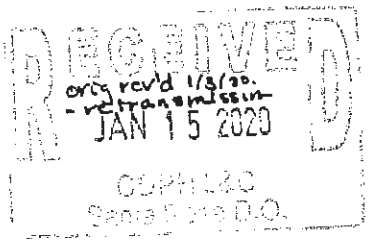
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a RECERTIFICATION SURVEY. Representing the California Department of Public Health: Health Facilities Evaluator Nurses 38322, 41175 and 41333. Census on the date of entry, 11/12/19, was 65. There were 17 sampled residents. Incorporated into the survey process was Facility Reported Incident CA00663390: Facility Reported Incident CA00663390 was substantiated with one deficiency.	F 000	 COPY	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	F 550 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident 96 no longer resides in the facility. Residents 98 and 203: Director of Staff Development (DSD) or designee will conduct weekly facility rounds to ensure privacy and dignity are being provided during toileting and privacy curtains are being fully utilized. ***How the facility will identify other residents having the potential to be***	

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

Nathan Noe Administrator 1/2/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC was accepted on 1/13/20 and Nathan Noe was notified by Surveyor 38322 Blake Carberry RN HFES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care promoting dignity and respect for 3 of 17 sampled residents (Residents 96, 98, 203) and one anonymous resident. This failure resulted in vulnerable residents feeling upset, almost in tears, and left in view of the public in undignified circumstances. Findings: During an interview on 11/12/19 at 10:39 a.m., Resident 96 stated she had waited up to 45 minutes for assistance to the bathroom. Resident 96 stated she took a diuretic (water pill) and had	F 550	***affected by the same deficient practice and what corrective action will be taken:*** Residents who are assessed with self-care performance deficit have the potential to be affected by this deficient practice. DSD has not found any other residents to be affected by the deficient practice during his observations. Interdisciplinary team (IDT) will assess, review, and update care plans as appropriate with the least restrictive Activities of Daily Living (ADL) function interventions for residents who are determined to have self-care performance deficit. DSD provided in-service training to licensed nurses, CNA's, and therapists on resident's rights/preservation of resident dignity, provision for privacy focusing on importance of following required care assistance as noted in resident's care plan by November 26th, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** DSD provided in-service training to licensed nurses, Certified Nursing Assistants (CNA's), and therapists on resident's rights/preservation of resident dignity, provision for privacy focusing on importance of following required care assistance as noted in resident's care plan by November 26th, 2019.	11/26/19 11/26/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 an accident from waiting so long. During an interview on 11/13/19 at 10:18 a.m., Anonymous Resident stated she waited for one hour to be helped off a bed pan. She stated this made her so upset she was almost in tears. Anonymous Resident also stated she had to wait two hours for pain medication. She stated she had to cancel a therapy session one day because she was in so much pain. The therapist brought her back to her room, then the therapist went to tell her nurse she needed pain medication. She had to wait two hours for the pain medications to come. During an interview on 11/14/19 at 2:43 p.m., Resident 96 stated when she was having her adult incontinence brief changed on Friday night, her certified nursing assistant (CNA) hardly said two words to her, and she was very hostile, and she was not kind. Instead of asking Resident 96 to roll over she waved her hand indicating she wanted her to roll. The CNA struggled to pull the tab on the new brief and when she ripped it she said "shit!" Resident 96 stated this didn't make her feel very good. Another CNA came in the room and chatted with her CNA like she wasn't even there. During an observation and concurrent interview on 11/15/19 at 10:01 a.m., Resident 98 was visible from the hallway laying sideways in her bed. She had her pants pulled down around her knees and was wearing an adult incontinence brief. The door to her room was open and her privacy curtain was not pulled. When queried, Resident 98 stated she "can't pee." She stated a whole group of people came in her room earlier, helped her pull her pants down, and then left	F 550	***How the facility plans to monitor its performance to make sure that solutions are sustained:*** DSD will randomly observe CNA's during ADL care for residents requiring toileting assistance with focus on timely response and preservation of dignity and report to the Director of Nursing (DON) for compliance. This will be done weekly for one month and bi-weekly for two months thereafter. Findings will be brought to the facility Quality Assurance Performance Improvement (QAPI) Committee and if there are concerns, an action plan will be developed, implemented and evaluated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 without taking her to the bathroom. She stated she doesn't know why they left, "They said they would come back but never did." When informed Resident 98 was waiting for help to the bathroom, Licensed Nurse A stated she had already told the CNA to help Resident 98. Licensed Nurse A then went to Resident 98's room and started to help her up. A staff member came to the door and told Licensed Nurse A she had a phone call. Licensed Nurse A left Resident 98 in her bed and went to the nurses' station. The staff member at Resident 98's doorway asked Resident 98 what she needed, and Resident 98 told her she needed help to bathroom. The staff member stated she would find someone and left the room. Then Social Services Manager (SSM) came in, and asked Resident 98 how she was doing. Resident 98 repeated her need, and SSM stated she would find someone to help. Resident 98 stated, "That will be a miracle!" At least five people were in and out of Resident 98's room before she got toileting assistance. During an observation on 11/12/19 at 10:38 a.m., Resident 203 did not have a lap cover while on a bedside commode, which exposed her buttocks and legs. The curtain was opened to the other side of the bed, and her call light was not within reach. The door was wide open and no was CNA present for immediate assistance. Resident 203 was not provided with privacy and dignity while using a bedside commode. During an interview on 11/18/19 at 10 a.m., Infection Control Consultant (ICC) and the Director of Staff Development (DSD) stated residents were to be given privacy when using a bedside commode. The CNA must be present or in the room while the resident was on a commode	F 550		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 for any immediate assistance and the curtain closed for privacy and dignity. The ICC stated that staff received in-service training on dignity and privacy. Review of facility policy, "Resident Rights," dated 10/2009, indicated, "Employees shall treat residents with kindness, respect, and dignity."	