

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555869	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Laurel Heights Community Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2740 California St San Francisco, CA 94115	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40478 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs when: On 4/15/24 at 10:15 AM Resident 9's call light was found on the floor and was not plugged in the wall socket. This failure created an un-individualized care and an environment that promotes neglect. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) require but the facility fails to provide them to the resident(s) resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress. FINDINGS: During a review of Resident 9's admission record, it indicated, he was admitted with diagnoses of major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain, depriving them of oxygen and nutrients), and type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) among others. During a review of Resident 9's minimum data set (MDS - an assessment tool for nursing home residents), his brief interview for mental status (BIMS - an evaluation tool to assess the resident's cognition) score was 6 indicating he has severe cognitive impairment. During observation on 4/15/24 at 10:15 A.M. in Resident 9's room, observed the resident was awake, alert, and responsive in bed. Observed he was happy to be interviewed. His bed was neat, and his belongings were stacked neatly on his nightstand. He had stuffed animals at his bedside. His left eye was closed while awake but opens when talking. During a concurrent interview and observation with Resident 9 on 4/15/24 at 10:15 A.M. in his room, when asked if he had breakfast, he stated did I have breakfast yet? observed a certified nurse assistant (CNA3) came in and answered, yes. you did. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 9 on 4/15/24, observed his call light was not within his reach. Observed a white cord on the floor. When asked where his call light was, Resident 9 did not answer. CNA3 looked for the call light and was told it was on the floor. CNA3 was asked to turn the call light on while this surveyor went out to check the light above Resident 9's door. Asked CNA3 to press it the second time but there was no light above the door. CNA3 was asked to check if the call light was plugged in the socket on the wall. Observed CNA3 pushed the curtain away from the wall, and suddenly the light was on, and CNA3 stated, it is now working. During observation, CNA3 was observed putting the call light on Resident 9's bed cover without first sanitizing the call light and the cord. CNA3 was asked to sanitize the system before putting it back within resident's reach. During an interview with LVN 1 on 4/15/24 she stated, the call light must be within the patient's reach. During an interview with the Infection Preventionist (IP) on 4/18/24 in the hallway by the med cart, he stated, oh yes, we were told about the call light. It had to be sanitized . that's infection control. During a review of the facility's policy and procedure (P&P) titled, Quality of Care, Call System, Residents, dated September 2022, the policy statement indicated: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Review of the facility's P&P titled call system, policy interpretation and implementation are as follows: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed . 2. Call system may be audible or visual. 3. The resident call system remains functional at all times . 5. The resident call system is routinely maintained and tested by the maintenance department. 6. Calls for assistance are answered as soon as possible, but no longer than 5 minutes . 7. Call light response times are reviewed as part of the QAPI program. Infection control - Please Cross Reference F880 #3		

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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** 38612 Based on record review and interview, the facility failed to complete a comprehensive assessment and failed to monitor weight weekly for one of two sampled residents (Resident 26) after Resident 26 had an unplanned, significant weight gain of 9.4% in February 2024. This failure had the potential for Resident 26 to not receive necessary treatment and care to related to the unplanned, significant weight variance, leading to medical related complications. Findings: Review of undated facility policy titled Weight Assessment and Intervention, indicated, Policy Statement - The nursing staff and the Dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation . 3. Any weight change of greater than or less than 5 (five) pounds within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will notify the physician and responsible party. 4. If the resident has a confirmed weight change of greater than or less than 5 pounds within 30 days, resident will be weighed weekly for monitoring. 5 . Negative will be assessed and addressed by the Dietitian whether or not the definition of Significant Weight Change is met. 6. Significant Weight Changes are defined as: a. More or less than 5% (percent) within 30 days . Review of undated facility policy titled Change in a Resident's Condition or Status, indicated, Policy Interpretation and Implementation . 6. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 7. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted . Review of Resident 26's admission Record, indicated Resident 26 was admitted on [DATE] with diagnoses that include non-traumatic Intracranial hemorrhage (bleeding between the brain tissue and the skull), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills), dysphagia (swallowing difficulties), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a concurrent interview with Certified Nursing Assistant (CNA) 2 with the Director of Staff Development (DSD) present, and record review on 4/18/24 at 2:00 PM, CNA 2 reviewed Resident 26's Weight Record (WR), dated 8/8/23 to 4/6/24. CNA 2 stated the WR was the monthly weight record of Resident 26. The WR indicated Resident 26's weight on 1/1/24 was 113.6 pounds and 125.4 pounds on 2/1/24. Resident 26 gained 11.8 pounds (9.4%) in one month. Review of Resident 26's Minimum Data Set (MDS- a standardized assessment tool that measures health status of residents in nursing homes and are completed every 3 months (or more often, depending on circumstances) indicated Resident 26 had an MDS quarterly assessment on 12/10/23 and a yearly assessment on 3/11/24. There was no assessment completed for significant weight gain on 2/24. (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/19/24 at 10:18 AM, the DSD stated Resident 26's weight gain of 9.4% between 1/24 and 2/24 was a significant weight change. The DSD also stated, If there's a significant weight change, it should be considered as change in condition or status. We should monitor weight gain or loss. When more or less 5 pounds (weight change) in a month, it should be reported to RD (Registered Dietitian) for recommendation and the resident's physician. During further interview, the DSD stated, RD comes monthly or as needed, at least. If we notice continuously change of weight and the care plan is not helpful, then we call physician. During an interview on 4/19/2024 at 11:29 AM, the DSD was asked if an assessment for significant change of condition in 2/24 for the weight gain and monitoring of the weights were conducted for Resident 26. The DSD stated, It wasn't done.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan (CP) for one of 12 sampled residents (Resident 26) when Resident 26's care plan did not include the physician's order to use heel protectors (devices designed for the heel of the foot that help remove the pressure from the heels and prevent and treat pressure ulcers [breakdown of skin integrity due to pressure]). This failure resulted in the care plan not accurately reflecting individualized, person-centered intervention necessary to meet the care needs of Resident 26. Findings: Review of Resident 26's Admission Record, indicated Resident 26 was admitted on [DATE] with diagnoses that include acute non-traumatic intracranial hemorrhage (spontaneous bleeding inside the skull or brain) with possible cystic lesion (lump or small pocket of tissue in the brain) and hemiparesis (weakness or inability to move on one side of the body). Review of Resident 26's Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents), dated 3/11/24, indicated Resident 26's both lower extremities had limitation in movement. Review of Resident 26's Braden Scale - For Predicting Pressure Sore (also known as pressure ulcer) Risk, dated 3/10/24, indicated Resident 26 had a score of 13, representing a high risk for development of pressure ulcer. During an observation on 4/15/24 at 10:56 AM, Resident 26 was in bed, lying on her back, covered with a blanket from the lower legs up to her chest, with both feet exposed, bare, and resting on the bed. There were no heel protectors applied to Resident 26's feet. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 2 on 4/15/24 at 2:10 PM, Resident 26 was in bed, lying on her back with her feet covered with a blanket. After requesting permission from Resident 26, CNA 2 lifted the blanket and showed Resident 26's bare feet resting on the bed. Resident 26 was not wearing heel protectors. CNA 2 verified the observation and stated, She does not have one (heel protectors). CNA 2 added, She is supposed to have one on. During a concurrent interview and record review on 4/17/24 at 10:28 AM, Licensed Vocational Nurse (LVN) 1 reviewed Resident 26's Current Physicians Orders (CPO), dated 4/24. The CPO indicated Heel protectors on bilateral (both sides) feet at all times (in and out of bed), with a start date of 3/11/24. LVN 1 also reviewed Resident 26's CP titled, Resident at risk for skin break/ulcer formation, dated 3/20/24. The CP indicated Resident 26 had impaired mobility, history of skin tears/ulcers, and thin, fragile skin. The CP did not indicate the use of heel protectors for Resident 26. LVN 1 stated, It (use of heel protectors) should be added here (referring to Resident 26's CP). It (use of heel protectors) should be there (CP) so that the CNAs know that they should put it on. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 10:30 AM, the Director of Staff Development stated the resident's CP should reflect the physician's orders, so that staff know what interventions to do, in her (Resident 26) case, to prevent pressure ulcers. Review of the facility policy, titled Comprehensive Care Plans, dated 2021, indicated Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on observation, interview, and record review, the facility failed to provide care to prevent pressure ulcer for one of 12 sampled residents (Resident 26) when the physician's order to apply bilateral heel protectors was not carried out. This failure placed Resident 26 at risk to develop pressure injuries. Findings: Review of Resident 26's Admission Record, indicated Resident 26 was admitted on [DATE] with diagnoses that include acute non-traumatic intracranial hemorrhage (spontaneous bleeding inside the skull or brain) with possible cystic lesion (lump or small pocket of tissue in the brain) and hemiparesis (weakness or inability to move on one side of the body). Review of Resident 26's Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents), dated 3/11/24, indicated Resident 26's both lower extremities had limitation in movement. Review of Resident 26's Braden Scale - For Predicting Pressure Sore (Pressure Injury) Risk, dated 3/10/24, indicated Resident 26 had a score of 13, representing a high risk for development of pressure injury. During an observation on 4/15/24 at 10:56 AM, Resident 26 was in bed, lying on her back, covered with a blanket from the lower legs up to her chest, with both feet exposed, bare, and resting on the bed. There were no heel protectors applied to Resident 26's feet. