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

PRINTED: 12/06/2018
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 _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith ranch KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	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 reflects the findings of the California Department of Public Health during an annual recertification survey. Representing the California Department of Public Health: Surveyors 38088, 31424, 38335, 41175, 40402, Health Facilities Evaluator Nurses. There were 28 residents on the day of entry.	F 000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 578 SS=B	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	F 578	**F578** **Request/Refuse/Discontinue Treatment; Formulate Adv Dir** CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents #15, 16, 126, 127, 8, 176, 125 and 6 POLST and Advanced Care Directives Acknowledgements (ACDA) have been completed.	

RECEIVED
JAN 04 2019
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/4/19

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

1/10/19 C1113
POC#2 Accepted via phone, Janice Minutti #38088

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	555685	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the 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 observation, interview and record review, the facility failed to adequately assess resident wishes for Advanced Directives, for residents or responsible parties, when documentation of discussions and offers to complete documentation on the POLST and ADVANCED CARE DIRECTIVE ACKNOWLEDGEMENT form were incomplete or not found for 8 sampled residents (Residents #15, 16, 126, 127, 8, 176, 125, 6) out of 12 sampled residents records. This failure had the potential for harm if resident's wishes for end of life care were not respected and followed. Findings: During a record review for Resident 126, on 11/08/18, at 11:31 a.m., the document titled, "POLST," dated 11/4/18, Section D, titled "INFORMATION AND SIGNATURES," indicated "No Advance Directive." A History and Physical from a hospital discharge, dated 11/6/18, indicated Resident 126 had an advanced	F 578	**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;** All residents have the potential to be affected by the deficient practice. All resident's Advanced Directives were adequately assessed for resident wishes for residents or responsible parties and documentation of discussions and offers to complete documentation on the POLST and Advanced Care Directive Acknowledgement were reviewed and all were found to be complete. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** MRD/Designee will conduct daily POLST and ACDA forms for all new admissions to ensure completion.	

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	556066	A. BUILDING _____ B. WING _____	11/16/2018

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 578	Continued From page 2 directive. The document titled; "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 11/7/18, indicated the discussion documentation was incomplete. During a record review for Resident 127, on 11/8/18, at 12 p.m., the document titled, "Physician Orders for Life-Sustaining Treatment (POLST), dated 11/7/18, was incomplete. Sections C, titled "ARTIFICIALLY ADMINISTERED NUTRITION" and the document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 10/31/18, indicated the Resident did not sign the form in two places and the discussion documentation was incomplete. During a record review for Resident 176, the document titled, "POLST," dated 10/25/18, Section D, titled "INFORMATION AND SIGNATURES," was incomplete. The document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 10/26/18, indicated the discussion documentation was incomplete. During a record review for Resident 8, the document titled, "POLST," dated 9/28/18, and the document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," were incomplete. During a record review for Resident 126, the document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 11/1/18, indicated the discussion documentation was incomplete, and the signature of the resident was missing. During a record review for Resident 16, the	F 578	Weekly audits will be completed thereafter for all residents to ensure patient's POLST and ACDA forms are adequately assessed and completed weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. MRD will forward any concerns to the Director of Nursing (DON)/Designee for review. **How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/Designee will track and trend reported findings and present to the monthly QAPI. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure.	12/16/18

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 678	Continued From page 3 document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 10/15/18, indicated the discussion documentation was incomplete. During a record review for Resident 6, the document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," dated 9/15/18, indicated the discussion documentation was incomplete, and the signature of the resident was missing. During a record review for Resident's 16, and concurrent interview, with Licensed Staff (L.S.) L, on 11/14/18, at 10:50 a.m., the document titled, "POLST," was not found in Resident 16's medical record. The document titled, "ADVANCED DIRECTIVE ACKNOWLEDGEMENT," not dated, indicated the discussion documentation was incomplete. L.S. L stated Resident 16's POLST was not in the chart, and the Advanced Care Acknowledgement form was not filled out completely. She stated the form is supposed to be filled out by an Administrative Registered Nurse within 24 hours. During a record review and concurrent interview, with Administrative Staff (A.S.) A, on 11/14/18, at 11:06 a.m., A.S. A reviewed the medical record for Residents 16, 15 and 127. A.S. A stated the POLST and Advanced Directive Acknowledgement forms were incomplete or missing for all the charts. She stated the forms should be filled out completely without any missing information. A.S. A stated the purpose of the ADVANCED DIRECTIVE ACKNOWLEDGEMENT form was to document a discussion took place with the resident about advanced directives, and if it wasn't complete it	F 678		

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1660 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 578	Continued From page 4 didn't happen. During a record review and concurrent interview, with A.S. A, and Unlicensed Staff (U.S.) V, on 11/14/18, at 12 p.m., A.S. A stated she could not find Resident 16's POLST in the medical record. She stated it was supposed to be in the medical record. U.S. V stated he could not find the POLST in the Resident 16's medical record. U.S. V left the interview and returned with a copy of Resident 16's POLST. He stated it was in the stored medical record for Resident 16. U.S. V stated every resident is supposed to have a POLST in the front of the medical record. A.S. A and U.S. V stated the risk to residents from not having completed POLST and Advanced Directive information in their medical record was if a resident who had indicated on the POLST they did not want to be resuscitated, was resuscitated. A review of the facility Policy and Procedure (P&P), titled "Advanced Directives," revised December 2016, indicated "7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. B. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance."	F 578		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656	F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 16 no longer resides at the facility.	