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578	F 578 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents 96, 197, and 295 no longer reside in the facility. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:*** Any resident has the potential to be affected by the deficient practice. Medical Records (MR) has not found any other residents to be affected by this deficient practice during their audits. Both the Social Services Director (SSD) and the admissions nurses will ensure completion of the Physician Orders for Life-Sustaining Treatment (POLST)/Advance Directive on admission.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement their policies in the provision of written information on Advance Directives (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) when three out of 17 sampled residents (Resident 96, Resident 197, and Resident 295) had unsigned Advanced Directive Acknowledgment Forms upon their admission. This failure had the potential for harm if residents' wishes for end-of-life care were not respected and followed. Findings: During a medical record review on 11/19/19 at 9:30 a.m., Resident 96's face sheet revealed she had been admitted 11/8/19. Review of Resident 96's document titled Physician Orders for Life-Sustaining Treatment (POLST) revealed sections A, B, C, and D (areas where life-sustaining treatments should be indicated, status of advanced directives, and for the	F 578	MR will audit POLST/Advanced Directive completion weekly for the duration of one month, and then bi-monthly for the duration of two months to ensure POLST/Advance Directives are being completed timely and accurately. DON will in-service admissions nurses, social services staff, and MR staff on proper completion of the POLST/Advance Directives. Attending physicians will be queried if there are any issues completing the POLST/Advance Directive by December 31st, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Both the SSD and the admissions nurses will ensure completion of the POLST/Advance Directive on admission. MR will audit POLST/Advanced Directive completion weekly for the duration of one month, and then bi-monthly for the duration of two months to ensure POLST/Advance Directives are being completed timely and accurately. DON will in-service admissions nurses, social services staff, and MR staff on proper completion of the POLST/Advance Directives. Attending physicians will be queried if there are any issues completing the POLST/Advance Directive by December 31st, 2019.	12/31/19 12/31/19

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 patient's and physician's signatures) were left blank. Resident 96's document titled "Advanced Directive Acknowledgement" indicated her room number. The rest of the form was blank. During an interview on 11/19/19 at 11:08 a.m., Social Services Staff J acknowledged Resident 96's POLST and Advanced Directive Acknowledgement form were unsigned. Social Services Staff J confirmed both forms should have been completed at this point in Resident 96's stay. During a record review on 11/19/19, Resident 197's POLST dated 11/15/19 was not signed by the Medical Doctor (MD). There was a note in the chart next to the signature which indicated, "Please sign". There was a note inside the clinical record, on the POLST, for nurses, which indicated, please have the MD sign the POLST. Resident 197 was admitted on 11/12/19. During a record review on 11/13/19 at 2 p.m., Resident 295's "Admission Record" indicated he was admitted to the facility on 11/9/19. His POLST and Advance Directive Acknowledgment Forms remained unsigned by the physician. During an interview on 11/18/19 at 11:16 a.m., when queried how soon the forms were supposed to be signed, Licensed Nurse H stated, "as soon as possible." During a subsequent record review on 11/18/19 at 3:35 p.m., Resident 295's POLST and Advance Directive Acknowledgment Forms had physician signatures, and was dated "11/9/19".	F 578	***How the facility plans to monitor its performance to make sure that solutions are sustained:*** MR will audit POLST/Advanced Directive completion weekly for the duration of one month, and then bi-monthly for the duration of two months to ensure POLST/Advance Directives are being completed timely and accurately. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7 A review of the facility policy titled "Advance Directives §483.10(c)(6)", effective date October 2017, indicated "Upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care..."	F 578		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623	F 623 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents 9, 102, and 40 no longer reside in the facility. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:*** Any resident has the potential to be affected by this deficient practice. MR has not found any other residents to be affected by this deficient practice during their audits. Case managers will complete the discharge notice for planned discharges and provide the resident/ responsible party and fax the Ombudsman a copy at the time the Notice of Medicare Non Coverage (NOMNC) is given. Licensed nurses will complete the discharge notice and fax a copy to the Ombudsman at the time that any residents transfer to the hospital.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623	Case management will in-service licensed nurses on proper completion and submission of discharge or transfer notices by December 31st, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Case managers will complete the discharge notice for planned discharges and provide the resident/ responsible party and fax the Ombudsman a copy at the time the NOMNC is given. Licensed nurses will complete the discharge notice and fax a copy to the Ombudsman at the time that any residents transfer to the hospital. Case management will in-service licensed nurses on proper completion and submission of discharge or transfer notices by December 31st, 2019. ***How the facility plans to monitor its performance to make sure that solutions are sustained:*** MR will audit notices of transfer/discharges daily Monday through Thursday, and Friday through Sunday will be audited the following Monday to ensure they are being completed accurately. This will continue indefinitely. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated.	12/31/19 12/31/19