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 2 on 4/15/24 at 2:10 PM, Resident 26 was lying in bed with her feet covered with a blanket. After requesting permission from Resident 26, CNA 2 lifted the blanket and showed Resident 26's feet bare feet resting on the bed. Resident 26 was not wearing heel protectors. CNA 2 verified the observation and stated, She does not have one (heel protectors). CNA 2 added, She is supposed to have one on. During a concurrent interview and record review on 4/17/24 at 10:28 AM, Licensed Vocational Nurse (LVN) 1 reviewed Resident 26's Current Physicians Orders (CPO), dated 4/24. The CPO indicated Heel protectors on bilateral (both sides) feet at all times (in and out of bed), with a start date of 3/11/24. LVN 1 stated the physician's order to apply heel protectors should be carried out. LVN 1 added She (Resident 26) crosses her feet a lot, feet are bony prominent, so that could develop redness, could lead to pressure ulcer. She's at risk for pressure ulcer . During an interview on 4/18/24 at 10:30 AM, the Director of Staff Development (DSD) stated the physician's orders should be carried out as ordered. The DSD stated, She (Resident 26) has a higher risk (of developing pressure ulcer) because she is bedbound (confined to bed), they're (heel protectors) used as preventative measure. She might develop skin issues on that area if we don't put them on. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled, Prevention of Pressure Ulcers, last revised on 3/05, indicated General Guidelines-1. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time, causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of a pressure ulcer is where the bone is near the surface of the body, including .heels, ankles, and toes. Interventions and Preventive Measures: Residents with Risk Factors .5. Risk Factor - Immobility .c. When in bed, every attempt should be made to float heels (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician .		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) that require dialysis (mechanical removal of wastes and excess fluids from the body) receive services as consistent with professional standards of practice when there was no ongoing communication between the nursing home and the dialysis facility. This failure had the potential to result in misinformation that may negatively affect patient care. Findings: Review of Resident 2's Admission Record, indicated Resident 2 was admitted on [DATE] with diagnoses that include end stage renal disease (a condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance). During an interview on 4/15/24 at 1:12 PM, Resident 2 stated she goes to dialysis treatment every Tuesday, Thursday, and Saturday. Review of Resident 2's Current Physicians Orders, dated 4/24 indicated Dialysis .Schedule: Tuesday, Thursday, Saturday .Review Dialysis Communication Log Pre (before) and Post (after) Dialysis, with a start date of 1/20. During a concurrent interview and record review on 4/19/24 at 10:32 AM, Licensed Vocational Nurse (LVN) 2 reviewed Resident 2's Dialysis Communication Records (DCR), dated from 2/1/24 to 4/18/24. The section Dialysis Unit ([NAME]) on the DCR was not completed by the dialysis facility on 2/9/24, 2/29/24, 3/2/24, 3/12/24, 3/14/24, 3/19/24, and 4/18/24. LVN 2 stated, This part is for the dialysis staff. It's very important this part is completed to see how much fluid have been removed from the patient . if there's any changes in condition during dialysis. During a concurrent interview and record review on 4/19/24 at 10:50 AM, the Director of Staff Development (DSD) reviewed Resident 2's DCR. The DSD stated, Dialysis units fill out that section ([NAME]) at the end of treatment. Nurses should review it upon return (of the resident). The DSD also stated that if the [NAME] section on the DCR was not completed by the dialysis facility, the nursing home staff should communicate with the dialysis facility by fax or telephone to ensure the DCR is completed. The DSD added, It's for our nurses to know if there's anything that happened during dialysis. If there's a new order from the doctor. It's for their (residents) safety and continued care as well. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy and procedure, titled Policy and Procedures for Dialysis Patient indicated Policy: The Facility will arrange for dialysis care as ordered by the Attending Physician. The facility maintains a contract with the dialysis service provider, which addresses communication between the Facility and the Provider. Procedure: .4. Communication and Collaboration. A. The nursing staff, dialysis provider staff and the Attending Physician will collaborate on a regular basis concerning the resident's care as follows: .ii. The Dialysis Provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required .6. Documentation. A. All documentation concerning dialysis services and the care of the dialysis resident will be maintained in the resident's medical record. B. Dialysis Communication Record. 1. The Nursing Staff send a dialysis communication form to the dialysis center every time a resident is scheduled for off site dialysis. ii. The provider Dialysis Nurse, will be responsible for documentation of dialysis treatment. iii. Documentation will be maintained in the resident medical record.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on interview and record review, the facility failed to ensure one of 12 sampled residents (Resident 131) was free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) when there was no side effect (also known as adverse reactions, are unwanted undesirable effects that are possibly related to a drug) monitoring for the use of Trazodone (a medication used to treat depression [a constant feeling of sadness and loss of interest, which stops a person from doing normal activities] or help with sleep problems). This failure had the potential to place Resident 131 at risk for unrecognized side effects associated with the use of Trazodone that could cause harm to resident. Findings: Review of Resident 131's Admission Record indicated Resident 131 was admitted on [DATE] with diagnoses that include insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). Review of Resident 131's Current Physicians Orders, dated 4/3/24, indicated Admitting Orders . Trazodone 50 mg [milligrams], give 1/2 [half] tablet (25 mg) by mouth PRN (pro re nata - as needed) at bedtime for insomnia . During a concurrent interview and record review on 4/18/24 at 10:10 AM, Licensed Vocational Nurse (LVN) 3 reviewed Resident 131's Medication Administration Record (MAR), for April 2024. The MAR indicated Trazodone 50 mg 1/2 tablet (25 mg) was administered to Resident 131 from 4/5/24 to 4/17/24 at 9:00 PM. There was no documentation of monitoring for side effects for the use of Trazodone in the MAR which LVN 3 confirmed. LVN 3 stated, I would say 'Yes,' when asked if the facility should monitor for side effects of Trazodone. During an interview on 4/19/24 at 10:30 AM, LVN 2 stated regarding the monitoring for side effects of Trazodone, It's a very important safety matter, it's important to monitor and document (side effects) to see if patient (Resident 131) is complaining of dizziness, it may be too strong and need to inform the doctor. During an interview on 4/19/24 at 10:55 AM, the Director of Staff Development (DSD) stated, Psychotropic medications are high risk medication, can cause increased sedation, patient (Resident 26) could decline rapidly, could cause decline in level of consciousness. The DSD also stated, It (side effect monitoring) has to be done every shift and notify the doctor if there are any concerns. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/19/24 at 2:02 PM, the Pharmacist Consultant (PC) stated Resident 131 should be monitored for side effects of Trazodone. The PC further stated, It (Trazodone) is an anti-depressant (medications used to treat depression) and can cause sedation (a state of calmness, relaxation, or sleepiness caused by certain drugs). The PC also stated, If they (residents) are taking any medications such as another (medication) that may cause sedation, such as antidepressant, it can cause heavier sedation. Review of the undated facility policy titled, Use of Psychotropic Medication indicated Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, As demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: anti psychotics, antidepressants, anti-anxiety, and hypnotics .10. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: .d. In accordance with the nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the residents comprehensive plan of care. 11. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40478 Based on observation, interview and record review, the facility failed to ensure the Aspart insulin bottle was dated when first opened when: On [DATE], an Aspart insulin bottle was found not dated when first opened for use. This practice of either advertently or inadvertently not dating the insulin bottle or vial when first opened will put the resident's health at risk by receiving an expired medication or an insulin that is not potent. It can potentially cause more elevation of the resident's blood sugar resulting to organ damage and/or death. FINDINGS: Resident 19 was admitted with the following diagnoses: Alcohol dependence with induced persisting dementia, epilepsy (also known as a seizure disorder - a brain condition that causes recurring seizures.), Type 2 diabetes mellitus (a chronic disease characterized by high levels of sugar in the blood - called hyperglycemia), and chronic kidney disease (CKD - also known as chronic kidney failure, meaning a gradual loss of kidney function over time), among others. Resident 19 had no score on his brief interview for mental status (BIMS) indicating he did not answer or finish his cognitive assessment test. On [DATE] at 1:40 PM, Resident 19's blood sugar (BS) test result was 349 mg/dL. According to the Centers for Disease Control and Prevention (CDCP) a normal blood sugar is 99 mg/dL or lower, 100 to 125 mg/dL indicates prediabetes, and 126 mg/dL or higher indicates you have diabetes. Diabetes is a chronic (long-lasting) health condition that affects how your body turns food into energy. During a concurrent observation and interview with LVN 1 on [DATE] at around 2 PM by the medication cart, LVN1 stated, he (Resident 19) gets Aspart sliding scale. For his BS of 349 he gets 5 units. Observed LVN 1 opened the medication cart drawer and picked up two insulin bottles (one Aspart, one Glargine) tied together with a rubber band. LVN 1 twisted both bottles looking for something. This surveyor suggested to LVN1 to remove the rubber band. Upon removing the rubber band, and the two bottles were separated. Observed the side of the Aspart bottle with a space for writing the date when it was opened was blank. LVN1 stated, there is no date. I don't know when this was opened. Whoever opened this did not write the date. I will discard this and get a new bottle of Aspart insulin. Observed LVN 1 brought the undated Aspart to the medication room and came back with a new box of Aspart insulin. She sanitized her hands; she dated the side of the bottle before drawing a dose. LVN 1 had another license nurse double checked the insulin in the syringe and then gave the dose to Resident 19, on the right upper arm subcutaneously. Resident 19 was ordered a sliding scale of Aspart insulin. For his blood sugar of 349 mg/dL he gets 5 units of Aspart insulin (a rapid-acting insulin that helps lower mealtime blood sugar spikes in adults and children with diabetes). Resident 19 is on a scheduled tube feeding. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Volume 26 Issue 9 Diabetes Care American Diabetes Association (diabetesjournals.org) indicated, the manufacturer seemed to stress that patients not use a started bottle of insulin for >28 days. The American Diabetes Association (ADA) reminds healthcare professionals that even though each insulin vial is stamped with an expiration date, a slight loss of potency may occur after the vial has been in use for more than 30 days, especially if stored at room temperature. During a review of https://www.mayoclinic.org/drugs-supplements/insulin-aspart-recombinant-intravenous-route-subcutaneous-route/proper-use/drg-20067762 for storage of Aspart insulin indicated, store opened vials, pens, or PenFill(R) cartridges for 28 days at room temperature, away from direct heat and light. You may also store opened vials and pens for 28 days. During a review of district office online reference, the Lexidrug on Insulin Aspart on page 12, under storage stability it indicated, dilutions for subcutaneous administration (vials only) diluted insulin aspart should be stored at temperatures <30 degrees centigrade (<86 F) and used within 28 days. During a review of the facility's undated policy and procedure titled: Labeling and storage of medications, it indicated: 1. All medications will be properly labeled and stored in accordance with State and Federal laws,		

