STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital and Rehabilitation Center	375 Laguna Honda Blvd San Francisco, CA 94116

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 46995 Based on observation, interview, and record review, the facility failed to visually monitor one of 70 sampled Residents (Resident 1301) physical restraint device (device attached to the resident body that cannot be easily removed which restricts freedom of movement). This failure had the potential to result in injury and limited mobility. Findings: Resident 1301 was admitted to the facility early 2019 with diagnoses which included Huntington's Disease (progressive brain disorder that causes uncontrolled movement). During a review of Resident 1301's Minimum Data Set (MDS, an assessment tool) dated 9/5/23, the MDS indicated severe cognitive impairment, and use of trunk (upper body) restraint when out of bed in chair. During a review of Resident 1301's Active Order Set: Restraint Orders, dated 11/21/23, the orders indicated Resident 1301 had a seat belt type restraint to be used during the day when in his chair or wheelchair. During a review of Resident 1301's Care Plans (CP) Physical Restraint, start date 2/1/23, the CP indicated, . Visual check of resident every 2 hours by LN [Licensed Nurse] and PCA [Patient Care Assistant] for safety . During an interview on 11/28/23 at 8:34 a.m., with Patient Care Assistant (PCA 7), PCA 7 was asked about the seat belt for Resident 1301. PCA 7 stated, He [Resident 1301] has the seat belt when he is up in the chair, we monitor that .He cannot release the seat belt .staff release and re-position every two hours while in the wheelchair. During an observation on 11/28/23 at 9:50 a.m., Resident 1301 was in a wheelchair in the dining room. He had a non-releasing seat belt across his lap. During an interview on 11/30/23 at 9:45 a.m., with Registered Nurse (RN 7) 7, RN 7 was asked how often the seat belt restraint for Resident 1301's was checked. RN 7 stated if the seat belt was on [Resident 1301] there should be every two-hour documentation on the flowsheet. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/30/23 at 12:04 p.m., with RN 7, Resident 1301's flowsheet for documentation of the non-releasing seat belt, dated 10/30/23-11/29/23 was reviewed. The flowsheet indicated there was no documentation for monitoring on 11/2/23, 11/5/23, 11/16/23, 11/19/23 and 11/23/23. RN 7 confirmed there were five days of missing documentation. RN 7 stated, I would expect to see documentation every day. There are holes in it [flowsheet] for sure. RN 7 was asked the importance of accurate monitoring and stated, .to make sure [Resident 1301] is being properly cared for and so it [seat belt] does not cause harm .to make sure there is no injury while the seat belt is on . During a review of facility's policy and procedure (P&P) titled, Restraint Free Environment, Revised 9/12/23, the P&P indicated, .DOCUMENTATION .Staff will provide ongoing monitoring and evaluation .release and document every 4 hours or sooner according to resident need .Monitoring and supervision are to be documented via EHR [electronic health record] .Monitoring will include .proper placement of restraint as ordered .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37797 Based on interview and record review, the facility failed to report within 2 hours one of five allegations of abuse to the California Department of Public Health (the Department). This failure could have delayed the Department's investigation of the allegation of abuse. Findings: A review of Form SOC 341 Report of Suspected Dependent Adult/Elder Abuse, dated 10/24/23, completed by Social Worker 1 (SW1), and submitted by the facility to the Department on 10/24/23, at 11:06 a.m., indicated Residents 61 and 657 had been involved in a resident-to-resident altercation. The report indicated Resident 61 grabbed the walker of Resident 657 who responded by striking one of Resident 61's wrist. The report indicated the incident happened on 10/23/23 at approximately 1 p.m. During an interview and record review on 11/30/23, at 11:49 a.m., Regulatory Affairs Nurses 1, 2 and 3 reviewed the Form SOC 341 Report of Suspected Dependent Adult/Elder Abuse, dated 10/24/23, concerning the resident-to-resident altercation involving Residents 61 and 657. They were asked the reason for reporting the incident to the Department only on the next day, instead of the required 2-hour reporting timeframe. They stated they believed the abuse was not intentional. A review of facility policy and procedure titled Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response, dated 11/14/23, indicated all allegations of abuse will be reported to the Department within 2 hours.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44899 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP- a detailed approach to care customized to an individual resident's needs) for six of 70 sampled residents (Residents 1153, 1151, 1253, 56, 859, and 1303) when: 1. For Resident 1153, there was no CP addressing the diagnosis of Hepatic Encephalopathy (a medical condition caused by a buildup of toxins in the brain that can happen with advanced liver disease), and the use of rifAXIMin antibiotic for Hepatic Encephalopathy. 2. For Resident 1151, there was no CP addressing the use of Calamine Zinc Ointment (medication used to relieve pain, itching and discomfort from minor skin irritations) for itching. 3. For Resident 1253, CP intervention for Passive Range of Motion (PROM: outside force causing movement to a joint for restorative purposes) was not implemented. 4. For Resident 56, CP intervention for frequency of Range of Motion were not created. 5. Resident 859 was not provided continuous close observation by assigned coach (staff assigned as resident supervisor) as indicated on the resident care plan. 6. For Resident 1303, CP for Peripherally Inserted Central Catheter (PICC, a long thin flexible tube that is placed into a vein in your arm and goes into larger veins near your heart) line were not created. 7. For Resident 1303, CP for Contact Isolation Precautions (intended to prevent transmission of infectious agent, usually requires wearing gowns, gloves and mask when entering a room) were not created. These failures had the potential to prevent the residents from receiving appropriate, and individualized care and services consistent with their needs. Findings: 1. During a review of Resident 1153's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/28/23, the AR indicated, Resident 1153 was admitted from the acute care hospital on 10/3/23 to the facility, with diagnoses that included Hepatic Encephalopathy, Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Pneumonia (lung infection caused by bacteria), Traumatic Brain Injury (TBI, an injury that affects how the brain works), and Seizure Disorder (a medical condition that can cause sudden, uncontrollable movements and change in level of consciousness). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/28/23 at 10:48 a.m., with Registered Nurse (RN) 5, Resident 1153's CP titled Problem: Gastrointestinal -Adult, with a start date of 10/8/23, was reviewed. The CP indicated, . Problem: Gastrointestinal . GI Distress and Dehydration . Interventions: 1. Encourage fluids as tolerated Q2 hours 2. Monitor for s/s of dehydration 3. Administer MD order as prescribed to relieve GI distress . RN 5 stated there was no specific care plan for Resident 1153's diagnosis of Hepatic Encephalopathy. RN 5 stated licensed nurses should care plan the diagnosis so that all nursing staff (caring for the resident) would know the plan of care for the resident and to ensure Resident 1153 was receiving the appropriate interventions. During a concurrent interview and record review on 11/28/23 at 10:55 a.m., with RN 5, Resident 1153's Physician Order (PO), dated 10/3/23, was reviewed. The PO indicated, . rifAXIMin 550 mg 2 times daily . for hepatic encephalopathy . 11/27/23 . start tapering from BID [twice a day] to daily . RN 5 stated there was no care plan for Resident 1153's use of rifAXIMin antibiotic. RN 5 stated licensed nurse should care plan the use of rifAXIMin so that all nursing staff would know the plan of care for the resident and to ensure Resident 1153 was receiving the appropriate interventions. RN 5 stated nursing staff should monitor for medication effectiveness and adverse side effects of rifAXIMINin such as stomach pain, headache, dizziness, swelling in the belly, arms, and legs, and shortness of breath. RN 5 stated without proper monitoring of antibiotic adverse side effects, Resident 1153 could potentially experience a negative health outcome. During a concurrent interview and record review on 11/29/23 at 11:12 a.m., with the Director of Nursing (ND) 2 , Resident 1153's CP, dated 10/8/23, was reviewed. The ND 2 stated a resident specific care plan should have been developed to address Resident 1153's diagnosis of Hepatic Encephalopathy and it was not done. The ND stated there should have been one developed, because the resident was at risk for increased confusion and buildup of toxins in the brain. The ND 2 stated, CP is our form of communication with other team members. Without a resident specific CP, we don't have a clear path to meet Resident 1153's medical, physical, mental, and psychosocial needs. During a concurrent interview and record review on 11/29/23 at 11:12 a.m., with the Director of Nursing (ND) 2 , Resident 1153's PO, dated 10/3/23, was reviewed. The ND 2 stated there should have been a specific care plan for Resident 1153's use of rifAXIMin and it was not done. The ND 2 stated licensed nurse should create a care plan specific to Resident 1153's use of rifAXIMin that includes monitoring for medication effectiveness and side effects. The ND 2 stated without a specific care plan for use of rifAXIMin, Resident 1153's medical needs could be potentially not met. During a review of the facility's policy and procedure (P&P) titled, Resident Care Plan (RCP), Resident Care Team (RCT), and Resident Care Conference (RCC), dated 9/2023, the P&P indicated, . 4. Comprehensive Care Plan . c. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment . 7. Developing Interventions . b. Interventions are specific, individualized and describe the team member(s) responsible for carrying it out and the frequency of conducting interventions . c. Interventions reflects standards of current professional practice . During a review of the facility's document titled, Job Description . Registered Nurse, dated 7/2022, the document indicated, . Under general supervision, performs nursing duties in hospitals, clinics, sanitariums, and other institutions . keeps related charts and records in accordance with standard practices . carrying out existing methods and procedures relating to various aspects of patient care . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the professional reference titled, Lexicomp dated 11/15/23, the professional reference indicated, . RifAXIMin . It is used to prevent brain problems caused by very bad liver disease . call your doctor or get medical help if any of the side effects . headache, feeling dizzy, tired, stomach pain . very bad side effects . a very bad skin reaction . swelling in arms or legs, swelling of belly , shortness of breath . 