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to properly notify, in writing, three of 17 sampled residents (Resident 102, Resident 40, and Resident 9) and the Office of the State Long-Term Care Ombudsman (a public official who is charged with representing the interests of the public by investigating and addressing complaints of violation of rights of long-term care residents) of discharges. This failure had the potential to result in unsafe discharges when residents and their responsible parties were not given enough time and information to decide if	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10 their discharge was safe, and the ombudsman was not given notice in order to advocate for the residents before the residents left the facility. Findings: During an interview on 11/15/19 at 10:56 a.m., a family member (FM) of Resident 102 stated she had been given verbal notice of Resident 102's discharge on a voice mail. FM stated the voice mail informed her she had 48 hours to take her husband home, but when she called back, the staff member she spoke to changed it to 72 hours notice. When asked if any other discharge planning had taken place, FM stated 30 days prior she had been told she should start looking for placement for Resident 102, but she had not been told what kind of placement to look for. During a review of Resident 102's medical record, Resident 102's face sheet revealed an admission date of 9/13/19 and multiple diagnoses including intracerebral hemorrage (stroke), abnormalities of gait and mobility, and lack of coordination. Review of Plan of Care Note, dated 10/25/19, revealed, "Spoke with Patient and [FM] to discuss Patient's Weekly Progress. . . . Let Patient/[FM] know Rehab recommends continuing skilled services, with a possible DC (discharge) date to be set at next weekly meeting on 10/31/19. . . . " Review of Plan of Care Note, dated 11/1/19, revealed, "Left [voicemail] for [FM] . . . to set up a date/time to meet for a Care Conference to discuss Patient's LCD (last covered day) of 11/5/19 with discharge on 11/6/19. . . . " Resident 102's physician order dated 11/6/19 indicated, "Discharge home on 11/9/19 with remaining medications."	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 During a concurrent interview and review of medical records on 11/15/19 at 10:33 a.m., Case Manager C stated Resident 40 and Resident 9's admission histories as: a. Resident 40 was admitted to the facility on 10/19/19. Resident 40 had two facility stays prior to his current admission: on 5/29/19-6/8/19, and 6/17/19-6/26/19. Case Manager C stated Resident 40 went home both times. Case Manager C stated Resident 40's home discharge on 6/26/19 was self-initiated. b. Resident 9 was admitted to the facility on 11/1/19. Resident 9 had six facility stays prior to his current admission: on June 2019-7/1/19, 7/11/19-7/19/19, 7/30/19-7/31/19, 8/9/19-8/16/19, 9/13/19-10/18/19, and 10/27/19-10/29/19. Case Manager C stated Resident 9's discharges were all to acute care except on 7/19/19, when Resident 9's home discharge was self-initiated. When queried about any written notices given to both residents prior to their discharge, Case Manager C stated a NOMNC (Notice of Medicare Non-Coverage [Medicare form that explains certain rights and costs of staying in the facility beyond the date covered by Medicare]) was provided for Resident 40 on 6/5/19. Case Manager C stated Resident 9 did not get any written notice for his self-initiated discharge nor for his discharges to acute care. During an interview on 11/15/19 at 3:07 p.m., Ombudsman B confirmed residents and his office had not been receiving discharge notifications from the facility. Ombudsman B stated he only received a list of planned discharges faxed to his office on Fridays. Ombudsman B stated faxing this list was not the agreed upon arangement with the facility to be informed of discharges.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 During an interview on 11/18/19 at 11:20 a.m., Case Manager C stated she faxed a list of transfers and discharges to the ombudsman's office every Friday. Case Manager C stated a detailed reason for a resident's discharge was only given to residents who file an appeal. She stated the reason for discharge and location of where the resident was being discharged to are discussed in care planning meetings, but this information was not given to the resident or responsible party in writing. Case Manager C stated the only notices given to residents before they are discharged are the SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice [another Medicare form that lets residents decide whether to get the care in question and to pay for the service out-of-pocket if Medicare denies payment]) and NOMNC forms. During an interview on 11/18/19 at 2:32 p.m., Case Manager L stated she was not aware of any other written notice given to residents upon discharge, aside from the NOMNC and/or SNF ABN forms. During a record review and concurrent interview on 11/18/19 at 3:29 p.m., a blank document titled "Notice of Transfer/Discharge" was found in Resident 102's chart with a sticky note attached that indicated, "Please complete transfer/discharge to home (and make a copy of completed signed form for chart)." Case Manager C stated she was not familiar with the document and confirmed she did not know who was responsible for filling it out or when it was to be filled out. During an interview on 11/18/19 at 3:45 p.m., Administrator stated his understanding was that	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13 they were following the regulation for notifying the ombudsman's office of discharges. He confirmed sending a list on Fridays met the criteria. Administrator stated he did not know that the resident was supposed to get any other discharge notification other than the SNF ABN or NOMNC notices. During an interview on 11/19/19 at 9:08 a.m., Administrator stated he looked into the regulation for discharge notifications and the "Notice of Transfer/Discharge" document. Administrator stated medical records staff placed the documents in residents' charts, and had in-serviced the floor nurses that they were to fill them out and give them to the residents. When asked if the nurses followed through on completing the forms, Administrator stated it was something they were "working on." A facility policy and procedure for discharge notifications was requested, but not provided.