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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. 34975 Based on observation, staff interviews, and review of facility documents, the facility failed to: 1. Comply with Federal regulations related to the oversight of food service operations when the facility did not have a full-time dietitian and the requirements were not met as specified in established standards (California Code, Health and Safety Code - HSC S 1265.4) for food service managers which required, employment of a full-time, qualified dietetic supervisor when the dietitian was not full time. The lack of a qualified, competent, full-time supervisor resulted in staff not having adequate supervision, training, and knowledge to carry out Food and Nutrition Services in a safe and sanitary manner. 2. Ensure the Registered Dietitian (RD) provided sufficient consultation to the Food and Nutrition Services department. The lack of a qualified, full-time, competent supervisor to oversee Food and Nutrition Services, and lack of sufficient consultation from the RD, placed 27 residents who received food from the kitchen at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) and/or decreased nutrient intake, both of which had the potential to result in death and/or nutritional related medical complications. Findings: 1. There was no full-time, qualified oversight of the Food and Nutrition Services Department. (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the California Code, Health, and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. Subdivision (b) includes the following: The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision. (7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6). Review of the facility's document titled Consultant Dietitian Agreement signed by the Administrator (ADM) and the Registered Dietitian (RD) on 6/22/2017, showed RD was contracted to provide about 15 consultation hours of per month. In an interview on 4/18/24 at 1:39 p.m., the Kitchen Supervisor (KS) stated she did coursework to become a dietary manager many years ago, but she did not want to take the exam to become certified. Review of the documents provided as the qualifications for KS showed KS completed 270 contact hours in the Dietary Managers Course through the University of North Dakota on 9/24/2007. An on-line review of the University of North Dakota showed the Nutrition & Foodservice Professional Training Program included 270 contact hours. To become a Certified Dietary Manager (CDM), you'll need to pass the CDM Credentialing Exam offered through the Certifying Board for Dietary Managers (CBDMDM) . Once you have successfully completed the Nutrition & Foodservice Professional Training Program, you're eligible to take the CDM Credentialing Exam. 2. Lack of sufficient consultation by the RD to the Food and Nutrition Services Department. (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's document titled Consultant Dietitian Agreement signed by the Administrator (ADM) and RD on 6/22/2017, showed RD was contracted to provide about 15 consultation hours of per month. The Consultant Dietitian Responsibilities included but were not limited to: consulting with Administration regarding planning, recommending and establishing Department goals and priorities integrating Dietetic Service into the Facility's total program; Observation of food preparation and service at mealtime and identifying problems and establishing priorities on a monthly basis; Support the Dietetic Service Supervisor in maintaining department standards of food selection, receiving, storage, preparation, and service; Provide in-service education and assistance with staff development programs for Dietary and Nursing personnel as needed; Maintain and provide written reports of consultation visits, recommendations, plans for improvement. According to the California Code, Health, and Safety Code - HSC S 1265.4: a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian. During the Re-certification Survey from 4/15/24-3/19/24, multiple issues were identified regarding: kitchen staff and kitchen supervisor competency (Cross-reference F802); not following the planned menu (Cross-reference F803); food was not palatable including taste and temperature (Cross-reference F804); pureed food was not an appropriate texture (Cross-reference F805); and food was not stored, prepared, and served in a safe and sanitary manner (Cross-reference F812). In an interview on 4/17/24 at 11:04 a.m., RD stated she worked at the facility for a couple of years. RD stated she did monthly inspections for the kitchen. RD stated she talked with kitchen staff about issues she identified in the kitchen, but she did not have documentation to show what, when, and who she discussed these identified issues. RD stated she did not necessarily conduct in-service trainings when she identified issues in the kitchen. RD stated she conducted in-services on various topics for kitchen staff once a month, but she did not have time to do more training for kitchen staff because she only worked at the facility about four hours once a week. RD stated she did not report all issues she identified to the Administrator (ADM).		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 34975 Based on observation, interview, and facility document review, the facility failed to ensure kitchen staff competency for: 1. Calibrating food thermometers; 2. Cooldown procedures for Time/Temperature Control for Safety (TCS) food (food which requires time and temperature monitoring to prevent the growth of harmful bacteria); 3. Procedures for monitoring dishmachine temperature and sanitizer strength; 4. Temperature monitoring for trayline food; 5. Temperature monitoring for food storage coolers; 6. Manual dishwashing using the two-compartment sink; and 7. Testing sanitizer strength used for food contact surfaces. The failure to ensure staff competency regarding required and/or performed tasks had the potential to result in contamination of food and/or utensils and equipment leading to illness caused by pathogens (harmful organisms) for 27 residents who received food from the kitchen. Findings: Review of the facility's undated job summary titled Dietary Supervisor showed the Dietary Supervisor was responsible for overseeing the dietary department. The supervisor was to manage dietary staff, oversee meal preparation, and ensure compliance with all health and safety regulations. Key responsibilities included but were not limited to: supervising activities of kitchen staff in meal preparation, serving, and clean-up, ensuring that health and safety standards were adhered to; train and mentor kitchen staff on proper food handling, preparation, and dietary regulations and standards. Review of the facility's policy and procedure titled Dietary Manager's Responsibilities dated 2005, showed a well-trained dietary manager was to ensure instructions for the food service department were properly carried out. Procedures included but were not limited to: instructions are prepared and carried out to assure good results in food preparation and service; food is prepared in a manner to prevent food borne illness. Review of the facility's undated job summary titled Kitchen Cook showed the kitchen Cook was responsible for preparing and cooking meals while adhering to food safety and sanitation standards. Key responsibilities included but were not limited to: monitoring food temperatures during preparation and storage to prevent foodborne illness; maintaining cleanliness of the kitchen, including equipment, utensils, and workstations; complying with health and safety regulations, including sanitation, hygiene, and food handling practices. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the competency evaluations titled Competency Test for Cooks and Dietary Staff showed the Kitchen Supervisor (KS) and Cook 2 completed the same two, 12 question competency exams which included questions regarding kitchen tasks. The date of the competency tests were 5/10/23. While the competency test showed if staff could answer the questions correctly, there was no documentation to show staff demonstrated tasks correctly. One test taken by KS showed KS answered 6 of 12 answers correctly. The other test showed KS answered 8 of 12 answers correctly. One test question included What is the temperature a food thermometer must be calibrated to when using an ice bath? KS answered the thermometer could be calibrated a range up to 40 degrees, and the answer was marked as incorrect. Questions regarding the Temperature Danger Zone for holding food; at what temperature does the cool down process begin for cooked foods; and the temperature cooldown process begins, and what to do if a beef stew was not cooled to 41 degrees within 6 hours and/or what to do if beef stew was not cooled to 70 degrees within 2 hours, were also marked as answered incorrectly by KS. The competency test also did not include an evaluation of all tasks completed by staff. The test did not include questions regarding use of the two-compartment sink for manual washing, the appropriate sanitizer strength for sanitizing food contact surfaces, what temperature food should be held on trayline, documenting food temperatures, reading/documenting cooler temperatures, and required dishmachine temperature. 1. Review of the facility policy and procedure titled Thermometer Use and Calibration dated 2018, showed thermometers are to be used and properly calibrated to ensure accurate temperature readings. To check the accuracy and calibrate a thermometer, fill a large glass with crushed ice and add tap water until slush is formed. Put the thermometer's stem into the ice water. The stem must remain in the ice water during the calibration process. For a bimetal or analog thermometer, use the stem cover's end that looks like a wrench, or use a wrench tool to attach the nut under the dial face of the thermometer. Firmly hold the nut in one hand and turn the face of the dial until the indicator is at 32 degrees. According to the 2022 Federal Food Code, food measuring devices scaled in Fahrenheit shall be accurate with a variance of 2 degrees F in the intended range of use. During an interview and concurrent observation on 4/16/24 at 9:45 a.m., KS stated everyone in the kitchen was responsible for calibrating food thermometers. KS stated thermometer calibration was done before each meal. A translucent, plastic container, on top of a food preparation table was filled with water and had several ice cubes floating in the water toward the top. The probe (also referred to as stem) end of a dial food thermometer (also referred to as bimetal or analog thermometer) was in the container of ice water. In addition, two pork roasts rested on top of the food preparation table. The probe of dial food thermometer was inserted in each roast. In a consecutive interview and observation on 4/16/24 at 9:46 a.m., KS demonstrated the calibration of a dial food thermometer. KS stated the thermometers should be calibrated to 40 degrees Fahrenheit (F). Then Cook 2 walked past and said to KS, no 32. Then KS stated the thermometer should be calibrated from 32 to 60 degrees F. Then KS stated she needed a tool in order to calibrate the thermometer and looked for the tool in a drawer, but KS did not find the tool. Cook 2 pointed to a container on the preparation directly in front of KS. The container held multiple thermometer probe covers. KS stated the probe covers were the tools needed to calibrate the thermometer. KS placed the thermometer probe inside the probe cover and twisted the probe around inside the cover, multiple times. KS stated she was not able to move the dial on the thermometer in order to calibrate it when she twisted the probe around in the cover. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a consecutive interview and observation on 4/16/24 at 9:51 a.m., Cook demonstrated calibration of the dial food thermometer. Cook 2 removed the thermometer from the ice water and attached the nut on the underside of the thermometer dial to an opening on the outside of the probe cover. Cook 2 twisted the thermometer nut using the tool to move the dial of the thermometer. She moved the dial on the thermometer, so the dial read 32 degrees F then placed the thermometer probe back inside the ice water and stated it was calibrated. The thermometer dial moved to zero degrees F inside the ice water. Cook 2 was asked to read the dial after it was placed in the ice water, and stated it read zero degrees. Then she removed the thermometer from the ice water and used the tool to adjust the dial again. She tried to adjust the dial for over five minutes then placed the thermometer inside the ice water and stated now the thermometer was calibrated to 32 degrees F. The thermometer dial moved to 20 degrees F inside the ice water. When Cook 2 was asked to read the dial of the thermometer, she confirmed it read 20 degrees F. In a consecutive observation and interview on 4/16/24 at 10 a.m., Cook 2 tried to calibrate the two dial food thermometers inside the pork roasts. Cook 2 placed the two thermometers in the ice water with another dial thermometer. The three facility thermometers read 20, 28, and 32 degrees F. When Cook 2 was asked if she could explain the temperature differences of the thermometers, Cook 2 stated there was too much water in the ice water, and more ice was needed. Cook 2 removed some water and placed more ice in the container so the ice filled the container and was close to the bottom. With more ice in the ice water, Cook 2 stated the facility thermometers read 20, 25, and 25 degrees F. When Cook 2 was asked if she could explain why the facility thermometers read below 32 degrees F, Cook 2 stated maybe there was too much ice in the ice water. 