2. During a review of Resident 1151's AR, dated 11/29/23, the AR indicated, Resident 1151 was admitted from the acute care hospital on 4/13/22 to the facility, with diagnoses that included Dementia, Congestive Heart Failure (CHF, weakness in the heart where fluid accumulates in the lungs), recurrent Urinary Tract Infection (UTI, bladder infection), Depression (a persistent feeling of sadness and loss of interest), and thin fragile skin. During a concurrent interview and record review on 11/29/23 at 10:26 a.m., with RN 6, Resident 1151's CP titled Problem: Skin/Tissue Integrity - Adult, with a start date of 4/13/22, and PO, dated 11/20/23 were reviewed. The CP indicated, . Description: Resident is at risk for skin discoloration, hematoma, and skin breakdown due to weakness, severe dry skin, impaired mobility, required assistance with Activities of Daily Living, incontinence of bowel and bladder . Interventions: Monitor skin discoloration every shift . Monitor for bruising . Maintain adequate hydration Appy skin moisturizer as prescribed . Physician Order (PO) on 11/20/23 . 11:48 a.m. calamine-zinc oxide lotion . topical . apply every shift . RN 6 stated there was no specific care plan for Resident 1151's use of calamine-zinc oxide lotion. RN 5 stated licensed nurse should care plan each medication so that all nursing staff would know the plan of care for the resident and to ensure Resident 1151 was receiving the appropriate interventions. During a concurrent interview and record review on 11/29/23 at 11:20 a.m., with the Director of Nursing (ND) 2 , Resident 1151's CP, dated 11/20/23 and PO, dated 11/20/23, were reviewed. The ND 2 stated there should be a resident-specific care plan for Resident 1151's use of calamine-zinc oxide lotion and it was not done. The ND 2 stated licensed nurse should create a care plan related to Resident 1151's use of calamine-zinc oxide lotion that includes monitoring for medication effectiveness and side effects. The ND 2 stated without a specific care plan for use of calamine-zinc oxide lotion, Resident 1151's medical needs could be potentially not met. During a review of the facility's policy and procedure (P&P) titled, Resident Care Plan (RCP), Resident Care Team (RCT), and Resident Care Conference (RCC), dated 9/2023, the P&P indicated, . 4. Comprehensive Care Plan . c. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment . 7. Developing Interventions . b. Interventions are specific, individualized and describe the team member(s) responsible for carrying it out and the frequency of conducting interventions . c. Interventions reflects standards of current professional practice . During a review of the facility's document titled, Job Description . Registered Nurse, dated 7/2022, the document indicated, . Under general supervision, performs nursing duties in hospitals, clinics, sanitariums, and other institutions . keeps related charts and records in accordance with standard practices . carrying out existing methods and procedures relating to various aspects of patient care . 46939 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 1253's Care plan, dated 6/22/21, the Care plan indicated, Problem: ADL[Activities of daily living: activities related to personal care] Maintenance. [Resident 1253] requires total assists from staff to complete his ADLs, unable to participate in self care due to hx [history] of TBI [traumatic brain injury] and consequent neurological deficit. [Resident 1253] is at risk for complications from immobility. Interventions.3. PROM [Passive range of motion: outside force causing movement to a joint for restorative purposes] in all extremities, 15 mins BID [two times daily]. During a review of Resident 1253's Minimum Data Set (MDS- a comprehensive assessment used to determine residents needs), dated 9/13/23, MDS section G0400 indicated, Functional Limitation in Range of Motion.Upper extremity (shoulder, elbow, wrist, hand) Impairment on both sides.Lower extremity (hip, knee, ankle, foot) Impairment on both sides. During a review of Resident 1253's MDS section G0110, dated 9/13/23, MDS indicated, A. Bed mobility-how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.4. Total dependence-full staff performance every time. During an interview on 11/29/23, at 10:41 a.m., with Nursing Manager (NM) 2, NM 2 stated, the Patient Care Assistants (PCAs) are supposed to perform PROM for Resident 1253, per the care plan two times daily for 15 minutes, and chart this was performed in the mobility section of the flowsheets located in Resident 1253's Electronic Health Record (EHR). During a concurrent interview and record review on 11/29/23 at 10:45 a.m. with NM2, Resident 1253's Flowsheet for Mobility, dated November 2023 was reviewed. The Flowsheet indicated, on 11/17/23 PROM for Resident 1253 was only charted as performed once this day at 0100. On 11/20/23, PROM for Resident 1253 was only charted as performed once this day at 0200. On 11/25/23, PROM for Resident 1253 was not charted as performed this day. On 11/26/23, PROM for Resident 1253 was not charted as performed this day. On 11/27/23, PROM for Resident 1253 was charted as performed only once this day at 0614. NM2 stated she could not confirm PROM was performed for Resident 1253 two times on 11/17/23, 11/20/23, 11/25/23, 11/26/23, or 11/27/23. NM2 stated, it is her expectation that staff implement all care plan interventions for Residents, PROM should be provided and charted twice daily for Resident 1253. During a review of the Facility's Policy and Procedure (P&P) titled, Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC).Purpose: It is the policy of [Facility name] to develop and implement a comprehensive person-centered care plan for each resident. 36471 4. A review of Resident 56's clinical record was conducted. Per the ADL (Activities of Daily Living) Maintenance, dated 11/6/23, under Interventions , the staff was to Perform active/passive ROM (Range of Motion) as tolerated/ordered by stabilizing the joint, moving slowly, gently and only to the point of slight resistance. However, the intervention did not include the frequency of the ROM exercise. On 11/29/23 at 11:15 A.M., a joint interview and record review was conducted with the MDS (Minimum Data Set Coordinator). The MDS stated Resident 56 was on palliative care, and the Patient Care Assistants (PCA) were supposed to do the ROM. The MDS further stated she could not say how often [during ADL care, every shift, or daily]. The MDS stated the care plan intervention should have frequency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/29/23 at 12:45 P.M., a joint interview and record was conducted with PCA 12. PCA 12 said she would check her worklist at the beginning of the shift to see if any assigned residents needed ROM. PCA 12 further stated Resident 56 did not have ROM in the worklist, which meant she would not have to do the ROM or document. On 11/30/23 at 9:30 A.M., a joint interview and record review was conducted with the Nurse Manger (NM) 5. The NM 5 stated Resident 56 had an ADL care plan for the PCA to do the ROM. However, it did not indicate the frequency. The NM 5 further said Resident 56's care plan should be complete and measurable to prevent confusion. Per the facility's policy and procedure, dated 9/12/23, title Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), .Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions 39474 5. During an observation on 11/28/2023 at 9:55 a.m. Resident 859 was observed sitting up in bed, care giver at bedside, unable to answer questions. During an interview on 11/30/2023 at 11:30 a.m. with Nurse Manager 3 (NM3), NM3 stated, Resident 859 was found unattended on 9/28/2023 during change of shift at about 3:00 p.m. The Activities Therapist (AT2) witnessed the coach for Resident (859) was missing and reported the incident to nursing. The coach should have provided continuous close observation for Resident (859), it was written into the resident care plan. The need for a 24-hour coach for Resident (859) is in her care plan. Review of Resident (859)'s history and physical dated 9/28/2023 indicated, she is a [AGE] year-old female with a history of dementia, stroke, hypertension, heart failure and diabetes. During a review of Resident (859)'s Care Timeline documentation dated 9/28/202 at 5:07 p.m. indicated, While walking back to the office, this Activities Therapist (AT2) noticed the coach for Resident (859) was gone. AT2 turned around and saw resident (859)'s coach approaching from the nursing office . During a review of Resident (859)'s care plan dated 8/26/2023 at 11:06 a.m. indicated, .15. Provide coach 1:1 supervision every shift for safety related to falls . During a review of facility's policy and procedure titled, Resident Care Plan, Resident Care Team and Resident Care Conference, dated 9/12/2023 indicated, .Procedure: 1. The Resident Care Team b. The resident, family and or representative shall be part of the development and implementation of his or her person-centered plan of care, including but not limited to: iv. The right to receive the services and or items included in the plan of care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure titled, Coach Use for Close Observation, dated 12/13/2022 indicated, 1. Nursing Services is responsible for providing close observation of residents when needed .2. Resident behaviors that may require close observation include but are not limited to the following a. High risk for falls.7. Coaches shall provide continuous close observation or engage with the resident as appropriate and provide all care needs within their scope of their licensure or certification while avoiding distraction . 46995 6 and 7. Resident 1303 admitted to the facility late 2023 with diagnoses which included sepsis (life threatening complication of an infection), Multiple drug resistant organism (MRDO) Carbapenem- resistant Enterobacterales (CRE, germ that no longer responds to the antibiotic designed to kill them). Resident 1303 is cognitively intact. During a review of Resident 1303's document titled, Procedure Notes, (PN) dated 10/22/23, the PN indicated, .Insert PICC line . During a review of Resident 1303's Care Plans, no Care Plans for the PICC line were found. During a concurrent observation and interview on 11/28/23 at 10:10 a.m., with Resident 1303, Resident 1303 had a PICC line to his right upper arm. During an interview on 11/30/23 at 9:50 a.m., with Registered Nurse (RN 7) 7, RN 7 stated the PICC for Resident 1303 was inserted a few months ago. RN 7 confirmed there was no care plan created for the PCC line and stated there should have been a care plan. During a review of Resident 1303's document titled, Active Order Set, the document indicated Contact Isolation was added to the orders on 11/3/23. During a review of Resident 1303's Care Plans, no Care Plans for the Contact Isolation were found. During an observation on 11/29/23 at 9:35 a.m., outside Resident 1303's room, a sign for Contact Isolation was attached to the door. The sign indicated, STOP CONTACT PRECAUTIONS TO PREVENT THE SPEAD OF INFECTION ANYONE ENTERING THIS ROOM MUST HAND HYGIENE, GLOVES, GOWN . During an interview on 11/29/23 at 11:11 a.m., with Patient Care Assistant (PCA 6) 6, PCA 6 stated gown, mask, and gloves (contact precautions) were to be used when care was provided for Resident 1303's colostomy (an opening in the abdomen used for bowel movements) and indwelling catheter (tube placed in the bladder to empty urine). During an interview on 10/30/23 at 9:54 a.m., with RN 7, RN 7 confirmed there were no care plans specific to the contact isolation for Resident 1303's indwelling catheter or colostomy care. When asked if there should be a care plan and the importance of having one, RN 7 stated, Yes .So everyone is on the same page on how to take care of him properly .