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	F 657 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident 131 and 203 no longer reside in the facility. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 14 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement a resident-centered care plan for three of 17 sampled residents (Resident 131, Resident 203, and Resident 2) which resulted in: 1. Lack of a resident-centered care plan for individualized communication/hearing needs, (Resident 131). 2. Lack of including the resident (Resident 131) in communicating the daily plan of care. 3. Lack of a pressure ulcer care plan that included prevention, care, treatment, and monitoring of pressure ulcers (Residents 131 and 203). Findings: 1. During an observation and concurrent interview on 11/12/19 at 11:27 a.m., Resident 131 was lying in bed wearing a hospital gown. Resident 131 stated that he had difficulty understanding the facility staff due to a language barrier. Resident	F 657	Any resident has the potential to be affected by this deficient practice. MR has not found any other residents to be affected by this deficient practice during their audits. Residents with communication/hearing needs will be accurately assessed and have individualized care plans that address their specific needs upon admission. Any changes in care plans will be brought to affected residents as soon as practicable. Residents with pressure ulcers will be assessed and have a care plan created that includes prevention, care, treatment, and monitoring of pressure ulcers upon admission. DSD will in-service licensed staff on accuracy and timeliness of communicating any hearing/communication needs, and timely completion of skin assessments, care planning and documentation by December 31st, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** DSD will in-service licensed staff on accuracy and timeliness of communicating any hearing/communication needs, and timely completion of skin assessments, care planning and documentation by December 31st, 2019.	12/31/19 12/31/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555695	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1660 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 15 131 stated, "99% of the staff can hardly speak English and are difficult to understand." On 11/14/19, Resident 131 stated his hearing aids were at home with his wife, and expressed concern of losing hearing aids if brought in the facility. During an interview on 11/14/19 at 3:22 p.m., Social Services Staff J stated that they have policies and procedures on securing resident's personal belongings including hearing aids. During a review of Resident 131's Care Plan, on 11/15/19, there was no documentation of a resident-centered care plan for individualized hearing/communication needs. 2. During an observation and concurrent interview with Resident 131 on 11/14/19, 10:40 a.m., Resident 131 was eating breakfast in bed. Resident 131 stated, his appointment for a diagnostic test was canceled that morning after he drank Ensure prior to his departure. Resident 131 expressed frustration with communication and lack of information regarding his daily plan of care. During an observation and concurrent interview on 11/14/19 at 2:47 p.m., Unlicensed Staff M stated her shift started at 7 a.m. Unlicensed Staff M received report that Resident 131 had an appointment and needed to be in his wheelchair ready to go by 7:30-7:45 a.m. Unlicensed Staff M stated Resident 131 requested a drink of Ensure. Unlicensed Staff M stated Resident 131 had to ask the nurse about having Ensure. During a concurrent observation, interview, and record review with Licensed Nurse A, on 11/15/19	F 657	MR will audit new admissions within 72 hours for identification of hearing/communication needs and timely and accurate skin assessments and care plan completion for the duration of one month. Thereafter, MR will continue to conduct audits weekly for the duration of two months. ***How the facility plans to monitor its performance to make sure that solutions are sustained:*** DSD will in-service licensed staff on accuracy and timeliness of communicating any hearing/communication needs, and timely completion of skin assessments, care planning and documentation by December 31st, 2019. MR will audit new admissions within 72 hours for identification of hearing/communication needs and timely and accurate skin assessments and care plan completion for the duration of one month. Thereafter, MR will continue to conduct audits weekly for the duration of two months. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated.	12/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 16 at 2:58 p.m., Licensed Nurse A was not able to locate the care plan for Resident 131. Licensed Nurse A stated the reason for Resident 131 receiving Ensure was because she was unaware of Resident 131's diet restrictions, due to a breakdown in communication and was not relayed during shift change report/ hand-off. 3. During a review of Resident 131's, "Order Summary Report," dated 11/15/19, indicated, Resident 131 was admitted to the facility on 10/11/19. There was a written order to "apply zinc oxide (topical medication) to sacrum, coccyx (tail bone - bottom of back bone/ spine), and buttock after cleaning up stool or urine." Furthermore, "monitor right buttock for breakdown (skin problems) every shift for skin monitoring, and also "add foam dressing every shift to right buttock for skin care." During a review of Resident 131's, "Care Plan," dated 10/25/19, indicated Resident 131's risk for nutritional decline related to a diagnosis of sepsis and he was admitted with a suspected deep tissue injury (pressure sores that develop in the tissue deep below the skin) on right buttock. The Care Plan did not indicate any documentation for pressure ulcer prevention, care, treatment, and/ or monitoring. A review of the facility's "Resident Matrix" (document used to identify residents' pertinent