2. Review of the facility's policy and procedure titled Reheating and Cooling of Potentially Hazardous Foods (PHF) also called Time/Temperature Control for Safety (TCS) During Meal Service (Trayline) dated 2020, showed PHF included but was not limited to meat, fish, cooked rice, pasta. Review of the policy and procedure titled Food Preparation dated 2018, showed food is not safe when it is between 41 to 140 degrees F. Therefore, as soon as hot food has dropped to 140 degrees F, the proper methods of cooling must be used. During the cooling process, use a clean, sanitized, and calibrated probe thermometer to measure the internal temperature of the food at the center of the product. Note menu item, date, time, temperature, and cook's initials on the Cool Down Log. Corrective action is to be taken when the cool-down process is not done correctly. Take corrective action as follows: discard cooked, hot food immediately when food is above 70 degrees F and more than 2 hours into the cooling process, or above 41 degrees F and more than 6 hours into the cooling process. Note any corrective action taken on the Cool Down Log. The Food and Nutrition Services (FNS) Director will visually monitor the food service employees and review and sign all logs prior to filing. During an interview on 4/16/24 at 9:30 a.m., KS described the cooling process for a cooked meat roast. She stated she would use ice in a pan. When she was asked the required time and temperature for cooling meat, KS stated the meat had to be cooled from 170 to 140. When KS was asked the required time to cool meat from 135 degrees Fahrenheit (F) to 41 degrees F, KS stated one to two hours. When KS was asked what she would do if the meat was above 41 degrees F after six hours, KS stated she would keep the meat in the refrigerator and check the temperature of the meat in another hour. When KS was asked if there was a cooling log, KS stated no. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a consecutive interview on 4/16/24 at 9:40 a.m., Cook 2 stated staff cooked food it was cooled. Cook 2 provided examples of food staff cooled including tuna salad, macaroni salad, and left-over meat. Cook 2 stated if a meat roast was cooked and the entire meat roast was not needed for trayline, the extra was stored in the refrigerator. During an interview on 4/17/24 at 11:04 a.m., the Registered Dietitian (RD) stated there was no cooldown log because staff did not cooldown food. When the RD was informed leftover pork and rice were cooled (Cross-reference F812), RD stated she was not aware cooling took place. RD stated she was aware staff made tuna salad and a cooling log should be used for tuna salad. RD also stated she did cooldown training for staff in the past but not recently because staff did not cool down food. 3. Review of the facility policy and procedure titled Dish Washing dated 2018, showed for a low-temperature dish machine, if manufacturer recommendations were not available, the dish machine should be used at a water temperature range of 120 to 140 degrees F. During an observation and concurrent interview on 04/15/24 at 9:30 a.m., KS washed dishes in the dish machine. An information plate attached to the front of the dish machine showed the minimum water temperature of the dish machine was 120 degrees F. KS demonstrated how to assess the dish machine was operating properly. She showed how to check the sanitizer in the dish machine. When asked if there was anything else to check to ensure the dish machine was operating properly, KS stated she did not check anything else. Then KS was asked about the dish machine water temperature. KS stated the water temperature should be 100 to 120 degrees F. When KS was asked how the water temperature was determined, she stated there was a temperature dial. She looked around the dish machine for a dial, then pointed to a dial on the front of the machine. When the dish machine was running through a cycle, KS stated the dial showed the water temperature was 100 degrees, when the dial actually read slightly over 120 degrees F. When KS was asked if she could show where 120 degrees was on the dial, KS stated she did not know where 120 degrees was on the dial. In an interview on 4/16/24 at 9:22 a.m., Cook 2 stated she measured dish machine water temperatures and documented them on the dish machine log. She stated she documented 110 degrees F for the dish machine temperature this morning. Cook 2 stated 110 degrees F was okay and if the water temperature was too low, she had to call the dish machine company. A dish machine temperature log was attached to the front of the machine. Under the breakfast column on 4/16/24, 110 was documented for the wash temperature. Review of the facility's Dishmachine Temperature Log for the dates 4/1/24 to 4/15/24, 37 out of 45 documented wash water temperatures ranged from 110 to 118 degrees F. 4. Review of the facility policy and procedure titled Cold Storage Temperature Logging dated 2018, showed Food and Nutrition Services staff shall review and record temperatures of all refrigerator and freezers to ensure they are at the correct temperature for food storage and handling. Food and Nutrition Services staff will record and initial the temperatures at the beginning of the A.M., and P.M. shifts. Review of the facility's policy and procedure titled Procedure for Freezer Storage showed freezer temperatures should be recorded twice daily. Temperatures are to be recorded upon opening and closing of kitchen and logged in the Cold Storage Temperature Log. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 4/15/24 at 10:56 a.m., KS stated all kitchen staff recorded temperatures of the refrigerators and freezers. An internal thermometer located inside a reach-in freezer toward the top shelf, read negative 20 degrees F. KS read the thermometer, which was above her eye level and stated the temperature showed zero degrees. KS stated the thermometer was difficult to see. It was noted a Refrigerator/Freezer Units Temp Log dated March 2024 was attached to the freezer door. The log showed temperatures were recorded once a day. All 15 documented freezer temperatures from April 1 to April 15 were negative one and over five of the temperatures were documented by KS. 5. Review of the facility policy and procedure titled Meal Service dated 2018, showed the Food and Nutrition Services staff member will take the food temperature prior to service of the meal with a thermometer. It may be necessary to take the temperature in more than one location on the food item to confirm the proper temperature has been reached. The food temperatures will be recorded. The food will be served on trayline at the recommended temperatures: meat, rice, and vegetable 160-170 degrees F. The minimum hot holding temperature on steam table is 140 degrees F. Review of the facility policy and procedure titled Thermometer Use and Calibration dated 2018, showed to take the temperature of food, to insert thermometer in the thickest part of the meat. During and observation and interview on 4/15/24 at 11:52 a.m., showed multiple types of food in pans on a steam table ready to be served for trayline lunch service. KS measured the temperature of pureed rice, then stated she was ready to start trayline. KS began placing food on plates. While it was not observed that KS documented food temperatures for the lunch trayline food, when asked if she recorded the trayline food temperatures, KS stated yes. Then she was asked if she recorded the temperatures of food for the breakfast trayline today, KS stated she forgot. During a consecutive observation and interview at the beginning of trayline food service on 4/15/24 at 12:04 p.m., when KS was asked if she measured other food temperatures on trayline in addition to the pureed rice, KS stated she forgot. Then KS proceeded to take the temperatures of more food in pans on the steam table. KS measured temperature of pieces of chicken. KS placed the thermometer through a piece of chicken and stated the chicken was 136 degrees F. When KS measured the temperature, she inserted the probe of the thermometer straight down into the chicken in the pan filled with many pieces of chicken. The way in which the thermometer was placed, it could not be determine how much of the probe was inside the piece of chicken. The surveyor measured the temperature of the center of the thickest parts of three pieces of chicken with a calibrated thermometer and the temperatures were 121.5, 129.4, and 132.8 degrees F. Other temperatures measured by KS included pureed chicken 165 degrees F and regular textured rice 139 degrees F. In a consecutive observation and interview on 4/15/24 at 12:19 a.m., KS measured the temperature of cooked vegetables. KS stated her thermometer read 125 degrees, when her thermometer read 130 degrees F. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 4/16/24 at 12:57 p.m., the temperature log for lunch on 4/15/24 was reviewed with KS. The log titled Food Preparation Temperatures dated 4/15/24. showed the temperature for regular, pureed, and mechanical (ground/chopped) poultry were all 170 degrees F. A vegetable temperature was not recorded. The temperature of regular textured rice showed 150 degrees F and the temperature of pureed rice showed 150 degrees F. When KS was asked to explain why the documented temperatures did not match the temperatures observed for lunch on 4/15/24, KS stated the temperatures she documented on the log were not accurate. It was also noted the breakfast temperatures on 4/15/24 were documented. KS stated she remembered the temperatures and entered them later after breakfast. In an interview with the Registered Dietitian (RD) on 4/17/24 at 11:04 a.m., RD stated she was aware the kitchen staff did not log temperatures right away and this was something to work on. In an interview on 4/18/24 at 10:40 a.m., RD stated staff needed training on documenting the actual temperatures. 6. Review of the policy and procedure titled 3 Compartment Procedure for Manual Dish Washing dated 2018, showed if the dish machine is not working properly, the Food and Nutrition Services Director and Nutrition staff will need to initiate manual dish washing procedures. In the case of only a two-compartment sink, a third bin is necessary. You may use on of the following as the third sink compartment: a large trash can, purchased and labeled specifically for dishwashing; a portable basin purchased from your chemical supply company; a large tub purchased and labeled specifically for dishwashing. The trash can or basin must be large enough to allow utensils, pots, and pans, and trays to be submerged. The third compartment or bin is used for sanitizing. All washed items are to be immersed for 60 seconds. During and observation and interview on 4/16/24 at 10:15 a.m., Cook 2 stood in front of the two-compartment sink and described how items such as dishes, cooking utensils, and cooking equipment would be cleaned using the two-compartment sink in the event the dishmachine could not be used. Cook 2 stated the first sink would be filled and used for washing, and the second sink was for rinsing. Then Cook 2 stated items would be sanitized in a deep metal cooking pan. When Cook 2 was asked if items needed to be cleaned would fit in the metal pan, she placed a large cooking pot in the pan. The pot was larger in height compared to the metal pan, so it did not completely fit inside the pan. When asked how long items had to be in the sanitizer, Cook 2 stated she would use the sanitizer in a container which was labeled as dimethyl benzyl ammonium chloride (Quat; a type of sanitizer) sanitizer and items had to be in the sanitizer for 30 seconds. The manufacturer's label on the Quat sanitizer showed items immersed in sanitizer should remain wet for 60 seconds. 