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility did not revise the care plan related to the denture care, when a resident received a new upper and partial denture on July 21, 2023, for one of one resident reviewed (Resident 62). This failure resulted in Resident 62, not being compliant of wearing his new dentures, and Patient Care Assistant (PCA) were not able to implement the specific care of Resident 62's new dentures. In addition this failure had the potential to affect the necessary care specific for Resident 62's new dentures and potential for the developmental of complications for not wearing his new dentures that will create adverse effect on dental health. Findings: During a concurrent observation and interview, on 11/27/23, at 12:50 p.m., with the Nurse Manager (NM) 4, in South 4, Resident 62 was observed awake, alert and able to verbalize his needs. Resident 62 stated he just had his lunch and ate most of his meal. Resident 62 was observed without his teeth. He stated he had new dentures but he had to get used in wearing them. He stated he needed to be reminded of using his new dentures before eating. During a concurrent interview and record review, on 11/27/23, at 3:11 p.m., with NM 4, indicated, Resident 62 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (a disease in which the body's immune system attacks the protective covering of the nerve cells in the brain). Recent readmission was on 03/07/2023, with diagnoses which included urosepsis (kidney infection). The Minimum Data (MDS - an assessment tool) dated September 6, 2023, indicated Resident 62 had a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition) Score of 14 (cognitively intact). Activity Of Daily Living (ADL) indicated, Resident 62 required total dependence on his personal hygiene requiring one to two persons assistance. The dental progress note dated 6/20/23, indicated Resident 62 had a scheduled appointment for full arch tooth try in for upper complete denture and lower partial. The note further indicated, Resident 62's last appointment dentures should have been fabricated but lab (laboratory) sent back in new shade. Resident 62 had denture try in, checked bite and occlusion, and was satisfied with esthetics of new tooth color. The Nursing Weekly Summary dated 07/10/2023, entered at 3:37 p.m., indicated, .ADL Maintenance . Teeth/Oral care/Dentures: Total . The nursing note dated 07/21/23, at 3:09 p.m., indicated Resident 62 had a dental appointment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

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Laguna Honda Hospital and Rehabilitation Center	375 Laguna Honda Blvd San Francisco, CA 94116

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dental progress note dated 07/21/23, indicated, Resident 62 had received complete maxillary (upper) denture and mandibular (lower) resin-based partial dentures. Denture home care instructions given .patient instructions. The dental instructions indicated, Please do not brush the dentures with toothpaste. Remove food particles after each meal by rinsing with water and brush with a sponge or soft cloth. Use a non-abrasive dish soap and soak in water daily . may also use a denture cleaning tablet following manufacturer's instructions several times a week. Resident 62's baseline care plan for ADLs and Routines, under Resident Preferences was reviewed with NM 4. The ADLs indicated, .Teeth/Oral (mouth) care/Dentures . There was no documented evidence the care plan for Resident 62's oral and denture care were updated and revised when Resident 62 got fitted for his new dentures on 07/21/23. NM 4 stated the care plan was not updated when Resident 62 had his new dentures on 07/21/23. NM 4 further stated the licensed staff should have updated and revised Resident 62's care plan related to his new dentures on 07/21/23. During a review of Resident 62's care plan on 11/28/23, at 3 p.m., further record review indicated, updated care plan did not include specific dental instructions as written by Resident 62's dentist on 07/21/2023. During a concurrent observation and interview on 11/29/23, at 10:23 a.m.,with NM 4 for Resident 62, indicated, Resident 62 was awake, alert and able to verbalize his needs. Resident 62 was observed not wearing his dentures. He stated he did not use his dentures since 11/27/23. Resident 62 gave permission for NM 4 and HFEN (Health Facility Evaluator Nurse) to check his dentures on top of his side cabinet. A closed container with resident's dentures was observed. The upper full and lower partial dentures were soaked in water, smelling the cleaning tablet. Dentures clean with no food particles. During an interview on 11/29/23, at 10:45 a.m., with Patient Care Assistant (PCA) 8, indicated PCA 8 took care of Resident 62, two weeks ago in the afternoon shift from 3 p.m. to 11:30 p.m. Today 11/29/23, a Home Health Aide assisted Resident 62 for breakfast. PCA 8 stated he was aware Resident 62 had dentures at bedside. PCA 8 stated he would rinse the dentures with water and apply dental gum before putting them in resident's mouth. He stated after meals he would rinse resident's dentures with warm water and use denture brush to clean the dentures and placed the dentures in a cup with new water and denture tablet. During a review of nursing weekly summary on 11/29/23, under CARE PLAN .CARE PLAN interventions . Resident Preferences and care needs .Teeth/Oral care/Denture: Total . indicated, the care plan from August 1, 2023 to November 1, 2023, related Resident 62's new denture care were not updated and revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/30/2023, at 9:30 a.m., with NM 4 for Resident 62, indicated Resident 62 was awake, alert, and able to verbalize his needs. Resident 62 stated he had breakfast and ate well. Resident 62 was observed not wearing his dentures. Resident 62 stated he did not use his dentures during breakfast. HFEN asked Resident 62's permission to check the oral care items at bedside. Resident 62 consented. The following items were observed on top of the side cabinet: - Two tubes of denture adhesive (Sparkle Fresh Denture Adhesive Cream and Fixodent extra hold powder); - A box of denture tablet and; - A denture brush. The facility's policy and procedure titled, RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC), dated September 12, 2023, was reviewed. The policy indicated, . The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries . every quarter during quarterly assessment, and revised as needed during change of condition to serve as an essential resource for improved resident outcomes. Nursing will document these summaries on the Electronic Health Record (EHR) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility did not document the specific dental care instruction when a resident received his new dentures on July 21, 2023, on the facility's worklist tasks section of resident's Electronic Health Record (EHR) for one of one resident reviewed (Resident 62). This failure resulted in Resident 62, not being compliant of wearing his new dentures, and Patient Care Assistant (PCA) were not able to implement the specific care of Resident 62's new dentures. In addition this failure had the potential to affect the necessary care specific for Resident 62's new dentures and potential for the developmental of complications for not wearing his new dentures that will create adverse effect on dental health. Findings: During a concurrent observation and interview, on 11/27/23, at 12:50 p.m., with the Nurse Manager (NM) 4, in South 4, Resident 62 was observed awake, alert and able to verbalize his needs. Resident 62 stated he just had his lunch and ate most of his meal. Resident 62 was observed without his teeth. He stated he had new dentures but he had to get used in wearing them. He stated he needed to be reminded of using his new dentures before eating. During a concurrent interview and record review, on 11/27/23, at 3:11 p. m., with NM 4, indicated, Resident 62 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (a disease in which the body's immune system attacks the protective covering of the nerve cells in the brain). Recent readmission was on 03/07/2023, with diagnoses which included urosepsis (kidney infection). The Minimum Data (MDS - an assessment tool) dated September 6, 2023, indicated, Resident 62 had a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition) Score of 14 (cognitively intact). Activity Of Daily Living (ADL) indicated Resident 62 required total dependence on his personal hygiene requiring one to two persons assistance. The dental progress note dated 6/20/23, indicated Resident 62 had a scheduled appointment for full arch tooth try in for upper complete denture and lower partial. The note further indicated, Resident 62's last appointment dentures should have been fabricated but lab (laboratory) sent back in new shade. Resident 62 had denture try in, checked bite and occlusion, and was satisfied with esthetics of new tooth color. The Nursing Weekly Summary dated 07/10/2023, entered at 3:37 p.m., indicated .ADL Maintenance . Teeth/Oral care/Dentures: Total . The nursing note dated 07/21/23, at 3:09 p.m., indicated Resident 62 had a dental appointment. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dental progress note dated 07/21/23, indicated Resident 62 had received complete maxillary (upper) denture and mandibular (lower) resin-based partial dentures. Denture home care instructions given .patient instructions. The dental instructions indicated, Please do not brush the dentures with toothpaste. Remove food particles after each meal by rinsing with water and brush with a sponge or soft cloth. Use a non-abrasive dish soap and soak in water daily . may also use a denture cleaning tablet following manufacturer's instructions several times a week. During a concurrent observation and interview on 11/29/23, at 10:23 a.m.,with NM 4 for Resident 62, indicated, Resident 62 was awake, alert and able to verbalize his needs. Resident 62 was observed not wearing his dentures. He stated he did not use his dentures since 11/27/23. Resident 62 gave permission for NM 4 and HFEN (Health Facility Evaluator Nurse) to check his dentures on top of his side cabinet. A closed container with resident's dentures was observed. The upper full and lower partial dentures were soaked in water smelling the cleaning tablet. Dentures clean with no food particles. During an interview on 11/29/23, at 10:45 a.m., with Patient Care Assistant (PCA) 8, indicated PCA 8 took care of Resident 62, two weeks ago in the afternoon shift from 3 p.m. to 11:30 p.m. He stated a Home Health Aide (HHA) assisted Resident 62 for breakfast this morning. PCA 8 stated he was aware Resident 62 had dentures at bedside. PCA 8 stated he would rinse the dentures with water and apply dental gum before putting them on at resident's mouth. He stated after meals he would rinse resident's dentures with warm water and use denture brush to clean the dentures and placed the dentures in a cup with new water and denture tablet. During a concurrent interview and record review with NM 4, on 11/29/23, at 11:37 a.m., indicated, the dental instructions on 07/21/23, for Resident 62 was not transcribed in resident's record. NM 4 stated the dental instructions for Resident 62's new dentures should have been transcribed to the facility's work list tasks section of electronic health record (EHR). NM 4 stated the licensed staff and PCA would be able to view the specific denture care for Resident 62's dentures under the work list tasks section. NM 4 further stated the licensed staff should have transcribed the dental instructions on 07/21/23, for Resident 62. During a concurrent observation and interview on 11/30/2023, at 9:30 a.m., with NM 4 for Resident 62, indicated Resident 62 was awake, alert, and able to verbalize his needs. Resident 62 stated he had breakfast and ate well. Resident 62 was observed not wearing his dentures. Resident 62 stated he did not use his dentures during breakfast. HFEN asked Resident 62's permission to check the oral care items at bedside. Resident 62 consented. The following items were observed on top of the side cabinet: - Two tubes of denture adhesive (Sparkle Fresh Denture Adhesive Cream and Fixodent extra hold powder); (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A box of denture tablet and; - A denture brush. During a review of facility's policy and procedure titled, TRANSCRIPTION AND PROCESSING OF ORDERS, dated December 13, 2022, indicated, .Licensed nurses, including Registered Nurses (RN) and Licensed Vocational Nurses (LVN), are responsible for acknowledging orders prescribed on their shift .