standards of care. Residents will be free of injury on a daily basis. A review of the facility Policy and Procedure titled, Post Acute Fall Prevention and Management dated 6/2025, indicated, .All residents are considered universally at a fall risks, regardless of their individual fall risk assessment, due to chronic health conditions, physical decline, mobility difficulties, cognitive impairment and pharmaceutical drug regimens which characterize the resident population. Each care setting shall be assessed to determine the needs for resident specific assessment and reassessments. The level of assessed risk shall determine the degree and/or frequency of resident specific risk assessment and interventions.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to ensure the Interim Dietary Director (IDD), who is also a registered dietitian and oversees the kitchen, was fully sufficient when she did not ensure that auditing of the dish machine logs and cooling (Cooling is the specific method and guideline used to rapidly lower the temperature of cooked food to a safe storage level, preventing bacterial growth. Improper cooling is a major factor in causing foodborne illness. Taking too long to chill potentially hazardous food, which means food that requires time/temperature control for safety to limit the growth of pathogens, has been consistently identified as one factor contributing to foodborne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease-causing microorganisms that may have survived the cooking process (e.g., spore-formers). Cooked potentially hazardous foods that are subject to time and temperature control for safety are best cooled rapidly within 2 hours, from 135 F to 70 F, and within 4 more hours to the temperature of approximately 41 F. The total time for cooling from 135 F to 41 F should not exceed 6 hours.) logs was done in the kitchen. This failure had the potential for inadequate supervision of the dietary department which serves food for the entire facility. During a concurrent observation and interview on 8/12/25 at 3:29 PM with IDD in the kitchen, the facility's dish machine was observed. IDD stated, their dish machine is a high-temperature dishwasher. IDD stated, the wash temperature should be above or equal to 160 F, and the final rinse temperature should be above or equal to 180 F for the dish machine. During a concurrent interview and record review on 8/12/25 at 3:33 PM with Food Service Aide (FSA) 2 in the kitchen, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 and August 2025 were reviewed. The DISHMACHINE TEMPERATURES in June 2025 indicated, the dish machine temperatures did not reach 180 F for final rinse on the following dates: 1) 6/9/25; 2) 6/10/25; 3) 6/11/25; 4) 6/12/25; 5) 6/13/25; 6) 6/24/25; 7) 6/25/25; 8) 6/26/25; 9) 6/30/25. The DISHMACHINE TEMPERATURES in August 2025 indicated, the dish machine temperatures did not reach 180 F for final rinse on the following dates: 1) 8/3/25; 2) 8/4/25; 3) 8/5/25; 4) 8/6/25; 5) 8/11/25; 6) 8/12/25. During a concurrent interview and record review on 8/12/25 at 3:38 PM with IDD in the kitchen, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 and August 2025 were reviewed. IDD stated, It did not reach the temperature when asked if the dish machine temperatures reached 180 F for final rinse on the following dates: 1) 6/9/25; 2) 6/10/25; 3) 6/11/25; 4) 6/12/25; 5) 6/13/25; 6) 6/24/25; 7) 6/25/25; 8) 6/26/25; 9) 6/30/25; 10) 8/3/25; 11) 8/4/25; 12) 8/5/25; 13) 8/6/25; 14) 8/11/25; 15) 8/12/25. Review of the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 indicated, . Dishmachine Procedure . Final rinse temperature and flow pressure gauges are accurate only when a rack enters the final rinse area and water is flowing. The acceptable temperature range for the wash cycle is 160 F and Final Rinse is 180 F-195 F . Review of the facility's P&P titled, IC 8-F: INFECTION CONTROL-NUTRITION AND FOOD SERVICES revised in December 2022 indicated, . D. Dishwashing . 2. Final rinse must be 180-195 degrees Fahrenheit . During a concurrent interview and record review on 8/13/25 at 10:50 AM with Interim Dietary Director (IDD) and Cook, the facility's document titled, COOKING AND COOLING LOG dated 7/28/25 was reviewed. The log indicated, it took 3 hours to check the porridge temperature, from 6 AM to 9 AM. IDD stated, food temperatures should be checked in 2 hours to ensure it reaches 70 F when asked about cooling procedures from the initial cooling temperature. IDD stated, That's 3 hours when asked how many hours from 6 AM to 9 AM. IDD and [NAME] acknowledged, the porridge temperature was not checked in 2 hours when asked. The log also indicated, it took 5 more hours to check the porridge temperature, from 9 AM to 2 PM. In addition, the gravy temperature was 112 F at 9 AM after the first 2 hours, starting from the initial cooling temperature of 180 F at 7 AM. Then it was blank after 9 AM. IDD acknowledged, 112 F at 9 AM meant it did not reach 70 F in 2 hours. IDD stated, It should be below 70 (F). The log also indicated, (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the tomato soup temperature was checked at 9:30 AM, then after that, it was also blank. IDD further stated, They didn't do the follow up when asked about the gravy and tomato soup. IDD acknowledged, the kitchen staff did not follow cooling procedures when asked. IDD stated, I will give them in-service. During a concurrent interview and record review on 8/13/25 at 10:55 AM with IDD, the COOKING AND COOLING LOG dated 7/30/25 was reviewed. The log indicated, the rice temperature was 110 F at 9 AM, two hours after starting to cool from the initial temperature of 175 F at 7 AM. IDD stated, The temperature was not right, when asked about 110 F at 9 AM. During a concurrent interview and record review on 8/13/25 at 10:57 AM with IDD, the COOKING AND COOLING LOG dated 8/3/25 was reviewed. The log indicated, the porridge temperature was checked at 8 AM after 4:48 AM when the initial cooling temperature was checked. IDD stated, That's 3 hours, when asked. During a concurrent interview and record review on 8/13/25 at 11 AM with IDD, the COOKING AND COOLING LOG dated 8/8/25 was reviewed. The log indicated, the porridge temperature was 110 F at 8:50 AM two hours after starting to cool from the initial temperature of 173 F at 6:50 AM. IDD stated, The temperature was not low enough when asked if the porridge temperature 110 F at 8:50 AM was good enough. During a concurrent interview and record review on 8/13/25 at 11:04 AM with IDD, the COOKING AND COOLING LOG dated 8/12/25 was reviewed. The log indicated, the porridge temperature was 78 F at 8 AM after the initial cooling temperature was 179 F at 5 AM. IDD stated, It's wrong. It should be reached 70 (F) within 2hours, when asked. During a concurrent interview and record review on 8/13/25 at 11:05 AM with IDD, COOKING AND COOLING LOG dated 8/13/25 was reviewed. The log indicated, the porridge temperature was 68 F at 8 AM after the initial cooling temperature was 179 F at 5 AM. IDD stated, It's 3 hours. Below 70 (F) within 2 hours, when asked how many hours from 5 AM to 8 AM. During a concurrent interview and record review on 8/13/25 at 1:12 PM with IDD, the COOKING AND COOLING LOG from July 2025 to August 2025 were reviewed. The logs indicated, INSTRUCTIONS . Internal temperature must reach 70 F within 2 hours of reaching 140 F . Internal temperature must reach 41 F or below within 4 hours of reaching 70 F . IDD stated, This form needs to be changed. It's confusing, when asked about the instructions on the logs. During an interview on 8/13/25 at 1:19 PM with IDD, IDD acknowledged, they did not follow cooling procedures when asked. IDD also acknowledged, the instructions on the COOKING AND COOLING LOG were not correct. During an interview on 8/13/25 at 1:56 PM with IDD, IDD stated, they can spread infection to the entire facility if they continue to use the dish machine when it did not reach 180 F for the final rinse, when asked. IDD stated, . I started on June 16th (in 2025) . when asked. IDD verified, she is the registered dietitian. IDD stated, she oversees the kitchen when asked what her role is. IDD stated, There is no supervisor to audit in the kitchen . when asked if she audits the logs. IDD stated, the facility needs to have a supervisor to do audits because she is too busy dealing with whatever comes up in the kitchen to do an audit herself. During an interview on 8/14/25 at 9:25 AM with Diet Clerk II, Diet Clerk II verified, the kitchen does not have the supervisor below IDD when asked. Diet Clerk II stated, IDD is only a temporary and nobody is auditing the logs such as DISHMACHINE TEMPERATURES and COOKING AND COOLING LOG to check if the kitchen staff are checking the right temperatures regarding the dish machine and cooling procedures. Diet Clerk II stated, they should have somebody who will audit to remind the kitchen staff about the correct temperatures and to correct the kitchen staff's wrong