7. During an observation and interview on 4/16/24 at 10:19 a.m., a red bucket filled with a liquid was on the counter of the dirty side of the dish machine. A rag was in the bucket. Cook 2 stated the red bucket was filled with the Quat sanitizer solution. Cook 2 stated the solution was tested every 30 minutes. Cook 2 tested the solution by dipping a Quat test strip into the solution and immediately removing the strip. The test strip turned dark green in color. Cook 2 compared the test strip to a color chart located inside the test strip container and held it so the surveyor could read the results. Cook 2 stated the color showed, Cook 2 the solution was 400 so the solution was good. The manufacturer's instructions on the Quat container showed for sanitizing equipment and utensils, prepare a 200 ppm (parts per million) solution.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34975 Based on observation, interview, and facility document review, the facility failed to follow the planned menu. This failure had the potential to result in inadequate and/or inappropriate nutrients served to residents leading to nutrient related medical complications for 27 residents who received food from the kitchen. Findings: Review of the facility's policy and procedure titled Food Preparation Portion Control dated 2018, showed to be sure portions served equal portion sizes listed on the menu, portion control equipment must be used. During an observation and interview on 4/15/24 at 11:15 a.m., the Kitchen Supervisor (KS) provided a document titled Week at a Glance, when she was asked for a copy of the spreadsheet used for trayline food service to indicate foods and serving sizes to serve for different prescribed diets. Week at a Glance showed the menu for the Regular diet for the week. It did not include therapeutic diets and it did not include serving sizes. When KS was asked how serving sizes and foods to serve for therapeutic diets were determined during trayline, she did not have an answer and stated she would ask the Registered Dietitian (RD) if there was a menu spreadsheet showing therapeutic diet menus and serving sizes. During an observation and interview on 4/15/24 at 11:52 a.m., KS and Cook 1 prepared for trayline food service. Pureed (modified to a smooth consistency and holds its shape on a spoon) bread was portioned in individual bowls. KS stated the serving size for the pureed bread was a number 16 scoop (2 ounces [oz]; 1/4 cup [c]). There were also pans filled with food held on the steam table. KS placed a scoop in the rice and stated the serving size for regular textured rice was a number 12 scoops (2.58 oz; 1/3 c). KS placed scoops in the other pans of food and stated the serving size for pureed chicken was a number 8 scoop (4 oz; 1/2 c). A consecutive observation and interview on 4/15/24 at 12:04 p.m., showed pureed cake portioned in individual bowls and placed on trays for residents with traycards indicating a pureed diet. KS stated the portion size for the pureed cake was a number 16 scoop. In a consecutive observation and interview on 4/15/24 at 12:05 p.m., trayline food service began and KS placed hot food on plates according to the diet listed on the tray cards (traycards listed the name of the prescribed diet, food preferences, and food allergies). KS used a slotted serving spoon to serve the mechanical textured (altered to a chopped or ground texture) chicken. When KS was asked what serving size she provided for the mechanical chicken, she could not say what size portion the slotted spoon held. Then KS said the portion for the mechanical chicken was supposed to be a number 16 scoop, and retrieved a number 16 scoop from a drawer, then continued to use the slotted spoon to serve the mechanical meat. All regular and mechanical soft textured diets received a half piece of buttered bread. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As trayline continued, an observation and interview on 4/15/24 starting at 12:05 p.m., many trays included individual bowls of canned pears. Cook 1 stated the No Concentrated Sweets (NCS; a diet which eliminates sugary foods. This diet was typically prescribed for those who had difficulty controlling blood sugar. The Controlled Carbohydrate diet is the current standard in place of the NCS diet) diets received a number 16 scoop of pears instead of cake. As trayline continued, an observation on 4/15/24 starting at 12:05 p.m., showed Renal diets (a diet typically prescribed to a person with kidney disease. This diet restricts certain foods which could be harmful to a person with kidney disease) received all the same food as the Regular diets. In an interview with RD and KS on 4/15/24 at 1:10 p.m., RD stated KS needed to follow the spreadsheet during trayline. KS held a spreadsheet in her hand and stated she followed the spreadsheet during trayline. The spreadsheet was reviewed in front of RD and KS, and many serving sizes and some foods served on trayline did not match the spreadsheet. Then KS admitted she did not follow the spreadsheet. Review of the Daily Spreadsheet Monday dated March 18, 2024, showed food items and respective serving sizes for the Regular and therapeutic diets. The spreadsheet showed Regular diets received a number 8 scoop (4 oz) of Spanish Rice (a number 12 scoop [2.58 oz] was served), and one piece of bread or roll (a 1/2 piece of bread was served). The spreadsheet also showed Pureed diets received a number 6 scoop (5.3 oz; 2/3 c) of pureed chicken (a number 8 scoop [4 oz] was served), and a number 10 scoop (3 oz; 3/8 c) of pureed cake (a number 16 scoop [2 oz] portion was served). No Concentrated Sweets diet was not on the spreadsheet. The spreadsheet showed Consistent Carbohydrate diets (CCHO; a diet typically prescribed to a person with difficulty controlling blood sugars. The amount of carbohydrates are consistent for each meal. It is more liberal than the NCS diet) received cake without frosting (canned pears were served instead of cake), and Renal diets received Paprika Rice (Spanish Rice was served). It was noted Mechanical soft was not a therapeutic diet listed on the spreadsheet. Review of the undated recipe titled Spanish Rice, showed Spanish Rice was not appropriate for the Renal diet. Review of the undated recipe titled Paprika Rice, showed Paprika Rice was appropriate for Renal diets. Review of the undated recipe titled Frosted Cake (Mix) showed to omit the frosting for CCHO diets. An observation on 4/18/24 at 12:35 p.m., showed Certified Nursing Assistant 1 (CNA1) delivered a lunch tray to Resident 2. CNA 1 set up the lunch tray on a bedside table for Resident 2. Resident 2 sat at the side of her bed with her tray table in front of her and began eating her lunch. Resident 2's lunch tray contained potatoes. The tray card on Resident 2's lunch tray showed she was to receive a Renal diet. Review of the Daily Spreadsheet Thursday dated March 21, 2024, showed Regular diets received Rissole Potatoes and Renal diets received Parslied Rice in place of potatoes. In an interview on 4/18/24 at 12:45 p.m., KS stated Resident 2 should have received rice and not potatoes.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34975 Based on observation, interview, and facility document review, the facility failed to serve food that was flavorful and at a palatable temperature. This failure had the potential for decreased food intake leading to nutrient related complications for 27 residents who received food from the kitchen. Findings: Review of the facility policy and procedure titled Meal Service dated 2018, showed the Food and Nutrition Services staff member will take the food temperature prior to service of the meal with a thermometer. It may be necessary to take the temperature in more than one location on the food item to confirm the proper temperature has been reached. The food temperatures will be recorded. The food will be served on trayline at the recommended temperatures: meat, rice, and vegetable 160-170 degrees F. The minimum hot holding temperature on steam table is 140 degrees F. Temperatures of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. The suggested minimum temperature for a hot entree, starch, and vegetable is 120 degrees F. An observation and interview on 4/15/24 at 11:52 a.m., showed multiple types of food in pans on a steam table ready for trayline lunch service. KS measured the temperature of pureed rice, then stated she was ready to start trayline. KS began placing food on plates. During a consecutive observation and interview on 4/15/24 at 12:04 p.m., KS was asked if she measured the other food temperatures on trayline in addition to the rice. KS stated she forgot, then proceeded to take the temperatures of more food in pans on the steam table. KS measured the temperature of pieces of chicken. KS placed the thermometer through a piece of chicken and stated the chicken was 136 degrees F. The surveyor measured the temperature of the center of the thickest parts of three pieces of chicken and the temperatures were 121.5, 129.4, and 132.8 degrees F. In a consecutive observation and interview on 4/15/24 at 12:19 p.m., KS measured the temperature of cooked vegetables. KS stated her thermometer read 125 degrees, when her thermometer read 130 degrees F. It was noted the pan of cooked vegetables were not inside the steam table well, like the other hot foods. The pan of cooked vegetables was resting on top of table because there was not room for the pan in the well. KS stated all food on trayline should be held at 165 degrees F, except for the vegetables which should be held at 155 degrees F. Then KS served the food. The food was served on ceramic plates or in ceramic bowls. The food served in bowls was covered with plastic wrap. The food served on plates was covered with a metal lid. It was noted the plates and bowls used were stored on the preparation table at room temperature. It was also noted an open cart was used to hold the trays to transfer them upstairs to the residents. In a consecutive observation on 4/15/24 at 12:53 p.m., the food temperatures were measured on trayline with a calibrated thermometer, just as the last tray was plated. The temperatures were as follows (there was not enough pureed chicken or pureed rice to measure the temperature): Regular textured Cilantro Lime Chicken 108.1 degrees F (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regular textured Spanish Rice 155 degrees F Regular textured Zucchini and Yellow Squash 107.6 degrees F Pureed Zucchini and Yellow Squash 106 degrees F. During an observation and interview with the Registered Dietitian (RD) on 4/15/24 at 1:02 p.m., a test tray (the purpose of a test tray audit is to evaluate the quality of a meal during meal service) was conducted immediately after the last lunch tray was served to residents. Pureed and regular food was assessed. The food temperatures measured with a calibrated thermometer and were as follows: Regular textured Cilantro Lime Chicken 102.6 degrees Fahrenheit (F) Regular textured Zucchini and Yellow Squash 98.4 degrees F Pureed Spanish Rice 109.2 degrees F and 110.7 degrees F (two bowls of pureed rice were provided) Pureed Zucchini and Yellow Squash 107.4 During the test tray assessment with the RD on 4/15/24 at 1:02 p.m., the food felt barely warm or even cool in the mouth. The flavors of the pureed vegetables and pureed rice were very bland. RD confirmed the vegetables were cold and the chicken was not warm. RD also confirmed the pureed rice was bland. RD stated she did not conduct test trays to assess food temperatures upon delivery to the residents. She stated there were no complaints about the food. While, according to the RD, there were no complaints of food, review of 27 residents' Brief Interview for Mental Status (BIMS) assessments (a point system that ranges from 0-15 used in nursing homes to monitor resident cognition) provided by the facility showed, 19 residents had a BIMS of 0-7 (suggests severe cognitive impairment), four residents had a BIMS score of 8-12 (suggests moderate cognitive impairment), and four residents had a score of 99 (when a resident chooses not to participate or four or more items coded 0 because of nonsensical responses). In an interview on 4/17/24 at 11:04 a.m., the RD stated when she sampled food, she tasted the food in kitchen during trayline not at service to residents. RD confirmed there were no additional devices in addition to the steam table, used to keep food warm during service.