STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555418	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Healthcare Center	718 Bartlett Ave Hayward, CA 94541

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38534 Based on interview and record review, the facility failed to ensure adequate supervision of two of three sampled residents (Resident 1 and Resident 2). The facility failed to ensure the two residents who were roomed together and had the same surname were properly identified by facility staff before initiating a transfer for dialysis treatment. The facility failed to ensure staff properly identified Resident 1 so Resident 1 could be sent for dialysis treatment (a treatment for kidney failure to remove waste products and excess fluids by external filtration of blood). These failures resulted in Resident 2 being unnecessarily transported to the dialysis center, and a one-hour delay in pick-up for Resident 1's dialysis treatment. For Resident 1, the one-hour delay in pick-up for dialysis had the potential to result in shortened or unavailable dialysis treatment. For Resident 2, the unnecessary trip caused emotional distress. Findings: A review of Resident 1's Admission Record, undated, indicated Resident 1 was admitted to the facility with multiple diagnoses including end stage renal disease (a permanent condition where the kidneys are no longer able to function and filter waste from the blood. This leads to a buildup of toxins in the body that can be life-threatening if not treated with dialysis or a kidney transplant). The Admission Record indicated Resident 1 had a family member as the responsible party. A review of Resident 1's physician Order Summary Report, dated active orders 8/19/24, indicated an order with start date 8/14/24, for a dialysis schedule three times a week on Tuesday, Thursday and Saturday. The order indicated Resident 1 should be picked up for dialysis between 7:20 a.m. and 7:50 a.m.; dialysis treatment time from 8:15 a.m. to 12:15 p.m.; return to facility 12:15 p.m. to 12:45 p.m. During an interview on 8/26/24 at 11:52 a.m. with the Director of Nursing (DON), the DON stated when Resident 1 was admitted the only bed available was in the same room as Resident 2. The DON stated both Resident 1 and Resident 2 had the same surname. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24, at 12:33, with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was sent to dialysis instead of Resident 1 on 8/17/24. LVN 1 stated the transport crew arrived to take Resident 1 to dialysis while LVN 1 was reporting off to the oncoming shift. LVN 1 stated LVN 1 had showed the transport crew Resident 1's room location but did not go into the room to identify Resident 1 to the transport crew. During an interview on 8/26/24 at 12:03 p.m. with the DON, the DON stated Resident 1 was scheduled for pick-up for dialysis at 7:20 a.m. to 7:50 a.m. for an 8:15 start time of dialysis. DON stated on August 17, Resident 1 was picked up for dialysis at 8:30 a.m. A review of Resident 1's nursing progress note dated 8/17/24 at 10:04 a.m., the note indicated Resident 1 left for dialysis around 8:30 a.m. During an interview on 8/23/24 at 2:20 p.m. with a family member of Resident 1, the family member stated Resident 1 was admitted to the facility and roomed with another resident with the same last name. The family member stated on 8/17/24, facility staff had sent Resident 1's roommate, Resident 2, to dialysis instead of sending Resident 1. The family member stated the family was worried the dialysis center would refuse to treat Resident 1 if treatments were missed as they were on August 17. A review of Resident 2's Admission Record, undated, indicated Resident 2 was admitted to the facility with multiple diagnoses including lung cancer. The Admission Record had no diagnosis for kidney impairment. The Admission Record indicated Resident 2 was his own responsible party. A review of Resident 2's nursing progress note dated 8/17/24, indicated Resident 2 had been transported to the dialysis center this morning, but had arranged soon after for the transport crew to return Resident 2 to the facility. During an interview on 8/26/24 at 12:55 p.m. with Resident 2, Resident 2 stated he was sent to the dialysis center instead of his roommate, Resident 1. Resident 2 stated after he arrived, dialysis staff realized he shouldn't be at the dialysis center and sent him back to the facility. Resident 2 stated the trip to the dialysis center was unnecessary and he was still upset by the trip. Resident 2 stated he could be harmed if dialysis had been provided to him, and now he distrusted the facility.