practices. During an interview on 8/14/25 at 9:50 AM with IDD, IDD verified, Not right now when asked again if the facility has a supervisor below her who can audit the logs. During a concurrent interview and record review on 8/14/25 at 9:55 AM with IDD, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 was reviewed. The log indicated, the wash temperatures and final rinse temperatures were not documented on the following dates: 1) 6/1/25; 2) 6/2/25; 3) 6/3/25; 4) 6/4/25; 5) 6/5/25; 6) 6/6/25; 7) 6/7/25; 8) 6/8/25; 9) 6/9/25 AM; 10) 6/27/25; 11) 6/28/25; 12) 6/29/25. There was no evidence that the kitchen staff checked the dish machine temperatures on these days when asked. Review of the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 indicated, . Dishmachine Procedure . Temperature of (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wash and rinse cycle should be checked for adequacy before use . Review of the facility's document titled, Organizational Chart Post Acute Care undated indicated, IDD was under ACOO (Associated Chief Operation's Officer), and there should be a food service supervisor under IDD. Review of the facility's Job description titled, JOB TITLE: Certified Dietary Manager undated indicated, . Reports to: Director of Food & Nutrition JOB SUMMARY: Responsible for the daily operations of the foodservice department in accordance with facility policy and procedures as well as federal and state regulations. Provide leadership and guidance to ensure that food quality, safety standards, and client expectations are satisfactorily met . Foodservice Management . Manage staff to ensure compliance with safety and sanitation regulations, including safe receiving, storage, preparation, and service of food .		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure governing body oversight of the facility's Quality Assurance Program (QAPI) program and activities when plan of action to correct identified deficiencies were not implemented and maintained. This failure had the potential to negatively affect the care and services rendered to the residents, including their quality of life. Review of the facility's QAPI Meeting Minutes from September 2025 to November 2025 indicated, .Continue with POC (plan of correction) . The QAPI Meeting Minutes did not show any oversight of how the plan of action was being implemented to address the identified deficiencies. During an interview on 12/10/25 at 4:40 PM, Chief Clinical & Quality Officer (CCQO) stated that the Director of Nursing (DON) and Manager of the Subacute were responsible for the implementation of the plan of correction. During an interview on 12/11/25 at 11:37 AM, Registered Nurse (RN) 2 stated that the staff were not made aware of the facility's approved plan of correction thus, they did not know what needs to be implemented in the POC. RN 2 stated, I don't know what was added in the POC. Review of the facility's Quality Assurance and Performance Improvement, revised 9/25, indicated, .From the Board to the bedside, the focus is providing patient centered care rooted in evidence based practice and ensuring Medicare Condition of Participation (COPs) are followed . Objectives: To support and maintain a culture of safety throughout the facility. To support a strong internal, non-punitive reporting through the IMP system. And, to encourage a culture of reporting to support improvement learning . To support ongoing implementation of newer and known safe practices; to examine potential adverse events and redesign care processes and systems to improve response and outcome. To increase communication and promote an environment where collaboration and teamwork thrive . Monitor and evaluate compliance with regulatory requirements . Assist operations with developing performance improvement projects (PIPs) when gaps are identified between current and desired status . Governing Body: Ultimate responsibility for the QAPI plan and the care that is provided. Oversees the development, implementation, and assessment of the plan . Evaluates the effectiveness of the plan. Quality, Risk, Safety, and Compliance Department: . Maintain oversight of on-going organization wide QAPI program. Ensure the integrity of data collection and reporting .		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to identify on-going systemic issues, develop, implement, and evaluate its plan of action to correct the identified deficiencies when: The facility failed to report an alleged abuse incident involving Resident J within the required 2-hour timeframe. Additionally, the facility did not conduct a thorough investigation of the alleged abuse incident. (Cross reference to F609 and F610) The facility failed to report the results of investigation within five (5) working days of the incident for two reported abuse allegations involving Resident J, Resident L, and Resident M. (Cross reference to F609) The facility failed to evaluate, develop, and implement interventions after Resident A was identified with a significant weight loss. (Cross reference to F656 and F692) The facility did not ensure valid copy of the Physician Orders for Life-Sustaining Treatment (POLST, a written medical order that assists people in making decisions about medical treatment and life saving measures during end-of-life care or medical crisis) for Resident 5 had complete and accurate information. (Cross reference to F578) Audit logs were not completed as stated in the plan of correction. The facility failed to ensure hand hygiene was performed between resident care. (Cross reference to F880) The cumulative effect of these failures to implement the plan of correction for the identified deficiencies resulted in repeated noncompliance, which could jeopardize the health, safety, and well-being of the residents. Quality Assurance and Performance Program (QAPI) program is a data driven and proactive approach to quality improvement to ensure services provided are meeting quality standards and assuring care reaches a certain level. Review of the facility's QAPI Meeting Minutes from September 2025 to November 2025 indicated, .Continue with POC (plan of correction) . During an interview on 12/10/25 at 4:40 PM, Chief Clinical & Quality Officer (CCQO) stated that the Director of Nursing (DON) and Manager of the Subacute were responsible for the implementation of the plan of correction. 1. Review of the facility's QAPI Meeting Minutes from September 2025 to November 2025 indicated, .Continue with POC (plan of correction) . Review of the facility's plan of correction (POC) with a completed date of 9/22/25, indicated, .D. In order to maintain and sustain the corrective action, the DON/designee will ensure that the abuse and neglect log is current and will conduct an audit of all allegations of abuse and neglect on a monthly basis to determine compliance with timely reporting. The expectation is 100% compliance &ndash; that every allegation of abuse will be reported to the Ombudsman and CDPH within 2 hours. Results of the audit will be presented and discussed during the QAPI meetings . During an interview on 12/10/25 at 2:03 PM, the DON confirmed that the allegation was not reported within the required timeframe due to Resident J's allegation was not clear to her (DON). 2. During an interview on 12/10/25 at 3:05 PM, the DON confirmed that the result of investigation was not completed and faxed to CDPH within the required timeframe of 5 working days after the incident. 3. During a concurrent interview and record review with RN 1 on 12/9/25 at 9:51 AM, Resident A's clinical record including progress notes, assessments, and care plan was reviewed. RN 1 did not find documentation of a change of condition, nutritional assessment, or care plan after Resident A's significant weight loss on 10/7/25. RN 1 confirmed there was a Risk for Altered Nutrition Status care plan, however, none of the care plan addressed Resident A's actual weight loss. Furthermore, RN 1 confirmed that a change of condition and care plan should have been completed, and weekly weights (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have been initiated. During an interview on 12/11/25 at 11:37 AM, Registered Nurse (RN) 2 stated that the staff were not made aware of the facility's approved plan of correction thus, they did not know what needs to be implemented in the POC. RN 2 stated, I don't know what was added in the POC. Review of the facility's Quality Assurance and Performance Improvement, revised 9/25, indicated, The purpose of performance improvement (PI) is to provide a comprehensive data based program that continually assess the Quality of Care provided to the residents, and provides feedback that enables the facility to identify adjustments needed to improve residents care. From the Board to the bedside, the focus is providing patient centered care rooted in evidence based practice and ensuring Medicare Condition of Participation (COPs) are followed . The QAPI program is an ongoing, comprehensive, integrated program that provides a transparent view of the Quality of Services provided . It ensures that established policies, procedures, and guidelines are followed in the provision of care (including state, federal, accreditation, and professional standards) . Objectives: . To support ongoing implementation of newer and known safe practices; to examine potential adverse events and redesign care processes and systems to improve response and outcome . To use standardized tools and methodology to demonstrate improvement. Evaluate the adequacy of clinical documentation utilizing standardized audit tools . Identify opportunities for improvement and evaluate the effectiveness and safety of services . Monitor and evaluate compliance with regulatory requirements . 