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 34975 Based on observation, interview, and facility document review, the facility failed to ensure the appropriate texture of pureed food was served to residents. This failure had the potential for residents to aspirate (breath in fluid into the lungs which can cause choking, aspiration pneumonia, and/or death) while consuming food for 10 residents with a prescribed a pureed diet. Findings: Review of the Daily Spreadsheet Monday dated March 18, 2024, (and was the spreadsheet for lunch served on 4/15/24) showed the foods and respective serving size to serve for therapeutic diets. On the spreadsheet, the therapeutic diet was indicated as Pureed (PU4). Also, the foods pureed diets received for lunch included but were not limited to pureed Spanish Rice and pureed Zucchini and Yellow Squash. Review of the Ala Carte Menus by [menu company name] Diet Manual dated 2021, showed Pureed (PU4) was a modified diet designed for people who have severe chewing and/or swallowing problems. Puree all foods to a smooth, lump-free, extremely thick consistency, and use an appropriate recipe. Foods on this level must pass the fork drip and spoon tilt test. Food sits in a mound on a fork, does not drip continuously through the tines of a fork, holds its shape on a spoon and is not sticky. Review of the undated recipe titled Spanish Rice, showed for the puree modification use Recipe #P17. Review of undated Recipe Pureed Potatoes, Pasta, Rice and other Grains Recipe #: P17, showed directions on how to puree the food and to ensure the mixture achieved a moist mashed potato or pudding-like consistency. Review of the undated recipe titled Zucchini and Yellow Squash, showed for the puree modification use Recipe #P27. Review of undated Recipe Pureed Vegetables Recipe #: P27, showed directions on how to puree the food and to ensure the mixture achieved moist mashed potato or pudding-like consistency. An observation and interview on 4/15/24 at 12:50 p.m., showed the Kitchen Supervisor (KS) placed servings of pureed food into small individual bowls, so each type of pureed food was served in a separate bowl. The pureed foods, including the chicken, rice, and vegetables, were very thin and runny. KS stated she served the pureed food in bowls because the pureed food was soupy and would run together if it was served on a plate. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with the Registered Dietitian (RD) on 4/15/24 at 1:02 p.m., a test tray was conducted, and pureed food was assessed. The pureed rice was very thin and watery. The pureed vegetable was slightly thicker and was the consistency of a thick cream soup. Both the pureed vegetable and pureed rice did not hold their shape on a spoon and were pourable. RD confirmed the pureed rice was too thin and confirmed the pureed vegetables did not hold shape on a spoon. RD stated the food probably would not hold shape if it was placed on a plate. It was noted the pureed chicken was not provided to assess because there was not enough available after trayline food service.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 34975 The facility failed to serve food in a safe and sanitary manner when: 1. Time/Temperature Control for Safety (TCS; food which requires time and temperature monitoring to prevent the growth of harmful bacteria) foods were not monitored for cool down; 2. Raw meat was stored directly next to produce; 3. Different types of thawing meat were commingled; 4. Stored and ready to use utensils and equipment were not clean and/or in poor condition; a. Two of two food processors; b. Seven of seven cutting boards; c. A variety of cooking tools and equipment stored in drawers and on shelving; 5. [NAME] shelving, cabinets, and drawers had peeling paint and/or built-up residue and grime; 6. TCS food was not discarded by storage recommendations; 7. A storage container holding coffee was not cleaned before refilling; and 8. A freezer gasket was not maintained clean. This failure put residents at risk for consuming contaminated food and/or using contaminated utensils resulting in illness caused by pathogens (harmful organisms) for 27 residents who received food from the kitchen. Findings: 1. Review of the facility's policy and procedure titled Reheating and Cooling of Potentially Hazardous Foods (PHF) also called Time/Temperature Control for Safety (TCS) During Meal Service (Trayline) dated 2020, showed TCS food included but was not limited to meat, fish, cooked rice, pasta. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy and procedure titled Food Preparation dated 2018, showed food is not safe when it is between 41 to 140 degrees Fahrenheit (F). Therefore, as soon as hot food has dropped to 140 degrees F, the proper methods of cooling must be used. During the cooling process, use a clean, sanitized, and calibrated probe thermometer to measure the internal temperature of the food at the center of the product. Note menu item, date, time, temperature, and cook's initials on the Cool Down Log. Corrective action is to be taken when the cool-down process is not done correctly. Take corrective action as follows: discard cooked, hot food immediately when food is above 70 degrees F and more than 2 hours into the cooling process, or above 41 degrees F and more than 6 hours into the cooling process. Note any corrective action taken on the Cool Down Log. The Food and Nutrition Services (FNS) Director will visually monitor the food service employees and review and sign all logs prior to filing. During an interview on 4/16/24 at 9:30 a.m., the Kitchen Supervisor (KS) stated there was no cool down log to document cooling of cooked, left-over food. In a consecutive interview on 4/16/24 at 9:40 a.m., Cook 2 stated cooked foods were cooled. Cook 2 provided examples of food which were cooled including tuna salad, macaroni salad, and left-over meat. Cook 2 stated if a meat roast was cooked and the entire meat roast was not needed for trayline, the extra was stored in the refrigerator. Cook 2 stated there was no cool down log to document cooling food temperatures. Review of the Daily Spreadsheet Tuesday dated March 19, 2024, and used as the menu for [NAME] on 4/16/24, showed Savory Roasted Pork Loin was the entree for all diets and Seasoned Rice was the starch for residents prescribed Renal diets (a diet typically prescribed to a person with kidney disease). An observation on 4/16/24 at 1:35 p.m., after trayline lunch service, showed an uncovered plastic, reusable container filled with cooked meat and an uncovered plastic, reusable container filled with cooked rice, stored on a preparation table in the kitchen. An observation on 4/16/24 at 1:42 p.m., showed the same two uncovered containers filled with cooked meat and cooked rice stored on the preparation table in the kitchen. An observation and interview on 4/16/24 at 3:30 p.m., showed the reusable, plastic container of cooked meat with a handwritten label on the lid showing pork 4/16/24, and the reusable, plastic container of cooked rice with a handwritten label on the lid showing rice 4/16/24, stored in the reach-in refrigerator. Cook 2 stated the meat was pork and both the pork and cooked rice was left over from the lunch trayline. When Cook 2 was asked if cooldown was being monitored for these items, Cook 2 stated yes. When Cook 2 was asked if there was documentation for cooling of pork and rice, Cook 2 stated no, because she had it in her head. Then Cook 2 stated she did not have to document the temperatures because the food was 40 degrees F at 1:30 p. m. The temperature of the food was measured with a calibrated thermometer in the presence of Cook 2. The pork was 81.3 degrees F, and the rice was 65.1 degrees F. An observation and interview on 4/16/24 at 5:03 p.m., showed the containers of pork and rice remained in the refrigerator. Cook 2 stated there was no documentation for cool down temperatures for the cooling pork and rice. Cook 2 stated the leftover pork and rice would be used tomorrow for residents who did not like the food on the menu. (continued on next page)		

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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 - Many	An observation on 4/17/24 at 10:45 a.m., showed the leftover pork and rice remained stored in the reach-in refrigerator. During an interview on 4/17/24 at 11:04 a.m., the Registered Dietitian (RD) stated there was no cooldown log because staff did not cooldown food. When RD was informed leftover pork and rice was cooled, RD stated she was not aware cooling was taking place. She stated she was aware staff made tuna salad and staff should monitor cool down for the tuna salad. 2. Review of the facility's policy and procedure titled Food Preparation dated 2018, showed store raw meat, poultry, and fish separately from cooked and ready-to-eat food to prevent cross contamination. Store ready-to-eat food above raw meat, poultry, and fish, if these items are stored in the same unit. This will prevent raw-product juices from dripping onto the prepared food and causing food borne illness. Store raw meat, poultry, and fish in the order from top to bottom. This order is based on the required minimum internal cooking temperatures of each food (this p&p showed the minimum internal cooking temperature of vegetables was 135 degrees F): a. Whole fish (minimum internal cooking temperature 145 degrees F) b. Whole cuts of beef and pork (minimum internal cooking temperature 145 degrees F) c. Ground meat and fish (minimum internal cooking temperature 155 degrees F) d. Whole and ground poultry (minimum internal cooking temperature 165 degrees F) According to the 2022 Federal Food Code, food is to be protected from cross contamination by separating raw animal foods during storage from fruits and vegetables before they are washed, as well as raw ready-to-eat food such as fruits and vegetables. An observation of a reach-in refrigerator located in the kitchen and concurrent interview with the Kitchen Supervisor (KS) on 4/15/24 at 10:19 a.m., showed raw meat stored in a metal pan and fresh produce stored inside a cardboard box with holes in the side of the box, stored directly next one another on the bottom shelf of the refrigerator. In addition, fresh produce including whole leaf lettuce was wrapped in a plastic bag on a tray, stored on top of the box of fresh produce. There was a hole in one of the plastic bags with produce protruding through the hole. KS stated the raw meat included chicken, pork loin, and ground beef. An observation of a reach-in refrigerator located in the kitchen on 4/17/24 at 10:45 a.m., showed a metal pan filled with raw meat stored directly next to a cardboard box with holes in the side filled with fresh produce. Plastic bags filled with fresh produce such as bell peppers were on a tray stored on top of the box of produce. The pan containing the raw meat was so full, a plastic bag filled with raw chicken extended beyond the top and sides of the pan, so the chicken was not contained in the pan. The plastic bag containing raw chicken came in direct contact with the plastic bag holding the bell peppers. The items were all stored on the bottom shelf of the refrigerator. In an interview on 4/17/24 at 11:04 a.m., RD stated it was not ideal to store raw thawing meat next to the produce. She stated food in the refrigerator should be stored above one another according to required cooking temperatures. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the facility's policy and procedure titled Food Preparation dated 2018, showed to never store chicken and beef on the same tray. Store raw meat, poultry, and fish in the order from top to bottom. This order is based on the required minimum internal cooking temperatures of each food: a. Whole fish (minimum internal cooking temperature 145 degrees F) b. Whole cuts of beef and pork (minimum internal cooking temperature 145 degrees F) c. Ground meat and fish (minimum internal cooking temperature 155 degrees F) d. Whole and ground poultry (minimum internal cooking temperature 165 degrees F) According to the 2022 Federal Food Code, food is to be protected from contamination by separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage (except when combined as ingredients) by using separate equipment for each type and arranging each type of food in equipment so that cross contamination of one type with another is prevented. An observation of the contents of a reach-in refrigerator located in the kitchen and concurrent interview with the Kitchen Supervisor (KS) on 4/15/24 at 10:19 a.m., showed raw meat stored together in a metal pan. KS stated the raw meat included chicken, pork loin, and ground beef. KS stated the meat was thawing for upcoming meals. In an interview on 4/17/24 at 11:04 a.m., RD stated food in the refrigerator should be stored above one another according to required cooking temperatures. 