E SURVEY IPLETED		E CONSTRUCTION	A BUILDING	(X1) PROVIDER/SUPPLIER/CI IA IDENTIFICATION NUMBER:	OF DEFICIENCIES OF CORRECTION	
16/2018	11/1		D. WING	555595	TO LINE OF THE PARTY OF THE PAR	DATE OF
	Æ	REET ADDRESS, CITY, STATE, ZIP CODE 660 SILVEIRA PARKWAY AN RAFAEL, CA 94903	18	ARE AND REHAB - SMITH RANCH	PROVIDER OR SUPPLIE The Manch TRANSITIONAL C	SMI
(X5) COMPLETION DATE	HOULD BE	PROVIDER'S PLAN OF CORREC (EACH CONRECTIVE ACTION SHO CROSS-REFERENCE) TO THE APPL DEFICIENCY)	ID PREFIX TAC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(FACH DEFICIEN	(X4) ID PREFIX TAG
	ι	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	F 000	ects the findings of the nent of Public Health during an	California Departr annual recertificat Representing the Health: Surveyors	F 000
EIV	BY:	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	right to request, refuse, and/or nent, to participate in or refuse perimental research, and to noe directive. Ining In this paragraph should be ight of the resident to receive edical treatment or medical medically unnecessary or e facility must comply with the diffed in 42 CFR part 489, a Directives). The treatment of all adulting the right to accopt or refuse all treatment and, at the formulate an advance directive, written description of the implement advance directives.	Request/Refuse/LCFR(s): 483.10(c) §483.10(c)(6) The discontinue treatment oparticipate in experiment of participate in experiment of participate in experiment of participate in experiment of the provision of material of the provision of the	F 578 SS≂B
CXV) DATE	1	Administrator		DER/SUPPLIER REPRESENTATIVE'S SIGN	MAMA	ORATORY

program participation. FORM CMS-2007(02-00) Provinus Vemione Obnotete Facility ID: CA220000772 Event ID: PXAY11

If continuation shoot Page 1 of 36

1/10/19 01113 POC#2 Accepted via shane, garrice Minthi #

		AND HUMAN SERVICES			PRIMIED March	: 12/06/2018 APPROVED
		& MEDICAID SERVICES			MR AMC	.0938-0391
STATEMENT AND PLAN C	OF DEMCIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A DUILDING			T. SURVEY
	3	65\$685	a. Wing_		11/	16/2010
NAMEOFI	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		TOTAL TO
KINDREI	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH	•	1980 SILYEIRA PANKWAY SAN RAFAEL, CA 94H03		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST HE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIVE ACTION SHOW CROSS-REFFERENCED TO THE APPROPRICE OF THE	D SC	(X8) COMPLETION DATE
F 578	requirements of this (iv) If an adult indivitime of admission a Information or artice, has executed an admay give advance of individual's resident with State Law. (v) The facility is no provide this informator she is able to re- Follow-up procedure the information to the information of the information of the information of decumentation of decimentation of decumentation of decumentation of decumentation of decimentation of deci	s section are met, dual is incapacitated at the ind is unable to receive illate whether or not lie or she lyance directive, the facility litrective information to the representative in accordance trelieved of its obligation to dion to the individual once he selve such information. es must be in place to provide the individual directly at the individual directly at the individual directly assess Advanced Directives, for sible parties, when iscussions and offers to tation on the POLST and	F 57	· How the facility will identify	-	
	"INFORMATION AN "No Advance Direct from a hospital disc	ID SIGNATURES," indicated live." A History and Physical harge, dated 11/6/18, 128 had an advanced	3			·

DEPART	MENT OF HEALTH	AND.HUMAN SERVICES		•	PRINTED	: 12/06/2018
		& MEDICAID SERVICES			FORM	IAPPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO, 0988-0; (X3) DATE SURVEY COMPLETED	
Ì		850086	B. WING		1	
NAME OF F	MOVIDER OR BUPPLIER		<u> </u>	STREET AUDRESS, CITY, STATE, ZIP CODE	1 11/	16/2018
KINDRE	TRANSITIONAL CA	RE AND REHAB - SMITH RANCI	. 1	650 SILVEIRA PARKWAY		1
			<u> </u>	9AN RAFAEL, CA 94903		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies (Must be preceded by Full, 80 identifying information)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTI (BACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DIFFICIENCY)	ON DBE PRIATE	(KE) COMPLETION CAYE
F 578	DIRECTIVE ACKNO 11/7/18, indicated it was incomplete. During a record rev 11/8/18, at 12 p.m., "Physician Orders if (POLST), dated 11/ Sections C, titled "A ADMINISTERED N titled, "ADVANCED ACKNOWLEDGEM indicated the Residition places and the was incomplete, During a record rev document fitled, "POCED ACKNOWLEDGEM indicated the discus lincomplete. During a record rev document titled, "AI ACKNOWLEDGEM indicated the discus lincomplete. During a record rev document titled, "AI ACKNOWLEDGEM During a record rev document titled, "AI ACKNOWLEDGEM indicated the discus lincomplete.	ment titled, "ADVANGED DWLEDGEMENT," dated no discussion documentation lew for Resident 127, on the document titled, or Life-Sustaining Treatment 7/18, was incomplete. VETIFICIALLY UTRITION" and the document DIRECTIVE IENT," dated 10/31/18, ent did not sign the form in discussion documentation lew for Resident 176, the DLST," dated 10/25/18, FORMATION AND s incomplete. The document	F 578	Weekly audits will be completed		12/16/18
	<u>.</u>	lew for Resident 16, the				

		AND HUMAN SERVICES			PRINTED: FORM	:- 12/06/2018 APPROVED
· '		& MEDICAID SERVICES	·		OMBINO	. 0938-0391
	l'of deficiencies of correction	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(Xa) DAT	E SURVEY IPLETED
		555695	B. WING		}	16/2018
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		HOLEUTO
KINDRE	D TRANSITIONAL CA	REAND REHAB - SMITH ŔANC	.H 15	50 SILVEIRA FARKWAY AN RAFAEL, CA 94903		•
(X4) ID PREFIX TAG	i (EACH D超的CIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE AUTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	TION JULD BE ROPRIATE	(X6) COMPLETION CATE
F 678	document filled, "A ACKNOWLEDGEN	ge 3 DVANCED DIRECTIVE IENT," dated 10/15/18, ssion documentation was	F 678			· .
, ,	document titled, "A ACKNOVVLEDGEN indicated the discus	lew for Resident 6, the DVANCED DIRECTIVE IENT," dated 9/15/18, selon documentation was a signature of the resident was				·
•	concurrent interview on 31/14/18, at 10:5 "POLST," was not for record. The docume DIRECTIVE ACKNOW indicated the discussincomplete, L.S. L.s. was not in the chart Acknowledgement completely. She sta	lew for Resident's 18, and v, with Licensed Staff (L.S.) L, 50 a.m., the document titled, ound in Resident 16's medical entitled, "ADVANCED DWILEDGEMENT," not dated, seion documentation was stated Resident 16's POLST t, and the Advanced Care form was not filled out that the form is supposed to dministrative Registered are.				
	with Administrative 11:06 a.m., A.S. An for Residents 16, 16 POLST and Advance Acknowledgement in missing for all the central benefit out missing information the ADVANCED DIFACKNOWLEDGEM discussion took plan	forms were incomplete or harts. She stated the forms completely without any . A.S. A stated the purpose of	1			

		I AND HUMAN SERVICES E & MEDICAID SERVICES	· 		FORM	: 12/06/2018 APPROVEL : 0938-0391
	of difficiencies Correction	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	ECONSTRUCTION	(X3) DAT	E SURVEY IPLEMED
l		555595	B. WING		441	16/2018
	PROVIDER OR SUPPLIER D'TRANSITIONAL CA	RE AND REHAB - SMITH RANCH	, 1	YREET AUDRESS, CITY, STATE, ZIP CODE 050 SILVEIRA PARKWAY AN RAFAEL, CA 94903	1 11/	10/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be precided by full BC identifying information)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-RI, FERENCIA) TO THE APPRO DEFICIENCY)	LO an <u>.</u>	(Xb) COMPLETION DATE
F 578	with A.S. A, and U 11/14/18, at 12 p.m. tind Resident 16's She stated if was s record. U.S. V state POLST in the Resi V left the interview Resident 16's POL stored medical roc stated every reside POLST in the front and U.S. V stated i having completed i Directive informatic if a resident who ha	riew and concurrent interview, nlicensed Staff (U.S.) V, on, A.S. A stated sive could not POLST in the medical record. upposed to be in the medical ed he could not find the dent 16's medical record. U.S. and returned with a copy of ST. He stated it was in the ord for Resident 16. U.S. V nt is supposed to have a of the medical record. A.S. A he risk to residents from not POLST and Advanced on in their medical record was ad indicated on the POLST obe resuscitated, was	F 578			
F 656 SS=E	(P&P), titled "Advan December 2016, in whether or not the advance directive a in the medical recodecument in the mand the resident's cassistance." Develop/limplement CFR(s): 483,21(b)(\$483,21(b) Compris \$483,21(b)(1) The implement a comprise plan for each	lity Policy and Procedure need Directives," revised dicated "7. Information about resident has executed an shall be displayed prominently rd. 8. b. Nursing staff will edical record the offer to assist secision to accept or decline to Comprehensive Care Plan 1). The change of the care plans facility must develop and fohersive person-centered resident, consistent with the forth at §483.10(c)(2) and	F 656	V656 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.		

