STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555869	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Heights Community Care	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan within 7 days after completion of the comprehensive assessment in collaboration with the Interdisciplinary (professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident) Team (IDT) and hospice provider for 1 of 3 residents (Resident 29) receiving hospice services.The deficient practice resulted in the potential for unmet physical, emotional and psychosocial needs, and lack of coordination between the facility and hospice.During a review of facility's clinical document titled admission Record dated 7/27/2025, the admission record indicated, Resident 29 was admitted in the facility 4/3/2024 with primary admitting diagnosis is Vascular Dementia (where the brain doesn't get enough blood flow, which damages brain cells and causes problems with thinking, memory).A review on Resident 29's care plan, on 7/29/2025, indicated, there was no documented participation or collaboration with the hospice IDT ((interdisciplinary team, a group of healthcare professionals from different fields who work together to provide comprehensive patient care) in revising or updating the resident's care plan.During an interview on 7/29/2025 at 10:35AM with Registered Nurse/Infection Preventionist (RN/IP) 1, RN/IP 1, stated, At first, a physician from Program of All-Inclusive Care for the Elderly (PACE) agency will come to visit the resident and let us know that the resident will be in hospice, and a hospice agency contracted by them will come after hours for additional nursing services, if we need something. There are no hospice progress notes present in the chart.During an interview on 7/30/2025 at 11:16AM with Director of Nursing (DON), the DON stated, No IDT because what I did, When the physician from PACE agency, told me that the resident will be on hospice that was on 6/18/2025, that's the time that I did the significant change assessment on MDS, after that I called the resident family to let them know that resident will be on Hospice. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, undated, the P&P indicated, Policy Interpretation and Implementation, indicated,.5. Coordinated Plan of Care. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the residents' current status.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary condition was met for food storage in the kitchen when there was a slight dent on a can of Hunt's Tomato Sauce in the storage room. This failure was likely to result in putting residents at risk for foodborne illness (diseases caused by consuming contaminated food or drink).During a concurrent observation and interview on 7/27/25 at 11:52 AM with Dietary Service Supervisor (DSS) in the storage room in the kitchen, there was a dent on the can of Hunt's Tomato Sauce on a shelf. The can indicated, . BEST BY OCT (October) 17 2026 . NET WT (Weight) 15 OZ (an abbreviation for ounce, a unit of weight or fluid volume) (425g (gram, a unit of mass in the metric system, equal to one thousandth of a kilogram)) . DSS stated, the can should not have the dent and he needed to throw it away. DSS further stated, I need to return it to the Sysco Company. During an Interview on 7/27/25 at 12:04 PM with DSS, DSS stated, Botulis (sic: Botulism is a rare but serious illness caused by a toxin that attacks the nervous system and can cause paralysis) . They can be sick with food posing . food borne illness when asked about the possible risk of the dented Hunt's tomato sauce can. Then DSS threw the can away. During an interview on 7/30/25 at 2:14 PM with Infection Preventionist (IP), IP acknowledged, the can of Hunt's Tomato Sauce with the dent could cause food borne illness if residents ate the tomato sauce when asked. Review of the facility's policy and procedure (P&P) titled, FOOD STORAGE-DENTED CANS dated 2018 indicated, . All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specific labeled area for return to purveyor for refund .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to provide a written agreement with the hospice that defined the services to be provided, respective responsibilities, and established a process for communication and collaboration for one of three sampled residents (Resident 29).This deficient practice resulted in the potential for compromised quality of care due to lack of defined roles, responsibilities and communication between the facility and hospice provider for all residents receiving hospice services.During a review of facility's clinical document titled admission Record, dated 7/24/2025, admission record, indicated, resident 29 was admitted on [DATE], and is a Medicare and Medi-Cal beneficiary.During an interview on 7/29/2025 at 10:35AM with Registered Nurse/Infection Preventionist (RN/IP) 1, RN/IP 1, stated, I cant find a hospice written agreement that's why I've been calling Program of All-Inclusive Care for the Elderly (PACE) agency requesting the hospice agreement needed today for the survey but as of now they still have not send it. I don't know our responsibilities here in the facility and they don't share their clinical notes for the hospice residents. At first, a physician from PACE Agency will come to visit the resident and let us know that the resident will be on hospice, and a hospice agency will come after hours if we need something. There are no hospice progress notes present in the chart.During an interview on 7/30/2025 at 11:16AM with Director of Nursing (DON), DON stated, Only now that we get their Hospice notes from PACE Agency, and noted that a Licensed Vocational Nurse (LVN) from the contracted hospice agency admitted and did the assessment. The admitting date and hospice diagnosis were not in the 3 resident charts. I all I know is that the resident has Dementia. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, undated, the P&P indicated, Policy Interpretation and Implementation, 3.When a resident has been diagnosed as terminally ill, the Director of Nursing Services will contact our hospice agency and request that a visit/interview with the resident/family be conducted to determine the resident's wishes relative to participation in the hospice program. 4. Our facility ensures timely and appropriate access to hospice services for enrolled PACE Agency participants during after-hours (evening, weekends, and holidays) in collaboration with PACE Agency contracted hospice provider. This policy supports the delivery of person-centered, palliative care consistent with the goals of the PACE Agency program and federal/state hospice regulations. 5. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the residents' current status. 6.All hospice services are provided under contractual arrangement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is on file in the business office and hospice agency. 7. The agreement with the hospice provider must be signed by a representative from this facility and a representative from the hospice agency before hospice services are furnished to any resident.

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F 0912 Level of Harm - Potential for minimal 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** Based on observation, interview, and record review, the facility failed to ensure in two (resident rooms [ROOM NUMBERS]) of 14 residents' rooms met the required minimum of 80 square feet (sq ft) per resident.This failure has the potential for residents to not to have enough appropriate space for the provision of care or daily living.During an observation on 7/27/2025 at 10:00 AM, in the course of the initial tour of the facility conducted on the first-floor room [ROOM NUMBER] were occupied by three beds divided by curtains two residents, room [ROOM NUMBER] were occupied by three beds with three residents, with curtains to divide each bed.During an interview on 7/28/25 at 10:20 AM, Resident 24 in Room14, Resident was asked how the space was in their room. Resident 24 stated, I am okay staying with this room, I don't have any issue sharing it to my two neighbors.During an interview on 7/30/2025 at 2:44PM with Certified Nursing Assistant (CNA)1, CNA 1 stated, it's okay, when we use the Hoyer lift and there is still space, we can do it one by oneDuring an interview on 7/30/2025 at 2:48PM with CNA 2, stated that Geri-chair can fit in and out of the room and we can maneuver using the Hoyer, we still have space and no issue when doing care to each of the resident at room [ROOM NUMBER].A review of facility-submitted documents, titled Laurel Heights Community Care-Requested for Variance, dated 5/30/2024, completed by the Administrator. The Administrator provided a copy of the letter addressed to Manager, Survey and Certification Branch, Center for Medicare and Medicaid Services and to California Department of Public Health San Francisco District Office, requesting for a waiver for variance in room size, which indicated the following facts and circumstances. 1. The affected rooms each afford a reasonable amount of privacy, closet and storage space for the residents and the availability of bedside stands for each resident. The following contains the measurements of each Affected Room, which are based on the guidelines for F485. room [ROOM NUMBER]: This is a three (3) bedroom. The room contains a total of 214 square feet, resulting in 71.333 square feet per resident. room [ROOM NUMBER]: This is a three (3) bedroom. The room contains a total of 214 square feet, resulting in 71.333 square feet per resident.