4. Review of the policy and procedure titled Sanitation revised April 2006, showed all equipment shall be kept clean, maintained in good repair and shall be free from corrosions that may affect their use or proper cleaning. Review of the facility's policy and procedure titled Storage of Food and Supplies dated 2020, showed shelves and cupboards will not be lined with liners. According to the 2022 Federal Food Code, multiuse food-contact surfaces are to be smooth, free of inclusions, pits, and similar imperfections. In addition, equipment food-contact surfaces are to be clean to sight and touch. Materials used in the constructions of food-contact surfaces of equipment may not allow the migration of deleterious substances to food and under normal use conditions are to be resistant to scratching, scoring, pitting, and decomposition. Cutting surfaces such as cutting boards that are subject to scratching and scoring shall be resurfaced and if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Food-contact surfaces of cooking equipment and pans are to be kept free of encrusted grease deposits and other soil accumulation. Clean equipment and utensils are to be stored in a self-draining position that allows air drying. Cleaned equipment and utensils and single service articles are to be stored in a clean location where they are not exposed to contamination. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of food residue and other debris. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4a. An observation during the initial tour of the kitchen on 4/15/24 at 10:28 a.m., showed two food processors stored on a preparation table. One food processor had a plastic bowl. The inside surface of the plastic bowl was significantly scratched and felt rough to the touch. The blade inside the food processor had orange residue on the surface. In addition, there was a significant amount of thick, black residue under the rubber seal (to prevent leakage when the food processor is in use) lining the inside circumference of the lid. The rubber seal was removable. When the rubber seal was removed and wiped with a white, paper napkin, the black residue transferred to the napkin. An observation of the second food processor on 4/15/24 at 10:34 a.m., showed it had a metal bowl and on the surface of the inside the bowl there was white, wet residue. A rubber paddle attached to the lid of the food processor was initially light gray in color but was discolored with a residue so almost the entire surface of the paddle appeared brown. The base of the food processor had brown residue build-up in crevices. In a consecutive interview and observation on 4/15/24 at 10:35 a.m., KS looked at the food processors and stated the equipment was old. KS stated she used the food processors that morning and already cleaned them after using them. 4b. An observation and interview during the initial tour of the kitchen on 4/15/24 at 10:51 a.m., showed seven cutting boards stored in a rack under a preparation table. Each side of all seven cutting boards were significantly scratched so the surfaces appeared white and were rough to the touch. There were also bits of plastic coating peeling off of the cutting boards. Three of the seven cutting boards had black residue imbedded in the surfaces. One of the seven cutting boards had orange residue, resembling food residue, on the surface. KS stated the cutting boards should be replaced when scratched so much they looked white. KS also stated some of the cutting boards were stored dirty. KS stated it was probably time to replace the cutting boards. 4c. An observation during the initial tour of the kitchen on 4/15/24 at 10:34 a.m., showed a preparation table located against a wall by the stove with wood drawers attached to the underside of the table. Stored in one drawer were miscellaneous items such as a garlic press which had orange residue on the surface, an egg slicer with orange and brown residue on the surface, and a clear plastic scoop with yellow and brown residue on the surface. A consecutive observation and interview of wood shelving located under the preparation table on 4/15/24 at 10:38 a.m., showed six sheet pans stored on the shelving with thick, black residue on the top, side surfaces. KS stated the pans were used to prepare cookies. Also, four square pans, which KS stated were used for food, were stacked, and had white residue on the inside surface. Two of the metal pans were wet. In addition, a large pot stored on the shelving had loose, orange, and black grime on the inside surface which resembled food particles. A plastic bag holding food scoops was stored on the shelving. One scoop handle was significantly scratched, rough to the touch, had a coating which was partially peeled off, and was discolored with an orange residue. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As the initial tour of the kitchen continued, an observation and interview on 4/15/24 at 10:56 a.m., showed another preparation table in the center of the kitchen with drawers attached to the underside of the table. One drawer contained a plastic eating utensil holder, which held forks, knives, spoons, and measuring utensils. The inside surface of the utensil holder which came into contact with the utensils, had particles on the surface, resembling food crumbs. Also, stored in the drawer was a plastic measuring spoon with orange residue on the surface. KS stated the measuring spoon was used to measure food thickener. In a consecutive observation and interview on 4/15/24 at 10:56 a.m., metal containers holding single use, plastic eating utensils, was stored on a shelf under the center preparation table. There were particles, resembling food crumbs, on the inside surface of the container which came into contact with the eating utensils. KS stated the metal containers were not clean and the utensils were used for residents on isolation precaution. In a consecutive observation on 4/15/24 at 10:59 a.m., another drawer was observed under the center preparation table. The drawer contained 14 food scoops which had dry, white residue on the inside scoop surface. One scoop had brown residue on the handle. 5. Review of the facility's policy and procedure titled Sanitation revised April 2006, showed all counters and shelves shall be kept clean, maintained in good repair, and shall be free from corrosions, cracks, chipped areas that may affect their proper use or cleaning. Kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. Review of the facility's policy and procedure titled Storage of Food and Supplies dated 2020, showed shelves and cupboards will not be lined with liners. According to the 2022 Federal Food Code, nonfood-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling or that require frequent cleaning are to be constructed of corrosion-resistant, nonabsorbent, smooth material. Nonfood-contact surfaces are to be free of unnecessary ledges, projections, and crevices, and designed to allow easy cleaning and facilitate maintenance. Nonfood-contact surfaces of equipment are to be cleaned at a frequency necessary to preclude accumulation of soil residue. Physical facilities are to be maintained in good repair and cleaned as often as necessary to keep them clean. An observation during the initial tour of the kitchen on 4/15/24 starting at 9:28 a.m., showed wood cabinets, shelving, and drawers throughout the kitchen. Shelving in the dry food storeroom had a transparent coating on the shelves which was peeling away. In addition, the end surfaces of the shelves were painted white, and bits of white paint were peeling off. As the initial tour continued, an observation on 4/15/24 at 10:14 a.m., showed wood shelving just outside the dry storeroom which held boxes and containers of dried food, was painted white and the shelves had a rough surface with peeling paint. In addition, there was dark residue build-up in the shelf crevices. When the shelf was wiped with a white napkin, black residue transferred to the napkin. On the opposite side of this shelving unit was a wood cabinet storing containers of oatmeal and dry cereal. There was a layer of dry, loose particles, resembling crumbs on the shelving inside the cabinet. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As the initial tour continued, an observation on 4/15/24 at 10:34 a.m., showed a preparation table located against the back wall of kitchen next to the stove, had multiple wood drawers attached to the underside of the table. The wood drawers were painted white, and the paint was peeling. Some of the drawers had white rags lining the inside surface. The rags did not cover the entire surface so cooking equipment held in the drawers came into contact with the drawer surface. One drawer which held plastic lids for containers, was not lined with a rag. This drawer had orange residue on the inside bottom surface of the drawer in addition to peeling paint. As the initial tour continued on 4/15/24 at 10:38 a.m., wood shelving under the preparation table held cooking equipment such as strainers and pans. There were white rags lining the shelving which did cover the entire surface of the shelves. Some rags were torn, and one rag had green residue on the surface. The shelves had a rough surface, were painted white, and the paint was peeling. There was also dark residue build-up on the painted white surface of the shelves. Cooking equipment such as a strainer came into direct contact with the peeling painted surface with dark residue. As the initial tour continued, an observation on 4/15/24 at 10:51 a.m., showed wood shelving under the center preparation table held cooking equipment, dishware, and food such as spices and condiments. The shelving was painted white, and the paint was peeling. There was also black residue and particles resembling food crumbs on the surface of the shelving. The surface of one shelf under this preparation table was very rough, warped, and had peeled white paint. Items such as measuring cups were stored upside down on the shelf, so the top surfaces of the measuring cups were in contact with the warped, rough surface. As the initial tour continued, an observation on 4/15/24 at 10:56 a.m., showed wood drawers attached just under the top of the middle preparation table. The drawers held cooking utensils were painted white and the paint was peeling. One drawer lined with a white rag held 14 food scoops stored on top of the rag. The rag had brown particles, resembling food crumbs, on the surface and came into contact with the scoops. In addition, the lip under the preparation table, just above the drawers, was painted white and had a rough surface. The paint was peeling and there was dried orange residue along the lip. As the initial tour continued on 4/15/24 at 11:15 a.m., an observation showed wood shelving located under a counter holding a countertop refrigerator. The shelving held various items such as uncovered coffee filter and a container holding ground coffee. The coating on the surface of the wood shelving was peeling off. In addition, the ends of the shelves were painted white and peeling. In an interview on 4/16/24 at 12:55 a.m., KS stated she thought she reported the peeling paint throughout the kitchen about a year ago but did not report it since then. In an interview and observation with Maintenance Staff (MS) on 4/16/24 at 1:55 p.m., a walk-through of the kitchen was done. MS confirmed there was peeling paint throughout the kitchen and stated he was not notified of the peeling paint. MS stated the warped shelf holding measuring cups under the middle preparation table was warped because the shelf was made of particle board and moisture made it [NAME]. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/17/24 at 11:04 a.m., RD stated she did monthly inspections of the kitchen and was aware of the wood surfaces and peeling paint in the kitchen. RD stated the kitchen was old and she did not provide recommendations to the administrator about replacing any wood, painted storage areas with peeling paint or not using rags to line the drawers. 