		AND HUMAN SERVICES		rı	FORM MRON	APPROVED
		& MEDICAID SERVICES		O	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUER/BLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLISTED
] 	·	555595	e. WING	•	11/16/2018	
NAME OF	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE		(0)21/10
VINDSE	N TEANGHTONIAL AL	DE 1118 DELLA	ما	550 SILVEIRA PARKWAY		
KINDKE	· · · · · · · · · · · · · · · · · ·	REAND REHAB - SMITH RANCH		san Rafael, ca 94903		{
(X4) ID PREFIX TAG	Summary Sta (Bach Deficienc) Regulatory or L	Jement of Depiciencies I must be preceded by full, 8C (Dentifying Information)	DEPORTED ID PROVIDER'S PLAN OF CORRECTION OF STREET			
F 656	§483.10(c)(3), that objectives and time medical, nursing, an needs that are iden assessment. The codescribe the following in the services that or maintain the residence in the regulared under §48.24, §48 provided due to the under §483.10, inche treatment under §48(iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS, rationale in the resident's represent (A) The resident's provide as a result resident's represent (A) The resident's provide as a result resident's represent (A) The resident's provide as a result resident's provide as a result recommunity was associted outcomes. (B) The resident's provide in the res	includes measurable frames to meet a resident's and mental and psychosocial diffed in the comprehensive comprehensive care plan must are to be furnished to attain dent's highest practicable at psychosocial well-being as 9.24, §483.25 or §483.40; and at would otherwise be required 13.26 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(o)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the dent's medical record. with the resident and the tative(s)- poals for admission and reference and potential for sellities must document offs desire to return to the sessed and any referrals to les and/or other appropriate pose. In the comprehensive care a, in accordance with the oth in paragraph (c) of this NT is not met as evidenced few, observation and record	F 658			
	by:	•				
		iew, observation and record lid not ensure realdents who		,		

		AND HUMAN SERVICES 8 MEDICAID SERVICES				FÖRM	12/06/2018 APPROVED
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSITY SERVICES (X1) PROVIDENSITY SERVICES (X1) PROVIDENSITY SERVICES			E CONSTRUCTION C	(X3) DATI	0938-0391 F SURVEY PLETED
 		ő55595	B. WING	·		100	16/2018
NAMEOF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1972010
KINDRE	D TRANSITIONAL ÇA	RE AND REHAB - SMITH RANCH			650 SILVEIRA PARKWAY		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		3	ian Rafael, ca 84903		
PREFIX TAG	(EACH DETICIENE)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS/REFERENCED TO THE APPROF DEFICIENCY)	DBE I	COMPLETION DATE
F 658	Residents (Resider accurately assess to and develop a care procedure (P&P). The effective communicate for Resident 16 have contributed to rehospitalization ampost operative wound Findings: During an interview Resident 16, on 11/1 he was in the facility care. Resident 16 is admitted on 9/26/18 Malignant Neoplastic surgery appletting at the fact of the for Attention to Illos plastic surgery appletting diagnosis infected post opera readmitted to the fact antibiotic therapy in admitting diagnosis infection Following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity) admits diagnosis infection following Space Surgical Site his first admission, (disposable incontinuity) admits diagnosis infection following Space Surgical Site his first admission followi	fection for one of 12 Sampled at 16), when they did not the post-op aurgical wound plan per facility policy and this failure did not provide staff ration and guidance of nursing 6, and had the potential to Resident 16's d subsequent readmission for a infection. and record review with 07/18, at 1:53 p.m., he stated y for post operative wound a 75 year old male, originally 6, with a diagnosis of m of Prostate, Acquired 3enital Organs, and Encounter tomy. Resident 16 had a pintment on 10/3/18, and was d to a local hospital for tive wound. He was religity after completion of the hospital, on 10/11/16. His included Urethral Fistula and a Procedure, Organ and a Procedure, Organ and staff gave me pull ups sent ahorts), the urine drained ups and my post operative and it got infected. on 11/13/18, at 10:04 a.m., N stated the care plan for for wound care three times a	F	356	care plan. The care plan will		
	Resident 16, on 11/ he was in the facility care. Resident 16 is admitted on 9/26/18 Malignant Neoplast Absence of Other Conference of Other Ot	107/18, at 1:53 p.m., he stated by for post operative wound is a 75 year old male, originally is, with a diagnosis of m of Prostate, Acquired senital Organs, and Encounter tomy. Resident 16 had a comment on 10/3/18, and was dito a local hospital for tive wound. He was wilkly after completion of the hospital, on 10/11/18. His included Urethral Fistula and a Procedure, Organ and a Resident 16 stated during staff gave me pull ups tent shorts), the urine drained ups and my post operative and it got infected.			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 nerse for follow-up action. The audits will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. MDS Nurse/Designce will review and revise care plans as necessary as residents' condition		

DEPARTMENT OF HEALTH / CENTERS FOR MEDICARE				FORM	: 12/00/2018 APPROVED
	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		TIPLE CONSTRUCTION	TACI (EX)	. 0938-0891 TE SURVEY IPLL'TED
	666595	F MING		141	16/2018
NAME OF PROVIDER OR BUFFLIER			STREET ADDRESS, GITY, STATE, ZIP CODE		10/2010
KINDRED TRANSITIONAL CAR	REAND REHAD - SMITH RANCH		1660 Silveira Parkway San Rafael, ga 94903	,	Î
PREEDO (EACH DEFICIENCY)	ement of deploichcies Milst de preceded by full C identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(XS) GOMPLETION DATE
with L.S. AA, on 11/1 stated care plans are residents. She stated 24 hours after admis presents. L.S. AA was documentation of Re risk of infection care state if the care plans Resident's 16 readm for wound infection. During a concurrent on 11/13/18, at 11:51 (A.S.) A reviewed Re and stated she could documentation on Re the facility, including wound care. She state everything, and was infection in the progn notes in any of Resid During an interview of A.S. A left her office ficensed nurse. A.S. wound wasn't open a when Resident 16 was appointment on 10/3 During an interview a on 11/13/18, at 12:11 Licensed Staff (L.S.) assessments done for A document tilled "W Report," dated 9/26/- wound at "Rectum, 5	and concurrent record review, 13/18, at 10:34 a.m., she is used to guide the care of dithey should be completed asion or new condition as not able to find esident 16's wound care or plan. She was unable to a were updated after also from a hospitalization interview and record review a.m., Administrative Staff esident 16's medical record not find any updated esident 16's readmission to wound care or post operative sted I have looked through unable to find anything about ease notes or wound care into talk to Resident 16's Astated the post operative and didn't appear infected ant to his Plastic Surgery 1/18. and conourrent record review I p.m., A.S. A asked N to find a wound	Fð	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. Uow 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 reevaluate the corrective measure.		12/16/18

		AND HUMAN SERVICES			PRINTED: 12 FORM APP OMB NO. 098	PROVED
STATEMENY AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER&UPPLIER&LIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X8) DATE SUI	RVEY
		555595	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	\$1	REET ADDRESS, CITY, STATE, ZIP COD	<u> 11/16/2</u> E	018
KINDREI	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH	15	550 SILVEIRA FARKWAY AN RAFAEL, CA 94903		
(X4) ID PRBPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL BC IDENTIFYING IMPORMATION)	ID PREFIX TAG	Provider's Plan of Corre (Each Corrective action st Gross-Referenced to The Ap Deficiency)	IOUD RE COL	(XS) MPLÉTITIN OATE
F 656	other wound essess Skin Check docume "Monitor skin for an S/S of infection. L.S skin checks documenginal admission of When asked to des wound, based on the L.S. N stated it was inadequate description.	smant was found. A weekly ent dated 10/11/18 indicated y changes and breakdown, i. N stated there were only two ented since Resident 16's on 9/26/18, a total of 41 days, cribe the ofiginal surgical se documentation on 9/26/18, 5 om. A.S. A stated it was an tion for a post operative there should have been more	F 656			
	review, on 11/13/16 reviewed the care p stated the normal p everything under sk Care Plan for "Acturelated to shrasion surgical wound statinitiated 10/11/18, d related to the risk of was no Care Plan fi status post infection she updated the Carelated to surgical w rectourethral fistula.	on 11/13/18, as directed by nt. Interventions included and "Monitor for				
	9/26/18, titled "Resi to skin integrity rela on upper back, surg rectourethral fistula did not not include i	t Care Plan initiated on dent 16 had actual Impairment ted to abrasion on chin, resh plost wound status post "The Goal, dated 9/26/18, anguage regarding infaction ound. The interventions dated				

		I AND HUMAN SERVICES 8 MEDICAID SERVICES					FORM	: 12/06/2018 APPROVED
	OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/OLIA	(32) Muu Tu	OF CASSISTED SAN	/NF	0	<u>MB NO</u>	<u>. 0938-0391</u>
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. HUILDING					e survey Pleted
<u></u>		585595	B. WING		·		44,	16 <i>1</i> 2018
NAME OF I	ROYDER ON SUPPLIER	· · · · · · · · · · · · · · · · · · ·	'	87 REET ADDRES	S, CITY, STATE, ZO	CODE	177	1012010
KINDRE	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH		1560 SILVEIRA F				
<u></u>				9an Rafael,	CA 94903		_	
(X4) ID PRÉFIX	SUMMARY SYA MEACH DEFICIENDS	O'EMENT OF DEFICIENCIES O' MUST HE PRECEDED BY FULL	1D PREFIX	PROV	MOER'S PLAN OF C CORRECTIVE ACTION	ORKECTION	1	(X5) COMPLETION
TAG	REGULATORY OR U	SC IDENTIFYING INFORMATION)	PAG	CROSS-RI	EFERENÇED TO TH DEHICLENCY	IE APPROPE	RATE	DATE
		7/11/1		 	- Total	 		
F 656	Continued From pa		F 650	3∤ .	•			
	9/26/18 did not inch	ude language related to risk of						
[.		new Care Plan for skin 1/18, was identical to the			•			
(9/26/18 skin integril	ty Care Plans and did not	ļ					
ļ	include any languag	e related to wound infection						
	in the Goal or Interv)	,				
	related to infection t	10/11/18, for "Risk for falls following surgery," did not	•	1				
	include language in	the Goal or Intervention			*			
[related to risk of infe	ection.		1.				
	' A Care Plan for "At	risk for fatigue, At risk for		[
]		23/18, did not include at or intervention related to						
	risk of infection.	*		}				•
		he risk of not providing				-		
		plan specific to Resident 16's and he would be at risk of]				
	developing another			ļ				
í l	· • •	·						
	A record review of a	document without a title,		1				
	dated 10/11/18, Incl.	uded the primary physician 16. In the section titled						
		on: Skin; left thigh dressing		<u> </u> '				
ł i	incision clean/dry/ ir	ntact without discharge.						
	Assessments 5. Lo	cal infection of the skin and						
·	about risk of Wound	e, " did not include language Infection						
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	A record review, of:	a document titled "Order		İ				•
. !		dated 9/25/18, and 10/11/18,						
		orders for observation for risk ones of wound infection.						
	• • •	•			•			
		documents titled "Progress		1	-			
[18, and 10/11/18, included "Aspiration precaution, Fall.						
	preception." and did	Aspiration precedution, rail. I not include any language for		}				
	wound infection.	was a way transfer that	•		•	•		
				· _				