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	556696	A. BUILDING _____ B. WING _____	11/16/2018

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F 656	Continued From page 5 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on on interview, observation and record review, the facility did not ensure residents who	F 656	**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;** All residents with post op surgical wounds have the potential to be affected by the deficient practice. Residents with post op surgical wound were accurately assessed and had a care plan with a risk for wound infection in place. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** All new patient admissions and re-admissions will be reviewed by the Interdisciplinary team (IDT) for potential skin issues and for potential wound infections. The IDT will accurately assess post-op surgical wounds and develop a	

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F 656	Continued From page 6 were at risk from infection for one of 12 Sampled Residents (Resident 16), when they did not accurately assess the post-op surgical wound and develop a care plan per facility policy and procedure (P&P). This failure did not provide staff effective communication and guidance of nursing care for Resident 16, and had the potential to have contributed to Resident 16's rehospitalization and subsequent readmission for post operative wound infection. Findings: During an interview and record review with Resident 16, on 11/07/18, at 1:53 p.m., he stated he was in the facility for post operative wound care. Resident 16 is a 75 year old male, originally admitted on 9/26/18, with a diagnosis of Malignant Neoplasm of Prostate, Acquired Absence of Other Genital Organs, and Encounter for Attention to Illostomy. Resident 16 had a plastic surgery appointment on 10/3/18, and was emergently admitted to a local hospital for infected post operative wound. He was readmitted to the facility after completion of antibiotic therapy in the hospital, on 10/11/18. His admitting diagnosis included Urethral Fistula and Infection Following a Procedure, Organ and Space Surgical Site. Resident 16 stated during his first admission, staff gave me pull ups (disposable incontinent shorts), the urine drained directly into the pull ups and my post operative wound became wet and it got infected. During an interview on 11/13/18, at 10:04 a.m., Licensed Staff (L.S.) N stated the care plan for Resident 16 called for wound care three times a day and the ostomy bag changes. She stated that's it.	F 656	care plan. The care plan will include treatment and monitoring for signs and symptoms of wound infection and physician notification. The care plan will provide staff effective communication and guidance for nursing staff that are caring for the resident. DSD will inservice all licensed nurses on the accuracy and timeliness of skin assessments, care planning and documentation. MRD will audit all new admission within 72 hours for completion of skin assessments and completion of resident care plans. Any findings will be reported to the DON and Minimum Data Set (MDS) licensed nurse for follow-up action. The audits will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. MDS Nurse/Designee will review and revise care plans as necessary as residents' condition warrants.	

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F 656	Continued From page 7 During an interview and concurrent record review, with L.S. AA, on 11/13/18, at 10:34 a.m., she stated care plans are used to guide the care of residents. She stated they should be completed 24 hours after admission or new condition presents. L.S. AA was not able to find documentation of Resident 16's wound care or risk of infection care plan. She was unable to state if the care plans were updated after Resident's 16 readmission from a hospitalization for wound infection. During a concurrent interview and record review on 11/13/18, at 11:51 a.m., Administrative Staff (A.S.) A reviewed Resident 16's medical record and stated she could not find any updated documentation on Resident 16's readmission to the facility, including wound care or post operative wound care. She stated I have looked through everything, and was unable to find anything about infection in the progress notes or wound care notes in any of Resident 16's documentation. During an interview on 11/13/18 at 12:01 p.m., A.S. A left her office to talk to Resident 16's licensed nurse. A.S. A stated the post operative wound wasn't open and didn't appear infected when Resident 16 went to his Plastic Surgery appointment on 10/3/18. During an interview and concurrent record review on 11/13/18, at 12:11 p.m., A.S. A asked Licensed Staff (L.S.) N to find a wound assessments done for Resident 16. A document titled "Weekly Skin Alteration Report," dated 9/26/18 indicated, "Surgical" wound at "Rectum, 5 cm Red, Moist Grainy, . optimal granulation." From 9/26/18 to 10/3/18 no	F 656	MRD will audit ten random charts weekly for completion of weekly skin assessments. Any findings will be reported to the DON/Designee for follow-up action. The audits will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. The audits will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. **How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/Designee will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure.	12/16/18

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F 656	Continued From page 8 other wound assessment was found. A weekly Skin Check document dated 10/11/18 indicated "Monitor skin for any changes and breakdown, S/S of infection. L.S. N stated there were only two skin checks documented since Resident 16's original admission on 9/26/18, a total of 41 days. When asked to describe the original surgical wound, based on the documentation on 9/26/18, L.S. N stated it was 5 cm. A.S. A stated it was an inadequate description for a post operative wound. She stated there should have been more detailed surgical wound assessments. During an interview and concurrent document review, on 11/13/18, at 12:33 p.m., A.S. F reviewed the care plans for Resident 16 and stated the normal process for wounds is to group everything under skin integrity. A review of the Care Plan for "Actual impairment to skin integrity related to abrasion on chin, rash on upper back, surgical wound status post rectourethral fistula," initiated 10/11/18, did not have any language related to the risk of infection. A.S. A stated there was no Care Plan for risk of infection related to status post infection interventions. A.S. F stated she updated the Care Plan for skin integrity related to surgical wound status post rectourethral fistula on 11/13/18, as directed by the facility consultant. Interventions included "WOUND CARE..." and "Monitor for signs/symptoms of infection." A record review of a Care Plan initiated on 9/26/18, titled "Resident 16 had actual impairment to skin integrity related to abrasion on chin, rash on upper back, surgical wound status post rectourethral fistula." The Goal, dated 9/26/18, did not not include language regarding infection of post operative wound. The interventions dated	F 656		

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F 656	Continued From page 9 9/26/18 did not include language related to risk of wound infection. A new Care Plan for skin integrity, dated 10/11/18, was identical to the 9/26/18 skin integrity Care Plans and did not include any language related to wound infection in the Goal or Interventions area. A Care Plan, dated 10/11/18, for "Risk for falls related to infection following surgery," did not include language in the Goal or Intervention related to risk of infection. A Care Plan for "At risk for fatigue, At risk for infection, dated 10/23/18, did not include language in the Goal or Intervention related to risk of infection. When asked what the risk of not providing Resident 16 a care plan specific to Resident 16's wound, A.S. F stated he would be at risk of developing another wound infection. A record review of a document without a title, dated 10/11/18, included the primary physician notes for Resident 16. In the section titled "General Examination: Skin: left thigh dressing incision clean/dry/ intact without discharge. Assessments 5. Local infection of the skin and subcutaneous tissue, " did not include language about risk of wound infection. A record review, of a document titled "Order Summary Report," dated 9/25/18, and 10/11/18, did not include any orders for observation for risk of signs and symptoms of wound infection. A record review, of documents titled "Progress Notes," dated 9/25/18, and 10/11/18, included language regarding "Aspiration precaution, Fall precaution," and did not include any language for wound infection.	F 656		

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 656	Continued From page 10 A review of a document titled "Care Planning - Interdisciplinary Team," revised 2013, indicated "1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment(MDS)." A review of a document titled "Charting and Documentation," revised April 2008, indicated "7. Care plans shall be reviewed and revised at a minimum of quarterly or more often as the resident's condition warrants and be in accordance with Stated and Federal Regulations."	F 656		
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. (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	F 657	**F657** **Care Plan Timing and Revision** CFR(s): 483.21(b)(2)(i)-(iii) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 11, 16 and 127 no longer resides in the facility.	