4. A review of facility's plan of correction (POC) dated 9/18/2025, POC indicated, .B. all residents have the potential to be affected by the practice. The Direction of Nursing (DON) and or designee will review the POLST form of each resident to ensure accuracy, completion, and to determine the need of revision.Discrepancies and omissions will be corrected upon discovery, and POLST will be updated. During a concurrent interview and record review on 12/9/2025 at 10:30 AM with the Director of Nursing (DON), the DON reviewed Resident 5's POLST to verify completion of the form. The DON confirmed that the form was not fully completed, the signature and date of the physician/nurse practitioner/physician assistant and the signature and mailing address of the legally recognized decision maker were left blank. During a concurrent interview and record review on 12/9/2025 at 11:49 AM with the Assistant Director of Nursing (ADON), the ADON reviewed Resident C's POLST to verify completion of the form. The POLST indicated that the date the form was prepared was 11/19/2023. Section D showed that the physician/nurse practitioner/physician assistant signed and dated the form on 11/22/2024, and the patient or legally recognized decision maker signed on 12/10/2024. The ADON stated, I don't know what happened here; it took a year to complete the form. Review of the facility's policy and procedure titled, POLST-Physician Orders for Life -Sustaining Treatment, revised 9/2025, indicated, .3. Completing a POLST form with the patient.E. In order to be valid, the POLST must be signed by a physician, and by the patient. Review of Resident 5's POLST dated 8/30/2025 indicated, .A copy of the signed POLST form is legally valid physician order.To be valid a POLST form must be signed by (1) physician, or by a nurse practitioner.and (2) the patient or decision maker. 5. A review of facility's plan of correction (POC) dated 9/18/2025, POC indicated, .B. all residents within the facility have the potential to be affected. The facility will ensure that all residents' (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	personal possessions are safeguarded. Residents belongings are inventoried on admission, entered into the residents Belonging List, signed by the resident/RP, and countersigned by witnessing staff. Record review, facility's plan of correction (POC) dated 9/18/2025, POC indicated, .D. The DON and or designee will audit 10 resident valuables listed remain safe and are not misplaced/lost. The DON and/or designee will document discrepancies. During a concurrent interview and record review on 12/9/2025 at 2:38 PM with Assistant Director of Nursing (ADON), the ADON reviewed Resident G's patient belongings record, which indicated valuable: a cellphone with a quantity of one (1). The ADON stated, We never saw any cellphone before or during our audit, and the facility's audit form shows none. Although we understood that we should have reviewed the residents' belongings inventory, we instead proceeded to check directly in each resident's room. We only did what was instructed. An interview on 12/9/2025 at 2:44PM Resident D stated, Yes, they came to check every day my belongings, do I need a copy of the belongings record? Because I don't have a copy of it. An interview on 12/9/2025 at 2:55PM Resident E stated, yes, it's true that they are checking on my stuff every day, I have phone, tablets, tv. But I don't have a copy of my belongings record. An interview on 12/9/2025 at 3:08PM with Resident F stated, Resident F stated they come to check my things every single time, but I don't have a copy of my belonging record. Review of Resident E's Patient Belonging Record undated, indicated, no signature and undated on patient or responsible party and witness. Review of Resident F's Patient Belonging Record undated, indicated, no signature and undated on patient or responsible party and witness. A review of facility's policy titled Loss and Theft- Residents Personal Belongings, revised 9/2025, indicated, .Residents Valuable Form, All residents or their responsible parties are provided a Residents Belonging Record form for signature upon admission.The resident Valuables form requires the signature of the resident or the resident's responsible party on admission and on discharge. Receipt for valuables.the copy of the receipt is given to the resident or responsible party to serve as a claim check for the release of the valuables.		

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NAME OF PROVIDER OR SUPPLIER Ahmc Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Avenue Daly City, CA 94015	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were met for food storage in the kitchen when: 1. Multiple small packs of butter in a black container in the kitchen refrigerator had no expiration dates. 2. Multiple small packs of butter in a stainless-steel container in the kitchen refrigerator were expired. 3. The freezer temperature for the ice cream in the kitchen was out of range. 4. Six packs of MY OWN MEAL FLORENTINE LASAGNA in the kitchen storage room were expired. 5. The dish machine temperature log indicated the final rinse temperature was below 180 F (degrees Fahrenheit, a scale for measuring temperature) for multiple days in June and August 2025. 6. The dish machine temperature was not checked for multiple days in June 2025. 7. The cooling log indicated, the facility did not follow cooling procedures for multiple days in July and August 2025. These failures were likely to result in putting residents at risk for foodborne illness (diseases caused by consuming contaminated food or drink). 1. During a concurrent observation and interview on 8/11/25 at 9:57 AM with Dietary Clerk (DC) 1 in the kitchen, multiple small packs of butter were stored in a black container in the refrigerator, but there were no expiration dates. DC 1 did not answer when asked if she could see the expiration date. DC 1 acknowledged, there was no label indicating the expiration date when asked again. Review of the facility's policy and procedure (P&P) titled, IC 8-F: INFECTION CONTROL-NUTRITION AND FOOD SERVICES revised in December 2022 indicated, . L. Storage of Foods . d. All food will be label (sic) and dated . 2. During a concurrent observation and interview on 8/11/25 at 9:58 AM with DC 1 in the kitchen, multiple small packs of butter were stored in a stainless-steel container in the refrigerator. The label on the stainless-steel container indicated, . Butter . Prep Date (the date when food is initially prepared or processed) 6-26-25 (June 26th, 2025) Use By 7-26-25 (July 26th, 2025) . DC 1 stated, It's like an expiration (date) . supposed to be the last day . when asked what the Use By date means. She acknowledged, July 26th, 2025, was last month when asked. During a concurrent observation and interview on 8/11/25 at 10:38 AM with [NAME] in the kitchen, the pictures of the multiple small packs of butter in the stainless-steel container with the label of Use By 7-26-25 in the kitchen refrigerator were shown to him. [NAME] stated, Expired when asked. [NAME] stated, Yes when asked whether it was correct that food should not be used past its Use By date. [NAME] acknowledged, the butters were expired and should not be used. During a concurrent observation and interview on 8/11/25 at 10:53 AM with Food Service Aide (FSA) 1 in the kitchen, the pictures of the multiple small packs of butter in the stainless-steel container labeled Use By 7-26-25 in the kitchen refrigerator were shown to her. FSA 1 stated, It means that it's expired when asked what Use By 7-26-25 means for the butter. FSA 1 stated, the butters should have been thrown away after their Use By date. During an interview on 8/13/25 at 1:40 PM with Interim Dietary Director (IDD), IDD stated, they should not use food after the Use By date when asked what Use By date means. IDD acknowledged, food consumed after the Use By date has the risk of foodborne illness. During a concurrent interview and record review on 8/14/25 at 9:20 AM with Diet Clerk II, the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 was reviewed. The P&P indicated, . 