				FORM	r izvorzoje IAPPROVED
		T		<u>OMB NO</u>	. 0938-0391
OF DEFICIENCIES F CORRECTION	DENTIFICATION NUMBER;	1		(X9) DATE SURVEY COMPLETED	
	555595	B. WING		144	19/2018
PROVIDER OR SUPPLIER		· s	TREET ADDRESS, CITY, STATE, ZIP GODE	<u>- </u>	14/2010
D TRANSITIONAL CA	RE AND REHAR - SWITH RANCH	. ∫ 1	550 SILVEIRA PARKWAY		
		' 8	Ban Rafael, ca 84903		
SUMMARY STA (EACH DEFICIENCY REGULATORY OR U	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	II) PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	OOMPLETION DATE
A review of a documenterdisciplinary Team 1. A comprehensivity of the resident asset A review of a documentation, are care plans shall be minimum of quarter resident's condition accordance with St.	nent titled "Care Planning - arn," revised 2013, indicated to care plan for each resident seven (7) days of completion sesment(MDS)." ment titled "Charting and evised April 2008, indicated "7. reviewed and revised at a rily or more often as the warrants and be in	F 656			
CFR(s): 463.21(b)(3 \$483.21(b) Compre \$483.21(b)(2) A cor- be- (I) Developed within the comprehensive (II) Prepared by an i- includes but is not II (A) The attending p (B) A registered nur resident. (C) A nurse aide will resident. (D) A member of for (E) To the extent pa the resident and the An explanation mus medical record if the and their resident re- not practicable for ti- resident's care plan (F) Other appropria	2)(i)-(iii) chenaive Care Plans imprehensive care plan must in 7 days after completion of assessment. interdisciplinary team, that imited to— chysician. rse with responsibility for the ith responsibility for the acticable, the participation of a resident's representative(s), at he included in a resident's e participation of the resident epresentative is determined ine development of the ithe staff or professionals in	F 657	F657 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(ili) 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.		
	RS FOR MEDICARE TO DEFICIENCIES TO DEFICIENCIES TO CORRECTION PROVIDER OR SUPPLIER D TRANSITIONAL CAI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa A review of a docum Interdisciplinary Tea "1. A comprehensive is developed within of the resident asset A review of a docum Documentation," recare plans shall be minimum of quarter resident's condition accordance with Sta Regulations," Care Plan Timing at CFR(s): 463.21(b)(2) \$483.21(b) Compre	DENTIFICATION NUMBER: 555565 PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB - SMITH RANCH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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." Care Plan Timing and Revision CFR(s): 463.21(b)(2)(i)-(iii) \$483.21(b) Comprehensive Care Plans \$483.21(b) Comprehensive care plan must be- (1) 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 side with responsibility for the	RS FOR MEDICARE & MEDICAID SERVICES TO DEFICIENCIES TO DEFICIENCIES TO DEFICIENCIES TO DEFICIENCIES TO DEFICIENCIES TO DEFICIENCIES TO TRANSITIONAL CARE AND REHAB - SMITH RANCH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 A review of a document titled "Care Planning - Interdisciplinery 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." Care Plan Timing and Revision CFR(s): 463.21(b)(2)(i)-(iii) \$483.21(b) 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 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Officer appropriate staff or professionals in	RESPORMEDICARE & MEDICAPD SERVICES OF DEFICIENCIES OF DEFICIENCIES OF CORRECTION (XY) PROVIDERSUPPLEERCULA DESTRUCTION NUMBER: S55598 B. VINNS PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB - SMITH RANCH RESULATORY OR LOCATE PRECIDENCIES (RACH DESPICEAYS MUST OF DEPICIENCIES) (RACH DESPICEAYS MUST OF DEPICIENCIES OF TOUL RESULATORY OR LOCATE PROVIDERS PY FULL RESULATORY OR LOCATE DESTRUCTION OF THE APPROVIDERS PARAMETER PROVIDERS PLAN OF CORRECTION OF THE APPROVIDERS PARAMETER PROVIDERS PLAN OF CORRECTION OF THE APPROVIDERS PLAN OF CORRECTIVE ACTION OF T	RS FOR MEDICARE & MEDICALD SERVICES ON PROVIDER SUPPLIES (2) PROVIDER SUPPLIES (3) PROVIDER SUPPLIES (4) PROVIDE SUPPLIE

DEPART	RINTED: FÖRM	12/06/2016 APPROVED				
	KS FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA	(VA) NULTIN	<u> OMB NO, 0938</u>		
	F CORRECTION	DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E BURVEY PLETED
<u> </u>		555596	B. WING_		ga tr	l <i>ein</i> ůdo
NAME OF	ROVIDER OR SUPPLIER		1 8	TREET ADDRESS, DITY, STATE, ZIP CODE	1 116	6/2018 <u> </u>
KINDREI	TRANSITIONAL CA	re and rehab - Smith Ranch	1 1	ego silveira parkyvay Ban Rafael, ca 94903		
(X4) (D) PREPIX	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	in .	- RANGE
PREPIX TAC	(FACH DEFICIENCY REGULATORY OR LE	Must be preceded by full sc identifying (Nformation)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP DEFICIENCY)	≯BE	(X5) COMPLETION DATE
F 657	Continued From pa or as requested by	the resident	F 657	other residents having the		
	teem after each ass domprehensive and	wised by the interdisciplinary seasment, including both the quarterly review		potential to be affected by the same deficient practice and what corrective action will be	l	:
	essessments. This REQUIREMEN by:	IT is not met as evidenced		taken; 1.) All residents with post-	 	
	facility failed to ensu accurate care plans resident care for 3 c (Residents #11, 16,	, and document review, the are residents had current and to guide staff on individual of 12 sampled residents 127). The facility failed to ensive care plan when;		operative surgical wound infection have the potential to be affected by the deficient practice. Residents with post-		
	of Infection, from his to 11/14/18, after a	lagnosis of post operative	,	operative surgleal wound infection care plan were reviewed and all had risk of infection in place. 2.) All residents who have		
		not have a Cere Plan for er she expressed a fear of her	 - 	expressed fear have the potential to be affected by the deficient practice, Residents who		
	Gastro Intestinal (G	ot have a Care Plan for I) bleed until 47 days eiter espitalization for GI bleed,	ı	expressed fear were reviewed and had a care plan in place.		
		the potential for resident harm urrent Care Plan for the s of residents,		All residents with a diagnosis of GI bleed have the potential to be affected by the	٠	
	Findings:			deficient practice. Residents who have a		
	Resident 16, on 11/ he was in the facility care. Resident 16 is	ew and record review with 07/18, at 1:53 p.m., he stated y for post operative wound s a 75 year old male, originally b, with a diagnosis of		diagnosis of GI bleed were reviewed and all had a care plan in place.		

		& MEDICAID SERVICES				FÖRM	APPROVED
	OF DEPICIENCIES		<u> </u>			<u>NB NO.</u>	0938-0391
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) IMULT A. BUILDI		CONSTRUCTION	(X8) DAT	E SURVEY
	,	556596	B. WING			14/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			81	REET ADDRESS, CITY, STATE, ZIP CODE	<u>-/ " 54,</u>	1012010
MINDOET	TEANGPHANAL AN	REAND REHAB - SMITH RANCH	.		50 BILVEIRA PARKWAY		
				8/	an Rafael, ca 94903		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY MALL	(D	\Box	PROVIDER'S PLAN OF CORRECTION	N	(305)
TAG	REGULATORY OR L	EC IDENTIFYING INFORMATION)	PRISH(X TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP DEPICIENCY)) ae 'Riate	(X3) COMPLUTION DATE
F 657	Continued From pa	na 12	F 61		What measures will be put		•
		m of Prostate, Acquired	F 69	10/	into place or what systematic		
1	Absonce of Other C	an of Prosinte, Acquired Penital Organs, and Encounter .		1	changes will the facility make		
	for Affention to Iline:	tomy." While in the facility,		-	to ensure that the deficient		
	Resident 16 had a r	plastic surgery appointment on		-	practice does not recur;		J
· · · · · · · · · · · · · · · · · · ·	10/3/18, and was a	mergently admitted to a local	ı	1		-	·
İ	hospital for infected	post operative wound. He		.	Licensed nurse will initiate care		J
	was readmitted to the	he facility after completion		-	plans on admission, for changes		[
	antiblotic therapy in	the hospital, on 10/11/18. His	ı	- [of conditions and/or unusual		j -
	readmission diagno	sis included "Urethral Fistula			occurrences to meet		¹ I
	and infection Follow	ving a Procedure, Organ and	1		individualized needs of		
ļ	Space Surgical Site			ı	residents.		ľ
. i		during his first admission,					
[aran gave me pun u	ps (disposable incontinent wined directly into the pull ups		-	DSD will inservice all licensed		١,
	anous, me mne u	ive wound became wet and it	'	-	nurses in completing the care		
j	got infected,	A ALONDA DOCUME MET GILD IT	•		plans. This includes patient		j
	gr	}		- [centered goals and interventions		
. !	During an interview	on 11/13/18, at 10:04 a.m.,			for the resident which will		}
1) N stated the care plan for			provide offective		
	day and the ostomy	for wound care three times a bag changes. She stated		-	communication for facility staff.	-	
	that's it.				MRD will audit all new		
, 1	Theine on Internet	and concurrent record review.		-	admissions for completion of		
İ		and concurrent recom review, 14/18, at 10:34 a.m., she			resident's care plan weekly for		Í
1	stated care glane at	re used to guide the care of			100% compliance. Once 100%		'
1	residents. She state	at they should be completed			compliance is met, the audits		
, 1	24 hours after admi	ssion or new condition			will become monthly.		
·	presents. L.S. AA w	es not able to find	ı]			
ſ		esident 16's wound care or			MRD will also audit daily for		,
		e was unable to state if the			change of condition care plans.		
, l	care plans were upo	dated after the readmission.		.	Any findings will be reported to the DON and MDS nurse for		
j	During an Interview	and record review on			follow-up action.		
1	11/14/18, et 11:51 a	.m., Administrative Staff			•		
	(A.S.) A neviewed R	esident 16's medical record					
ł t		d not find any documentation			·		
		admission to the facility,					
	wound care plan or	post operative wound care			· · · · · · · · · · · · · · · · · · ·		