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F 657	Continued From page 11 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 interview, and document review, the facility failed to ensure residents had current and accurate care plans to guide staff on individual resident care for 3 of 12 sampled residents (Residents #11, 16, 127). The facility failed to develop a comprehensive care plan when; 1. Resident 16 did not have a Care Plan for Risk of Infection, from his initial admission on 9/25/18 to 11/14/18, after a discharge from a hospitalization for diagnosis of post operative surgical wound infection. 2. Resident 127 did not have a Care Plan for Potential Abuse, after she expressed a fear of her husband. 3. Resident 11 did not have a Care Plan for Gastro Intestinal (GI) bleed until 47 days after discharge from a hospitalization for GI bleed. These failures had the potential for resident harm by not providing a current Care Plan for the individualized needs of residents. Findings: 1. During an interview and record review with Resident 16, on 11/07/18, at 1:53 p.m., he stated he was in the facility for post operative wound care. Resident 16 is a 75 year old male, originally admitted on 9/25/18, with a diagnosis of	F 657	**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;** 1.) All residents with post-operative surgical wound infection have the potential to be affected by the deficient practice. Residents with post-operative surgical wound infection care plan were reviewed and all had risk of infection in place. 2.) All residents who have expressed fear have the potential to be affected by the deficient practice. Residents who expressed fear were reviewed and had a care plan in place. 3.) All residents with a diagnosis of GI bleed have the potential to be affected by the deficient practice. Residents who have a diagnosis of GI bleed were reviewed and all had a care plan in place.	

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F 657	Continued From page 12 "Malignant Neoplasm of Prostate, Acquired Absence of Other Genital Organs, and Encounter for Attention to Ilostomy." While in the facility, Resident 16 had a plastic surgery appointment on 10/3/18, and was emergently admitted to a local hospital for infected post operative wound. He was readmitted to the facility after completion antibiotic therapy in the hospital, on 10/11/18. His readmission diagnosis included "Urethral Fistula and Infection Following a Procedure, Organ and Space Surgical Site." Resident 16 stated during his first admission, staff gave me pull ups (disposable incontinent shorts), the urine drained directly into the pull ups and my post operative wound became wet and it got infected. During an interview on 11/13/18, at 10:04 a.m., Licensed Staff (L.S.) N stated the care plan for Resident 16 called for wound care three times a day and the ostomy bag changes. She stated that's it. During an interview and concurrent record review, with L.S. AA, on 11/14/18, at 10:34 a.m., she stated care plans are used to guide the care of residents. She stated they should be completed 24 hours after admission or new condition presents. L.S. AA was not able to find documentation of Resident 16's wound care or risk of infection. She was unable to state if the care plans were updated after the readmission. During an interview and record review on 11/14/18, at 11:51 a.m., Administrative Staff (A.S.) A reviewed Resident 16's medical record and stated she could not find any documentation on Resident 16's readmission to the facility, wound care plan or post operative wound care	F 657	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Licensed nurse will initiate care plans on admission, for changes of conditions and/or unusual occurrences to meet individualized needs of residents. DSD will inservice all licensed nurses in completing the care plans. This includes patient centered goals and interventions for the resident which will provide effective communication for facility staff. MRD will audit all new admissions for completion of resident's care plan weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. MRD will also audit daily for change of condition care plans. Any findings will be reported to the DON and MDS nurse for follow-up action.	

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F 657	Continued From page 13 plan. She stated I have looked through everything, and was unable to find anything about infection in the care plan, progress notes or wound care notes in any of Resident 16's documentation. During an interview and concurrent document review, on 11/14/18, at 12:33 p.m., A.S. F reviewed the care plans for Resident 16 and stated the normal process for wounds is to group everything under skin integrity. A review of the Care Plan for "Actual impairment to skin integrity related to abrasion on chin, rash on upper back, surgical wound status post rectourethral fistula," initiated 10/11/18, did not have any language related to the risk of infection. A.S. A stated there was no Care Plan for risk of infection related to status post infection interventions. A.S. F stated she updated the Care Plan for skin integrity related to surgical wound status post rectourethral fistula on 11/13/18, as directed by the facility consultant. Interventions included "WOUND CARE..." and "Monitor for signs/symptoms of infection." A record review of a Care Plan initiated on 9/26/18, titled "Resident 16 had actual impairment to skin integrity related to abrasion on chin, rash on upper back, surgical wound status post rectourethral fistula." The Goal, dated 9/26/18, did not not include language regarding infection of post operative wound. The Interventions dated 9/26/18 did not include language related to risk of wound infection. A new Care Plan for skin integrity, dated 10/11/18, was identical to the 9/26/18 skin integrity Care Plans and did not include any language related to wound infection in the Goal or Interventions area. A Care Plan, dated 10/11/18, for "Risk for falls -	F 657	**How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/Designee will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure.	12/14/18