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34448 Based on observation, interview, and record review, the facility failed to ensure for one of 70 sampled residents (Resident 451), that necessary assistance was provided during mealtime. This failure had the potential to impact the health and well-being of the resident. Findings: During a concurrent lunch observation and interview on 11/27/23 at 12:50 p.m., in Resident 451's room with Certified Nursing Assistant (CNA 1), Resident 451 was seated in a wheelchair positioned sideways to the lunch tray on the resident's bedside table. Resident 451 was observed using her right hand to feed herself, with her left arm underneath her protective clothing cover. Occasionally Resident 451 would spill food onto herself and the floor. Resident 451 picked up the orange juice container and attempted to peel back the juice container's cover using her teeth making a small opening. CNA 1 did not intervene to assist Resident 451 to open the juice container. In addition, Resident 451 ate frozen ice cream from a small container, which would move around the meal tray with each spoonful. CNA 1 stated she was assigned as a 1:1 coach for Resident 451 who had been transferred into the Covid (COVID-19, a contagious respiratory disease) Unit. CNA 1 stated she was not familiar with Resident 451's meal assistance needs. During a concurrent breakfast observation and interview on 11/29/23 at 9 a.m., in Resident 451's room with CNA 2, Resident 451 was seated in a wheelchair positioned with the bedside table in front of the resident. Resident 451 was observed eating pudding from a small container, which would move around the meal tray with each spoonful. CNA 2 stated, She can still eat it, it's just a little harder. She doesn't use her left hand. During a review of Resident 451's clinical record, a Physician's progress note, dated 11/16/23, indicated Resident 451 had a history of right thalamic hemorrhage (stroke) with residual left extremity weakness and dementia (decline in cognitive abilities affecting a person's ability to perform everyday activities). The progress note also indicated Resident 451 needed set up assistance with meals. During a concurrent interview and record review on 11/30/23 at 8:37 a.m., with Registered Nurse (RN 9), RN 9 stated staff was supposed to set up the meal tray and provide assistance when needed. RN 9 stated she did not know Resident 451 had opened the juice container with her teeth, and had difficulty eating from the small pudding and ice cream containers. RN 9 stated Resident 451's care plans did not include specific personalized interventions how to assist Resident 451 during meals. During an interview on 11/30/23 at 9:06 a.m., with Nursing Supervisor (NS 2), NS 2 stated when a resident had extremity weakness an Occupational Therapy (healthcare discipline that helps people improve their ability to perform every day tasks when having difficulty) referral should be ordered for possible adaptive devices. During an interview on 12/1/23 at 9 a.m., with Resident 451 and the Activity Therapist (AT) as translator, in Resident 451's room, Resident 451 was questioned if she needed more assistance during meals. Resident 451 nodded her head yes in response to the question. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, ASSISTING RESIDENTS DURING MEALTIME, revised 4/11/23, the P&P indicated, POLICY: 1. Nursing staff will assist the resident for meals . Nursing will provide residents with adaptive devices . if needed, during mealtime . Position the food tray according to resident's ability to see the contents, use utensils, and swallow . Assist the resident to open cartons, remove coverings and to cut up food as necessary . Resident should sit upright in a comfortable position utilizing good body alignment to minimize aspiration . Prepare the food from the tray for eating . Open all containers if the resident cannot even if resident many not eat the contents .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31403 Based on interview and record review, the skilled nursing facility did not monitor wound progression for one of 70 sampled residents (Resident 351). Resident 351 had developed an infection on his left lower leg. Staff did not document in the medical record the continued status of the infection. This failure resuled in the potential for staff to not be aware of the lack of wound healing. Findings: Record review on 11/28/23 at 4:12 p.m. of the document titled (with Resident's Name) showed the facility admitted Resident 351 on 9/14/2021. Review of the document Discharge Summary dated 11/2/2023 showed diagnoses included a history of a right leg amputation. In an interview on 11/27/2023 at 1:20 p.m., Registered Nurse 2 (RN 2) stated Resident 351 had completed a round of antibiotics for a soft tissue infection on his leg. Review of the hospital summary document (not titled) on 12/1/2023 at 9 a.m. showed Resident 351 was admitted to the hospital on 11/2/2023 and discharged back to the facility on [DATE]. Review of the section Problem-based Assessment & Plan showed, while hospitalized , Resident 351 had been treated with antibiotics for left lower extremity cellulitis (infection of the skin and soft tissue of the skin). Review of the document Discharge Summaries dated 11/7/2023 showed Resident 351 arrived at the hospital with a warm, erythematous (swollen) leg, knee and upper thigh on left lower extremity . Record review on 12/1/2023 at 9 a.m. of the document Nursing Note dated 11/8/2023 showed Resident 351 was on antibiotics for left lower extremity cellulitis. There was no documentation which described the wound. In an interview and concurrent record review on 11/28/2023 at 9:45 a.m., (21 days since Resident 351's readmission to the facility) Registered Nurse 1 (RN 1) confirmed there was no documentation in the clinical record which described the status of the soft tissue. RN 1 stated the status of the infection should have been documented so staff could assess how the wound was progressing. On 11/30/23 at 10:35 a.m., Resident 351's wounds were observed during a dressing change. In a concurrent interview RN 2 and Registered Nurse 3 (RN 3) stated the dressing was used to protect the reddened areas on the heel/top of foot and to the sides of both great toes. The areas were red without any opened sites. RN 2 and RN 3 were not able to confirm if the foot area had been the site of the infection or if it had been on another part of the leg. In an interview on 11/30/23 at 11:30 a.m., RN 3 stated, when Resident 351 returned from the hospital on 11/7/23 he observed an area of redness on Resident 351's left upper thigh which had old markings around it from the hospital. RN 3 stated he had not documented the redness in the clinical record but should have in order to ensure the infection did not worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 11/30/2023 at 2 p.m. of the document Wound Assessment and Management dated 3/10/2023 showed staff were to .document a complete wound assessment (e.g. location, description of wound, including size, quantity and quality of drainage if present, progress towards healing and when deterioration of the wound is observed or suspected) weekly. Document progress towards healing .

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	555929	A. Building B. Wing	12/01/2023

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46939 Based on interview and record review, the facility failed to provide Passive Range of Motion (PROM: outside force causing movement to a joint for restorative purposes) to one of 70 sampled residents, when PROM was not charted as performed according to the active orders. This failure had the potential for Resident 1251's mobility and functional status to decline. Findings: During a record review of Resident 1251's Active orders, dated 11/2/23, Active orders indicated, Activity (specify); please do PROM both lower extremities Q [every] shift to prevent further contractures [a condition of shortening and hardening of muscles, tendons or other tissues, leading to deformity and hardness of joints]. During an interview with Resident 1251 on 11/29/23 at 10:23 a.m., Resident 1251 stated, the staff do not regularly provide PROM or exercise to his legs. Resident 1251 could not recall when it was last performed. Resident stated, he cannot perform the exercises himself and relies on staff to do them. During a review of Resident 1251's Minimum Data Set (MDS: a comprehensive assessment used to determine needs) dated 10/9/23, MDS section C0500 indicated a BIMS (Brief Interview for Mental Status- an exam used to determine residents' mental status) was scored as 15, indicated no cognitive impairment or memory issues. During an interview with Nursing Manager (NM) 2 on 11/29/23 at 1:30 p.m., NM2 stated, if a resident has an order for PROM the staff will chart that it was performed in the Work Task List, which will then be reflected on the Resident's Work List Task History. NM2 stated, if it is showing a 'C' then the task was charted as performed, if there is an 'x' then the task was not charted as performed. NM2 stated, the order for Resident 1251's PROM is ordered for every shift, and at this facility we have three shifts, the AM shift is 11 p.m.-7:30 a.m., the Day shift is 7:00 a.m.-3:30 p.m., and the PM shift is 3:00 p.m.-11:30 p.m. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/29/23 at 2:13 p.m. with NM2, Resident 1251's Work List Task History dated 11/16/23-11/29/23 was reviewed. Work List indicated, on 11/20/23 PCA: PROM both lower extremities Q Shift was only charted as performed for two of three shifts, at 0300 and 1900, No PROM was charted for 1100 (day shift). On 11/22/23 PCA: PROM both lower extremities Q Shift was only charted as performed for two of three shifts, at 0300 and 1900, No PROM was charted for 1100 (day shift). On 11/24/23 PCA: PROM both lower extremities Q Shift was only charted as performed for two of three shifts, at 0300 and 1900, No PROM was charted for 1100 (day shift). On 11/25/23 PCA: PROM both lower extremities Q Shift was only charted as performed for two of three shifts, at 0300 and 1900, No PROM was charted for 1100 (day shift). On 11/26/23 PCA: PROM both lower extremities Q Shift was only charted as performed for two of three shifts, at 0300 and 1900, No PROM was charted for 1100 (day shift). NM2 stated, she could not confirm that PROM was provided per active orders, for Resident 1251 on the dates, 11/20/23, 11/22/23, 11/24/23, 11/25,23, and 11/26/23. NM2 stated, for each of these dates there is no documentation PROM was performed for Resident 1251 during the day shift (7:00 a.m.