		AND HUMAN SERVICES		ŗ	CUNTERN MICHAEL	12/06/2018
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES '			MIRNO ON RIM	APPROVED 0930-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	E SLINVEY IPLETED
		566595	B. WING		441	16/2018
NAME OF	PROVIDER OR GUPPLIER	This is a second of the second	' -	STREET ADDRESS, CITY, STATE, ZIP CODE	1.11	IOZUIA
KINDDE	h TOANGPERATAL AA	MIT Anist system of the second	. 1	1560 SILVEIRA PARKWAY	•	
NINDISE	U IRANSITIONAL CA	RE AND REHAB - SMITH RANCH	1	SAN RAFAEL, CA 94903		Î
(X4) ID PTUEFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies (Mist be preceded by Full SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REPERENCED TO THE APPROPE DEFICIENCY)	HE	(X6) COMPLETION DATE
F 657	plan. She stated 1 h evorything, and was infection in the care wound care notes in documentation. During an interview review, on 11/14/18 reviewed the care p stated the normal p everything under sk Care Plan for "Actu related to abrasion surgical wound stat initiated 10/11/18, d related to the risk of was no Care Plan fi status post infection she updated the Ca related to surgical y rectourethral fistula	ave looked through a unable to find anything about plan, progress notes or any of Resident 16's and concurrent document and concurrent document at 12:33 p.m., A.S. Falans for Resident 16 and rocess for wounds is to group an integrity. A review of the all impairment to skin integrity on chin, rash on upper back, us post rectourethral fishula," id not have any language of infection. A.S. A stated there for risk of infection related to a interventions. A.S. F stated are Plan for skin integrity wound status post on 11/13/18, as directed by and "Mortitor for	F 65	How the facility plans to monitor its performance to make sore that solutions are sustained; The DON/Designee will track and trend reported findings and present to the monthly QAPI meeting. If 100% complimee is not achieved within 3 months then the Administrator and Director of Nursing will recevaluate the corrective measure.		12/16/18
	A record review of a 9/26/18, titled "Resi to skin integrity rela on upper back, surprectourethnel fistula did not not include I of post operative w 9/26/18 did not include wound infection. A integrity, dated 10/19/26/18 skin integrit include any languagin the Goal or Inten	a Care Plan Initiated on dent 16 had actual impairment ted to abraston on chin, rash pical wound status post. "The Goal, dated 9/26/18, anguage regarding infection ound. The Interventions dated to risk of new Care Plan for skin 1/18, was identical to the by Care Plans and did not pe related to wound infection				

		AND HUMAN SERVICES 8 MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA	(No. Let II Time	E CONSTRUCTION	<u>O</u> [<u>VIB NO</u>	<u>0938-0391</u>
	F CORRECTION	IDENTIFICATION NUMBER:	Valuations		•	(XS) DAT COM	E SURVEY IPLETED
		555595	B. WING			444	1619Ara
NAME OF F	PROVIDER OR SUPPLIER		ş	TREET ADDRESS, CITY, STATE, ZIP	CODE	111	16/2018
KINDRE	TRANSITIONAL CA	RE AND REHAB - SMITH RANG	н і	550 SILVEIRA PARKWAY			-
/94L to 1	GI DALAGY FITA	TELEBOY ME HEPTONI DAME	-	AN RAFAEL, CA 94903			
(X4) ID PREPIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMBNY OF DEFICIENCIES MUST BE PRECEDED BY FULL BUILDENTIFYING INFORMATION)	PREHX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH (XEFICIENCY)	ON SHOULD JE APPROPE	RE.	CATE COMPLETION DATE
F 667	Continued From pa	ge 14	F 657				
	related to infection (following surgery," did not	[[
•	include languzge in	the Goal or Intervention	}] [
[related to risk of Info A Care Plan for "At	scuon. risk for faligue. At risk for		•			
	infection, dated 10/	23/18, did not include		,	•		
	language in the Goaniek of infection.	al or Intervention related to					
		he risk of not providing	'	•			ļ
	Resident 16 a care	plan specific to Resident 16's	<u>}</u> .			•	
	wound, A.S. F state developing another	id he would be at risk of wound infection.					
	Ucensed Staff (L.S. she attated that Res Resident's husband to her statement of abuse from her hus	ew and record review with) M, on 11/15/18, 9:30 a.m., ident 127 had stated the I was not allowed to visit, due fear for physical and mental band, and didn't want him to of Resident 127's Care Plan					
	did not include lang stated the facility in claims and put a no	uage for risk of abuse. L.S. M vestigated Resident 127's te in the paper chart to usband was not allowed to					
,	titled "Admission Re 127, was a 89 year 10/31/18 with diagn	iew, on 11/15/18, a document acord," indicated Resident old woman, admitted on osis of "Muscle Spasm, lopathy, Abnormalities of gait f coordination."					
	A, on 11/15/18, at 1 an investigation of it wanting her husban abuse, A.S. A state the nursing station:	and record review with A.S. 0 a.m., she stated there was Resident 127's claim of not id to visit because of fear of it there used to be a sign in about not letting the husband put in Resident 127's chart.			·	·	

		AND HUMAN SERVICES & MÉDICAID SERVICES				FORM	: 12/06/2018 IAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(XS) DAT	. 0938-0391 E SURVRY PLETED
		556598	B. WING	<u> </u>	·		dan dan
NAME OF	PROVIDER OR SUPPLIER		1	BTI	RGET ADDREGO, CITY, STATE, ZIP CODE	<u> </u>	16/2018
KINDREI	D TRANSITIONAL CAI	re and rehab - smith ranch			io silveira parkway N Rafael, ca 94903		
(X4) ID PREFIX TAG	(EACH DÉFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRICEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREPD TAG	7 "	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED TO THE APPRO DEFICIENCY)	D BE	(X6) OGMFLETION DATE
F 667	sign was observed in review of Resident there was no note in maybe they took the 127 keeps changing not she wants to se indicated the facility communicating issue A review of a document review br>review reviw review review review review review review review review	eing Station 2 with A.S. A., no in the Nursing Station, and 127's medical record indicated of the chart. A.S. A stated e sign down because Resident gher mind about whether or the her husband. She also has to do a better job less.	F6	57			
	"It was reported to be concerns about her meet with the patier husband of 17 years that he was very about she resents his indicated Adult Protinvestigated and the come back into the	en by Administrator, indicated his writer that the patient had husband. This writer went to his and she stated that her singhtens her. She stated usive to her in the past and in for it. "The document ective Services social workers husband was asked to not facility. "Per residents request will not allow pt's husband into eli-being."				.	
	a document recogni 11/13/18, 11 days at became aware of Ro husband, a Focus a "expressed concern Goelwill feel safe environment. Interv not be allowed in the agreed"	27's medical record indicated ized as a Care Plan, dated fler the first the facility esident 127's fear of her rea indicated Resident 127 that husband frightens her. I have an account in her reality for her safety and pt. and Procedure, revised					
	December 2007, till Residente," indicate	ed "Safety and Supervision of d, "Resident-Oriented Resident-Oriented Approach					·

		AND HUMAN SERVICES				1		: 12/06/2016 APPROVED
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		<u> </u>		0	MB NO	, <u>0</u> 936- <u>0391</u>
	OF DEFIDIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIF(CATION NUMBER;	(X2) MULT A. BUILDS		STRUCTION		(X3) DAT	E SURVEY PLETCU
<u> </u>		585586	B. WING_				445	16/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE	ZIP CODE		I OI E O I O
KINDREI) Transitional Ca	RE AND REHAB - SMITH RANCH	,		VEIRA PARKWAY NFAEL, CA 94903			
(X4) JD PREFIX TAC	(PACH DEFICIENCY	TEMENT OF PETFICIENCIES MUST BE PRECIDED BY FULL SC IDI. NTIFYING INFORMATION)	ID PRISTX TAG		PROVIDER'S PLAN (EACH CORRECTIVE A ROSS-REFERENCE) T DEFICIE	ACTION SHOULD O THE APPROP) HIT	(Xi) COMPLETION DATE
F 657	accident risks and it following: d. ensuring implemented; and of Systems Approach facility-oriented and to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used to safety are used in individual resident accordance within of the resident asset A review of a documentation," recar plans shall be minimum of quarter resident's condition accordance with St. Regulations." 3. During a concuminterview with Licen 11:42 a.m., she stat readmitted from the 09/27/18. A review of Summary, dated 00 part of the primary a staff L was unable to addressing GI bleed.	enting interventions to reduce nazards shall include the ag that interventions are a documenting interventions. To Safety 1. The includent of the safety 1. The includent of the safety, which considers the attention to safety, which considers the attention the environment and isk factors, and the adjusts dingly. Inent titled "Care Planning and includent of the care plan for each resident seven (7) days of completion issment(MDS)." Inent titled "Charting and vised April 2008, indicated "7, reviewed and revised at a fly or more ofton as the warrants and be in ated and Federal Bent record review and sed Staff L, on 11/13/18, at the Resident 11 was a hospital to the facility on of the Initial Care Plan 1/28/18, Indicated Gi bleen as admitting diagnoses. Licensed to locate any care plan in	F6	57				
		t Interview and record review > Staff C, on 11/13/18, at 11:48		-				

		AND HUMAN SERVICES		•	FORM	APPROVED
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			ON AMC	. 0938-0391
STATEMENT AND PLAN (of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(Xa) DAT	ë survey Pleted
		655595	B. WING		147	10/2018
NAME OF	PROVIDER OR SUPPLIER		87	TREET ADDRESS, CITY, STATE, ZIP CODE	-1	IVIAVIO
KINDDE	AN IAMONTOMATO	RE AND REHAB - SMITH RANCH		SED SILVEIRA PARKWAY		. }
MINIME	A TRANSMITTENANT CO	RE ARD REHAB - SMITH RANCH	9,	an Rafael, ca 94903		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST 62 PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE PRIATE	(X6) COMPLETION DATE
F 657	addressed the GI b During a concurren with Administrative a.m., she reviewed unable to find doou the GI bleed diagno During an interview	le to locate a care plan that leed. t record review and interview Staff F, on 11/13/18, at 11:51 the clinical record and was mentation of a care plan for sis. with Administrative Staff A, on m., she stated the admission	F 657	•		
	comprehensive can Administrative Staff is supposed to initia if it was missed dur next shift catches it Mondays, site revie weekend admission She stated that if no	e plan gets developed by F, and every licensed nurse Ite care plans. She stated that ing a shift, the nurses on the She also stated that on we the care plans for the is, so it would not get missed o care plan is made, the staff o properly care for the				
F 658 SS=D	confirmed that the i bleed in Resident 1 survey inquiry. The facility policy at Planning - Interdisc September 2013", i care plan for each 1 seven (7) days of cl assessment (MDS) Services Provided I	F, on 11/13/18, at 11:61 a.m. adility had not included the Glas care plan until after the od procedure titled "Care plinary Team," dated "Revised adicated, "1. A comprehensive esident is developed within completion of the resident."	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.		