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F 657	Continued From page 14 related to infection following surgery," did not include language in the Goal or Intervention related to risk of infection. A Care Plan for "At risk for fatigue, At risk for infection, dated 10/23/18, did not include language in the Goal or Intervention related to risk of infection. When asked what the risk of not providing Resident 16 a care plan specific to Resident 16's wound, A.S. F stated he would be at risk of developing another wound infection. 2. During an interview and record review with Licensed Staff (L.S.) M, on 11/15/18, 9:30 a.m., she stated that Resident 127 had stated the Resident's husband was not allowed to visit, due to her statement of fear for physical and mental abuse from her husband, and didn't want him to visit her. A review of Resident 127's Care Plan did not include language for risk of abuse. L.S. M stated the facility investigated Resident 127's claims and put a note in the paper chart to communicate the husband was not allowed to visit. During a record review, on 11/15/18, a document titled "Admission Record," indicated Resident 127, was a 89 year old woman, admitted on 10/31/18 with diagnosis of "Muscle Spasm, Metabolic Encephalopathy, Abnormalities of gait and mobility, lack of coordination." During an interview and record review with A.S. A, on 11/15/18, at 10 a.m., she stated there was an investigation of Resident 127's claim of not wanting her husband to visit because of fear of abuse. A.S. A stated there used to be a sign in the nursing station about not letting the husband visit and a note was put in Resident 127's chart.	F 657		

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F 657	Continued From page 15 During a tour of Nursing Station 2 with A.S. A , no sign was observed in the Nursing Station, and review of Resident 127's medical record indicated there was no note in the chart. A.S. A stated maybe they took the sign down because Resident 127 keeps changing her mind about whether or not she wants to see her husband. She also indicated the facility has to do a better job communicating issues. A review of a document titled "Progress Notes," dated 11/2/18, written by Administrator, indicated "It was reported to this writer that the patient had concerns about her husband. This writer went to meet with the patient and she stated that her husband of 17 years frightens her. She stated that he was very abusive to her in the past and that she resents him for it. " The document indicated Adult Protective Services social workers investigated and the husband was asked to not come back into the facility. "Per residents request as of today, facility will not allow pt's husband into the facility for her well-being." A review Resident 127's medical record indicated a document recognized as a Care Plan, dated 11/13/18, 11 days after the first the facility became aware of Resident 127's fear of her husband, a Focus area indicated Resident 127 "expressed concern that husband frightens her. Goal ....will feel safe and secure in her environment. Interventions / Tasks Husband will not be allowed in the facility for her safety and pt. agreed..." A review of a Policy and Procedure, revised December 2007, titled "Safety and Supervision of Residents," indicated, "Resident-Oriented Approach to Safety Resident-Oriented Approach	F 657		

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F 657	Continued From page 16 to Safety 4. Implementing interventions to reduce accident risks and hazards shall include the following: d. ensuring that interventions are implemented; and e. documenting interventions. Systems Approach to Safety 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and the adjusts interventions accordingly. A review of a document titled "Care Planning - Interdisciplinary Team," revised 2013, indicated "1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment(MDS)." A review of a document titled "Charting and Documentation," revised April 2008, indicated "7. Care plans shall be reviewed and revised at a minimum of quarterly or more often as the resident's condition warrants and be in accordance with Stated and Federal Regulations." 3. During a concurrent record review and interview with Licensed Staff L, on 11/13/18, at 11:42 a.m., she stated Resident 11 was readmitted from the hospital to the facility on 09/27/18. A review of the Initial Care Plan Summary, dated 09/28/18, indicated GI bleed as part of the primary admitting diagnoses. Licensed Staff L was unable to locate any care plan addressing GI bleed. During a concurrent interview and record review with Administrative Staff C, on 11/13/18, at 11:46	F 657		

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F 657	Continued From page 17 a.m., she was unable to locate a care plan that addressed the GI bleed. During a concurrent record review and interview with Administrative Staff F, on 11/13/18, at 11:51 a.m., she reviewed the clinical record and was unable to find documentation of a care plan for the GI bleed diagnosis. During an interview with Administrative Staff A, on 11/13/18, at 2:34 p.m., she stated the admission nurse starts the care plans, a more comprehensive care plan gets developed by Administrative Staff F, and every licensed nurse is supposed to initiate care plans. She stated that if it was missed during a shift, the nurses on the next shift catches it. She also stated that on Mondays, she reviews the care plans for the weekend admissions, so it would not get missed. She stated that if no care plan is made, the staff would not be able to properly care for the residents. An interview and record review with Administrative Staff F, on 11/13/18, at 11:51 a.m. confirmed that the facility had not included the GI bleed in Resident 1's care plan until after the survey inquiry. The facility policy and procedure titled "Care Planning - Interdisciplinary Team," dated "Revised September 2013", indicated, "1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS)."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	**F658** **Services Provided Meet Professional Standards** CFR(s): 483.21(b)(3)(i) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 11 no longer resides at the facility.	

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F 658	Continued From page 18 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the nursing staff failed to address Resident 11's significant weight gain on 10/15/18. This failure had the potential to worsen his Congestive Heart Failure (CHF) symptoms. Findings: During an interview with Administrative Staff C on 11/09/18, at 12:27 p.m., she reviewed the clinical record and stated the weight entries for dates 10/14/18 as 171 (pounds) lbs sitting, and for 10/15/18 as 181.2 lbs standing. She was unable to show documentation that the nursing staff notified the physician of the 10.2-lb weight gain. A review of the clinical record for Resident 11, the Weights and Vitals Summary dated 11/15/18, at 2:30 p.m., indicated that from 10/1/18 to 10/14/18, Resident 11's weights ranged from 171 lbs to 176 lbs. From 10/15/18 to 10/28/18, Resident 11's weights ranged from 177.4 lbs to 182 lbs. During an interview with Licensed Staff M on 11/16/18, at 9:45 a.m., she stated that standing and sitting scales are the same. She stated that the nursing staff weigh the residents prior to breakfast so as not to have food intake impact the values. During a concurrent interview with Administrative Staff A and Administrative Staff K on 11/16/18, at	F 658	**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;** All residents with diagnosis of Congestive Heart Failure were reviewed for significant weight gain. No resident with significant weight gain were found to have the deficient practice. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DSD will inservice all licensed nurses regarding weight protocol for residents with diagnosis of Congestive Heart Failure (CHF) to be weighed daily. An increase of 3 pounds per day or 5 pound weight gain in one week should prompt notification to the physician and Registered Dietitian (RD) and DON. Residents are reweighed if weight is 5 pounds above the last weight for verification and accuracy. CNAs will obtain weights daily for CHF patients and will notify licensed nurse and RD if there is a significant change.	