6. Review of the facility's policy and procedure titled Storage of Food and Supplies dated 2020, showed all food will be used per times specified in the Dry Food Storage Guidelines. Review of the facility's undated Refrigerator and Freezer Storage: Time frame guidelines, showed opened lunch meat could be stored in the refrigerator for three days. The list also showed leftover cooked pork could be stored for 3 days. Review of the facility's Refrigerated Storage Guide dated 2019, showed the maximum refrigeration time for luncheon meats, ham was five days. During an observation and interview in the kitchen on 4/15/24 at 11:07 a.m., showed a refrigerator stored on top of a counter by the front door which stored perishable food. One item in the refrigerator was a reusable plastic container containing sliced ham. There was also some liquid in the container which the ham was sitting in. The container lid had a hand-written label showing 4/2/24. KS stated the ham should not be stored for more than three days. An observation and interview on 4/16/24 at 11:40 a.m., showed a list pinned to a cork board titled Refrigerator and Freezer Storage: Time frame guidelines. KS was asked if she could determine how long ham could be stored. KS confirmed she was looking for the ham for sandwiches on the list. KS was not able to determine how long the ham could be stored according to the list. In an interview on 4/17/24 at 11:04 a.m., RD stated items should be discarded by the use-by-date. RD stated staff dated food items when they were opened and should refer to the list to show when the item needed to be used or discarded. 7. Review of the facility's policy and procedure titled Storage of Food and Supplies dated 2020, showed dry, bulk foods should be stored in seamless metal or plastic containers or bins which are easily sanitized. Do not add more product to a bin container until it is empty and sanitized. According to the 2022 Federal Food Code, materials used in the construction of multiuse food-contact surfaces of equipment are to have a smooth, easily cleanable surface resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. An observation and interview on 4/15/24 at 11:15 a.m., showed ground coffee stored in a metal container. The container was significantly dented, and the painted outside surface had many areas where the paint was scratched or peeled off. KS stated staff refilled the container with coffee grounds, but the container never washed or cleaned. 8. An observation on 04/15/24 at 9:58 a.m. of a reach-in freezer located in the kitchen, showed the rubber gasket door seal had brown, beige, and black particles resembling food crumbs imbedded in the crevices of the gasket. In addition, there was black residue throughout the surface of the gasket. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Kitchen Cleaning schedule dated April 2024, showed the kitchen freezer was cleaned monthly, on a Friday. While the cleaning schedule showed the freezer was cleaned monthly, the freezer was not clean.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures when: 1. The urine drainage bag of Resident 131 was touching the floor. 2. Staff did not perform hand hygiene (a way of cleaning one's hands that substantially reduces harmful microorganisms on the hands) in between clean and dirty tasks. 3. Staff did not sanitize Resident 9's call light after picking it up from the floor and prior to placing it on Resident 9's bed. 4. Staff did not perform hand hygiene after handling dirty linens. These failures placed Resident 131 at risk for transmission of infectious organisms from the floor to the urinary tract and had the potential for spread of germs in the facility. Findings: 1. Review of Resident 131's Admission Record indicated Resident 131 was admitted on [DATE]. Review of Resident 131's Discharge Summary (DS), from the general acute care hospital, dated 4/3/24, indicated Resident 131 had diagnoses that include nephrolithiasis (kidney stones) and acute pyelonephritis (kidney infection). The DS also indicated Resident 131 had a nephrostomy tube (a tube that lets urine drain from the kidney through an opening in the skin on the back) placement on her right side. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 on 4/15/24 at 10:51 AM, Resident 131 was in bed, lying on her left side with her trunk covered by a blanket. An uncovered urine drainage bag connected to a catheter tubing was hanging on the right side of Resident 131's bed. CNA 1 stated, It's (tubing) coming from the back, not sure what it is. During a concurrent observation and interview with CNA 1, on 4/16/24 at 2:02 PM, Resident 131's urine drainage bag was not covered and touching the floor. CNA 1 verified the observation. CNA acknowledged the urine drainage bag should not have been touching the floor. CNA 1 was asked if the urine drainage should be covered, she stated, Yes, with cloth bag. I don't know where to find a bag. During an interview on 4/17/24 at 9:46 AM, the Infection Preventionist (IP) stated that Resident 131's urine drainage bag should have been placed inside a protective bag and should be kept off the floor. The IP stated, It can cause contamination and may cause infection to the resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy and procedure (P&P), titled Catheter Care, Nephrostomy, indicated Purpose - The purpose of this procedure is to prevent infection for residents with a nephrostomy tube. Further review of the P&P indicated, General Guidelines - 8. Be sure the catheter tubing and drainage bag are kept off the floor . The P&P did not indicate urine drainage bag should be covered or placed inside a protective bag. 2. During an observation on 4/15/24 at 10:38 AM, Resident 131 was in bed and positioned on her left side. CNA 1 was standing by Resident 131's bed, wearing gloves. A basin and a container of disposable wipes were placed on Resident 131's over bed table. A trash can was placed at bedside. CNA 1 stated Resident 131 had a bowel movement, and she was about to clean her and proceeded to clean Resident 131 using disposable wipes and discarding them into a trash bag. After cleaning Resident 131, CNA 1 applied clean disposable briefs using the same gloves. CNA 1 removed her gloves and disposed them in the trash bag. CNA 1 did not perform hand hygiene after glove removal and with bare hands, CNA 1 proceeded to pick up the trash can and moved it on the floor at the foot of the bed. CNA 1 then pushed the privacy curtain, went towards the bed and repositioned Resident 131. CNA 1 then walked towards Resident 131's nightstand drawer, took out the bed remote controller to elevate the head of the bed, and placed the bed remote controller back in the drawer. During continued observation, CNA 1 picked up a comb from Resident 131's night stand, and combed Resident 131's hair. Afterwards, CNA 1 picked up the trash bag containing the used wipes, opened Resident 131's door, exited the room, and disposed the trash bag in the trash bin located in the hallway. CNA 1 did not perform hand hygiene after exiting Resident 131's room. During an interview on 4/15/24 at 10:51 AM, CNA 1 acknowledged she did not perform hand hygiene and stated, I should have. During an interview on 4/17/24 at 9:46 AM, the Infection Preventionist (IP) stated that cleaning a resident after bowel movement is a dirty task and staff should perform hand hygiene in between clean and dirty tasks, before putting on and removing gloves. The IP also stated staff should perform hand hygiene before and after exiting a resident's room. The IP stated not doing so could cause contamination and risk of infection to the residents. 40478 3. Resident 9's admission record indicated, he was admitted with diagnoses of major depressive disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain, depriving them of oxygen and nutrients), and type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) among others. Resident 9's minimum data set (MDS - an assessment tool for nursing home residents), his brief interview for mental status (BIMS - an evaluation tool to assess resident's cognition) score was 6 indicating severe cognitive impairment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with Resident 9 on 4/15/24, observed his call light was not within his reach. Observed a white cord on the floor. When asked where his call light was, Resident 9 did not answer. CNA3 looked for the call light and was told it was on the floor. CNA3 was asked to turn the call light on while this surveyor went out to check the light above Resident 9's door. Asked CNA3 to press it the second time but there was no light above the door. CNA3 was asked to check if the call light was plugged in the socket on the wall, she did, and suddenly the light was on, to which CNA3 stated, it is now working. During observation, CNA3 was observed putting the call light on Resident 9's bed cover without first sanitizing the call light and the cord. CNA3 was asked to sanitize the system before putting it back within resident's reach. During an interview with LVN 1 on 4/15/24 she stated, the call light must be within the patient's reach. During an interview with the Infection Preventionist (IP) on 4/18/24 in the hallway by the med cart, he stated, oh yes, we were told about the call light. It had to be sanitized . that's infection control. I will give them an in-service on infection control. 4. During a concurrent observation and interview with laundry staff 1 on 4/17/24 at 1:30 PM on the second floor, Laundry staff1 grabbed the handle of the cart with a transparent bag of dirty linens sitting on it. Following Laundry staff1 back to the elevator, and to the first floor she took a pair of gloves from a box on top of a running washing machine and put the gloves on without washing her hands. During interview, laundry staff 1 stated, I did not touch the dirty linens. I just touched the cart. During an interview with the Infection Preventionist (IP) on 4/17/24 at around 2 PM in the dining room, he stated, that's infection control. She must wash her hands. I will give them an in-service on hand hygiene. During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, with revised date 8/15, indicated, Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after direct contact with residents .h. before moving from a contaminated body site to a clean body site during resident care .m. After removing gloves .9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555869	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Laurel Heights Community Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2740 California St San Francisco, CA 94115	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 34975 Based on observation and interview, the facility failed to maintain one of three food refrigerators free of significant ice build-up. This failure had the potential to affect the quality and safety of food stored inside the refrigerator. Findings: According to the 2022 Federal Food Code, equipment shall be designed and constructed to retain their characteristic qualities under normal use. Equipment shall be maintained in a state of repair. Door seals shall be kept intact and tight. An observation on 4/15/24 at 11:07 a.m., showed a milk dispensing refrigerator located in the kitchen being used as refrigerator to store a variety of foods. There was a significant amount of ice build-up, in some areas over one inch thick, covering the majority of the interior sides and ceiling. In addition, it was noted the rubber gasket (the gasket creates a tight seal when the cooler door is closed in order to keep cool air inside the refrigerator) on the perimeter of the interior side of the door was dented, and was not a continuous, intact gasket. In an interview and observation on 4/16/24 at 1:55 p.m., Maintenance Staff (MS) stated refrigerators should not have ice build-up.		

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612 Based on observation and record review, the facility failed to provide 80 square feet of living space for each resident, in two of 14 resident rooms (resident rooms [ROOM NUMBERS]). This failure had the potential to prevent staff from providing the necessary care and services to the residents, and it could potentially prevent the residents from having enough space for their personal belongings. Findings: During an observation on 4/15/24 at 10:37 AM, there were three were three occupied beds in resident room [ROOM NUMBER] and three occupied beds in resident room [ROOM NUMBER]. Review of the facility-provided floor plan indicated rooms [ROOM NUMBERS] had total of 214 square feet for each room providing only 71.3 square feet per resident. Review of the facility's resident census, dated 4/15/24 indicated resident rooms [ROOM NUMBERS] had three residents residing in each room. During an interview on 4/15/14 at 10:38 AM, Certified Nursing Assistant (CNA) 1 stated she has been taking care of the residents in rooms [ROOM NUMBERS] and had no problems providing individual care to each resident in rooms [ROOM NUMBERS]. During observations on all the days of the survey, there were no concerns noted regarding the provision of care in resident rooms [ROOM NUMBERS]. There were also no concerns noted regarding storage space for the residents' personal items, such as clothing.		