STATEMENT OF DEFIDIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA EDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED 11/16/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903			AND HUMAN SERVICES & MEDICAID SERVICES	-		FORM	12/06/2018 APPROVED
MAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH (A) ID PREPIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 falled to address Resident 11's significant weight gain on 10/15/18. This fallure had the potential to worsen his Congestive Heart Fallure were found to have the deficient	STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY	
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH (XA) ID PREFIX TAG (XA) ID PREFIX (EACH DEFICIENCY MUST OF DEFICIENCIES (EACH DEFICIENCY MUST OF DEFICIENCY) F 658 Continued From page 18 Continued From page 18 F 658 Continued From page 18 F 658 Continued From page 18 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 were found to have the deficient		_ <u></u>	555595	B. WING		947	SBIONAD
SAN RAFAEL, CA 94903 (X4) D REFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) FRESULATORY OR LSC IDENTIFYING INFORMATION) FRESULT OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COROSS-REFERENCED TO THE APPROPRIATE OF COMPLETING (I) WITH COLUMN SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE COMPLETING (EACH CORRECTIVE ACTION SHOULD BE C	NAME OF	PROVIDER OR SUPPLIER		3	TREET ADDRESS, OITY, STATE, ZIP GODE		IUIZUIG
F 658 Continued From page 18 S483.21(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 falled to address Resident 11's significant weight gain on 10/15/18. This fallure had the potential to worsen his Congestive Heart Fallure were found to have the deficient	KINDRE	D TRANSITIONAL CA	RE AND REHAD - SMITH RANCH	1 -			
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, musi- (I) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the nursing staff falled to address Resident 11's significant weight gain on 10/15/18. This fallure had the potential to worsen his Congestive Heart Fallure were found to have the deficient		(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	Prenx	(SACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DRE	(XE) COMPLETION DATE
During an interview with Administrative Staff C on 11/08/18, at 12:27 p.m., she reviewed the olinical record and stated the weight entries for dates 10/14/18 as 171 (pounds) lbs sitting, and for 10/16/18 as 181.2 lbs standing, she was unable to show documentation that the nursing staff notified the physiolan of the 10.2-lb weight gain. A review of the olinical 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 K on 11/16/18, at 1845 and Administrative Staff K on 11/1	F 868	§483.21(b)(3) Com The services provides outlined by the comust- (I) Meet professions This REQUIREMENT by: Based on interview nursing staff falled in significant weight good had the potential to Failure (CHF) sympt Findings: During an interview 11/08/18, st 12:27 procord and stated in 10/14/18 as 181.2 procord and stated in 10/14/18 as 181.2 procord in the clinical review of the clinical review of the clinical Weights and Vitals 2:30 p.m., indicated 10/14/18, Resident 10/14/18, Resident 10/14/18, at 9:45 a. and sitting scales at the nursing staff we breakfast so as not the values. During a concurrent	prehensive Care Plans led or arranged by the facility, comprehensive care plan, al standards of quality. It is not met as evidenced or and record review, the to address Resident 11's aln on 10/15/18. This failure worsen his Congestive Heart otoms. I with Administrative Staff C on o.m., she reviewed the clinical ne weight entries for dates ounds) los sitting, and for be standing, she was unable all record for Resident 11, the Summary dated 11/15/18, at I that from 10/1/18 to 11's weights ranged from 171 in 10/15/18 to 10/28/18, its ranged from 177.4 lbs to with Licensed Staff M on in, she stated that standing re the same. She stated that eigh the residents prior to to have food intake impact	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 Fathers 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 Dictitian (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		

		AND HUMAN SERVICES		t*	KUDIN (ED)	: 12/06/2018 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO	0936-0391
	of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		655595	B. WING		111	1 6 /2018
NAME OF	YROVIDER OH SUPPLIER	1		STREET ADDRESS, CITY, STAYL, ZIP CODE		10/20/10
KINDRE	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH		650 SILVERIA PARKWAY		
	As as de a limit de desarra		<u> </u>	SAN RAFAEL, CA 94803		
(X4) ID PREFIX TAG	(GACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BF HRECEDED IN FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	GOMPLETION DATE
F 658	standing scale is us permits it. Administ scales are identical as part of its mainted buring an interview 11/16/18, at 10:16 and standing scales be calls an outside callbration. Upon re Preventive Maintant and Scales", dated was able to provide	e Staff A stated that the sed if the resident's condition rative Staff K stated that both and are inspected quarterly mance. with Administrative Staff E on the stated that the sitting are identical. He stated that	F 658	RD/Director of Nursing/Licensed Nurse will review daily weights for all residents with CTIF 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;		
F 084 SS=D	Assessment and In: 2008", indicated "3. more since the last retaken the next da weight is verified, ni the Dietitian in writing Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents received accordance with processes plan, and the resident and the resident, and the resident and the reside	care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure to treatment and care in ofessional standards of ehensivo person-centered	F 684	The DON/RD will track and trend reported findings and present to the monthly QAP1 meating. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will revaluate the corrective measure. F684 Quality of Care CPR(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.		12/16/18

		AND HUMAN SERVICES		•	FORM	APPROVED
		& MEDICAID SERVICES		C	MB NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION	(EX)	E SURVEY NYLETED
		565596	B. WING_		401	16/2018
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		MINTO
i Vinde	A LAMOTTICHES CO.	RE AND REHAB - SMITH RANCH		1860 SILVEIRA PARKWAY		
MADINE	O (WARRING MALE CA	KE AND RENAD - BINITH RANCH		SAN RAFAEL, CA 94903	•	
(X4) ID FARTEX TAG	(EACH DEFICIENCY	RC IDEN JUSANG INLOKWALIOM) NMASA, NE BUSCHOED BA WAI'T AEMFAJA, OL DEFICIENCIES	PREMIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION GHOUL) CROSS-RETERENCED TO THE APPROP DEFICIENCY)) DE	(XB) COMPLETRIAN DAYL
F 684 F 761 S\$=D	by; Based on observat review, nursing stat quality of care by fa orders for one sam; weigh daily. This fa overlook and report worsen Resident 11 (CHF). Findings: An interview with Ar 11/08/18, at 12:27 p were ordered on 09 for Resident 11. During an interview 11/19/18 at 2:30 p.z log and was unable Resident 11's weigh 09/17/18, 09/18/18, 10/23/18, 10/24/18, 11/05/18, and 11/07 The facility policy at and Documentation indicated "All servic any changes in the condition, shall be of medical record." Label/Store Drugs of	ion, interview and record fidd not provide adequate filing to follow the physician's pled resident (Resident 11) to illure had the potential to illure had the potential to weight changes that could be Congestive Heart Fallure diministrative Staff C, on the conference of the could be congestive Heart Fallure diministrative Staff C, on the conference of the could be congestive Heart Fallure diministrative Staff C, on the conference of the could be congestive Heart Fallure diministrative Staff L on the conference of the congestive diministrative Staff L on the could be congested as the congestive diministrative Staff L on the congestive diministrative Staff L on the congestive diministrative F 684	How the facility will identify other residents having the potential to be affected by the same delicient 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 muses 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 recard by the licensed muses and obvision			
33-0	§483.45(g) Labeling Drugs and biologics	of Drugs and Biologicals als used in the facility must be alse with currently accepted				•

		AND HUMAN SERVICES			P	(JET MIX PARA	12/06/2018 1APPROVED
	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	& MEDICAID SERVICES	·			WB MO	. 0938-0391
	r of Oeficiencias of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(XO) DAT	F SURVEY WLETED
	•	556695	H. WING	·		. 44	16/2018
NAME (OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZE' CODE		10/2016
KINDRE	D TRANSITIONAL CA	RE AND REHAE - SMITH RANCH			650 SILVETRA PARKWAY		
	P HANGHIMAL GA	IL AND ICHAS SUMMIN FORMER	. 1	9	AN RAFAEL, CA 94903		
(XI) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BY PRECEDED BY FULL SO IDENTIFYING INFORMATION)	IVG IREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPE DEFICIENCY)	B)÷	(200) COMPLETION DATE
F 761	appropriate accessinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptance in locked in locked temperature control personnel to have a series of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is more readily detected. This REQUIREMENTHE REQUIREMENTHE In their policy and proceimergency medications, when an expired medication textured in patient hexpired medication.	ory and cautionary a expiration date when of Drugs and Biologicals cordance with State and citity must store all drugs and d compartments under proper is, and permit only authorized access to the keys, facility must provide separately y affixed compartments for d drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to a the facility uses single unit button systems in which the inimal and a missing dose can it is not met as evidenced ion, Interview and ew, the facility failed to follow		761	RD will audit all residents on		12/14/18
	with the A-DON, of ton 11/13/16 at 10:45	on and concurrent interview, the medication storage room 5 a.m., E-klis locked in a red for contents and expired		İ	delicient practice; No residents were affected by the deficient practice.		