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F 658	Continued From page 19 1010, Administrative Staff A stated that the standing scale is used if the resident's condition permits it. Administrative Staff K stated that both scales are identical, and are inspected quarterly as part of its maintenance. During an interview with Administrative Staff E on 11/16/18, at 10:15 a.m., he stated that the sitting and standing scales are identical. He stated that he calls an outside company if it needs calibration. Upon review of the record titled "GHC Preventive Maintenance Schedule: Medical Lifts and Scales", dated "2018", Administrative Staff E was able to provide documentation that the accuracy of the scales was checked quarterly as required. The facility policy and procedure titled "Weight Assessment and Intervention" dated "Revised 2008", indicated "3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing."	F 658	RD/Director of Nursing/Licensed Nurse will review daily weights for all residents with CHF and provide the necessary documentation in the medical record. RD will notify DON and physician in writing of the finding. The audits will be completed daily by the RD/Director of Nursing/Licensed Nurse for 100% compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/RD will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure.	12/16/18
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684	**F684 Quality of Care** CFR(s): 483.25 **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 11 no longer resides in the facility.	

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1560 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 684	Continued From page 20 by; Based on observation, interview and record review, nursing staff did not provide adequate quality of care by failing to follow the physician's orders for one sampled resident (Resident 11) to weigh daily. This failure had the potential to overlook and report weight changes that could worsen Resident 11's Congestive Heart Failure (CHF). Findings: An interview with Administrative Staff C, on 11/08/18, at 12:27 p.m., revealed daily weights were ordered on 09/10/18 and again on 09/27/18 for Resident 11. During an interview with Licensed Staff L on 11/13/18 at 2:30 p.m., she reviewed the weight log and was unable to find documentation of Resident 11's weights for dates 09/11/18, 09/17/18, 09/18/18, 09/30/18, 10/11/18, 10/16/18, 10/23/18, 10/24/18, 10/25/18, 11/03/18, 11/04/18, 11/05/18, and 11/07/18. The facility policy and procedure titled "Charting and Documentation" dated "Revised April 2008", indicated "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."	F 684	**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;** All residents with a diagnosis of CHF have the potential to be affected by the deficient practice. Residents with a diagnosis of CHF and has a physician order to weigh daily were reviewed and that they are followed. No deficient practice was observed. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DSD will inservice licensed nurses on daily weight documentation. It will be recorded in the EMAR daily. Any weight changes of 3 pounds in one day or 5 pounds in one week will be documented in the medical record by the licensed nurses and physician, RD and DON will be notified.	
F 761 SS=D	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	F 761		

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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 _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 761	Continued From page 21 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 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 documentation review, the facility failed to follow their policy and procedure for checking emergency medication kits (E-kit) for expired medications, when one of three E-kits contained an expired medication. This failure could have resulted in patient harm if a resident received an expired medication and would not receive the full effects of the medication to treat a condition. Findings: During an observation and concurrent interview, with the A-DON, of the medication storage room on 11/13/18 at 10:45 a.m., E-kits locked in a cabinet were reviewed for contents and expired	F 761	RD will audit all residents on daily weights to ensure weights are being acquired daily by nursing staff. Any findings will be reported to the DON/Designee for follow-up action. The audits will be completed daily by the RD/Director of Nursing/Licensed Nurse for 100% compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/Designee will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure. **F761 Label/Store Drugs and Biologicals** CFR(s): 483.45(g)(h)(1)(2) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficient practice.	12/16/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1600 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 761	Continued From page 22 medications. One E-kit contained oral control medications was found to have eight tablets of Clonazepam 0.5 mg (a drug to treat anxiety and panic disorder) with an expiration date of 10/18. The E-kit was opened to check the contents of the additional drugs. During a concurrent interview with the A-DON, she stated that the pharmacy is responsible to check the expired status of E-kits. The pharmacy comes monthly and when the E-kits are opened. The A-DON stated that the E-kits are checked daily by the nursing staff, the pharmacy is called when the E-kit medications are used, the staff faxes over a medication slip and calls the pharmacy to replace the E-kit. When asked how the staff reviews the E-kits she stated the staff looks to see if any E-kits have been opened. The A-DON stated there is no log to show the E-kits have been checked. During the interview the A-DON asked the charge nurse to call the pharmacy to replace the E-Kit that was opened. The A-DON stated the pharmacy will come today and replace the open E-kits. During an interview with the DON on 11/13/18 at 2:29 p.m., she stated the E-kits are checked daily by the nurses to observe if they have been opened. No documentation for checking the E-kits was available. During a second observation and concurrent interview of the medication storage room on 11/15/18 at 11:29 a.m., the E-kits opened on 11/13/18 at 2:29 p.m., were still present in the locked cabinet. The DON stated she called the pharmacy again to pick-up the E-kits and she was told the pharmacy would come in the afternoon. A medication destruction log was provided on	F 761	The expired medication in the Emergency kit (E-kit) was replaced with a non-expired medication by the pharmacy. Director of Nursing inspected all E-kits for other expired medications – none were found. **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;** All residents have the potential to be affected by the deficient practice. The Ekit was replaced with a non expired Ekit immediately and no residents were affected by the deficient practice. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DSD will inservice all licensed nurses on checking E-kits for expiration dates and when the E-kits were opened. Licensed nurses will call the pharmacy to replace the Ekits within 72 hours after being opened and document pharmacy call in Point Click Care communication.	