19. Spoiled or contaminated food will not be served in any manner . Diet Clerk II, stated, the food past the Use By date can be considered spoiled or contaminated if it is used after this date when asked. Diet Clerk II acknowledged, there is a risk of foodborne illness to the residents if the kitchen staff do not follow the food safety standards in the kitchen. 3. During a concurrent observation and interview on 8/11/25 at 10:15 AM with DC 1 in the kitchen, the ice cream freezer temperature was 35 F. DC 1 stated, Yes when asked if it was the freezer. DC 1 stated, 35 (F) when asked what temperature the freezer was at. The ice cream in the small packs were not completely frozen in the freezer. The Strawberry Flavored Ice Cream indicated, . NET 4 FL OZ (fluid ounce, a unit of volume used to measure liquids) (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(118ml) . BEST USED BY 01/10/26, and the Vanilla Flavored Ice Cream indicated, . NET 4 FL OZ (118ml) . BEST USED BY 07/01/26. But they were not frozen hard when pressed. DC 1 acknowledged, the ice creams were not frozen hard when asked. The ice creams were so soft and squishy that they leaked a little when they were pressed. So, DC 1 brought some wipes to clean the leaked ice cream. During a concurrent observation and interview on 8/11/25 at 10:30 AM with [NAME] in the kitchen, the ice cream freezer temperature was still 35 F. [NAME] stated, I think it's below negative 5 when asked about the appropriate temperature for the freezer. [NAME] stated, No when asked if the ice creams were frozen. [NAME] acknowledged, the freezer temperature for the ice cream in the kitchen was out of range. [NAME] stated, 26 for strawberry flavored ice cream and 15 for vanilla flavored ice cream when asked how many unfrozen ice creams there were. [NAME] stated, the ice creams should be frozen when asked, then he threw out all ice creams. During a concurrent interview and record review on 8/13/25 at 1:43 PM with IDD, the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 was reviewed. The P&P indicated, . ce cream and frozen foods 0 F or less . IDD stated, Yes, it is ice cream, when asked what ce cream means. IDD acknowledged, the freezer temperature above 0 F was out of range and ice cream should be frozen hard in the freezer. Review of P&P titled, IC 8-F: INFECTION CONTROL-NUTRITION AND FOOD SERVICES revised in December 2022 indicated, . K. Chilling of Foods . Freezer temperatures are held at below 0 degrees Fahrenheit . 4. During a concurrent observation and interview on 8/11/25 at 11:15 AM with [NAME] in the kitchen storage room, there were 6 packs of MY OWN MEAL FLORENTINE LASAGNA on a shelf, labeled [DATE]/23. [NAME] stated, [DATE]/23 means the kitchen received the lasagna packs in October 2023 when asked. The lasagna packs themselves indicated, . FULLY COOKED & READY TO EAT . NO REFRIGERATION NEEDED . BEST BY 07/2025 . [NAME] stated, BEST BY 07/2025 means they should have used the lasagna until July 2025 when asked. [NAME] acknowledged, all 6 packs of MY OWN MEAL FLORENTINE LASAGNA were expired when asked. [NAME] stated, I need to throw away, then he threw all of them away. [NAME] stated, all 6 packs of MY OWN MEAL FLORENTINE LASAGNA should not be used. During an interview on 8/15/25 at 3:11 PM with Infection Preventionist (IP), IP stated, the food past the Use By or Best By dates should be discarded when asked. IP stated, there is a risk of infection, such as foodborne illnesses, if residents eat food past the Use By or Best By dates. 5. During a concurrent observation and interview on 8/12/25 at 3:29 PM with Interim Dietary Director (IDD) in the kitchen, the facility's dish machine was observed. IDD stated, their dish machine is a high-temperature dishwasher. IDD stated, the wash temperature should be above or equal to 160 F, and the final rinse temperature should be above or equal to 180 F for the dish machine. During a concurrent interview and record review on 8/12/25 at 3:33 PM with Food Service Aide (FSA) 2 in the kitchen, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 and August 2025 were reviewed. The DISHMACHINE TEMPERATURES in June 2025 indicated, the dish machine temperatures did not reach 180 F for final rinse on the following dates: 1) 6/9/25; 2) 6/10/25; 3) 6/11/25; 4) 6/12/25; 5) 6/13/25; 6) 6/24/25; 7) 6/25/25; 8) 6/26/25; 9) 6/30/25. The DISHMACHINE TEMPERATURES in August 2025 indicated, the dish machine temperatures did not reach 180 F for final rinse on the following dates: 1) 8/3/25; 2) 8/4/25; 3) 8/5/25; 4) 8/6/25; 5) 8/11/25; 6) 8/12/25. During a concurrent interview and record review on 8/12/25 at 3:38 PM with IDD in the kitchen, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 and August 2025 were reviewed. IDD stated, It did not reach the temperature when asked if the dish machine temperatures reached 180 F for final rinse on the following dates: 1) 6/9/25; 2) 6/10/25; 3) 6/11/25; 4) 6/12/25; 5) 6/13/25; 6) 6/24/25; 7) 6/25/25; 8) 6/26/25; 9) 6/30/25; 10) 8/3/25; 11) 8/4/25; 12) 8/5/25; 13) 8/6/25; 14) 8/11/25; 15) 8/12/25. During a concurrent observation and interview on 8/13/25 at 1:01 PM with Territory Representative of ***** (Name of the company regarding dishmachine) in the kitchen, the dish machine temperature reached 180 F for final rinse. The representative verified, there was no issue with the dish machine. During an interview on 8/13/25 at 1:17 PM with IDD, IDD stated, They (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be better, when asked about the kitchen staff's practices on the dish machine temperatures logs in June 2025 and August 2025. IDD stated, Dishwasher needs 30 minutes recovery from time of fill. IDD further stated, the kitchen staff should not use the dish machine until the correct temperatures reach. IDD stated, They need to wait, when asked. During an interview on 8/13/25 at 1:56 PM with IDD. IDD stated, they can spread infection to the entire facility if they continue to use the dish machine when it did not reach 180 F for the final rinse, when asked. Review of the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 indicated, . Dishmachine Procedure . Final rinse temperature and flow pressure gauges are accurate only when a rack enters the final rinse area and water is flowing. The acceptable temperature range for the wash cycle is 160 F and Final Rinse is 180 F-195 F . Review of the facility's P&P titled, IC 8-F: INFECTION CONTROL-NUTRITION AND FOOD SERVICES revised in December 2022 indicated, . D. Dishwashing . 2. Final rinse must be 180-195 degrees Fahrenheit . 6. During a concurrent interview and record review on 8/14/25 at 9:55 AM with IDD, the facility's log titled, DISHMACHINE TEMPERATURES in June 2025 was reviewed. The log indicated, the wash temperatures and final rinse temperatures were not documented on the following dates: 1) 6/1/25; 2) 6/2/25; 3) 6/3/25; 4) 6/4/25; 5) 6/5/25; 6) 6/6/25; 7) 6/7/25; 8) 6/8/25; 9) 6/9/25 AM; 10) 6/27/25; 11) 6/28/25; 12) 6/29/25. There was no evidence that the kitchen staff checked the dish machine temperatures on these days when asked. Review of the facility's policy and procedure (P&P) titled, FOOD SAFETY STANDARDS revised in May 2025 indicated, . Dishmachine Procedure . Temperature of wash and rinse cycle should be checked for adequacy before use . 7. Cooling is the specific method and guideline used to rapidly lower the temperature of cooked food to a safe storage level, preventing bacterial growth. Improper cooling is a major factor in causing foodborne illness. Taking too long to chill potentially hazardous food, which means food that requires time/temperature control for safety to limit the growth of pathogens, has been consistently identified as one factor contributing to foodborne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease-causing microorganisms that may have survived the cooking process (e.g., spore-formers). Cooked potentially hazardous foods that are subject to time and temperature control for safety are best cooled rapidly within 2 hours, from 135 F to 70 F, and within 4 more hours to the temperature of approximately 41 F. The total time for cooling from 135 F to 41 F should not exceed 6 hours. 