

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER San Luis Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Bishop Street San Luis Obispo, CA 93401	

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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation, interview, and record review, the facility failed to have the most recent recertification survey results posted and readily accessible to residents, family members, and to the resident's legal representatives. This facility failure denied the opportunity for residents, family members, and resident legal representatives to be aware of the facility's survey results. During a concurrent observation and interview on 7/30/25 at 8:56 a.m. with Administrator Assistant (AA), the survey results or survey binder were not visible in the facility areas that are prominent and accessible to the public and residents. AA stated the survey results were in a binder that is kept inside the Administration office. AA further added, the Administration office is locked after normal business hours. During a concurrent interview and review on 7/30/25 09:34 a.m. with AA, federal requirement 483.10(g)(11) was reviewed. The regulation indicated in part, The facility must (i) Post (referring to survey results) in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. AA acknowledged and confirmed the survey results were not posted in a location that was readily accessible. During a review of the facility's policy and procedure (P&P) titled, Right to Survey Results/Advocate Agency Information, undated, the P&P indicated in part, Residents may examine the results of the most recent survey of the facility conducted by Federal or State surveyors. This will include any plan of correction in effect. The facility shall make the results of the most recent survey available for examination in a place readily accessible to residents.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER San Luis Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Bishop Street San Luis Obispo, CA 93401	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a tool used to assess all residents in Medicare or Medicaid certified nursing homes) assessment accurately reflected the assessment for 2 of 8 sampled residents (Resident 11 and Resident 24) when: 1. Resident 11's functional limitations in range of motion indicated the resident had no impairment for upper extremity (shoulder, elbow, wrist, hand) or lower extremity (hip, knee, ankle, foot). 2. Resident 24's functional limitations in range of motion indicated the resident had upper extremity limitations but no impairment in the lower extremities. These failures had the potential to result in inaccurate care plans, inappropriate interventions, and unmet needs. 1. During a review of Resident #11's admission Record (AR), dated 7/30/25, the AR indicated the diagnoses included a fracture (a break in a bone) of left pubis (pubic bone on the pelvis area), acute pain due to trauma, history of falling and difficulty walking. During a review of Resident 11's Physical Therapy (PT) notes, dated 7/9/25 - 8/07/25, indicated the resident functional mobility assessment as follows: Bed mobility (roll left to right, sit to lying, lying to sitting on side of bed): substantial/maximal assistance Transfers (sit to stand, chair/bed to chair transfer): Partial/moderate assistance Ambulation (walk): Dependent During a review of Resident 11's MDS section GG for Functional Abilities, dated 7/11/25, section GG0110 indicated there was no range of motion limitations for upper (arms, hands, and shoulders) and lower (legs, feet, and hips) extremities which were contrary to the PT notes. 7/30/25 10:03 AM During a concurrent interview and review on 7/30/25 at 10:03 a.m. with Director of Nursing (DON), Resident 11's MDS section GG0110 was reviewed. The DON stated MDS section GG0110 was coded incorrectly and confirmed Resident 11 had lower extremity range of motion limitations from the pubic bone fracture and GG0110 should have been coded as a one for lower extremity impairment on one side. 2. During a review of Resident #24's admission Record (AR), dated 7/30/25, the AR indicated the diagnoses included encounter for surgical after care following surgery of the circulatory system (heart, blood vessels, blood, lymph, and lymphatic vessels and glands), embolism (obstruction by a clot of blood or air bubble) and thrombosis (a clot obstructing blood flow) of lower extremity arteries, and unspecified atherosclerosis of right leg arteries. In further review of Resident 24's History and Physical (H&P), dated 7/19/25, the H&P indicated the resident was discharged from the hospital post thromboembolectomy (surgical removal of a blood clot) with staples intact in the right groin/thigh area. During a review of Resident 24's MDS section GG for Functional Abilities, dated 7/20/25, section GG0110 was coded as 1 meaning impairment on one side of upper extremity and the lower extremity was coded as 0 meaning no impairment on either side. During a concurrent interview and record review on 7/30/25 at 3:56 p.m. with DON and Assistant Administrator (AA), Resident #24's MDS section GG0110 dated 7/30/25 was reviewed. The DON stated that Resident 24 does not have upper extremity ROM limitations but does have lower extremity range of motion limitations on one side due to post femoral (relating to femur or thigh) surgery. AA stated the MDS was not coded appropriately - upper extremity should have been coded as zero for no impairment and lower extremity should be coded as one for one side impairment. During a review of the facility's policy and procedure (P&P) titled, MDS Policy, dated October 2024, the P&P indicated Staff assigned to complete designated sections of the MDS assessments and tracking forms will do so following the coding guidance and instructions of the MDS 3.0 RAI User's Manual to insure OBRA and PDPM compliance for timeliness and accuracy of assessments. MDS nurses and coordinators will communicate this to designated facility staff in a timely manner following established procedures. MDS Sections are assigned as follows. GG - Qualified clinicians including MDS nurse, Rehab