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	556685	A. BUILDING _____ B. WING _____	11/16/2018

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1650 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 761	Continued From page 23 11/16/18 and only contained destroyed medications from 11/14/18. A review of the facility policy and procedure titled "Emergency Pharmacy Service and Emergency Kits (E-kits)" dated 2007, indicated that emergency medications and supplies would be supplied in accordance with applicable state and federal regulations. Item 18, indicates "the nursing staff, consultant pharmacist and provider pharmacy designee checks the emergency kits regularly for expiration dating of the contents".	F 761	DON/DSD will follow up with pharmacy if the E-kits have not been replaced in 72 hours to ensure compliance. DSD will inservice all licensed nurse on destruction of non-narcotic medications. DSD/Designee will perform weekly audits of the E-kits and its medication inside to ensure that it has not expired. The DSD will also check that the E-kit has been replaced by the pharmacy within 72 hours after being opened per facility policy and procedure. The audit will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. **How the facility plans to monitor its performance to make sure that solutions are sustained;** The DON/Designee will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will re-evaluate the corrective measure.	12/16/18
F 812 SS=E	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 food preparation observations, dietary staff interview, and dietary document review	F 812		

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F 812	Continued From page 24 including facility logs and departmental policies and procedures, the facility failed to ensure food preparation was in accordance with professional standards of practice to ensure food safety when: 1) Dietary Staff did not monitor egg salad temperatures to ensure adequate cooling and 2) Dietary Staff washed parsley in the dirty pot/dish sink. These failures caused potential for all residents who had parsley on their lunch trays or who ate egg salad sandwiches to be exposed to foodborne illness. Nursing home residents risk serious complications from foodborne illness as a result of their compromised health status. Symptoms of foodborne illness may include diarrhea, vomiting, fever and confusion. When these conditions persist they can lead to dehydration and may require hospitalization and in severe instances may result in death. Findings: 1) During an observation and concurrent interview on 11/8/18 at 11:04 a.m., Unlicensed Staff Q was making egg salad sandwiches. Unlicensed Staff Q stated the egg salad sandwiches would be served for lunch that day. During an interview on 11/8/18 at 2:45 p.m., Administrative Staff G was asked about use of cool down logs (documentation of food's cooling temperatures that ensure food is within safe temperature limits within six hours). She stated the facility did not use them because food was made fresh daily. When asked how staff would know the egg salad was at the correct	F 812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary** CFR(s): 483.60(i)(1)(2) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1.) No residents were affected by this deficient practice. Cooling logs were initiated for items prepared for Potentially Hazardous Foods (PHF). 2.) No residents were affected by this deficient practice. Sink identification signage has been posted to enhance proper usage of each identified area of food preparation. **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;** 1.) All residents have the potential to be affected by the same deficient practice.	

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F 812	Continued From page 25 temperature after making the egg salad, Administrative Staff G stated, "you would need a log" to know that. During and interview at on 11/8/18 at 4:45 p.m., Unlicensed Staff P stated staff did not check the temperature of egg salad after it was made. During and interview at on 11/8/18 at 5:25 p.m., Administrative Staff J was informed facility staff were not checking the temperature of egg salad after it was made. Administrative Staff J, "they (staff) should be temping and recording it." Review of facility recipe titled, "Egg Salad," subtitled, "Preparation" (undated) indicated, "3. Combine all ingredients. Mix well....Hold refrigerated at internal temperature of 40 degrees F. or below for use." Potentially hazardous foods (PHF's) are those capable of supporting bacterial growth associated with foodborne illness. PHF's include previously prepared protein based foods such as cooked meat and canned tuna prepared from room temperature ingredients. The standard of practice for food safety is to ensure cooked PHF's are cooled from 135-70 °F (degrees Fahrenheit) within 2 hours and to 41°F within an additional 4 hours, totaling no more than 6 hours. Similarly items prepared from room temperature ingredients must be cooled to 41°F within 4 hours (Food Code, 2013). 2) During an observation and interview on 11/8/18 at 11:20 a.m., the Administrative Staff I rinsed parsley the sink to the left of the oven. The sink contained dirty dishes and a hose that dispensed sanitizing solution. The Administrative Staff I was	F 812	Dietary Manager and Registered Dietitian (RD) will inservice Dietary Staff on proper infection control regarding PHF's & Cooling Log. New hires will be trained by the Dietary Manager on this policy upon working in the kitchen. The policy and procedure is also located in the cooling log binder for staff to refer to. The standard of practice for food safety is to ensure cooked PHF's are cooled from 135-70°F (degrees Fahrenheit) within 2 hours and to 41°F within an additional 4 hours, totaling no more than 6 hours. Similarly items prepared from room temperature ingredients must be cooled to 41°F within 4 hours. 2.) All residents have the potential to be affected by the same deficient practice. Dietary Manager and Registered Dietitian will inservices all Dietary Staff on proper infection control regarding food handling to review Infection Control – Prep Sinks, subtitled "Procedure".	

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 812	Continued From page 26 asked if he had rinsed the parsley in the sink and he stated, "yes." He further stated that sink was used for washing pots. During an Interview on 11/8/18 at 11:35 a.m., Unlicensed Staff Q was asked about the food preparation sinks. Unlicensed Staff Q stated the sink to the right of the ice machine was for vegetables and the sink to the left of the stove (where Administrative Staff I had washed the parsley) was used for washing paste/rice. During an Interview on 11/8/18 at 2:45 p.m., Administrative Staff G was asked about the food preparation sinks. Administrative Staff G stated the food preparation sink was to the right of the ice machine. She stated food should not be washed in the pot/dirty dish sink. Review of facility policy titled, "Infection Control - Prep Sinks" subtitled, "Procedure" (dated 1/10/18) indicated, "1. Designated prep sinks in the kitchen should only be used for the safe handling and preparation of foods (i.e. washing produce...."	F 812	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** 1.) Dietary Staff will obtain temperature of PHF's and record on the Cooling Log. Dietary Manager will monitor Log weekly to ensure food preparation was in accordance with professional standards of practice to ensure food safety. The audit will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. 2.) RD will continue to audit the kitchen monthly as a part of her routine. 3.) Dietary Manager will complete daily rounds; findings will be documented on Quick Rounds Form as a part of her routine.	
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. §483.80(a) Infection prevention and control program.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	3660 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 880	Continued From page 27 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 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	**How the facility plans to monitor its performance to make sure that solutions are sustained;** The Dietary Manager and RD will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator will re-evaluate the corrective measure. **F880 Infection Prevention & Control** CFR(s): 483.80(a)(1)(2)(4)(e)(f) **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by this deficient practice. 1.) Unlicensed staff 1 was inserviced on proper infection control and prevention and contact precautions per facility policy and procedure. 2.) Gowns were immediately provided to the laundry staff to utilize in the laundry room.	12/16/18