2022 Food Code from U.S. Food and Drug Administration (FDA) indicated, . Improper cooling remains a major contributor to bacterial foodborne illness . Cooked hot food should be discarded immediately if the food is: Above 70 F and more than two hours into the cooling process; or Above 41 F and more than six hours into the cooling process . During a concurrent interview and record review on 8/13/25 at 10:50 AM with Interim Dietary Director (IDD) and Cook, the facility's document titled, COOKING AND COOLING LOG dated 7/28/25 was reviewed. The log indicated, it took 3 hours to check the porridge temperature, from 6 AM to 9 AM. IDD stated, food temperatures should be checked in 2 hours to ensure it reaches 70 F when asked about cooling procedures from the initial cooling temperature. IDD stated, That's 3 hours when asked how many hours from 6 AM to 9 AM. IDD and [NAME] acknowledged, the porridge temperature was not checked in 2 hours when asked. The log also indicated, it took 5 more hours to check the porridge temperature, from 9 AM to 2 PM. In addition, the gravy temperature was 112 F at 9 AM after the first 2 hours, starting from the initial cooling temperature of 180 F at 7 AM. Then it was blank after 9 AM. IDD acknowledged, 112 F at 9 AM meant it did not reach 70 F in 2 hours. IDD stated, It should be below 70 (F). The log also indicated, the tomato soup temperature was checked at 9:30 AM, then after that, it was also blank. IDD further stated, They didn't do the follow up when asked about the gravy and tomato soup. IDD acknowledged, the kitchen staff did not follow cooling procedures when asked. IDD stated, I will give them in-service. During a concurrent interview and record review on 8/13/25 at 10:55 AM with IDD, the COOKING AND COOLING LOG dated 7/30/25 was reviewed. The log indicated, the rice temperature was 110 F at 9 AM, two hours after starting to cool from the initial temperature of 175 F at 7 AM. IDD stated, The temperature was not right, when asked about 110 F at (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9 AM. During a concurrent interview and record review on 8/13/25 at 10:57 AM with IDD, the COOKING AND COOLING LOG dated 8/3/25 was reviewed. The log indicated, the porridge temperature was checked at 8 AM after 4:48 AM when the initial cooling temperature was checked. IDD stated, That's 3 hours, when asked. During a concurrent interview and record review on 8/13/25 at 11 AM with IDD, the COOKING AND COOLING LOG dated 8/8/25 was reviewed. The log indicated, the porridge temperature was 110 F at 8:50 AM two hours after starting to cool from the initial temperature of 173 F at 6:50 AM. IDD stated, The temperature was not low enough when asked if the porridge temperature 110 F at 8:50 AM was good enough. During a concurrent interview and record review on 8/13/25 at 11:04 AM with IDD, the COOKING AND COOLING LOG dated 8/12/25 was reviewed. The log indicated, the porridge temperature was 78 F at 8 AM after the initial cooling temperature was 179 F at 5 AM. IDD stated, It's wrong. It should be reached 70 (F) within 2hours, when asked. During a concurrent interview and record review on 8/13/25 at 11:05 AM with IDD, COOKING AND COOLING LOG dated 8/13/25 was reviewed. The log indicated, the porridge temperature was 68 F at 8 AM after the initial cooling temperature was 179 F at 5 AM. IDD stated, It's 3 hours. Below 70 (F) within 2 hours, when asked how many hours from 5 AM to 8 AM. During a concurrent interview and record review on 8/13/25 at 1:12 PM with IDD, the COOKING AND COOLING LOG from July 2025 to August 2025 were reviewed. The logs indicated, INSTRUCTIONS . Internal temperature must reach 70 F within 2 hours of reaching 140 F . Internal temperature must reach 41 F or below within 4 hours of reaching 70 F . IDD stated, This form needs to be changed. It's confusing, when asked about the instructions on the logs. During an interview on 8/13/25 at 1:19 PM with IDD, IDD acknowledged, they did not follow cooling procedures when asked. IDD acknowledged, the instructions on the COOKING AND COOLING LOG were not correct. During a concurrent interview and record review on 8/14/25 at 9:45 AM with IDD, the facility's P&P titled, FOOD SAFETY STANDARDS revised in May 2025 was reviewed. The P&P indicated, . Cool food down rapidly to 41 F within 4 hours . If food temperature is more than 70 F after 2 hours, move to freezer to finish . Cooling and check after 4 hours . If food temperature is above 41 F after 4 hours, discard . IDD verified, it is not the right practice when asked about If food temperature is more than 70 F after 2 hours, move to freezer to finish. IDD stated, they should not use the food if its temperature exceeds 70 F after 2 hours from the initial cooling temperature. IDD acknowledged, the P&P was not fully correct. IDD stated, she will check 2022 Food Code from FDA, and change the P&P. IDD stated, she stopped the cooling procedure in the kitchen currently. IDD stated, the kitchen staff need in-service first before restarting the cooling procedure.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure valid copy of the Physician Orders for Life-Sustaining Treatment (POLST, a written medical order that assists people in making decisions about medical treatment and life saving measures during end-of-life care or medical crisis) for two of 26 sampled residents (Resident 5 and Resident 6) had complete and accurate information.1. For Resident 5, the POLST indicated Do Not Attempt Resuscitation (DNR, a medical order instructing healthcare professionals not to perform CPR (chest compressions, cardiac drugs, or intubation) if a person's heart stops or they stop breathing) and Selective Treatment, which conflicted with the physician's order stating, FULL CODE-DNR-Comfort Focused Treatment, resulting in inconsistent documentation regarding the resident's code status.2. For Resident 6, the POLST was missing required information of the resident, physician, and legally recognized decision maker. The deficient practice may result in Resident's end-of-life choices not being honored.1. Review of Resident 5's admission record indicated, was admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), drug induced subacute dyskinesia (a disorder of involuntary, repetitive muscle movements of the face, body, or limbs caused by medications), anxiety (a natural emotion that becomes a disorder when persistent worry interferes with daily life), and mild neurocognitive disorder due to known physiological condition with behavioral disturbance (indicates a decline in cognitive abilities (like memory, language, or problem-solving) that is noticeable but doesn't significantly impair daily functioning, and is caused by an identified medical condition, with accompanying behavioral changes). During further review, the admission record indicated there was no advance directive stored in Resident 5's clinical record. Review of Resident 5's active orders for [DATE] indicated an order dated [DATE], FULL CODE -DNR-Comfort Focused Treatment - No artificial nutrition, including feeding tubes.During a concurrent interview and record review on [DATE] at 10:39 AM, Registered Nurse (RN) 3 stated Resident 5 has no advance directive. RN 3 then reviewed Resident 5's POLST to verify code status. The POLST indicated the Date Form Prepared section was left blank (undated). The undated POLST indicated, Do Not Attempt Resuscitation/DNR.Selective Treatment.No artificial means of nutrition, including feeding tubes.Advance Directive not available. The undated POLST was signed by the Nurse Practitioner on [DATE] and the legally recognized decision maker on [DATE]. Review of the Social Services Quarterly assessment dated [DATE] for Resident 5 indicated, the code status was FULL CODE-DNR-Comfort Focused Treatment - No artificial nutrition, including feeding tubes.During an interview on [DATE] at 11:29 AM, Social Worker (SW) 1 stated that Resident 5's daughter did not attend the care conference meeting on [DATE] and was not able to verify the code status. During a concurrent interview and record review on [DATE] at 4:32 PM, the Director of Nursing (DON) reviewed Resident 5's POLST and physician's order for code status. The DON confirmed the two documents were inconsistent and stated that FULL CODE and DNR are conflicting orders. 2. Review of Resident 6's admission record indicated, was admitted on [DATE] with diagnoses including peripheral vascular disease (PVD - refers to reduced blood circulation in the limbs and organs other than the heart and brain, most commonly caused by atherosclerosis, or the narrowing and hardening of blood vessels due to fatty plaque buildup), stroke, and functional quadriplegia (complete immobility of all four limbs due to a severe physical disability or frailty from a condition other than a spinal cord injury).During a concurrent interview and record review on [DATE] at 10:39 AM, RN 2 reviewed Resident 6's POLST to verify code status. The Date Form Prepared was left blank (undated) and Section D of the POLST indicated no signature and mailing address of the legally recognized decisionmaker. Additionally, second page of the POLST form lacked the required information, including the resident's name, date of birth , gender; the physician's name; name and phone number of the Resident 6's additional contact; and the preparer's name and (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone number. During concurrent interview, RN 2 stated the form was not fully completed. Review of Resident 6's undated POLST indicated, .A copy of the signed POLST form is a legally valid physician order . To be valid a POLST form must be signed by (1) physician, or by a nurse practitioner.and (2) the patient or decisionmaker.Review of the facility's policy and procedure titled, POLST - Physician Orders for Life Sustaining Treatment, revised 6/20, indicated, .3. Completing a POLST Form with the Patient . B. A health care provider such as a nurse or social worker can explain the POLST form the patient's legally recognized health care surrogate decision maker . D. The POLST form is to be completed based on the patient's expressed treatment preferences and medication condition. If the patient lacks surrogate decision-making capacity and the POLST form is completed with the patient's legally recognized health care surrogate decision maker, it must be consistent with the known desires of and in the best interests of the patient.