care areas), dated 11/12/19, indicated Resident 203 had a Stage I pressure ulcer (Skin break down caused by unrelieved pressure and staged by severity, I-V. Stage I injuries have reddened skin, but no breaks or tears). A review of Resident 203's nursing care plan,	F 657		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17 dated 11/14/19, indicated Resident 203 was at risk for developing skin injury, but had no interventions for prevention of pressure ulcers. During an interview on 11/19/19 at 11 a.m., Admission Coordinator (AC) stated, Resident 203 had a small redness on the buttocks (Stage I), and it was treated with a topical cream. AC was not able to find a nursing care plan for the Stage I pressure ulcer that would provide nursing with interventions and a goal for improvement. A review of the facility's policy and procedure, "Care Plans, Comprehensive Person-Centered," revised 12/2016, indicated the facility prepared comprehensive, person-centered care plans for each resident, and they included treatment goals, timetables, and objectives. The procedure, page two, indicated nursing care plans also identified problem areas, their causes, and developed individualized interventions. The policy indicated resident assessments and care plans were revised as resident conditions changed.	F 657		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	F 761 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents 7 and 23 no longer reside in the facility. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:***	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safe medication administration and administration of formula through a gastric tube (GT tube, a surgically inserted tube that allows nutrition to be given directly into the stomach for people who have difficulty eating) for one of 17 sampled residents (Resident 7) and one un-sampled resident (Resident 23) which had the potential to result in medication error and harm when: 1) Resident 7's tube feeding formula bottle was not labeled with resident's name, date, time and doctor's order. 2) Resident 23's tube feeding formula bottle was not labeled with resident's name, date, time and doctor's order. Resident 23's gastric tube was not verified for placement and checked for gastric residual volume (GRV, refers to the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding. To measure GRV, nurses withdraw this fluid via the feeding tube by pulling back on the plunger of a large, usually 60	F 761	Any resident has the potential to be affected by this deficient practice. DON has not found any other residents to be affected by this deficient practice during their audits. An observational audit was conducted by the Infection Preventionist (IP) on all residents receiving nutrition via tube feeding. All residents were found to have proper labeling of Gastrostomy Tube (GT) formula bottle (resident's name, date, time, and doctor's order) Two medication carts were inspected by the IP and all opened medications were found to have proper labels. Licensed nurses will be in-serviced on proper labeling of GT formula bottles, opened medications, and proper procedure of verification of GT placement and checking for gastric residual volume by the IP/DSD by December 31st, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** An observational audit was conducted on all residents receiving nutrition via tube feeding. All residents were found to have proper labeling of GT formula bottle (resident's name, date, time, and doctor's order) Two medication carts were inspected by the IP and all opened medications were found to have proper labels.	12/31/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1650 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 19 mL syringe before administering medication through the feeding tube). 3) Medication Carts #1 and #2 contained opened, undated medications. Findings: 1) During an observation and concurrent interview on 11/14/19 at 9:42 a.m., Licensed Nurse K was preparing to administer medications to Resident 7. Resident 7 had tube feeding formula being administered into a GT tube by a pump on a pole at his bedside. The bottle of formula and the tubing were not labeled with a date or time the tube feeding was started. Licensed Nurse K confirmed the tube feeding was not labeled with a date or time, and confirmed that it should be. 2) During an observation on 11/13/19 at 10 a.m., Licensed Nurse (LN) A was administering medications through GT tube to Resident 23. A bottle of Jevity 1.5 for GT formula was hung on a pole and attached to a tube. The feeding tube was attached to an infusion pump set to deliver 75 milliliters (mL) per hour. There was no label to indicate the name of the resident, date, time or doctor's instructions. LN A did not verify placement of the GT tube by listening with a stethoscope. LN A did not check for GRV. Review of facility policy and procedure titled "Enteral Tube Feeding via Continuous Pump," last revised 3/2015, under section "Initiate Feeding," number 5 indicated, "On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order."	F 761	Licensed nurses will be in-serviced on proper labeling of GT formula bottles, opened medications, and proper procedure of verification of GT placement and checking for gastric residual volume by the IP/DSD by December 31st, 2019. IP will perform random audits weekly for the duration of one month to ensure GT formula bottles as well as opened medications are labeled correctly, and GT placement and gastric residual volume will be performed to ensure compliance. Random audits will be done bi-monthly for the duration of two months thereafter. ***How the facility plans to monitor its performance to make sure that solutions are sustained:*** IP will perform random audits weekly for the duration of one month to ensure GT formula bottles as well as opened medications are labeled correctly, and GT placement and gastric residual volume will be performed to ensure compliance. Random audits will be done bi-monthly for the duration of two months thereafter. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated.	12/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 20 Review of facility policy and procedure titled "Administering Medications through an Enteral Tube," last revised March 2015, under section "Steps in the Procedure," number 18 indicated, "Confirm Placement of feeding tube. . . . 20. Check gastric residual volume (GRV) to assess for tolerance of enteral feeding." 