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F 880	Continued From page 28 (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, interview and document review, the facility failed to ensure residents and staff were not exposed to infectious organisms when; 1. One staff did not follow the facility policy when exiting the room of a resident on contact precautions (Contact precautions are rules and procedures that staff and visitors must follow when they are in the room of a resident who has been diagnosed with an infectious disease that can be spread from person to person by direct contact (touching the infected person), or by indirect contact (touching surfaces or inanimate objects that the infected person has touched). 2. Laundry Staff did not use gowns to separate contaminated laundry. 3. Laundry Staff contaminated Resident blankets and the clean folding table when personal clothing and purses were placed on and under	F 880	3.) Laundry staff belongings were immediately from the clean folding table area. All resident blankets were re-washed. 4.) Hand hygiene alcohol gel was available on the contaminated side but not on the clean side and a dispenser was installed. 5.) Disinfect wipes were provided to the clean side of the laundry room to wipe down surfaces of the folding table, dryers and carts. 6.) Signs indicating "entering a clean area" and "entering a soiled area" was posted. 7.) Exposed, unpainted, chipping plaster in the clean and dirty side of laundry has been scheduled to be fixed by 1/10/19 with our painting service vendor. 8.) The rolled towel was immediately removed from the top of the washer machine. Facility also contacted vendor who supplies our laundry chemicals to adjust chemicals on dispenser to	

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F 880	Continued From page 29 the folding table in the clean side of the laundry room. 4. No hand hygiene alcohol gel was available in the clean / contaminated side of the laundry. 5. Disinfectant wipes not available in the clean side of the laundry room to wipe down surfaces of the folding table, dryers and carts. 6. No clear signage for clean and dirty areas inside the laundry. 7. Exposed, unpainted, chipping plaster in clean and dirty side of laundry prevented disinfection. 8. Washing machines were not maintained according to manufacturer's instructions when a rolled up towel was placed inside a compartment on top of the washer to prevent foam from escaping the washing machine. 9. Cleaning and disinfection of the laundry room did not include the area behind the washing machines, allowing dust, plaster and particulate matter to accumulate. By failing to follow the facility policy, manufacturer's instructions for use, and professional standards for infection control, staff had the potential to spread infectious organisms to other residents, staff, and the community at large, potentially causing illness. Findings 1. During an observation and concurrent interview with Unlicensed Staff (U.L.) T, on 11/7/18, at 2:45 p.m., he was observed exiting a	F 880	avoid the foam coming out of the vent. Vendor indicated to do full loads of linen to also prevent the foam coming out. The foam coming out from vent has stopped. 9.) Cleaning and disinfection of the laundry room behind the washer machine has been included in the routine cleaning of the laundry room. **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;** All residents have the potential to be affected by the deficient practice. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DSD will inservice staff on Personal Protective Equipment (PPE), hand hygiene and contact isolation precautions.	

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KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	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 30 Clostridium Difficile (C-Diff) (an infection of the intestines that can cause severe damage to the colon and even be fatal. Symptoms include diarrhea, belly pain, and fever), contact precautions resident room, wearing a yellow, disposable gown. He placed two cookies wrapped in a paper napkin on a chair outside the resident's room, removed his gown and placed it in a trashcan inside the resident room door, and used disinfectant alcohol gel for hand hygiene. When asked if he knew the facility Policy and Procedure for hand hygiene in contact precautions rooms, U.L. T stated when entering a C-Diff precautions room, use alcohol gel. He stated when exiting, wash hands in the resident bathroom and then use alcohol gel. U.L. T stated he was wore the disposable gown while he washed his hands in the resident's bathroom, removed the gown, used alcohol gel prior to exiting the room. He was unaware that after he washed his hands and removed the disposable gown, he cross contaminated (transfer of germs from a dirty area to a clean area) his hands. During an interview with Administrative Staff (A.S.) B, on 11/16/18, at 9:15 a.m., she stated hand hygiene for staff coming out of a Clostridium Difficile (C-Diff) isolation room includes washing hands with soap and water after removing gown and gloves. 2. During an observation and concurrent interview with Administrative Staff (A.S.) D, in the dirty side of the laundry room, on 11/16/18, carts of laundry were observed against the wall. A.S. D stated the carts contained dirty linen that is sorted by the staff. He stated staff wear gowns and gloves to sort dirty linen. When asked where are the gowns used by staff, A.S. D stated there were no	F 880	DON/DSD will observe 3 staff on each shift for compliance of PPE, hand hygiene and proper isolation precautions weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. Laundry Staff will be inserviced by the DSD and Housekeeping Supervisor on use of disposable gowns to separate contaminated Laundry and to stock at the beginning of their shift enough disposable gowns in the laundry room. Laundry Staff will be inserviced to not store their personal belongings in the laundry room. All personal belongings should be kept in their cars or lockers in the employee lounge. Laundry staff will be inserviced on how to disinfect after every shift and to stock disinfectant wipes of the beginning of their shift.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	555596	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1650 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