-3:30 a.m.). NM2 stated, her expectation is that staff follow all active orders, and chart when tasks have been performed. During a review of the facility's Policy and Procedure (P&P) titled, Restorative Nursing Care, dated 6/13/23, the P&P indicated, B. Restorative Nursing Care: .4. The exercises, treatments or activities are individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654 Based on observation, interview and record review, the facility failed to provide a safe environment for 3 of 70 sampled residents (Residents, 61, 1302, 805) when: 1. Patient Care Assistants failed to document the placement and function of Aero Scout (a device used to monitor wandering patients in unauthorized areas) for Residents 61 and 32 and; 2. Staff failed to utilize two staff people when providing care to a dependent resident per the plan of care for Resident 805. These failures resulted in the potential for Resident 61 and 1302 to elope from the facility and for Resident 805 to fall out of bed and be sent to the hospital Findings: 1a. Resident 61 admitted to facility in 2021 with a diagnosis of dementia (a condition characterized by loss of memory and abstract thinking) for services to general long-term care. During an interview on 11/29/23 at 9:10 a.m. north mezzanine nurses station, with Nurse Manager 1(NM) 1, NM 1 stated, could not state how often they test the system (Aero Scout)(Aero Scout- a patient monitor for location and status) or if they keep a record of patients. NM 1 stated, she would have to check the policy. NM 1 stated, she was not sure. During an interview on 11/29/23 at 10:00 a.m., north mezzanine with Patient Care Assistant (PCA) 2, stated, they do not check the bracelets (Aero Scout). PCA 2 stated, the bracelets flash red and that means the batteries are low. PCA 2 stated, they do not check the bracelets monthly or keep a log. During a concurrent interview and record review on 11/29/23 at 1:30 p.m., with Registered Nurse (RN) 4, Resident's Asset List (RAL)(Flowsheet document in EHR monitoring the function of AeroScout completed each shift.) , dated 11/29/23 was reviewed. The RAL indicated the following: 1. there were no RAL documentation on 11/1,2,3,4,5,6, 7th a.m. shift, 8th p.m. shift, 10th p.m. shift, 11, 12, 13th a.m. shift, 14th a.m. shift, 15th a.m. shift, 19,24,25,26,29/23. 2. there were no RAL documentation dated on, 11/,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22, 23,24,25,26,27,28,29/23. 3. there were no RAL documentation dated on, 11/1,2,4,5,6,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24, 26,28,29/23. 4. there were no RAL documentation dated on, 11/1, 2,4,5,6,7,8,9,10,11,12,13,14,15,16,19,20,21,22,23,24, 25,26,27,28,29/23. (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/30/23 at 8:49 a.m., with (RN) 8, RN 8 stated, the AeroScout placement were monitored every shift by the PCA's. During an interview on 11/30/23 at 9:10 a.m., with PCA 3, PCA 3 stated, the PCA staff only checked the placement of the AeroScout. PCA 3 stated, It [AeroScout] should be checked every shift. During an interview on 11/30/23 at 9:21 a.m., with Nursing Supervisor (NS1) 1, NS 1 stated the nursing staff documented the functionality of the AeroScout each shift, and the PCA would document the placement every shift. NS1 was unable to provide documentation and AeroScout were functioning by nursing staff at each shift. During an interview on 11/30/23 at 9:38 a.m., with RN 7, RN 7 stated, there is no individual monitoring for each resident's AeroScout functionality. The nurses check the function, but do not document for each resident. During an interview on 11/30/23 at 9:39 a.m., with RN 7, RN 7 stated, they document as a unit task. RN 7 verified there was no individual monitoring for the functionality of Resident 1302's AeroScout. During a concurrent interview and record review on 11/30/23 at 12:10 p.m., with RN 7, Resident 1302's Flowsheet, PCA documentation, AeroScout, placement, dated 10/31-11/29/23 was reviewed. The flowsheet indicated there was no documentation for 11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/15, 11/17, 11/19, 11/20, 11/23, 11/24, 11/25, 11/26, and 11/28. RN 7 verified there was missing documentation by PCA's. During an interview on 11/30/23 at 12:11 p.m., with RN 7, RN 7 stated, AeroScout not monitoring could lead to Resident 1302 wandering off or leaving the building. During a review of the facility policy and procedure (P&P) titled, Resident Locator System, dated 10/10/23, indicated,iii. Every shift, the Charge Nurse/designee will: Ensure that each nursing assistant verifies the placement of a resident's AeroScout tag and documents this information in the EHR. d. The assigned caregiver checks the resident's tag and strap for wear and tear at each shift. 39448 2. Per the facility's facesheet, Resident 805 was admitted to the facility on [DATE]. Per the facility's Weekly Summary, dated 10/26/23, there was a careplan titled ADL Maintenance which directed staff to, .When changing resident/repositioning - 2 person assist . Per the facility's Change of Condition Nursing Note, dated 10/29/23, .(Licensed Nurse (LN) 1) went to check resident .noted resident lying on his left side .on the floor mat .Per (Personal Care Assistant (PCA) 9) she was cleaning resident and he was faced towards her and all of a sudden resident turned towards the other side caused him fall . On 11/30/23 at 10:25 p.m., an interview was conducted with PCA 10. PCA 10 stated, Resident 805 required two staff at a time when changing his brief. PCA 10 further stated, Resident 805 had always required two staff at a time when changing his brief, and that it was not a recent change. (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/30/23 at 10:40 a.m., an interview was conducted with LN 1. LN 1 stated, she was the nurse on the shift that Resident 805 fell . LN 1 further stated, Resident 805 had always had involuntary jerky movements in his legs, which caused him to fall out of the bed on 10/29/23. LN 1 stated, when Resident 805 was calm, they only used one PCA to change him, and she was not aware of the careplan which required two staff when changing him. LN 1 further stated, Resident 805 was sent to the hospital on the day of his fall for swelling and bruising to his left hip. On 11/30/23 at 11 a.m., a joint interview and record review was conducted with Physical Therapist (PT) 1. PT 1 stated, on 6/20/23 she conducted a therapy evaluation of Resident 805. PT 1 further stated, Resident 805 had been dependent with all care and had limited ability to follow commands for the duration of his stay, and it was not a recent change. PT 1 stated, Resident 805 was not able to assist a caregiver with bed mobility and would not have been able to hold a position lying on his side. On 11/30/23 at 12:42 p.m., a telephone interview was conducted with PCA 9. PCA 9 stated, she was changing Resident 805's brief on 10/29/23 when he rolled off the side of the bed. PCA 9 further stated, that was her first time being assigned to Resident 805. PCA 9 stated, when she was assigned to a new resident, she asked other staff what the resident's needs were. PCA 9 further stated, no one had told her that Resident 805 required two staff when providing care. On 11/30/23 at 2:25 p.m., an interview was conducted with Director of Nursing (DON) 2. DON 2 stated, when a PCA was not familiar with a resident, they should have checked the medical record to confirm a resident's care needs. DON 2 further stated, PCA 9 should have followed the careplan. Per the facility's policy, titled Change of Shift Hand-Off (Nursing), dated 10/10/23, .The in-coming CNA/PCA will listen to the CN (Charge Nurse) hand-off report and listen to the LN hand-off report .The off-going CNA/PCA will provide any additional information to the in-coming CNA/PCA and discuss any unique needs of the resident's individualized Purposeful Rounding Plan .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 26917 Based on observations, interviews, and a review of records, it was found that the facility failed to maintain a medication error rate of less than 5%. During the medication pass, five medication errors were observed out of fifty-five opportunities, resulting in an error rate of 9%. Findings: 1. A review of the manufacturer's information indicated that metformin should be given with food to decrease the risk of stomach upset. Metformin is a medication used to control high blood sugar in people with type 2 diabetes. It works by reducing the amount of sugar your body absorbs from food and the amount of sugar your liver makes. This helps to lower the overall amount of sugar in your blood. It was recommended to take metformin with food to help reduce the chance of an upset stomach. During an observation on 11/27/23 at 8:11 a.m., RN 11 administered Metformin 850 mg to Resident 457 without food. Resident 457 had said that he had not had breakfast. RN 11 proceeded to administer the Metformin 850 mg without food. During an interview on 11/27/23 at 8:25 a.m., RN 11 stated that she forgot that Metformin should be given with meals. RN 11 also stated and acknowledged the lapse and expressed a commitment to being more mindful when administering Metformin in the future. 2. A review on 11/28/23 of the facility's eyedrop administration policy, titled Instillations of the Eye, Ear and Nose J 1.4 July 22, 2014, indicated that when administering eye drops to avoid contact between the bottle tip and patient's eyelashes when instilling drops. The facility policy also indicated that the proper technique, after administering the eye drop, also requires holding the inner corner of the eye to prevent drainage into the sinuses. During an observation on 11/28/23, RN 11 administered three different eye drops to Resident 457. RN 11 administered Timolol 0.5%, Alphagan 0.2%, and Trusopt 2% eyedrops in both eyes of Resident 457. Timolol 0.5% is a beta-blocker that reduces pressure inside the eye and is used to treat open-angle glaucoma and other causes of high pressure inside the eye. Alphagan 0.2% is an alpha-2 adrenergic receptor agonist that works by reducing pressure within the eyeball. It is used to treat conditions like open-angle glaucoma or ocular hypertension. Trusopt 2% is a carbonic anhydrase inhibitor that lowers the amount of fluid in the eye, thereby reducing eye pressure. It is used to treat ocular hypertension or open-angle glaucoma. However, these medications were administered without following the proper guidelines. The bottle tip touched the eyelashes, and the inner eye area was not compressed after drop instillation. During an interview on 11/28/23 at 8:59 a.m. RN 11 stated that she had forgotten to avoid the eye lashes and hold the inner eye area. RN 11 stated she was previously unaware of proper technique guidelines but would review the policies and make appropriate improvements moving forward. (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review on 11/28/23 of the facility's nasal spray administration policy, titled Instillations of the Eye Ear and Nose J 1.4 July 22, 2014, indicated that when administering for nasal spray advise patients to simultaneously squeeze the lower portion of the bottle, and then instruct to continue sniffing 3-4 times, and ask that he not blow his nose for at least two minutes. During an observation on 11/28/23 at 8:59 a.m. LVN 4 administered Saline Nasal Spray to Resident 1. Saline nasal spray is a sterile saltwater solution that is used to lubricate, moisturize, and flush nasal passages. It's a simple option for treating nasal and sinus dryness, itching, and congestion caused by colds and allergies. LVN 4 did not advise Resident 1 to simultaneously squeeze the lower portion of the bottle, and then instruct to continue sniffing 3-4 times, and ask that he not blow his nose for at least two minutes. LVN 4 did not the facility policy. During an observation on 11/28/23 at 8:59 a.m. interview about the lapse, LVN 2 stated she was previously unaware of proper technique required by the facility policy. LVN 2 also stated that she would review the policies and make appropriate improvements moving forward.