3) During an observation and concurrent interview on 11/14/19 at 2 p.m., a random check of medication stock in Medication Cart #1 revealed there were multiple opened medications which were not dated. Undated, opened medications included a box of Mucinex, GaviLax powder, Kayexalate powder, and fluticasone spray. A random check of medication stock in Medication Cart #2 also revealed multiple opened medications which were not dated. Undated, opened medications included Vitamin D, an albuterol inhaler, fluticasone, and Spiriva. Licensed Nurse C stated all medication containers must be dated when opened for use. Director of Nursing stated medications should have a date when opened. A review of facility policy and procedure "Labeling Medication Containers," last revised April 2007, number three, revealed: "Labels for individual drug containers shall include all necessary information . . . ."	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804	F 804 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 21 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide palatable and appetizing food for three unsampled residents (Resident 13, Resident 351, and Resident 296). This failure had the potential to cause a negative dining experience, loss of appetite, and a decrease in caloric intake that could lead to unintended weight loss. Findings: During an interview on 11/12/19 at 10:02 a.m., Unsampled Resident 13 stated, "The food is not the best." During an interview on 11/13/19 at 8:56 a.m., Unsampled Resident 351 laughingly stated, "The food is not very good. You'll see." During an interview on 11/13/19 at 10:24 a.m., Unsampled Resident 296 stated the food was "a hit or miss". Unsampled Resident 296 stated her family brings in food from home, which she preferred to eat. During test trays of the regular lunch and pureed regular lunch on 11/15/19 at 12:51 p.m., with Registered Dietician E present, the lunch consisted of cod, white rice, and peas and carrots. The cod tasted bland, and the rice had no flavor. The pureed regular lunch consisted of the same food items, with gravy added on top of the	F 804	Residents 13, 351, and 296 no longer reside in the facility. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:*** Any resident has the potential to be affected by this deficient practice. Dietary Supervisor (DS) has not found any other residents to be affected by this deficient practice during their audits. All food items will be prepared by to be palatable by methods that have been prepared and cooked to recipe as provided by the menu to include all ingredients, spice et. and at appropriate temperatures. This will conserve nutritive value, flavor and appearance. The DS conducted an in-service on December 19th, 2019 to dietary staff on food palatability, compliance in following recipes, tray ticket accuracy, and monitoring food temperatures. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** The DS conducted an in-service on December 19th, 2019 to dietary staff on food palatability, compliance in following recipes, tray ticket accuracy, and monitoring food temperatures.	12/19/19 12/19/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 22 cod. The scoops of pureed food plated together looked visually unappetizing. When asked if there were any seasonings used on the rice, the Registered Dietician E stated, "No." A review of the facility policy titled "Purpose and Objectives of the Food and Nutrition Services Department", dated 2017, indicated "The purpose of the food and nutrition services department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner."	F 804	The DS will conduct weekly meal preparation and service audits that include taste testing food prior to service to ensure palatability, recipe compliance, tray ticket accuracy, and food temperature compliance for the duration of one month. Audits will be conducted bi-monthly for the duration of two months thereafter. ***How the facility plans to monitor its performance to make sure that solutions are sustained:***	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to adhere to professional standards for food safety when two	F 812	The DS conducted an in-service on December 19th, 2019 to dietary staff on food palatability, compliance in following recipes, tray ticket accuracy, and monitoring food temperatures. The DS will conduct weekly meal preparation and service audits that include taste testing food prior to service to ensure palatability, recipe compliance, tray ticket accuracy, and food temperature compliance for the duration of one month. Audits will be conducted bi-monthly for the duration of two months thereafter. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated. F 812 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***	12/19/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1650 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 dented cans were not removed from the food supply for three months. This failure had the potential of serving adulterated food to the residents, that could lead to exposure to bacteria associated with foodborne illnesses. Findings: During the initial kitchen tour on 11/12/19 at 9:34 a.m., two dented cans of tomato sauce were observed in the dry storage area. Both cans were labeled "Delivery Date: 8/5/19". During a concurrent interview with Dietary Supervisor D, when queried about the facility's process on checking the quality of canned goods, she stated the delivery person checks the cans during delivery and removes the dented cans. Dietary Supervisor D confirmed that both cans had been delivered three months ago. Dietary Supervisor D stated, "These cans should not have been here." A review of the facility policy titled "Dry Storage Areas", dated 2017, indicated "Food in broken packages or swollen or dented cans, cans with a compromised seal, or food with abnormal appearance or odor will not be served."	F 812	No residents were found to be affected by this deficient practice. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:*** Any resident has the potential to be affected by this deficient practice. DS has not found any other residents to be affected by this deficient practice during their audits. All dented cans were immediately removed from the dry storage and placed in the designated area. All food items will be stored, prepared, distributed, and served in accordance with professional standards for food safety. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** Dietary staff were in-serviced on the facility food storage policy on December 19th, 2019. The DS will perform weekly inspections to ensure there are no dented cans in the dry storage area. Any dented cans that are found will be stored in the designated area and disposed of properly.	12/19/19