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F 880	Continued From page 31 gowns in the room. He searched the trash in the room and stated staff had not used gowns today. He reviewed the laundry log, which indicated 5 loads of laundry had been processed by staff without wearing gowns. A.S. D stated the risk to residents was infection when staff don't wear disposable gowns, cross contamination of staff clothing occurs during sorting, and then staff go into the clean room to move linen into the dryers, fold residents clean linen and clothing, and then distribute to residents. 3. During an observation and interview in the clean side of the laundry room, on 11/16/18, a large purse and sweatshirt were observed sitting on top of the clean folding table next to three stacks of resident blankets. Another purse was observed underneath the table. A.S. D stated the purses and clothing belong to staff and employees are not supposed to place items on clean folding table or in the clean room. He stated the facility provides space for staff to store personal items before entering the laundry room. A.S. D stated the folded resident blankets and clean folding table were compromised by cross contamination from staff purses and clothing. He stated the risk to residents was infection. 4. During an observation and concurrent interview with A.S. D, in the clean and dirty sides of the laundry room, on 11/16/18, he stated laundry staff completed hand hygiene by using disinfectant alcohol gel or washing their hands in the sinks on the dirty laundry side. An observation in the clean and dirty laundry rooms showed no alcohol disinfectant gel was available in either rooms. When asked how staff in the clean laundry side achieve hand hygiene, A.S.D stated they have to walk through an unmarked swinging door into the	F 880	Laundry staff will be inserviced to do full loads in washer machines to prevent foam from coming out on top of the washer machine. Per Ecolab's recommendation – if foam shall occur, staff should use a cloth to wipe away the foam. The cloth should be single use and washed after. Should the foaming worsen, staff is to notify the Maintenance Supervisor and Housekeeping Supervisor. Ecolab shall be contacted if needed. Laundry staff will be inserviced on including cleaning and disinfecting of the laundry room behind the washer machine in their routine cleaning of the laundry room. The Housekeeping supervisor 100% compliance as a part of his daily routine. The safety committee which includes the DSD will inspect the laundry room monthly as group. Any issues will be reported immediately to the Administrator.	

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F 880	Continued From page 32 dirty laundry room and wash their hands. An observation of the hallway outside the dirty and clean laundry room doors did not show any disinfectant alcohol gel was available. When asked where facility staff who drop off dirty laundry and pick up clean laundry perform hand hygiene, A.S. D shrugged his shoulders, and stated they have to enter the dirty room to wash their hands in the sink. 5. During an observation of the clean laundry room, and concurrent interview with A.S. D, on 11/16/18, he stated staff use disinfect wipes on surfaces and counters and dirty linen carts and equipment to reduce the risk of infection. No disinfectant wipes were observed in the clean laundry room. A.S. D stated staff would have to leave the room, walk across the hallway and enter a locked housekeeping closet to access disinfectant wipes. 6. During an observation of the laundry rooms, on 11/16/18, an observation of one swinging door separated the clean and dirty side of the laundry room. There was no signage observed that indicated entering a clean or dirty area, and no instructions for staff on proper technique to prevent cross contamination. 7. During an observation and concurrent interview with A.S. E, in the clean and dirty laundry rooms, on 11/16/18, multiple areas of exposed plaster were observed on the walls. A.S. E stated the chipping was a result of laundry carts hitting the walls. When asked if chipped, exposed, un-painted plaster can be disinfected, he shrugged his shoulders and did not answer. 8. During an observation and concurrent interview	F 880	**How the facility plans to monitor its performance to make sure that solutions are sustained;** The Maintenance Supervisor and Housekeeping Supervisor will track and trend reported findings and present to the monthly QAPI meeting. If 100% compliance is not achieved within 3 months then the Administrator will re-evaluate the corrective measure.	12/16/18

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F 880	Continued From page 33 with A.S. E, in the dirty laundry room, on 11/16/18, a terry cloth towel was observed poking out of an opening on the top of a washing machine. It had dark brown discoloration on the surface and appeared stained. A.S. E stated it was used to contain foam escaping from the washing machine during laundry cycles. A.S. E was unable to stated how long the towel had been in the machine or if it was changed with each load. He attempted to remove it and could not. A.S. E stated it is not in the machines manufacturers instructions for use to place a towel into the opening to contain the foam, and was unable to state with 100% confidence, the towel did not present an infection control risk from cross contamination between laundry loads. 9. During an observation and concurrent interview with A.S. E, in the dirty laundry room, on 11/16/18, the area behind the washing machine appeared to have rusty electrical conduit leading to the 220 volt wiring to the washing machines, the plaster on the wall under the detergent dispenser had extreme degradation resulting in crumbling plaster on the wall with plaster particulate and lint accumulating on the floor, and on the back of one washing machine was a PVC pipe extending from an opening in the back of the machine and the second washing machine had a PVC pipe laying on the floor. The area around the sides of the washers had linoleum flooring that was lifting away from the cement. A.S. E stated terminal cleaning of the laundry occurs once a week and the back of the washing machines is not cleaned. He stated he had no concerns about the condition of the area behind the washing machines impacting the cleanliness and infection risks in the front of the washing machines.	F 880		

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F 880	Continued From page 34 A P&P titled "Departmental (Environmental Services) - Laundry and Linen," revised 2014, indicated "General Guidelines .... Standard Precautions ... 2. Wash hands after handling soiled linen and before handling clean linen. 3. Consider all soiled linen to be potentially infectious and handle with standard precautions... Sorting Soiled Linen 1. Employees sorting or washing linen must wear a gown and gloves....Washing Linen and other Soiled Items...12. Wash hands before handling clean linen (i.e., when moving from washer to dryer, moving from dryer to sorting table, and through the sorting process). A P&P titled "Clostridium Difficile," revised July 2014, indicated "10. a. Healthcare workers will wear gloves and gowns upon entering the room of a of a resident with C.Difficule infection, and will remove gowns and gloves prior to exiting the room. 11. When caring for resident with diarrhea or fecal incontinence caused by C. Difficile, staff will maintain vigilant hand hygiene. 12. Glove use when caring for residents with D. difficile infection, washing hands with soap and water upon exiting the room of a resident with C. difficile infection AND strict adherence to hand hygiene in general is considered best practice." During a review of a document titled "Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Healthcare Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force ," dated 2014, indicated for Hand Hygiene, "Recommended Hand Hygiene includes; Wear gloves and gowns when treating patients with C.	F 880		

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F 880	Continued From page 35 difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves....any contact with the resident or surfaces in their immediate environment can contaminate the gloved and ungloved hands as well as clothing worn by the HCP..."	F 880		