SYMBADY OF PROPIERATES AND PLAN OF CORRECTION SSSERY AND PLAN OF CORRECTION SSSERY SSSERY AND PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH PREPRY TOO CONTINUED TO PROPINCE OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH PREPRY TOO CONTINUED TRANSITIONAL CARE AND REHAB - SMITH RANCH SUMMANY STAYLEMENT OF DEPTICENCES OF THE PROPINCE OF THE PROPIN			AND HUMAN SERVICES			FORM	: 12/06/2018 APPROVED
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH SUBMINIST TO CONTINUE OF CONTINUENCY OF DEPTOCRACIES OF THE PROVIDERS AND AFAEL, CA 94803 FOR THE CAMBRIDGHOW WHICH DEPTOCRACIES OF THE PROVIDERS FLAN OF CORRECTION BROULD BE CARREST AND PROVIDER AND THE PROVIDERS OF THE PROVIDERS FLAN OF CORRECTION BROULD BE CARREST AND PROVIDER AND THE PROVIDERS OF THE PROVIDERS FLAN OF CORRECTION BROULD BE CARREST AND PROVIDER AND THE PROVIDERS OF THE PROVIDERS	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DAY	≝ SURVEY
NAME OF PROVIDER ON SUPPLIER KINDRED TRANSITIONAL GARE AND REHAB - SMITH RANCH PREFIX TAOS COAD DESCRIPTION OF LOS DESTRUCTIONS OF THE PROVIDERS FIRST TAOS FOR THE PROVIDER OF THE PROVIDERS OF THE PROVIDERS FIRST TAOS FOR THE PROVIDER OF THE PROVIDERS OF THE PROVIDERS FIRST TAOS FOR THE PROVIDER OF THE PROVIDERS OF THE PROVIDERS FIRST TAOS FOR THE PROVIDER OF THE PROVIDERS OF THE PROVIDERS OF THE PROVIDERS OF THE PROVIDERS OF THE PROVIDER OF THE PROVIDERS OF THE PROVIDER						""	
STREET ADDRESS, CITY, 674TE, 2P CODE	ELABOR MAN	to a second to the second to t	556695	B. WING		13/	16/2018
SAN RAFAEL, CA 94903 SUMMANY SUTTEMENT OF DEPICIPACIES PROPERTY STATEMENT OF DEPICIPACIES PROPERTY STATEMENT OF DEPICIPACIES PROPERTY TAGE PROPERY	UNAVAC OF I	WOAIDEK OK SUMFIEK		ł			
F781 Continued From page 22 medications. One E-kit contained oral control medications was found to have aight tablets of Chorazepam 0.6 mg (a drup to treat anytic) and pank 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-kit medication are used, the staff reviews the E-kit medication are used, the staff reviews the E-kit medication are used, the staff reviews the E-kits are observed the open the E-kit have been opened. The A-DON attated the charmacy will norme today and replace the E-kit that was opened. The A-DON attated the pharmacy will corner be no log to show the E-kits have been checked. During the interview with the DON or 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 are solved from the E-kits are checked daily by the nurses to observe if they have been opened. No documentation for checking the E-kits are available. During a second observation and concurrent interview with the DON or 11/13/18 at 2:29 p.m., whe staff review the practice. During a second observation and concurrent interview with the DON or 11/13/18 at 2:29 p.m., were still present in the exists of the exist	KINDRE	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH	· .			
medications. One E-kit contained oral control medications was found to have eight tablets of Cionazepam 0.6 mg (a drug to treat anxiety and pento 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, he stated that the pharmacy is responsible to check the expired status of E-kits. The pharmacy comes monthly and when the E-kits are ohecked deily by the nursing leaff, the pharmacy is called when the E-kits have been opened. The A-DON attaled there is no log to show the E-kith have been checked. During the interview the A-DON attaled the oharge nurse to call the pharmacy to replace the E-kit that was opened. The A-DON attaled the pharmacy to replace the E-kit that was opened. The A-DON attaled the pharmacy will owne 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 deily by the nurses to observe if they have been opened. No documentation for checking the E-kits was available. During a seoond observation and concurrent interview of the medications. Provide all B-kits for other expired medications - none were found. How the facility will identify other residents having the putential 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 easure that the deficient practice does not recur; During a second observation and concurrent interview of the medications.—In the pharmacy to replace the E-kits within 72 bours.		(EACH DEFICIENCY	MUST BE PREDENIED BY FIX I	PREFU	(BACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	hoc	(X5) COMPLETION DATE
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 ancrosing opened and document pharmacy call in Point Click Care communication.	F 761	medications. One Emedications was for Cionazepam 0.6 miganic disorder) with The E-kit was open the additional drugs interview with the Apharmacy is responstatus of E-kits. The and when the E-kits attact that the E-kits nursing staff, the pickits and stated that the E-kits medications and the E-kits and stated the E-kits and stated the E-kits and stated the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits have been of the E-kits. During an interview 2:29 p.m., she state by the nurses to obtain the the color of the med 11/15/18 at 11:29 a. 11/13/18 at 2:29 p.m. locked cabinet. The DON stated on to pick-up the E-kits	i-kit contained oral control und to have eight tablets of collection of the contents of collection of the contents of collection of the contents of collection of the contents of collection of the contents of collection of the contents of collection of the contents of collection of the collection of	F7	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 surses 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		

		I AND HUMAN SERVICES		r	FORM	12/06/2018 APPROVED
	<u>NO PUR MEDICARE</u> l'OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/BUPPLIER/CLIA	1	C	MB NO.	<u>0938-0391</u>
	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	COW (X3) DAI	e gurvey Pleted
·		556685	B. WING		404	16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	14170.10
KINDRE	D TRANSITIONAL CA	RE AND REHAB - SMITH RANCH		1660 SILVEIRA PARKWAY		
<u></u>	<u> </u>			SAN RAFAEL, CA 94903		i
(X4) ID PREPIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DIRFIONNCIES / MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	IID PREPIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP DEVICIENCY)	N) BE RIATE	COMPLETION DATE
F 761	11/16/18 and only of medications from 1 A review of the facil "Emergency Pharm	ontained destroyed 1/14/18. Ify policy and procedure titled lacy Service and Emergency	F 761	DON/DSD will follow up with phermacy 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.		
F 812 SS≒E	emergency mediation supplied in accordance federal regulations. Inursing staff, consupharmacy designed regularly for expiration of Procurement,	2007, indicated that one and supplies would be ance with applicable state and item 13, indicates "the alliant pharmacist and provider a checks the emergency kits ion dating of the contents". Store/Prepare/Serve-Sanitary (2)	F 812	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		
		oure food from sources ered satisfactory by federal,	V	procedure. The audit will occur weekly for 100% compliance. Once 100% compliance is met, the audits will become monthly. How the facility plans to		•
	from local produces and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and fo	food items obtained directly s, subject to applicable State gulations, per not prohibit or prevent produce grown in facility compliance with applicable cod-handling practices, loes not preclude residents		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		
	from consuming for §483.80(I)(2) - Ston serve food in accor- standards for food of This REQUIREMENT by: Based on food pre	ods not procured by the facility. e, prepare, distribute and dance with professional		meeting. If 100% compliance is not achieved within 3 months then the Administrator and Director of Nursing will reevaluate the corrective measure.	• .	12/16/18

		AND HUMAN SERVICES		ř	KINTED:	: 12/06/2016 APPROVED.
		& MEDICAID SERVICES		G	ME NO.	0938-0391
	of Deficiencies If Correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DAT	SURVEY PLETED
a		559808	b. Wing_		144	[6/ 2 018
Name of f	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	.h	EMMA ID
KINDRE	TRANSITIONAL CA	re and rehad - Smith Ranch	ı [1960 SILVEIRA PARKWAY SAN RAFAEL, CA 94903	·	
(X4) 10 Prizerix Tag	(ČACH DEFYCIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL 9C IDENTIFYING IMFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N) BE RIAYE	(X6) OOMPLETION DATE
F 812	and procedures, the preparation was in a standards of practic 1) Dietary Staff did a temperatures to eas Dietary Staff washe atnk. These failures caus who had parsley on egg salad sandwich foodborne illness. Nursing home resid complications from of their compromise foodborne illness may result in death. Findings: 1) During an observe interview on 11/8/18 Staff Q was making Unicensed Staff Q sandwiches would it buring an interview Administrative Staff cool down logs (doctemperatures that etemperature limits were to east to the perature limits were to east to east the east to east to east the east to east to east the east to east the east to east the east to east the east to east the east to east the east to east the east to east the east to east the east the east to east the east to east the east to east the east to east the east to east the east to east the east to east the east the east the east to east the east to east the east the east to east the east t	s and departmental policies a facility failed to ensure food accordance with professional setu ensure food safety when: not monitor egg salad sure adequate cooling and 2) diparately in the dirty poudish ad potential for all residents fifeir lunch trays or who ate es to be exposed to ents risk serious foodborne fliness as a result in health status. Symptoms of ay include diprrhea, vomiting, When these conditions did be dehydration and may on and in severe instances	F 81	F017 Food Dynaman		
		When asked how staff would	·			

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 12/06/2018
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA		TIPLE CONSTE			E SURVEY
 WAD GEMAN	P GORREGIUM	IDENTIFICATION NUMBER:	A. BUILDI	NG		CON	APLEYED
		#55696	B. WING			ر ا	44
NAME OF F	Proyiden or Supplier	, <u>, , , , , , , , , , , , , , , , , , </u>	<u> </u>	STREET AD	DRESS, CITY, STATE, ZIP CODE	197	16/2018
KINDREI	TPANRITIONAL CAL	RE AND REHAB - SMITH RANCH	. 1		IRA PARKWAY		
-4114751202			'		AEL, CA 94908		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	מ		PROVIDER'S PLAN OF CORREC	TION	055
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	CRC	ACH COMRECTIVE ACTION SHO ISS-REFERENCED TO THE APPR DEFICIENCY)	ulii be Cpriate	GOHPLETION DATE
F 812	Continued From page	na OE		Die	tary Manager and		
''''		•	F 8	12 Rep	istered Dictitian (RD)		
	rempwintetive Staff	naking the egg salad, G stated, "you would need a	1	wiii	inservice Diotary Staff		i i
	log" to know that.	G stated, you would need 6	ļ	on ;	proper infection control]
	AND COLUMN COURT	•	1		arding PHF's & Cooling		j
!	During and Interview	v at on 11/8/18 at 4:45 p.m.,		Log	. New hires will be		1
1	Unificensed Staff P	stated staff did not check the		f tro	ined by the Dietary	•	j j
. }	temperature of egg	salad after it was made.			mager on this policy		į į
			ļ		on working in the		[]
, .	During and interview	v at on 11/8/18 at 5:25 p.m.,			chen. The policy and) }
	nere evirenzammon	J was informed facility staff he temperature of egg salad	}		ocedure is also located in		1 1
ĺ	siter it was mode. A	na temperature of egg salad Administrative Staff J., "they			e cooling log binder for		ł 1
i		nping and recording it."			iff to refer to. The		! . [
	•	· .	,		ndard of practice for food		1
	Review of facility re-	olpe titled, "Egg Saled,"	١.		fety is to ensure cooked		1
		on" (undated) indicated, "3.)		IF's are cooled from 135-		[]
		ents. Mix well Hold			°F (degrees Fahrenhelt)] • •]
ļ	retrigerated at interr	nal temperature of 40 degrees			thin 2 hours and to 41°F		1 1
	F. or below for use.	•	1		ithin an additional 4)
	Potentially hazardo	us foods (PHF's) are those	ł		ours, totaling no more than hours. Similarly items) (
		ng bacterial growth associated			epared from room		<u> </u>
		Bs. PHF's include previously	ł		mperature ingredients]]
	prepared protein ba	sed foods such as cooked			ust be cooled to 41°F		[]
	meat and canned tu	ins prepared from room			ithin 4 hours.		}
		ents. The standard of practice]]
	contact from 195-70	ensure cooked PHF's are "F (degrees Fahrenheit)		2.) A	li residents have the		1
	within 2 hours and b	r (degrees ramemes) o 41°F within an additional 4	}		orential to be affected by		1 1
		ore than 6 hours. Similarly		(th	e same deficient practice.		}
	items prepared from	n room temperature		7%	Internal Management		j i
	ingredients must be	cooled to 41°F within 4 hours			letary Manager and ogistered Dietitian will] [
	(Food Code, 2013).		-		ogastered Dietidan will iservices all Dietary Staff		
	ol pu i	and an analysis of the same			n proper infection control		()
		ration and Interview on 11/8/18	}		garding food handling to		} [
		volministrative Staff rinsed the left of the oven. The sink			view Infection Control -		
		ne leit of the ovent, I he sink es and a hose that dispensed :	j		rep Sinks, subtitled] {
		The Administrative Staff I was			Procedure".		
		,			· · · · · · · · · · · · · · · · · · ·		<u> </u>