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	555929	A. Building B. Wing	12/01/2023

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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. 26917 Based on the interview and document review, the facility failed to: 1. Respond to refrigerated temperature excursions for medications when the continuous temperature monitoring system Temptrak alarmed. There was no evidence of a response in accordance with facility policy. 2. Monitor temperature of the medication room located in the Pavilion Mezzanine skill nursing area. These failures could have resulted in medications not being stored in accordance with manufacturers recommendations. Findings: 1. A review on 11/27/23 of the facility policy, which was revised on April 11, 2023, titled Wireless Temperature Monitoring System, it was noted that medications requiring refrigeration should be stored within the temperature range of 36 to 46 degrees Fahrenheit. The policy also outlined the responsibility of the pharmacy to monitor all medication storage refrigerators, freezers, and medication rooms. In the event of a temperature alarm, the pharmacy was expected to immediately investigate and take appropriate corrective action to ensure medications were not compromised and were stored correctly within the allowable temperature range. Furthermore, the policy required the pharmacy to thoroughly document any alarm events and associated corrective actions taken in accordance with hospital procedures. Adherence to these temperature monitoring and documentation guidelines is critical to maintaining medication stability, potency, and patient safety. During an interview on 11/27/23 at 11:06 a.m., the pharmacist in charge (PIC) mentioned the existence of a pharmacy temperature log to document any identified storage temperature excursions. As per hospital policy updated on April 11, 2023, this comprehensive temperature log is intended to record pertinent details related to all noted instances of storage temperatures deviating outside the allowed 36 to 46 degrees Fahrenheit range for medication refrigerators and freezers. The policy clearly outlines the requisite corrective actions expected to be taken by pharmacy staff upon identifying a temperature excursion event. The pharmacist further emphasized the pharmacy's responsibility to not just diligently record each temperature deviation in the log, but also thoroughly document the appropriate investigative and corrective follow-up measures implemented to ensure proper in-range storage and prevent compromise of medications kept in refrigerators and freezers. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the review on 11/28/23 of the computerized temperature continuously monitoring system, it was observed that multiple temperature readings were graphed over a specific duration. The investigation focused on the pharmacy medication refrigerator, specifically for the month of November. On 11/1/23, it was noted that an alarm was triggered when the temperature reached 35.4 F. Similarly, on 11/7/23, another alarm was activated at a temperature of 35.8 F. Additionally, on 11/10/23, the alarm went off again when the temperature reached 35.3 F. A review on 11/28/2023 of the pharmacy medication refrigerator temperature log revealed no evidence of documented follow-up actions by the pharmacy for several instances where storage temperatures deviated outside the acceptable 36 F to 46 F range, triggering temperature excursion alarms during November. Specifically, the log failed to provide details on any corrective actions undertaken in response to the alarm events on 11/1/2023, 11/7/2023 and 11/10/2023 when temperatures reached 35.4 F, 35.8 F and 35.3 F respectively. These concerning gaps in documentation indicate lack of adherence to the hospital's updated policy on temperature logs effective April/11/2023 which clearly mandates the pharmacy to not just record temperature deviations, but also thoroughly document the appropriate investigative and preventative follow-up measures implemented after each temperature alarm. The pharmacy's lapse in protocol compliance compromises medication integrity and patient safety. A review on 11/27/2023 of the continuous temperature monitoring log, which recorded temperatures for the months of August and September, multiple alarms were identified indicating temperature excursions. The first alarm occurred on 8/23, with a temperature reading of 46.2 F. The following day, on 8/24, another alarm went off at 45.9 F. On 8/30, yet another alarm was triggered with a temperature of 46.2 F. Moving into September, an alarm occurred on 9/18 at 47.7 F. This was followed by alarms on 9/17 and 9/18, both at 46.2 F. Finally, on 9/20, an alarm went off at 49.8 F. A review on 11/27/2023 reviewing the pharmacy refrigerator temperature log, it was found that there was no documentation indicating that the pharmacy addressed the temperature excursions mentioned, in the previous paragraph, when the alarms went off. The log did not provide any information regarding the acknowledgment of the alarms, or the subsequent actions taken to address the temperature deviations. During an interview at 11:15 a.m., the Director of Pharmacy acknowledged the need for improvement in their system when the medication refrigerators trigger alarms. They confirmed that there is an ongoing discussion about this matter and emphasized the importance of proper documentation and follow-up to ensure that temperature excursions do not compromise the stability of medications. 27194 2. During a concurrent observation and interview on 11/30/23 at 11:38 a.m., with medication nurse (MN) in the Pavilion Mezzanine skill (PMS) nursing station, the MN stated the medication in the refrigerator and in medication room were monitored by Temptrak (remote wireless temperature monitoring system), but she could not locate the temperature sensor for monitoring the ambient room temperature of the medication room. And she also stated the engineering department maintains and has direct oversight of the entire Temptrak system. (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/30/23 at 1:13 p.m., with a Facility Engineer (FE 1), after he had reviewed the Temptrak monitoring system from a laptop, and he stated he was able to locate the working sensor in the medication refrigerator of that area, but there was none installed in that medicaton room of the PMS. During a review of the facility's policy and procedure (P&P) titled, Wireless Temperature Monitoring System dated 4/11/2023, the P&P indicated, 1. All blanket warmers, medication, nutrition and specimen related refrigerators or freezers, and medication rooms will be part of the wireless temperature monitoring system.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 17065 Based on observation, dietary staff interview and administrative document review, the facility failed to ensure ready to eat foods, obtained from Vendor 1, met current standards for food safety when facility did not verify whether the vendor completed corrective actions identified by the Food and Drug Administration. Findings: During initial tour on 11/27/23 beginning at 9:45 a.m., of the walk-in refrigerator adjacent to the cold food production area, there were greater than 10 cases of a variety of ready to eat food procured from an outside food vendor. In a concurrent interview, the Director of Food Services (DFS) stated the items were used in a variety of settings including the pantry of the resident units as well as the cafe. The DFS also indicated at one point between the last 12-18 months a facility Registered Dietitian visited the facility to evaluate the food safety aspects of the vendor's operation, on behalf of the facility, however as the facility was not local there have been no other inspections. The DFS also stated as part of the contract implementation the vendor submitted a food safety inspection. Review of a dietary departmental email document, to the vendor, dated 11/27/23 requested a third-party inspection document. The document from the US Food and Drug Administration (FDA), listed the date of inspection as 4/14-4/26/23. The inspection listed four observations, in relationship to food safety, that required attention by the vendor. In an interview on 9/28/23 beginning at 9:35 a.m., the surveyor inquired whether the facility completed a follow up on the issues identified by US FDA, associated with the vendor's operations. The DFS indicated the contracting process for food services included a request for any pertinent certifications at the time the contract was implemented. The DFS additionally indicated a yearly review called a Vendor Preference Request was completed. Current departmental contract review of the Vendor included monitoring product quality and temperature at the time of delivery as well as cleanliness of delivery vehicle. The DFS also indicated if issues were identified those would be incorporated into the departmental performance improvement program and ultimately into the vendor preference report. As of 11/27/23 the facility had not requested additional information from the vendor regarding the identified food safety concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital and Rehabilitation Center	375 Laguna Honda Blvd San Francisco, CA 94116

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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** 39723 Based on observation, interview, and record review, the facility failed to ensure the infection prevention and control program (IPCP) included a facility-wide program for the surveillance, prevention, and control of healthcare-associated infections (HAIs-infections acquired during the process of receiving healthcare that was not present during the time of admission) and other infectious diseases for nine of nine sampled residents (Residents 355, 404, 451, 460, 461, 462, 463, 553, and 1303) when: 1. For Resident 1303, the facility did not follow their policy and procedure on contact precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) and encouraged group activities. 2. For Resident 451, the facility did not follow the manufacturer's instructions for use (IFU) on Oxivir Disinfectant Cleaner while performing environmental cleaning. 3. For Resident 553 and Resident 1303, the facility did not follow their policy and procedure on Tuberculosis (TB-an infectious lung disease) symptom screenings upon readmission to the facility. 4. The facility did not follow the manufacturer's instructions on cleaning and maintaining linen warming cabinets (blanket warmers) for one of six sampled blanket warmers (Blanket Warmer 1). 5. For Resident 355, postings for isolation precaution were not visible, staff did not wear proper protective equipment when entering the resident's room, and staff were not aware of the reason for transmission based precautions. 6. For Resident 404, the facility did not ensure a staff member wore the proper personal protective equipment (PPE- equipment used to protect healthcare workers and prevent the spread of germs to others) upon entry into a contact and airborne precaution room (precautions used to prevent the spread of infection). 7. For Residents 460, 461, 462, and 463, the facility did not ensure a staff member handled and distributed clean linen in a safe manner. These failures created an increased risk of spreading infections and communicable diseases to the residents receiving care in the facility. Findings: An interview was conducted with the Director of Infection Prevention (DIP) and the Infection Control Nurse Manager (ICNM) on 11/27/23, at 11:12 a.m., in the DIP's office. The DIP stated the facility followed the following nationally recognized guidelines: A. Centers for Disease Control and Prevention (CDC, the national public health agency of the United States); (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1303's Care Plan, dated 11/3/23 to 2/1/24, indicated the following: Problem: Resident Activity Needs. Goal: Resident will participate in meaningful leisure of choice 2-3 times a week. Interventions: 1. Resident will attend at least one group activity 1 X week .3. At will encourage resident to be part of outdoor leisure activities such as . garden group activities . A review of Resident 1303's Care Plan, dated 11/3/23 to 2/1/24, indicated the following: Problem: Anxiety. Goal: Resident will describe decreased anxiety or demonstrate increase participation in care. Interventions: 8. Encourage [Name of Resident 1303] to attend relaxing activities in the Great Room . An interview was conducted with Resident 1303, on 11/29/23, at 8:30 a.m., in Resident 1303's room. Resident 1303 stated, I don't know if I understand the meaning of contact precautions. I enjoy going outside of my room to listen to music. During an interview with the DIP, ICNM, and the Infection Control Nurse (ICN) on 11/29/23, at 2:30 p.m., in the DIP's office, the DIP stated staff did not follow the contact precaution protocol because prior to the resident leaving the room, the resident should have had a full bath and was placed in a fresh contact transmission gown. The ICN confirmed there was no documentation that showed a physician, or an interdisciplinary team assessment had determined it was safe for Resident 1303 to participate in group activities. The ICN could not explain the process used for encouraging a resident to participate in group activities following a physician order for continuous contact precautions. The ICN stated that he agreed with the DIP, the facility did not follow their policy and procedure on contact precautions. The facility's policy and procedure, titled Transmission-Based Precautions and Resident Room Placement, revised December 13, 2022, indicated the following: policy: The facility uses a coordinated process of standard and transmission-based precautions to reduce the risk of transmission of communicable disease to patients, employees, and visitors. Responsibilities: .B. Supervisors, manager, and directors are required to enforce the provisions of this policy in their areas. Employees who do not follow the contents of this plan may be subject to disciplinary action. D. Any patient known or suspected to have a disease or condition that warrants transmission-based precautions will be placed in the appropriate transmission precaution upon admission .1. The nurse is responsible for ensuring that the precautions are initiated and maintained according to the specified protocol . Contact Precautions: .G. Transport of patients under contact precautions requires that the patient must be wearing a fresh contact transmission gown outside of the patient's room . A review of the CDC's guidelines for Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), indicated the following .III.B.1. Contact precautions: Contact Precautions are intended to prevent transmission of infectious agents .which are spread by direct or indirect contact with the patient or the patient's environment . 2. A review of Resident 451's History and Physical, dated 11/6/23, indicated Resident 451 was readmitted to the facility on [DATE], with diagnosis of comfort focus care (a patient care plan that is focused on symptom control, pain relief, and quality of life). (continued on next page)