lead or designee, DON or DON designee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER San Luis Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Bishop Street San Luis Obispo, CA 93401	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one expired package of Maxorb II alginate wound dressing (material applied directly onto an open wound to keep the wound clean and promote healing) was discarded and not readily available for staff use. This failure had the potential for residents to receive expired and ineffective wound dressings. During a concurrent observation and interview on [DATE] at 11:20 a.m., with the Director of Nursing (DON), one open package of Maxorb II Alginate wound dressing with an expiration date of [DATE] was observed stored in the treatment cart. DON acknowledged the Maxorb II Alginate wound dressing is expired and should have been discarded. DON stated, it was missed. During a review of the facility's policy and procedure (P&P) titled, Medication Storage: ID1: Storage of Medications, dated [DATE], the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers .are immediately removed from stock, disposed of according to procedures for medication disposal .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER San Luis Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Bishop Street San Luis Obispo, CA 93401	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on record review, observation, and interview, the facility failed to ensure standard and transmission-based precautions were followed to prevent the spread of infections when staff did not follow handwashing protocol per infection control standards to provide hand hygiene to five of eight sampled residents (Residents 25, 24, 2, 9 and 7) before residents began eating their lunch. These facility failures had the potential to transmit and spread infection to residents, visitors, and staff. During an observation on 7/28/25 at 12:11 p.m., Certified Nursing Assistant (CNA 1) placed a lunch tray on Resident #25's bedside table and did not offer hand sanitizer or hand washing before the resident started eating. Subsequently, observed Registered Dietitian (RD) distribute Resident 7's meal tray and did not offer hand sanitizer or hand washing. During an interview on 7/28/25 at 12:30 p.m. with Resident #24, the resident stated staff normally do not offer handwashing before or after meals. During an observation on 7/30/2025 at 12:05 p.m. during meal tray distribution, RD distributed meal trays to Residents #2 and #9. The residents began eating their meals and RD walked out of the rooms without offering hand hygiene. During an interview on 7/30/2025 at 12:15 p.m. with RD, the RD acknowledged hand sanitizer and hand washing was not offered to Residents #2 and #9 when meal tray was distributed. During a concurrent observation and interview on 7/30/2025 at 12:33 p.m. with Certified Nursing Assistant (CNA 2), CNA 2 wheeled Resident #24 to room upon arrival to the facility from a doctor's appointment. CNA 2 positioned the resident to eat lunch, removed the meal tray lid, and offered to heat the food as the meal tray had been sitting on the bedside table for approximately 20-30 minutes. Resident 24 lifted the hamburger bun with uncleaned right hand and with the other hand touched the meat patty and said, You don't need to warm it up, it still feels warm. CNA 2 acknowledged hand washing or hand sanitizer was not offered before Resident 24 touched the food. During a review of the facility's policy and procedure (P&P) titled Standard Precautions, dated 2001, the P&P indicated in part, a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b. Hand hygiene is performed with ABHR or soap and water. g. Personnel assist the residents with hand hygiene before meals, after toileting and when indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER San Luis Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Bishop Street San Luis Obispo, CA 93401	
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain one of one evaporative cooler (a device for cooling air) located in the kitchen, in safe operating condition when the manufacturer's recommended preventive maintenance was not performed. This failure had the potential for the unit to transmit mold, mildew, bacteria, and other allergens on resident's food and affect the facility's indoor air quality resulting in respiratory issues or exacerbating existing health conditions for residents and staff. During a concurrent observation and interview on 7/30/25 at 4:48 p.m. with Maintenance Director (MD), an evaporative cooler was observed to be located on a kitchen window that was blowing air directly on clean dishes and towards the stove cooking area. MD stated the filters are changed every six months but could not provide maintenance records for the evaporative unit. MD stated the filter cleaning/replacement is not documented. During a concurrent interview and record review on 7/31/25 at 09:15 a.m., with MD, the facility's policy and procedure (P&P) titled Heating, Ventilation and Air Conditioning Systems, undated, and the manufacturer maintenance instructions (MMI) titled Bonaire [NAME] 4500E Owner's Manual, undated, were reviewed. The P&P indicated in part, Policy: It is the policy of this facility to properly maintain and service the heating, cooling, and ventilation system(s) as to ensure a comfortable environment for our patients as free as possible of air pollutants and odors .Procedure: Air filters and Air Record - check all air filters monthly .Record inspection, cleaning, and/or replacement, and the date in the Maintenance Log and Air Filter Log. The MMI indicated in part, Gently hose down pads from both sides to remove any buildup of salts, dust and pollen.Check the water distributor, making sure it is clear and free from blockage.Keep the water tank clean and free from sediment and algae growth.Check that the fan spins freely and that there is no build up on the blades. Check the motor for corrosion and spray with an anti-corrosive agent if necessary . MD acknowledged and confirmed the facility is not performing the preventive maintenance that is listed on the Bonaire [NAME] MMI.</p>		