CENTERS FOR MEDICARE & MEDICAID SERVICES OND PROVIDER ON SUPPLEY (DOT) PROVIDER ON SUPPLEY (DOT) PROVIDER ON SUPPLEY (NODRED TRANSITIONAL CARE AND REHAR - SMITH RANCH SETHELIT ADDRESS. CITY, STATE, ZIP CODE SEMMANY STATEMENT OF REPORTING SET STATEMENT OF REP	DEPAR'	MENT OF HEALTH	AND HUMAN SERVICES		j.	RINTED	12/06/2018
### STATEMENT OF PERCENCIS ### CONTINUED ON SUPPLUE ### COMPLETED ### CONTINUED ON SUPPLUED ### CONTINUED ON SUPPLUED ### CONTINUED ON SUPPLUED ON	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			FURM MB NO.	APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH SAR RAFAEL, CA 9408 SAR RAFAEL, CA 9408 F 812 Continued From page 26 asked if he had rinsed the perskey in the sink and he stated, yes." He further stated that sink was used for washing pots. During an interview on 118/18 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 Lee machine was for vegetables and the sink to the right of the text and about the food preparation anks. Administrative Staff I and washed the parsity) was used for washing pastorice. During an interview on 118/18 at 245 p.m., Administrative Staff I and washed the parsity of the text and about the food preparation sinks was to the right of the text machine. Site stated does the house of preparation sinks was to the right of the text machine was for washed in the protein of foods (i.e., washing procurse			(X1) PROMIDER/SUPPLIER/CI.IA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY
STREET ADDRESS CITY, STATE, 2P CODE			555595	D. WING	2	144	arocus.
SAN RAFAEL, CA 94065 SUMMOND STREAM REPORT OF DESCRIPTIONS OF THE PROPOSED BY FIRE. SUMMOND STREAM REPORT OF DESCRIPTIONS OF THE PROPOSED BY FIRE. F 812 Continued From page 28 asked if he had rinsed the parakay in the sink and he stated, "yes." He further stated that sink was used for washing pots. During an interview on 11/8/16 at 11:35 a.m., Unlicensed Staff Q was asked about the food preparation sinks. Unicensed Staff Q is stated the sink to the sink to the sink to the sink to the sink to the sink to the sink to the sink to the parakino staff S as saked about the food preparation sinks. Administrative Staff G was asked about the food preparation sinks. Administrative Staff G is stated the parakey) was used for washing pastorice. During an interview on 11/8/16 at 2:45 p.m., Administrative Staff G was asked about the food preparation sinks. Administrative Staff G is stated the bord preparation sinks. Administrative Staff G is stated the sink to the laft of the store (winters Administrative Staff G was asked about the food preparation sinks. Administrative Staff G is stated the sink was to the right of the low machine. She stated food should not be washed in the put/filty disp sink. Review of facility poticy titled, "Infection Confroi-Prep Sinks" subtilled, "Procedure" (dated 1/10/18) indicated, "In Designated prep sinks in the kitchen should only be used for the safe handing and preparation of foods (i.e. washing proceduce" Infection prevention a Control Program designed to provide a safe, samilary and comfortable environment and to help provent the development and transmission of communicable diseases and infections. S483.80(a) Infection prevention and control program designed to provide a safe, samilary and comfortable diseases and infections. S483.80(a) Infection prevention and control program designed to provide a safe, samilary and comfortable diseases and infections.	NAME OF F	YROVIDER OR SUPPLIER	,		STMEET ADDRESS, CITY, STATE, ZIP CODE		(OIXO IO
SAN RAFAEL, CA. 94963 SAN RAFAEL, CA. 94963 SAN RAFAEL, CA. 94963 PRODUCTED PLAN OF COMPACTION STORY OR LSC INSTITUTION PRESENT ACTION STORY OR LSC INSTITUTION PROPERTY TAG	KINDREI	TRANSITIONAL CA	RE AND REHAB - SMITH RANCH	l 1			
F 812 Continued From page 26 asked if he had inseed the parsky in the sink and the stated, Yea." He further stated that sink was used for washing pots. During an interview on 11/8/18 at 11:35 a.m., Uhilcensed Staff Q was asked about the food preparation sinks. Uniformsed Staff Q stated the sink to the right of the ker machine was for vegetables and the sink to the left of the since (where Administrative Staff Q stated the parsley) was used for washing paste/rice. During an interview on 11/8/18 at 2.45 p.m., Administrative Staff Q stated the parsley) was used for washing paste/rice. During an interview on 11/8/18 at 2.45 p.m., Administrative Staff Q stated the parsley) was used for washing paste/rice. During an interview on 11/8/18 at 2.45 p.m., Administrative Staff Q stated the parsley) was used for washing paste/rice. Review of facility policy titled, "Infection Control-Prep Striks" subtilited, "Procedure" (dated 1/10/18) indicated, "I. Designated prep sinks in the kitchen should not be used for the safe handling and preparation of foods (i.e. washing produce F 380 F 580 F 680 F 880 F 880 A What measures will be put into place or what systematic changes will the facility make in ensure that the delictent practice does not recur; 1.) Dietury Staff will obtain temperature of PHF's and record on the Cooling Larg. Dietary Manager will nominor Log weakly to ensure food salidy, The sudit will professional standards of practice to consure food salidy, The sudit will professional standards of practice to consure food salidy, The sudit will professional standards of practice to consure food salidy, The sudit will professional standards of practice to consure food salidy, The sudit will professional standards of practice to consure food salidy, The sudit will become monthly. 2.) RD will continue to audit the kitchen monthly as a part of her routine. F 880 SS=F 680 F 880 F 880 F 880 A 83.80(a) Infection Control program designed to provide a safe, senilary and comfortable environment and to help p							
Continued From page 28 asked if he had rinsed the perskey 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 loe 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 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 stated the food preparation withs. Administrative Staff G stated the food preparation shk was to the right of the loe machine. She stated food should not be washed in the poblishy policy littled, "Infection Control-Prep Sinks" subtitled, "Procedure" (dated 1/10/18) indicated, "1. Designated prep sinks in the kitcher and bould only be used for the safe handling and preparation of foods (i.e. washing produce" F 5.880 SS=F FROM F 383.80(a)(1)(2)(4)(e)(1) \$483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sentlary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program designed to provide a safe, sentlary and comfortable environment and to help provent the development and transmission of communicable diseases and infections.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY POLL	PREFIX	(FACH CORRECTIVE ACTION SHOUL) CHOSS-REFERENCED TO THE APPROX) RE	DATE
F	988, 4	asked if he had rins he stated, "yes." He used for washing proceed for washing proceed of the control of the reparation sinks. It is not to the right of the reparation sinks. It is not the right of the reparation sinks. At the food preparation She is washed in the pot/direction of facility preparation in the pot/direction of facility produce" Infection Prevention CPR(s): 483.80(a)(1): \$483.80 Infection CT the facility must be infection prevention designed to provide comfortable enviror development and tradiseases and infection called the state of the	ted the parsisy in the sink and a further stated that sink was obta. You 11/8/18 at 11:35 a.m., was asked about the food inlicensed Staff Q stated the he ice machine was for sink to the left of the stove or Staff I had washed the for washing pastalrice. On 11/8/18 at 2:45 p.m., G was asked about the food in sink was to the right of the stated food should not be left of distributed food should not be leftly dish sink. If y liked, "infection Control of the safe ration of foods (Le. washing in a Control 1)(2)(4)(e)(1) Ontrol tablish and maintain an and control program as asic, sanitary and ament and to help prevent the ansmission of communicable tons.		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		

PRINTED: 12/08/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MINTIPLE CONSTRUCTION (X3) DAYE SURVEY a Buildang COMPLETED 5555AG D. WING 11/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1550 BILVEIRA PARKWAY KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH SAN RAFAEL, CA 94903 (X4) IU PREFIX **BUMMARY STATEMENT OF DEFICIENCIES** ID PREFIX PROVIDEN'S PLAN OF CORRECTION (XII) COMPLETION DATE (EACH DEFICIENCY MUST UE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BIT CROSS-REFERENCED TO THE APPROPRIATE REQUILATORY OR USC IDENTIFYING INFORMATION) TAG ΊΛG DEFICIENCY) How the facility plans to F 880 Continued From page 27 F 880 monitor its performance to The facility must establish an Infection prevention make sure that solutions are and control program (IPCP) that must include, at sustained: a minimum, the following elements: The Dietary Manager and RD §483.80(a)(1) A system for preventing, identifying, will track and trend reported reporting, investigating, and controlling infections findings and present to the and communicable diseases for all residents. monthly QAPI meeting. If 100% staff, volunteers, visitors, and other individuals compliance is not achieved providing services under a contractual within 3 months then the arrangement based upon the facility assessment Administrator will re-evaluate 12/16/18 conducted according to §483.70(e) and following the corrective measure. accepted national standards; §483.80(a)(2) Written standards, policies, and F880 Infection Prevention procedures for the program, which must include. & Control but are not limited to: (I) A system of surveillance designed to identify CFR(s): 483.80(a)(1)(2)(4)(e)(f) possible communicable diseases or infections before they can spread to other How the corrective action(s) persons in the racifity; will be accomplished for those (ii) When and to whom possible incidents of residents found to have been communicable disease or infections should be affected by the deficient reported: practice; (III) Standard and transmission-based precautions to be followed to prevent spread of infections: No residents were affected by (ly)When and how isolation should be used for a this deficient practice. resident; including but not limited to: (A) The type and duration of the Isolation. 1.) Unlicensed staff I was depending upon the infectious agent or organism inserviced on proper Involved, and infection control and (B) A requirement that the isolation should be the prevention and contact least restrictive possible for the resident under the precautions per facility circumstances. policy and procedure. (v) The circumstances under which the facility 2.) Gowns were immediately must prohibit employees with a communicable disease or infected skin lesions from direct provided to the laundry staff contact with residents or their food, if direct to utilize in the laundry contact will transmit the disease; and room,