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	***How the facility plans to monitor its performance to make sure that solutions are sustained:*** The DS will perform weekly inspections to ensure there are no dented cans in the dry storage area. Any dented cans that are found will be stored in the designated area and disposed of properly. The DS will perform audits weekly for one month and bi-monthly for two months thereafter. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated. F 880 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Resident #198: This resident is on regular monitoring for symptoms of Tuberculosis (TB) and has not been symptomatic since admission. Should resident 198 become symptomatic of TB he will be sent back to the acute immediately. Resident 23 and 209 no longer reside in the facility. ***How the facility will identify other residents having the potential to be***	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to establish and implement an effective infection prevention and control program when: 1) One resident (Resident 198) was admitted to the facility without a tuberculosis clearance, and, 2) LN A did not check the bandage on the stomach where the feeding tube was placed and assess the site for sign and symptoms of infection for Resident 23, and, 3) Isolation precautions were not provided for one resident (Resident 209) who was receiving chemotherapy, and, 4) Clean laundry was stored and transported in an uncovered garment rack. These cumulative failures had the potential to transmit communicable diseases and infections to the residents in a vulnerable population.	F 880	***affected by the same deficient practice and what corrective action will be taken:*** Any resident has the potential to be affected by this deficient practice. IP has not found any other residents to be affected by this deficient practice during their audits. On patient admission the licensed nurse will complete the resident screen upon admission and annual screen for Tuberculin Skin Test (TST) converters or reactors for all new admissions. If there is a history of positive TB test the admissions nurse or designee will notify Doctor of Medicine (MD) and obtain an order for a chest x-ray or if the patient already has a chest x-ray within 12 months clearing for TB the MD will be notified to review. If no history of positive TB test, administer 2-step Purified Protein Derivative (PPD). If patient has documentation of 2-step PPD in the last 90 days it is not necessary to repeat the test. If PPD is refused and the resident is not symptomatic a chest x-ray will be offered. If the chest x-ray is refused the MD will be notified and it will be documented in a progress note. If a resident is symptomatic the MD, Administrator, DON and IP will be notified. If symptomatic, place a mask on the resident and move them to a private room then prepare paper work to transfer the resident to the acute hospital. An in-service for licensed nurses on TB Policies and Procedures that included: procedures for refusal and procedure on admission for clearance will be	

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26 Findings: 1) Review of Resident 198's admission record indicated Resident 198 was admitted on 10/24/2019 from an acute care hospital. Resident 198 was admitted under hospice care. Review of Resident 198's immunization record indicated, "resident refused" a tuberculosis screening skin test (TST). (TB, an infectious disease caused by Mycobacterium tuberculosis bacteria. It primarily targets the lungs but may affect any area of the body such as the urinary tract, central nervous system, bones, joints, and/or other organs.) During an interview on 11/18/19 at 3 p.m., Infection Control Consultant (ICC) and Infection Control Interventionist (ICI), when asked what was the facility's policy when a newly admitted resident refused a TST and CXR (chest X-ray), they stated the facility did not have a policy and procedure for newly admitted residents who refused TST or a CXR. During an interview on 11/18/19 at 4:30 p.m., ICC and ICT stated Resident 198 had an order from the hospice's Medical Doctor (MD) that indicated Resident 198 refused TST and a CXR. There was no other instructions from the hospice MD regarding further TB screening. On 11/18/19 at 5 p.m, the Director of Nursing (DON) submitted a copy of MD's order from the hospice agency dated 11/18/19 at 3:55 p.m. which indicated "Pt refuses PPD (protein purified derivative-TST) and CXR" . Review of facility policy and procedure titled	F 880	completed by December 31st, 2019 by the IP. Licensed nurses will conduct assessments on feeding tube sites for signs and symptoms of infection every shift and change dressings daily with an accurate date and initial. An in-service for licensed nurses on tube feeding processes that included: labeling tubing and feeding, auscultation for placement, and daily inspection of insertion site with site care was provided by the IP on December 18th, 2019. Admissions Director (AD), DON, and/or IP will implement chemotherapy precautions upon admission. In-servicing for chemo precautions that included: oral chemo and when to establish chemo precautions was completed for licensed nurses by the IP on December 19th, 2019. Laundry staff will cover linen carts when transporting linens throughout the facility to prevent contamination. An in-service on proper linen transportation was provided to laundry staff by Environmental Services Director (ESD) on December 4th, 2019. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:***	12/31/19 12/19/19 12/19/19 12/4/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 "Tuberculosis Infection Control Program," last revised 1/2012, indicated, "The facility recognizes that tuberculosis (TB) transmission has been identified as a risk in healthcare settings. To try to prevent nosocomial (healthcare acquired) transmission of TB, our facility has instituted a Tuberculosis Infection Control Program." Review of facility policy titled "Tuberculosis, Screening Residents for," revised 7/2013, indicated, "This facility shall screen all residents for tuberculosis infection and disease (TB)." 