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to safeguard the personal property for one of 3 sampled residents (Resident 63) whose cellphone was reported missing on 2/9/25. Additionally, the facility failed to ensure the missing cellphone was replaced in accordance with the facility's Theft and Loss Policy. These failures resulted in the loss of Resident 63's cellphone; and may disrupt communication with family and friends and decrease sense of safety and trust in the facility's ability to protect residents and their belongings. Review of Resident 63's admission record indicated, was admitted on [DATE] with diagnoses including high blood pressure and vascular dementia with behavioral disturbance (a form of cognitive decline caused by reduced blood flow to the brain, often resulting from strokes or other vascular issues where a person experiences significant functional limitations and exhibits behavioral changes). Review of the quarterly Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/8/25 indicated, Resident 63 presents with moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. Review of Resident 63's Patient's Belongings Record dated 11/9/23 indicated that one (1) cellphone with charger was documented. Review of the Resident Progress Notes dated 2/9/25 indicated, During rounds with checking patient personal gadget/belonging, observed cellphone is missing. Cellphone includes in personal belonging lists upon admission. Tried to look on patients closet, bag, drawer, and dresser unable to find cellphone. per RP (resident representative) cellphone was a gift from the student. Theft/loss form completed and submitted. During an interview on 8/13/25 at 11:06 AM, confirmed that Resident 63's missing cellphone was listed on the belongings inventory and stated that they were unable to find the cellphone. Review of the Interdisciplinary Team (IDT - a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident) Note dated 2/9/25 indicated that Resident 63's missing cellphone was discussed. The IDT Note indicated the incident was reported to the police and appropriate state agencies. Additionally, the IDT Note indicated that Resident 63's former student visited the facility and provided the value of the cellphone, which was reported as \$130.00 with a monthly payment of \$15.00. Resident 63's former student and the facility attempted to contact the cellphone but were unsuccessful. During an interview on 8/13/25 at 11:12 AM, the Director of Nursing (DON) stated that the facility did not replace Resident 63's missing cellphone because the cellphone could not be located. The DON further explained that, according to the facility's Theft and Loss Policy, the Social Worker (SW) will arrange for replacement if the missing item is listed in the inventory list. During an interview on 8/13/25 at 3:14 PM, SW 1 stated that if a missing item is listed on the resident's inventory list, it will be reimbursed. If the item is not listed, efforts must be made to locate it. Review of the facility's policy and procedure titled, Theft and Loss, revised 8/20, indicated, The hospitals will provide for the safeguarding of the personal possessions of both residents and staff . 6. The Social Worker arranges for replacement if needed.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of abuse was reported immediately, not later two (2) hours after the allegation was made, as required by regulation involving resident 77. This failure resulted in a delay in reporting an abuse allegation and had potential to place all residents at risk for further abuse. A review of Resident 77 clinical document, titled Nurses Notes, dated 5/6/2025 at 12:14PM, the Nurses Notes indicated, incident dated 4/26/2025: redness under the left eye) Bruise? Reported to law enforcement asked the case number then she said that the police will come to investigate. SOC 341 was faxed to the following: Ombudsman - 650 364 5399, State - # 415 330 6350 Social worker ([NAME]) was informed that the IDT team decided to report the incident and CARE CONFERENCE (IDT) needed to cover regarding the incident that occurred on 4/26/2025. A review of SOC 341 (a form used in California for reporting suspected elder or dependent adult abuse) dated 5/6/2025. SOC 341 indicated, Date Completed 5/6/2025. Date/Time of incident 4/26/2025, E. Abuse resulted in other: discoloration under the left eye (red in color). F. When the pt's son came to visit he noticed a reddish discoloration under the left eye (Bruise?) (0.5cm x 2.8cm), Skin intact, no swelling, then he said who punched my mom?. Investigation started. During an interview on 08/15/2025 at 3:14 PM with Nurse Manager (NM)1, NM1 stated, I know we had a wrong Judgement about the incident, I know that we should report it in 2 hours. During an interview on 8/15/2025 at 4:43PM with Registered Nurse (RN)1, RN1, stated, When the son of resident 77 saw that there was a bruise or discoloration under the eye, the nurse supervisor started to investigate, it was not reported because the son was satisfied of the plan of care, but it should be reported right away.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation on an allegation involving physical and emotional abuse for one of 2 sampled residents (Resident J). Failure to thoroughly investigate an allegation of abuse did not ensure other residents were protected from abuse. A review of the face sheet indicated Resident J was admitted with diagnoses including injury to cervical (neck) spine, quadriplegia (loss of movement and sensation to arms and legs), osteoporosis (fragile bones), osteoarthritis (pain, swelling of the bones and joints), bipolar disorder (a mental illness that affects a person's energy, thoughts, and unusual shifts in mood from extremely highs [manic episode] to lows [depression], and anxiety (excessive, persistent feeling of worry and nervousness). A review of the minimum data set (MDS, a standard assessment tool) brief interview of mental status (BIMS, a brief memory test to help determine cognitive ability [ability to remember and make decision]) score of 14 indicated Resident J was cognitively intact. Under functional status, Resident J required physical assistance from two staff for dressing, mobility, and transfer. During an interview on 12/9/25, at 1:52 PM, Resident J stated that on 10/5/25, she was awakened by CNA 1's loud voice. Resident J stated CNA1 was upset that the day shift CNA put to her bed on her street clothes. Resident J stated CNA 1 was complaining and talking about it repeatedly. Resident J stated CNA 1 was tagging her, pushing and grabbing her. Resident J stated she kept interrupting CNA1, but CNA 1 was so upset and did not hear her when she asked her to stop. Resident J stated that CNA 1 spoke in Tagalog during the incident. Resident J further stated that she asked CNA 1 to not care for her any further. Resident J stated CNA 2 who was assisting CNA 1 during the incident did not intervene. During an interview on 12/9/25, at 3:04 PM, Social Services Director (SSD) stated that the allegation of abuse on 10/5/26 was addressed to her on 10/9/25. SSD reviewed her notes dated 10/13/25 which indicated Resident [NAME] stated that the CNA held her tightly and quickly while providing care and that the CNA appears mad. SSD visit notes dated 10/14/25, indicated Resident stated everything was okay and has no further issues. During an interview on 12/10/25, at 2:03 PM, the DON stated that she had multiple interviews with Resident J. The DON stated that she checked Resident J's left hand and, There was nothing. During a concurrent interview on 12/10/25, at 3:46 PM, the DON reviewed the facility investigation summary, dated 10/23/25, which indicated that on 10/9/25, the physician (medical doctor) was notified of the abuse allegation and gave an order to monitor Resident J's feeling upset about the incident. The Assistant Director of Nursing (ADON) reviewed Resident J's record and stated the physician order was not carried out and monitoring for Resident J was not started. A review of the facility Policy and Procedure titled, Abuse, Elder and Dependent Adult, dated 9/2025, indicated, .This procedure relates to anonymous, vague and/or unverified reports alleging that abuse has occurred as well as substantiated abuse. All staff members are responsible for reporting any witnessed or alleged abuse. Do not assume that someone else has reported the incident. If the incident was witnessed, take measures to protect the residents immediately. Remove the resident from the area to a safe place or instruct the individual in question to leave the room or the area. If the incident was not witnessed but reported by a resident, calm the resident before leaving resident to report it. Notify the DON, Nurse Manager, Charge Nurse or Administrative Nurse Supervisor of the incident. Be as detailed as possible about the incident. Note time, where it happened, witnesses who may have seen something, the condition of the resident, and any other details related to the incident. Complete an event report including all the above-mentioned details. For Physical abuse, complete a physical assessment of the resident including vital signs and document in medical record any signs of injury that might have occurred. Request physical assessment by a physician.