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	555929	A. Building B. Wing	12/01/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A tour was conducted of the South 6 unit, on 11/27/23, at 12:15 p.m., with the DIP and the ICNM. The environmental staff (ESS) was observed performing environmental cleaning in Resident 451's room. The ESS picked the water pitcher up from Resident 451's tray table, wiped the tray table with the Oxivir disinfectant wipe, and immediately placed the water pitcher back onto the tray table. The ESS proceeded to pick the piston/piston cover (a medical device used to create a vacuum or to move fluids or gases) up from the tray table, wiped the tray table with the Oxivir disinfectant wipe, and immediately placed the piston/piston cover back onto the tray table. The ESS did not allow the treated area to remain wet for one minute or allow the treated area to air dry prior to placing Resident 451's items back onto the tray table. A review of the manufacturer's label, titled, Oxivir Disinfectant Cleaner (brand of a germicidal solution), dated 2020, indicated the following instructions for use (IFU), .Allow treated area to remain wet for one (1) minute. Let air dry. During an interview, conducted with the DIP, on 11/27/23, at 12:33 p.m., outside of Resident 451's room, the DIP confirmed the Oxivir disinfectant wipe's contact time (the appropriate amount of time that a disinfectant must remain visibly moist on the surface being cleaned to effectively kill the germs, viruses, or bacteria) was one minute. The DIP stated the manufacturer's IFU was not followed because the ESS should have allowed the tray table to remain wet for one minute and allowed the table to air dry prior to placing items back onto Resident 451's table. A review of the CDC's guidelines for Best Practices for Environmental Cleaning in Healthcare Facilities (2019) indicated the following: .Disinfectant or Detergent-Disinfectant Wipes: . Follow manufacturer's instructions for storing wipes and reprocessing containers, as well as instruction for use (e.g., recommended contact times) . 3. The review of the facility's document titled, Tuberculosis Symptom Screening Tool, undated, showed the tuberculosis symptom screen must be performed upon admission to the facility and performed on readmission to the facility within 90 days of discharge. The tuberculosis symptom screening tool included the following assessment: -Blood sputum -Hoarseness lasting 3 week or more -Persistent cough lasting 3 weeks or more -Unexplained excessive fatigue -Unexplained excessive fever lasting 3 weeks or more -Unexplained excessive night sweats -Unexplained weight loss (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3a. For Resident 1303, a review of the History and Physical (H&P), dated 11/2/23, indicated Resident 1303 was readmitted to the facility on [DATE], with diagnoses which included sepsis (life threatening complication of an infection) and multiple drug resistant organism (MDRO) Carbapenem- resistant Enterobacterales (CRE- germs that no longer responds to the medicine designed to kill them). A review of Resident 1303's Medical Record, dated 11/2/23 to 11/29/23, was conducted with Registered Nurse (RN) 1, on 11/29/23, at 1:23 p.m., in the conference room. There was no documentation that showed a TB symptom screening assessment was completed upon readmission to the facility. A concurrent interview and review of Resident 1303's Medical Record dated 11/2/23 to 11/29/23, was conducted with Licensed Vocational Nurse (LVN) 3 on 11/30/23, at 10:45 a.m., in the nurse station. LVN 3 confirmed Resident 1303 did not have a TB symptom screening assessment completed upon readmission to the facility. 3b. For Resident 553, a review of the H &P dated 10/1/23, indicated Resident 553 was readmitted to the facility on [DATE], with diagnosis of hidradenitis suppurativa (a painful, long-term skin condition that causes skin abscesses [a pocket of pus] and scarring on the skin). A review of Resident 553's Medical Record, dated 10/1/23 to 11/29/23, was conducted with RN 1, on 11/29/23, at 1:35 p.m., in the conference room. There was no documentation that showed a TB symptom screening assessment was completed upon readmission to the facility. A concurrent interview and review of Resident 553's Medical Record dated 10/1/23 to 11/29/23, was conducted on 11/30/23, at 10:59 a.m., with Nurse Manager (NM) 5, in the nurse station. NM 5 confirmed Resident 553 did not have a TB symptom screening assessment completed upon readmission to the facility. NM 5 stated, It is my understanding that residents would have a TB symptom screening assessment completed upon readmission and would not necessarily require a tuberculosis skin test unless ordered by the physician. An interview was conducted with the Infection Control Medical Doctor (ICMD) and the Chief Medical Officer (CMO) on 11/30/23, at 1:45 p.m., in the DIP's office. The ICMD stated, as the policy is written, the facility did not follow the policy on tuberculosis symptom screening upon readmission for Resident 1303 and Resident 553. The ICMD stated the facility's surveillance plan included TB due to the high prevalence of the disease in the community and she was thankful that the inconsistencies of the TB policy were addressed on the current survey. The CMO stated the policy will be updated and staff, including physicians, will be educated on the TB symptom screening process for residents readmitted to the facility. The review of the facility's policy and procedure, titled, Guidelines for Prevention and Control of Tuberculosis, revised 1/10/23, indicated the following: .Purpose .2. Reduce the transmission of TB through prompt detection and management of active tuberculosis disease .Procedure: .2 .d. Residents Admission, Readmission, and Annual Screening: Readmission Screening: i. Residents who are readmitted to the facility within 90 days of discharge requires a TB symptom screen. 4. During a concurrent interview and observation of the North 4 unit with the Director of Prevention (DIP), on 11/27/23, at 2:11 p.m., four clean utility rooms were observed. Each utility room had one linen cart and one blanket warmer. The DIP opened Blanket Warmer 1, and the following contents were observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One temperature probe taped to the left side of the warmer; 2. Several pieces of torn tape attached to the left side of the warmer that contained brown fabric threads and black fuzzy matter; 3. Three brown blankets stored on an adjustable shelf; 4. A scant amount of grey fuzzy matter attached to the blankets; 5. Grey fuzzy matter throughout the warmer's surface area; and 6. Debris and black fuzzy matter on the base of the warmer. The DIP stated the blankets were contaminated and the blanket warmer should have been cleaned. An interview was conducted with Nurse Manager (NM) 4, on 11/27/23, at 2:11 p.m., in Clean Utility room [ROOM NUMBER]. NM 4 viewed the contents of Warmer 1 and stated that she was not aware Warmer 1 contained brown fabric threads or black fuzzy matter. During an interview with the Senior Stationary Engineer (SSE), on 11/27/23, at 2:30 p.m., in Clean Utility room [ROOM NUMBER], the SSE viewed the contents of Warmer 1 and stated the following: 1. The temperature probe tape is outdated and needed to be replaced; 2. The brown fabric threads were from the metal tape and should not have been visible; 3. The black and grey fuzzy matter was dust; and 4. The SSE stated he could not identify the debris. An interview was conducted with the Environmental Service Supervisor, on 11/27/23, at 2:40 p.m., in Clean Utility room [ROOM NUMBER]. The Environmental Service Supervisor stated the EVS department was responsible for cleaning the outer surface of the blanket warmer cabinet and she was not sure who was responsible for cleaning the inner surface of the blanket warmer cabinet. A follow-up interview was conducted with NM 4, on 11/27/23, at 2:45 p.m., in Clean Utility room [ROOM NUMBER]. NM 4 stated she was not aware that the nursing department was responsible for cleaning any portion of the blanket warmer cabinet. NM 4 stated she did not know the manufacturer's instructions on cleaning and maintaining the blanket warmer cabinet. During an interview with the Director of Nursing (DON) 2, on 11/28/23, at 11:20 am., outside of the administration office, DON 2 stated there was no cleaning logs for the blanket warming cabinets and he did not know who was assigned the responsibility. DON 2 stated the blanket warmer cabinets should have been included in the environmental rounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The review of the facility's document titled, Blanket Warmer Protocol, revised 5/12/15, indicated the following: Blanket Warmer Protocol .6. Report any broken or no-functioning blanket warmers by calling or submitting work order to Facility Services for any repair or services as needed. 7. The blanket warmer must be cleaned with the facility's approve stainless cleaner. Use detergent solution to wash all non-stainless surface, and rinse with tap water. Using sponge or damp cloth, wipe dry. 31403 5. Record Review on 11/30/2023 at 2:15 p.m. of the document (titled with the resident's name) showed Resident 355 was admitted to the facility on [DATE]. Diagnoses included a stroke. Record review at 10 a.m. on 12/1/2023 of the document Change of Condition Nursing Note dated 11/28/2023 showed Resident 355 had developed a cough with a sore throat and generalized body aches. Review of the document Nursing Note Addendum dated 11/28/2023 showed Resident 355 had been tested and found to be positive for Human Rhinovirus/Enterovirus. Resident 355 was then placed on droplet precautions. (droplet precautions: those entering her room must put on Personal Protective Equipment (or PPE) which included eye protection in addition to wearing a mask and hand hygiene) Record review on 12/1/2023 at 11 a.m. of the document MDS dated [DATE], showed Resident 355 was alert and oriented. (MDS: Minimum Data Set: resident assessment) In an interview and observation on 11/30/23 at 8:40 a.m., Resident 355 stated she had been Up all night because she had a sore throat which had started last Tuesday. Patient Care Assistant 1 (PCA 1) was observed in the room without eye protection. In an interview on 11/30/23 at 8:45 a.m. Registered Nurse 3 (RN 3) confirmed Resident 355 had a sore throat and was on droplet precautions but he Did not know why. On 11/30/2023 at 8:50 a.m. the door to Resident 355's room had a droplet precaution sign that was not visible to those entering the room. In a concurrent interview, PCA 1 confirmed the sliding pocket door was in the open position which meant the sign was hidden from anyone entering the room. PCA 1 stated, Yes, when the door is open you cannot see the sign. No one would know she was on droplet precautions. PCA 1 confirmed she had been in the room without PPE which could contribute to the spread of an infection. In an interview on 11/30/2023 at 11:30 a.m., RN 3 stated it was important to know the reason why someone is on transmission-based precautions so staff are aware of what type of protective equipment to use, how contagious it is and how it could potentially spread. Record review on 12/1/2023 at 11:30 a.m. of the document Transmission-Based Precautions and Resident Room Placement dated 12/13/2022, showed The facility uses a coordinated process of standard and transmission-based precautions to reduce the risk of transmission of communicable diseases to patients, employees, and visitors. Any patient known or suspected to have a disease or condition that warrants transmission-based precautions will be placed in the appropriate transmission precautions upon admission. The nurse is responsible for ensuring that the precautions are initiated and maintained according to the specified protocol. Signs will be placed on the outer room doors for patients placed on transmission-based precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37797 6. During an observation of the COVID-19 Unit (where residents with COVID-19 stay) on 11/29/23, at 1:20 p. m., Home Health Aide 3 (HHA 3) entered Resident 404's room to deliver a lunch tray. HHA 3 did not have gloves and entered the room holding the lunch tray with her bare hands. During an interview on 11/29/23, at 01:30 p.m., Nurse Manager 4 stated all residents in the COVID-19 Unit had tested positive for COVID-19 and the expectation was for staff to enter resident rooms with full Personal Protective Equipment (PPE), including gloves. During an interview on 11/29/23, at 1:40 p.m., HHA 3 stated she did not work in the COVID-19 Unit but was assigned to work there today. HHA 3 stated it was the first time she worked in the COVID-19 Unit. A review of sign posted outside Resident 404's room titled Airborne and Contact Precautions with Eye Protection., undated, indicated: To prevent the spread of infection, anyone entering this room must: hand hygiene, use gowns, masks, eye protection and gloves. 