2) During an observation on 11/13/19 at 9:25 a.m. in room 137, Licensed Nurse (LN) A administered medication imanitib 400 milligrams (m.g.) by mouth to Resident 209. This was a chemotherapy medication used for treatment of leukemia (cancer of the blood) and tumor in the stomach. During an observation on 11/14/19 at 11:30 a.m., the Director of Staff Development (DSD) placed an isolation sign in the front of room 137 where Resident 209 was roomed. DSD and another Certified Nursing Assistant (CNA) rolled a cart with personal protective equipment (PPE) inside room 137 and a yellow plastic container for garbage can, then closed the door. An interview with the Maintenance on 11/19/19 at 11 a.m. stated, a yellow plastic container was for hazardous waste products. A review of the facility guidelines for Chemotherapy Precaution revised 2/11/19 indicated after receiving chemotherapy, residents should be placed on chemotherapy precautions in a single room for 48 hours.	F 880	On patient admission the licensed nurse will complete the resident screen upon admission and annual screen for TST converters or reactors for all new admissions. If there is a history of positive TB test the admissions nurse or designee will notify MD and obtain an order for a chest x-ray or if the patient already has a chest x-ray within 12 months clearing for TB the MD will be notified to review. If no history of positive TB test, administer 2-step PPD. If patient has documentation of 2-step PPD in the last 90 days it is not necessary to repeat the test. If PPD is refused and the resident is not symptomatic a chest x-ray will be offered. If the chest x-ray is refused the MD will be notified and it will be documented in a progress note. If a resident is symptomatic the MD, Administrator DON and IP will be notified. If symptomatic, place a mask on the resident and move them to a private room then prepare paper work to transfer the resident to the acute hospital. An In-service for licensed nurses on TB Policies and Procedures that included: procedures for refusal and procedure on admission for clearance will be completed by December 31st, 2019 by the IP. Licensed nurses will conduct assessments on feeding tube sites for signs and symptoms of infection every shift and change dressings daily with an accurate date and initial. An In-service for licensed nurses on tube feeding processes that included: labeling tubing and feeding, auscultation for	12/31/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28 An interview with Infection control consultant (ICC) and Infection control interventionist (ICI) on 11/18/19 at 4:30 p.m. stated, the isolation sign for chemotherapy precautions was placed when a resident began the chemotherapy. The facility did not follow the guidelines for chemotherapy precautions in a timely manner when Resident 209 began his chemotherapy medication. 3) During an observation and concurrent interview on 11/13/19 at 10 a.m., Licensed Nurse (LN) A did not check or assess Resident 23's feeding tube site for signs and symptoms of infection. When the resident's gown was lifted, the bandage over the tube feedings was wrinkled, and had no date or initials that indicated when the bandage was changed. LN A stated the bandage was only changed as needed and not daily. A review of the clinical record for Resident 23 indicated there was no doctor's order for changing Resident 23's bandage at his feeding tube site in the stomach area. There was no documentation of the skin around the feeding tube site. During an interview with Director of Nursing (DON) on 11/14/19 at 1 p.m. stated, bandage changes were done by a treatment nurse. When asked who was the treatment nurse, the DON stated, the nurse who was in charge of the resident was to change the bandage. A review of facility policy titled "Dressings, Dry/Clean," last revised 6/2005, indicated, ". . . securing dressing at the end of the procedure and	F 880	placement, and daily inspection of insertion site with site care was provided by the IP on December 18th, 2019. AD, DON, and/or IP will implement chemotherapy precautions upon admission. In-servicing for chemo precautions that included: oral chemo and when to establish chemo precautions was completed for licensed nurses by the IP on December 19th, 2019. Laundry staff will cover linen carts when transporting linens throughout the facility to prevent contamination. An in-service on proper linen transportation was provided to laundry staff by ESD on December 4th, 2019. ***How the facility plans to monitor its performance to make sure that solutions are sustained:*** IP will conduct weekly audits on PPD testing for the duration of one month. Audits will be conducted bi-monthly for the duration of two months thereafter. IP will conduct weekly audits on proper tube feeding processes for the duration of one month. Audits will be conducted bi-monthly for the duration of two months thereafter. IP will monitor proper implementation of chemo precautions upon admission weekly for the duration of one month.	12/18/19 12/19/19 12/4/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH RANCH SKILLED NURSING & REHABILITATION CENTE	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29 add date and initials." According to Lippincott Nursing, 8th edition, copyright 2019, a feeding tube site needs to be assessed for skin breakdown, redness, swelling or presence of pus . . . . clean site daily and label the dressing with the date, time and initial. 4) During a concurrent observation and interview on 11/15/19 at 2:21 p.m., Unlicensed Staff G was in the elevator transporting laundry in an uncovered garment rack. Unlicensed Staff G stated the clothes on the rack were clean. During a subsequent observation and interview, the Housekeeping Manager F was observed outside the elevator door as it opened, and acknowledged the uncovered rack and stated, "That should have been covered." A review of an undated facility policy titled "Laundry Room Procedures Smith Ranch" indicated "When linen or personal clothing is being delivered to the linen closets or resident rooms, it must be covered to protect it from possible contamination."	F 880	Monitoring will continue bi-monthly for duration of two months thereafter. IP will monitor proper linen transportation weekly for the duration of one month. Monitoring will continue bi-monthly for duration of two months thereafter. Findings will be brought to the facility QAPI Committee and if there are concerns, an action plan will be developed, implemented and evaluated. 	