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA, is a comprehensive assessment for a resident that must be completed when the IDT (Interdisciplinary Team) has determined that a resident meets the significant change guidelines for either major improvement or decline) for one of 26 sampled residents (Resident 56) who had a significant change in status on 1/20/25. The deficient practice may result in delayed provision of care, treatment, and services for Resident 56. Review of Resident 56's admission record indicated, was readmitted to the facility on [DATE] with diagnoses including stroke, gastrostomy (stomach) status (refers to the presence of a gastrostomy tube [G-tube] surgically created opening in the stomach through which a tube can be inserted for feeding or other purposes), high blood pressure, kidney disease, osteoarthritis (joint disease that causes pain, stiffness, and swelling), and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). Review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated, Resident 56 had a SCSA with an Assessment Reference Date (ARD, specific endpoint for the look-back periods in the MDS assessment process) of 1/28/25. The MDS SCSA indicated that the assessment was signed as complete by the Registered Nurse (RN) Assessment Coordinator on 2/14/25. During concurrent interview and record review on 8/15/25, at 10:22 AM, MDS Coordinator (MDSC) 1 reviewed Resident 56's MDS assessments and stated Resident 56 was determined to have had a significant change in status when he was readmitted on [DATE] with a G-tube. MDSC 1 reviewed Resident 56's SCSA with an ARD of 1/28/25 and confirmed the assessment was completed on 2/14/25, four (4) days late. MDSC 1 stated that Resident 56's SCSA should have been completed on 2/10/25. Furthermore, MDSC 1 stated that a significant change in status assessment should be completed 14 days after a significant change in status was determined. According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, dated October 2024, indicated, .The OBRA (Omnibus Budget Reconciliation Act of 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents . The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline . A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure one of 26 sampled resident's (Resident 97) Minimum Data Set (MDS, a standard assessment tool) included the medical diagnosis of osteopenia (fragile bones). This facility failure resulted in inaccurate MDS to reflect the current health status for Resident 97. A review of the physician progress notes dated 4/24/25, indicated the diagnoses for Resident 97 included dementia (decline in memory or other thinking skills), diabetes (abnormally high blood sugar level) and hypertension (abnormally high blood pressure). A review of the facility reported incident dated 5/4/25, indicated on 4/25/25, Resident 97 fell out of bed and sustained a fracture (broken bone) through the right femur (thigh bone). A review of the facility reported incident dated 5/4/25, the result of the imaging (a procedure used to create a picture of the inside of the body) that was completed on 4/25/25, indicated Resident 97 has osteopenia (fragile bones). A review of the Minimum Data Set (MDS, a standard assessment tool, used to provide an individualized, resident centered care) dated 7/29/25, did not indicate osteopenia for Resident 97. During an interview on 8/15/25, at 2:38 PM, the MDS Coordinator (MDSC) 1 reviewed the electronic record for Resident 97 and acknowledged osteopenia was not entered in the MDS. MDSC 1 further stated, addressing osteopenia is significant because the resident is at risk for injury and fracture. A review of the facility Policy and Procedure titled, Assessment - MDS and CAA dated 9/2011, indicated, .There shall be a process in place for resident assessment on admission and ongoing reassessment which includes the completion of the MDS and Care Area Assessment . Residents are reassessed following a significant change in condition and/or as needed, and at a regularly scheduled times, example (i.e.) weekly by the assigned Team Leader, quarterly, and annually by the entire IDT .		

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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. Based on observation, interview, and record review, the facility failed to ensure one of 26 sampled residents (Resident 97) had a comprehensive care plan completed to address osteopenia (fragile bones). This facility failure had potential for Resident 97 to not receive necessary care and services. A review of the physician progress notes dated 4/24/25, indicated the diagnoses for Resident 97 included dementia (decline in memory or other thinking skills), diabetes (abnormally high blood sugar level) and hypertension (abnormally high blood pressure). A review of the facility reported incident dated 5/4/25, indicated on 4/25/25, Resident 97 fell out of bed and sustained a fracture (broken bone) through the right femur (thigh bone). A review of the facility reported incident dated 5/4/25, the result of the imaging (a procedure used to create a picture of the inside of the body) that was completed on 4/25/25, indicated Resident 97 has osteopenia (fragile bones). A review of the Minimum Data Set (MDS, a standard assessment tool, used to provide an individualized, resident centered care) dated 7/29/25, did not indicate osteopenia for Resident 97. During an interview on 8/15/25, at 2:38 PM, the MDS Coordinator (MDSC) 1 reviewed the electronic record for Resident 97 and acknowledged there was no comprehensive care plan completed to address osteopenia and stated, addressing osteopenia is significant because the resident is at risk for injury and fracture. The MDS Coordinator further stated the nurses are responsible in completing the residents care plan and the MDS reviews the completed care plan. A review of the facility Policy and Procedure titled Nursing Process, Plan of Care and Documentation dated 7/2017. Indicated, .The plan of care is individualized for each resident (patient) based on the information gathered through the nursing process. In addition, nurses must review physician progress notes to become familiar with the medical treatment plan as well as any changes in condition. As resident's needs are identified, it is the responsibility of the healthcare team to prioritize, and service delivered to assure that the residents needs are met. While the physician is recognized as being responsible for the prioritization of medical as well as overall care of the resident, each discipline likewise prioritizes the provision of their services respective to their level of involvement in the resident's care. The multidisciplinary Plan of Care may be initiated, reviewed or revised by other professional health care disciplines.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively assess, evaluate, and implement interventions consistent with the nutritional status for one of three sampled residents (Resident A) when: 1. The facility did not initiate a change of condition report to address Resident A's weight loss of 7.8 pounds (lbs.) within a month after it was identified on 10/7/25. 2. The facility failed to develop a care plan to address Resident A's weight loss of 7.8 pounds as identified on 10/7/25. 3. Weekly weight evaluations were not implemented in accordance with the facility's policy. 