34448 7. During an observation on 11/30/23 at 7:45 a.m., in Unit S4, Patient Care Assistant (PCA 11) was observed in the resident hallway exiting the clean linen closet carrying towels and washcloths. PCA 11 was observed to enter resident 462 and 463's room. When PCA 11 exited the room, PCA 11 held the linen against his uniform and performed hand hygiene. PCA 11 walked down the hallway holding the linen and entered resident 460 and 461's room. PCA 11 went behind Resident 460's privacy curtain. When PCA 11 came out from behind the privacy curtain, the towels brushed against the wall. PCA 11 placed the towels and washcloths on Resident 461's bed and left the room. During an interview on 11/30/23 at 8 a.m., with PCA 11, PCA 11 stated he should not have carried the clean towels and washcloths from room to room. PCA 11 stated, I shouldn't have done that. It's my mistake. During an interview on 11/30/23 at 1:19 p.m., with the Infection Control Nurse, Health Network Director of Infection Prevention, and Nurse Manager for Infection Prevention, the Infection Control Nurse stated, Staff training has been to go to the linen area, perform hand hygiene, and take only what you need to the resident's room. Then repeat that process for each resident. During a review of the facility's policy and procedure (P&P) titled, MANAGEMENT OF HOSPITAL-PROVIDED LINEN, revised 1/10/23, the P&P indicated, PROCEDURE: 1. Clean Linen . f. Do not take more clean linen than what is needed into the resident's room . Linens inside a resident room are considered contaminated and should not be used for others; if this occurs, place even unused linens in dirty hamper for laundering. During a review of the facility's policy and procedure (P&P) titled, STANDARD PRECAUTIONS, revised 9/13/22, the P&P indicated, 5. Environmental Controls . c. Linen . Hold all linen away from body/uniform to prevent contamination . Clean linen must remain covered on the cart when not in use . Do not move clean or soiled linens from one resident care area to another . Take only the linen needed for each resident in each room and discard unused linens in hamper before exiting room .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39723 Based on interview and record review, the facility failed to follow their policy and procedure on influenza immunizations when the medical record did not include influenza immunization information or the refusal of the vaccine for one of five sampled residents (Resident 1303). This failure resulted in an incomplete medical record which did not reflect Resident 1303's preferences or care needs. Findings: A review of Resident 1303's History and Physical, dated 11/2/23, indicated Resident 1303 was readmitted to the facility on [DATE], with diagnoses which included sepsis (life threatening complication of an infection) and multiple drug resistant organism (MDRO) Carbapenem- resistant Enterobacterales (CRE- germs that no longer responds to the medicine designed to kill them). A review of Resident 1303 Immunization Summary, dated 9/1/22 to 11/29/23, was conducted with Registered Nurse 1, on 11/29/23, at 1:17 p.m., in the conference room. There was no documentation that showed Resident 1303 received information on the risk and benefits of the influenza vaccine or documentation that indicated Resident 1303 had refused the vaccine. An interview was conducted with Resident 1303, on 11/30/23, at 9:45 a.m., in Resident 1303's room. Resident 1303 stated the nurse offered the influenza vaccine on two different occasions. Resident 1303 stated, I don't remember which nurse offered me the flu shot but I refused the flu shot twice. Resident 1303 could not articulate the risk and/or benefits of the influenza vaccine. An interview was conducted with the Director of Infection Prevention (DIP), on 12/1/23, at 9:15 a.m., in the DIP's office. The DIP confirmed there was no documentation in Resident 1303's medical record to indicate the vaccine was administered or the reason the vaccine was not given. The DIP stated all residents should receive the VIS (Vaccine Information Statements are information sheets produced by the Centers for Disease Control and Prevention that explains the benefits and risks of a vaccine) prior to the administration of the vaccine. The DIP stated, if the vaccine was not given, the nurse should have documented in Resident 1303's medical record the reason the vaccine was not given. The review of the facility's policy and procedure titled, Influenza Immunization for Patients, revised 1/10/23, indicated the following: .d. The licensed nurse documents the resident's vaccine administration and education provided in the electronic health record. If the vaccine was not given, document the reason(s) it was not administered .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555929	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Honda Hospital and Rehabilitation Center	375 Laguna Honda Blvd San Francisco, CA 94116

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17065 Based on dietetic services observations, dietetic and facility services interview and departmental document review, the facility failed to ensure equipment and physical environmental maintenance when 1) one of two dish machines had water leaking from underneath as well as from the top of the machine and the temperatuare dial for the final rinse was non-operational; 2) there were greater than 10 tiles in the hot and cold food production areas that had missing grout and resulting in a build-up of moisture and food particles; and 3) the flush drain for the ice machine filter was inserted directly into a soiled floor sink. Failure to ensure an effective maintenance program of spaces and equipment may result in practices that promote the harborage of pests. Findings: 1. An observation on 11/28/23 at 9:45 a.m., showed two dish machines located in the kitchen dish machine room. Staff were cleaning dishes in one of two of the dish machines. Steam and water was shooting up and out from a pressure valve at the top of the dish machine. Water was pooled on top of the dish machine and water was running down the side of the machine. There was also a significant amount of orange and white residue on top of the machine and down the side of the machine where the water was running down from the pressure valve. In addition, there was water on the floor around the dish machine and pooled under the machine. In a consecutive interview with Food Service Supervisor (FSS) 2 on 11/28/23 at 9:50 a.m., FSS 2 stated the dish machine was leaking for about a month. He said the machine was leaking at the top and from the bottom of the machine. FSS 2 stated he thought all the water on the floor was from the leak under the dish machine. In a concurrent observation and interview of the dish machine with FSS 2 on 11/28/23 at 9:50 a.m., the final rinse temperature gauge on the dish machine did not show the final rinse temperature when the dish machine was running. The gauge was constructed to show a maximum temperature of 220 degrees Fahrenheit (F). When the dish machine was running, the dial on the gauge moved past the maximum temperature on the gauge so it could not be identified what the final rinse temperature was. In an interview on 11/29/23 at 9:32 a.m., FSS 1 stated the dish machine dial was not working and the machine also had a steam leak and a pressure valve leak. He stated two work orders were created and were still open. FSS 1 stated he met with Facility Services once a month and discussed the issues with the dish machine. FFS 1 stated Facility Services claimed they fixed the dish machine, after they worked on the dish machine, but the dish machine was not fixed and the dish machine still leaked and the dial was still broken, so he did not close the work orders yet. Review of a work order titled Work Order Details dated 1/31/23, showed a work order was created by FSS 3 to please check gauge for the dish machine. Additional details provided on the work order request showed The gauge for the final rinse in the dish machine is not reading. [Facility Engineer 2] Replaced pressure regulator and hot water supply valve 2/6/2023. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a work order titled Work Order Details dated 9/11/23, showed a work order was created by Food Service Supervisor 1 (FSS 1) and read Please fix water leak on top of dish machine. Additional details provided on the work order showed Please fix water leak on top of dish machine. Looks like the pressure relief valve is leaking. Made adjustment to relief valve, leak stopped. 9/15/2023 [Senior Stationary Engineer]. An email regarding Pot Machine dated 10/14/23 and sent by Director of Food Service (DFS) and to the Executive Director of Engineering ([NAME]). The email read Hello All - The dish machine also has many water leaks from water tank compartments including the pressure release valve. In an interview with the Chief Engineer Facility Services (CEFS) and the Senior Stationary Engineer (SSE) on 11/29/23 9:45 a.m., SSE stated he was responsible for repairing the dish machine in the kitchen. He stated a work order was received yesterday for the temperature gauge, but there was another job he was working on first before he could look at the dish machine. He stated he had the gauge in stock. CEFS and SSE confirmed there was a water leak from under the dish machine which was caused by a gasket leak underneath the machine. CEFS stated the valve had to be replaced. CEFS and SSE also explained the water leak from the top of the machine was a water pressure valve that had to be replaced. SSE stated he would replace the valve when I get a window to work on it. CEFS stated the dish machine manufacturer was called regarding the leak at the bottom of the machine, but it was a big job. In a consecutive interview on 11/29/23 at 10 a.m., the work orders for the dish machine dated 1/31/23 for the temperature gauge and 9/15/23 for the leak at the top of the machine, were reviewed with CEFS and SSE. CEFS and SSE stated both work orders were for the same machine but a different job and both issues were fixed. In a consecutive observation of the dish machine and interview on 11/29/23 at 10:05 a.m., CEFS and SSE confirmed the final rinse temperature gauge dial went past the maximum temperature on the gauge and it was not working. CEFS and SSE also confirmed water was leaking from the top of the machine which CEFS stated was the steam relief vent, and it needed to be fixed. In an interview with on 11/29/23 at 10:15 a.m., DFS and FSS 1 confirmed the work orders for the dish machine dated 1/31/23 and 9/15/23 were for the current issues with the machine, the temperature gauge for the final rinse and the leak at the top of the machine. DFS and FSS 1 stated the work orders were not closed out because the issues were not fixed. DFS and FSS 1 stated work orders were not created yesterday as CEFS and SSE said. 2. It would be the standard of practice to ensure the materials for indoor floor, wall, and ceiling surfaces under conditions of normal use are maintained to ensure they are smooth, durable and easily cleanable. Additionally, the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (US Food Code, 2022). During general dietetic services observations on 11/27/23 beginning at 10:45 a.m., there were multiple tiles underneath the steam kettles where the grout was missing resulting in an accumulation of water and food debris. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/28/23 with the Director of Food Services (DFS) and the Food Service Supervisor (FSS) the surveyor inquired how the facility monitored the integrity of the flooring. They stated that facilities did monitoring. In addition, the FSS stated he meets with the Chief of Facilities at which time issues were addressed. The DFS and FSS also indicated if issues were identified a work order was completed. In an observation on 11/28/23 beginning at 10:25 a.m., revealed there were additional areas in the cold production area where the grout between the floor tiles was missing which also had an accumulation moisture and food debris. In an interview on 11/29/23 beginning at 2:30 p.m., the Chief Clinical Dietitian (CCD) indicated she did a monthly review of dietetic services, however had not completed one for 11/23. Review of documents titled Kitchen Observation dated 6/2, 8/15, 9/6 and 10/6/23 did not identify issues related to flooring maintenance. In a follow up interview on 11/30/23 at 2:15 p.m., the CCD in addition to the submitted kitchen observation tool there was an additional tool she used as a reference, however the tool was not utilized for documentation. On 11/30/23 the facility submitted an undated blank document titled Kitchen & Cafe Inspection Checklist. The checklist had a question that addressed broken tiles and/or missing grout which would result in the submission of a work order. The surveyor requested documentation for the submission of work orders, related to the floor integrity, in dietetic services beginning 6/15/23. As of 11/30/23 the survey team was unable to validate dietetic department requests for floor repair. 3. In an observation and concurrent interview 11/29/23 beginning at 09:40 a.m., preventive maintenance of the ice machines in dietetic services was reviewed with Facilities Engineer (FE) 1. It was noted there is a red tube, measuring approximately 1/4 inch in diameter that was inserted directly into the floor drain. The tube was described by FE 1 as a flush tube for the ice machine filter. It was also noted there was a grate covering the floor drain and the drain was not clean, rather had a build up of black slime type material and brown unidentified material. In a follow up observation on 11/30/23 at 9:47 a.m., the DFS attempted to remove the grate from the floor sink. It was noted the placement of the ice machine as well as the plumbing interfered with complete removal of the grate. Partial removal of the grate revealed the flush tube placed directly into the wastewater system, below the level of the floor sink. It was also noted there was a build-up of black material on the exterior or the flush tube.