4. There was no documented follow up assessment, actions, or interventions by a Registered Dietitian (RD, a health professional with special training in diet and nutrition) to address Resident A's weight loss. These failures had the potential to result in continued weight loss and poor nutritional status, which could negatively impact Resident A's overall health and well-being. Review of Resident A's admission record indicated, was admitted to the facility on [DATE] with diagnoses including congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), schizoaffective disorder (a mental health condition that includes symptoms of both schizophrenia and mood disorders), drug induced subacute dyskinesia (a neurological disorder characterized by involuntary movements of the face and jaw), and unspecified dementia (a group of symptoms affecting memory, thinking and social abilities). Review of the progress note titled SBAR (a communication framework for sharing information with teams and stands for Situation, Background, Assessment, and Recommendation or Requests), dated 10/1/25, indicated, Situation: Resident has been noted with episodes of refusing meals, mostly breakfast or lunch, and/or medications intermittently for the past 4 days. Resident has extensive history of self-restricting food intake due to preference where in resident engages in periods of fasting for religious and personal reasons. Recommendations: MD (medical doctor) [name] made aware and ordered MVI (multivitamins) with minerals daily for supplement as recommended by pharmacy. Continue to monitor self-restricting food behavior and refusal of medications. Consult with Registered Dietitian for any further recommendation regarding food preference. RP (responsible party) made aware. Care plan updated. Review of Resident A's Nutrition/Dietary Note dated 10/7/25 indicated, .Summary: Resident present with significant weight loss of 11.3% in 6 months. Weight loss likely due to resident refusing meals x 9 days to which he claims is because he is 'fasting' RD met with resident to encourage resident to eat and to obtain food preferences, however resident continues to refuse. ONS (oral nutrition supplement) with meals for wt. (weight) maintenance and overall status d/t (due to) age and dx (diagnosis). Goals for resident are to maintain nutrition status and weight without significant changes with PO intake >75%. Will continue (continue) to monitor nutritional parameters, weights, honor preferences, and f/u per MNT protocol. Weight Hx (history) -4.8% in 1 mo (month), -5.4% in 3 mo, -11.3% in 6 mo. Nutrition Recommendations: 1. Continue with diet order + ONS. 2. Encourage intake/fluids and honor food preferences. 3. Monitor wt, intake, and other nutrition parameters for any significant changes. Review of Resident A's Nursing Note dated 10/7/25 indicated, .resident has significant weight loss. (per resident he is fasting). Pt (patient) has hx of self-restricting meals secondary to fasting, Dx. schizophrenia and Dementia. During a concurrent interview and record review with Registered Nurse (RN) 2 on 12/8/25 at 4:30 PM, the weights and vitals summary for Resident A was reviewed. The weights and vitals summary indicated that Resident A's weight had decreased from 161.5 lbs. on 9/5/25 to 153.7 lbs. on 10/7/25. RN 2 stated that Resident A had not been eating due to self-imposed fasting. Review of Resident A's weights and vitals summary from August 2025 to December 2025 indicated the following weights: 08/02/2025 01:42 131 lbs. (Standing); 09/05/2025 08:09 161.5 lbs. (Standing); 10/07/2025 08:24 153.7 lbs. (Mechanical Lift); 11/04/2025 10:48 135.2 lbs. (Standing); 11/11/2025 12:56 153.7 lbs. (Standing); 11/28/2025 15:24 153.7 lbs. (Standing); (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/04/2025 10:42 147.5 lbs. (Standing).During an interview on 12/8/25 at 4:42 PM, RN 2 confirmed that the indicated weight of 153.7 lbs. taken on 10/7/25 was the only recorded weight for October 2025. RN 2 stated that no weekly weights were taken after 10/7/25 despite Resident A experiencing a significant weight loss. During a concurrent interview and record review with RN 1 on 12/9/25 at 9:51 AM, Resident A's clinical record including progress notes, assessments, and care plan was reviewed. RN 1 stated that a change in condition (referring to SBAR) was completed on 10/1/25 due to Resident A refusing meals and medications. RN 1 also stated that the RD made a note regarding Resident A having a significant weight loss on 10/7/25. During a record review, RN 1 did not find documentation of a change of condition, nutritional assessment, or care plan after Resident A's significant weight loss on 10/7/25. RN 1 confirmed there was a Risk for Altered Nutrition Status care plan, however, none of the care plan addressed Resident A's actual weight loss. Furthermore, RN 1 confirmed that a change of condition and care plan should have been completed, and weekly weights should have been initiated.Review of the Health Status Note dated 10/8/25 indicated, IDT (Interdisciplinary Team- a group of healthcare professionals with various areas of expertise who work together toward the goals of the residents): Care Conference with Brother.Resident is fasting for 2 weeks now. Resident has history of fasting yearly but this year it's more frequent. Recommendation: 1. Continue with diet as ordered. 2.encourage and offer food daily. 3. Provide fluid often and offer snack often as schedule. 4. Psyche as needed. 5. Nursing will continue to monitor behavior q shift. During an interview on 12/9/25 at 10:08 AM, RN 1 stated that the Interdisciplinary Team (IDT- a group of healthcare professionals with various areas of expertise who work together toward the goals of the residents) did not address Resident A's weight loss during the care conference meeting with Resident A's brother. RN 1 further stated that the IDT's recommendations did not include a plan to address the weight loss.Review of the physician's progress note dated 10/28/25 indicated, .10/22/2025.noted with persistent poor intake. Psychiatry service will continue to follow him. Assessment and Plan: .Noted with poor p.o. intake.Dietitian to reevaluate for nutrition support.During an interview and record review with the Charge Nurse (CN) on 12/9/25 at 1:55 PM, the nutritional assessment for Resident A was reviewed. The Charge Nurse did not find any follow-up assessment or notes on Resident A's weight loss. The last dietitian note for Resident A was a readmission note dated 7/14/25. During an interview on 12/9/25 at 3:01 PM, the RD confirmed Resident A's weight loss of 7.8 lbs. from 9/5/25 (161.5 lbs.) to 10/7/25 (153.7 lbs.). The RD stated that Resident A was placed on weekly weight checks and intake monitoring after the weight loss. However, the RD could not provide documentation of a follow-up assessment or re-evaluation of interventions for the weight loss.Review of the facility's policy and procedure titled Nursing Assessments, revised 4/25, indicated, A nursing assessment will be completed by staff for each admission, quarterly, annual and change of condition. These assessments will provide a data base from which to construct individualized treatment plans based on the strengths, deficits, and behavioral needs of residents . Documentation of Nursing Assessment will include: .Nutritional screen.Review of the facility's policy and procedure titled Weight Monitoring and Weight Variance, revised 8/25, indicated, Purpose: Residents are weighed regularly to monitor significant changes and/or changes in condition . Procedure. 5. Significant weight changes are defined as following: A. 3 pounds in one month for residents weighing less than 100 pounds; 5 pounds in one month for residents weighing >100 pounds. B. 5.0% total body weight in one month. C. 7.5% total body weight in three months. D. 10.0% total body weight in six months. 6. Significant weight changes initiate the following actions: A. Weekly weights for four weeks . C. Licensed nurses initiate a Change of Condition (COC). D. Interdisciplinary Weight Variance Team (IDT) reviews all weight changes . 9. Residents on weight variance are reviewed weekly until weight stabilizes .		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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** Based on observation, interview, and record review, the facility failed to ensure staff followed their infection control policy and procedure (P &P), when a Licensed Vocational Nurse (LVN) did not perform hand hygiene between glove changes during medication administration. This failure had the potential to expose residents to cross contamination and increase the risk of infection. During medication administration observation on 8/13/2025 at 10:04AM, room [ROOM NUMBER], LVN1 was preparing medications wearing gloves, LVN 1 was observed removing her gloves, checking the computer and donning a new pair of gloves without performing hand hygiene. During an interview on 8/13/2025 at 10:15 AM, LVN 1 acknowledged forgot to do hand hygiene before putting on a new pair of gloves, yes I know I should perform hand hygiene first. During a review of the facility's policy and procedure (P & P) titled, IC 2-I: Hand Hygiene, dated 5/2019, the P & P, indicated, To prevent the spread of infection to patients and healthcare workers by breaking the cycle of infection. Skin is a significant source of microbial contamination. To be in compliance with the Guidelines for Hand Hygiene in Health Care Settings from the Centers for Disease Control and Prevention . C. Hand sanitation with an alcohol-based hand sanitizing product (liquid, gel or foam) may be performed when hands are not visibly soiled. 11. Before and after preparing and administering medications. 12. Before putting on gloves. 13. After removing gloves.		