				FORM	12/05/2018 APPROVED
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(XS) DAT	E SUKAEA
·	\$55095	B, WING	· ·	444	16/2018
ROVIDER OR BUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		, OILU IU
TRANSITIONAL CA	re and rehab - Smith Ranci	-T P		ř	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREPIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION BIC CROSS-REPERENCED TO THE APPI DEFICIENCY)	TION IULD BE ROPRIATE	(XV) COMPLETION DATE
(vi)The hand hygler by staff involved in or \$483.80(a)(4) A system of the corrective actions to \$483.80(e) Linens. Personnel must har transport linens so sinfection. §483.80(f) Annual ransport linens ransport linens so sinfection. For and update the This REQUIREMENT by: Based on observatively when; 1. One staff did not exiting the room of exiting the room of precautions (Contact lines) are in the been diagnosed will can be spread from contact flouching the indirect contact (touching the indir	tem for recording incidents facility's IPCP and the sken by the facility. Indie, store, process, and as to prevent the spread of eview. It is not met as evidenced ion, interview and document alied to ensure residents and set to infectious organisms follow the facility policy when a resident on contact or precautions are rules and if and visitors must follow are rules and infectious disease that a person to person by direct infected person), or by ching surfaces or insnimate cted person has touched). not use gowns to separate interminated Resident blankets	F 880	clean folding table area. Al resident blankets were rewashed. 4.) Hand hygiene alcohol gel was available on the contaminated skie but not on the clean side and a dispenser was installed. 5.) Disinfect wipes were provided to the clean side the laundry room to wipe down surfaces of the folding table, dryers and carts. 6.) Signs indicating "entering clean area" and "entering soiled area" was posted. 7.) Exposed, unpainted, chipping plaster in the clean 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	of a a	
and the dean foldto	g table when personal				
	ROVIDER OR SUPPLIER TRANSITIONAL CAI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa (vi) The hand hygier by staff involved in the corrective actions the corrections (Contact Procedures actions	### STATEMENT OF DEFICIENCES (PACH DEFICIENCES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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(a) Liners. 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 mpt as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents and staff were not exposed to infectious organisms	IS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIE	SPERMEDICARE & MEDICAID SERVICES PROVIDER SUPPLIENTIAL PROVIDER SUPPLIEN	IS FOR MEDICARE & MEDICAID SERVICES OF DEFICENCIES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF DEFICENCES OF PROVIDER PLANT OF DEFICIENCES OF DEFICENCES OF

PRINTED: 12/08/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO, 0938-0391</u> (X1) PROVIDER/BUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) Date Survey Completed AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING. 555895 B. WING 11/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1860 ŞILYEIRA PARKWAY KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH SAN RAFAEL, CA 94903 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (XS) Odmpletion (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFIGIENCY evoid the foam coming out F 880 Continued From page 29 F 880 of the vent. Vendor the folding table in the clean side of the laundry indicated to do full loads of mom. linen to also provent the foam coming out. The foam No hand hygiene alcohol gel was available in coming out from yent has the clean / contaminated side of the laundry. stopped. 5. Disinfectant wipes not available in the clean Cleaning and disinfection of side of the laundry ruom to wipe down surfaces of the laundry room behind the the folding table, dryers and carts. washer machine has been included in the routine No clear signage for clean and dirty areas inside the laundry. cleaning of the laundry room. 7. Exposed, unpainted, chipping plaster in clean and dirty side of laundry prevented disinfection. How the facility will identify other residents having the 8. Washing machines were not maintained potential to be affected by the according to manufacturer's instructions when a same deficient practice and rolled up towel was placed inside a compartment what corrective action will be on top of the washer to prevent form from takenı escaping the washing machine. All residents have the potential Cleaning and disinfection of the laundry room. to be affected by the deficient did not include the area behind the washing practice. machines, allowing dust, plaster and particulate matter to accumulate. What measures will be put into place or what systematic By failing to follow the facility policy, manufacturer's instructions for use, and changes will the facility make professional standards for infection control, staff to ensure that the deficient had the potential to apread infectious organisms practice does not recur; to other residents, staff, and the community at large, potentially causing iliness. DSD will inservice staff on Personal Protective Equipment Findings (PPE), hand hygicne and contact isolation precautions. During an observation and concurrent interview with Unilcensed Staff (U.L.) T, on 11/7/18, at 2:45 p.m., he was observed exiting a

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING A. BUILDING A. BUILDING	(X8) DATE COMP	APPROVED 0938-0391 SURVEY
AND PLAN OF CORRECTION DESCRIPTION DESCRIP	(X8) DATE	SURVEY
695595 B. WING		2/1124
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTTY, STATE, ZIP CODE	13/79	6/2018
A		
SAN RAFAEL, CA 94903		[
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PAECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	DBB ((20) COMPLETION DATE
Continued From page 30 Clostridium Difficile (C-Diff) (an infection of the intestines that can cause severe damage to the colon and even he fatal. Symptoms include diarrhea, belly pain, and fever), contact preciations 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 pieced it in a trashcan inside the resident room door, and used distinicatint electhol get for hand hygiene. When asked if he knew the facility Policy and Procedure for hand hygiene in contact precautions rooms, U.L. Tatated when entering a C-Diff precautions room, use alcohol get. He stated when exiting, wash hands in the resident bathroom and then use elechol get plot to exiting the room. He was unaware that after he washed his hands in the resident's bathroom, removed the glown, used alcohol get prior to exiting the room. He was unaware that after he washed his hands and removed the disposable gown, he crose conteminated (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 9:16 a.m., site stated hand hygiene to restaff coming out of a Clostridium Difficile (C-Diff) isolation room includes washing hands with scap and weter after removing gown and gloves. 2. During an observation and concurrent interview with Administrative Staff (A.S.) D, in the dirty side of the leundry room, on 11/16/18, caris of laundry were observed against the wall. A.S. D stated there were no		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 12/06/2018 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(KS) DAT	. 0938-0391 E SURVEY IPLETED
	. ,	· 65596	B. WING		127	16/2018
NAME OF	PROVIDER OR SUPPLIER	,	8	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	Juneto
KINDRE	D TRANSITIONAL CA	RE AND REHAB - SMITH RANCH		880 SILVEITA PARKWAY IAN RAFAEL, CA 94803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X8) COMPLETION DATE
F 880	gowns in the room. room and stated stated the reviewed the lat loads of laundry her without wearing goversidents was infect disposable gowns, childing occurs during the clean room fold residents clean of the clean side of the lat large purse and switch on top of the clean stacks of resident on top of the clean stacks of resident between the facility provides personal items before an folding table of the facility provides personal items before an folding table of the facility provides personal items before an folding table of the facility provides personal items before an folding table of the facility provides personal items before an folding table of the facility provides personal items before an folding table of the facility provides personal items before an individual of the clean folding table of the facility provides personal items before an individual of the clean folding table of the facility provides personal items before an individual of the clean folding table of the facility provides personal items before an individual of the clean folding table of the facility provides personal items before an individual of the clean folding table of the facility provides personal items before an individual of the facility provides personal items before an individual of the facility provides personal items before an individual of the facility provides personal items before an individual of the facility provides and clean folding table of the facility provides personal items before and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean folding table of the facility provides and clean facility provides and clean folding table of the facility provides and clean facility provides and clean facility provides and clean facility pr	He searched the trash in the aff had not used gowns today. Indry log, which indicated 5 theen processed by staff was. A.S. D stated the risk to tion when staff don't wear cross contamination of staffing sorting, and then staff go to move linen into the dryers, linen and clothing, and then	F 890	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.		

		AND HUMAN SERVICES			PRINTED FORM): 12/06/2018 IAPPROVED
STATEMEN	<u>RS FOR MEDICARL</u> FOR DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIENCE/A IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO	0.0938-0391 TC SURVEY MPJ.ETED
		565696	B. WING_			/16/2018
	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHAB - SMITH RANCH		STREPT ADDRESS, CITY, STATE, ZIP CODE 1690 SILVEIRA PARKWAY SAN RAFAEL, CA 94913	·	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF INCTICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULDBE	(X5) COMPLETION DATE
F 880	dirty laundry rooms observation of the tolean laundry room disinfectant alcohol asked where facility laundry and pick up hygiene, A.S. D shr stated they have to their hands in the sisted they have to their hands in the sisted surfaces and count equipment to reduc disinfectant wipes viaundry room. A.S. leave the room, wal enter a locked house disinfectant wipes. 6. During an observation. There was a indicated entering a instructions for staff prevent cross containstructions for staff prevent cross containstructions, on the exposed plaster we A.S. E stated the chart exposed, un-painted the shrugged his shifting the wall exposed, un-painted the shrugged his shifting the shrugged his shif	and wash their hends. An hallway outside the dirty and doors did not show any gel was available. When a staff who drop off dirty of clean laundry perform hand ugged his shoulders, and enter the dirty room to wash ink. I wation of the clean laundry and interview with A.S. D., on staff use disinfect wipes on ers and dirty linen carts and the the risk of infection. No were observed in the clean D stated staff would have to k across the hallway and tekeeping closet to access the interview of the laundry rooms, on ration of one swinging door and dirty side of the laundry o signage observed that on proper technique to	F SE	How the facility plans to monitor its performance to make sure that solutions are sustained; The Malatenance 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 menths then the Administrator will re-evaluate the corrective measure.		12/16/18

		AND HUMAN SERVICES 8 MEDICAID SERVICES	•		FORM	7: 12/06/2018 MAPPROVED 0: 09/38-0391
BIATEMENT AND PLAN O	of Deficiencies F Correction	(X1) PROVIDER/BUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DA	TE SURVEY MPLETED
		555696	B. WING		1 44	/16/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
KINDREI	TRANSITIONAL CA	re and rehab - smith ranch		1560 Silvēira Parkway San Rafael, ga 94903]
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SMI CROSS-REFERENCED TO THE APP DEFICIENCY)	ひいしひ BE	(XA) COMPLETION DATE
F 880	a terry cloth towel woopening on the top dark brown discolor appeared stained, contain foam escap during laundry cycle stated how long the machine or if it was attempted to removistated it is not in the instructions for use opening to contain a state with 100% contain the contain the contain to contain the contain to contain the contain to contain the contain to contain the c	ilrty laundry room, on 11/16/18, res observed poking out of an of a washing machine. It had belon on the surface end A.S. E stated it was used to ling from the washing machine as, A.S. E was unable to a towel had been in the changed with each load. He is it and could not. A.S. E machines manufacturers to place a towel into the line foam, and was unable to officience, the towel did not a control risk from cross	,	0		
	interview with A.S. In 11/16/16, the area to appeared to have note the 220 volt wiring the plaster on the work dispenser had extreorembling plaster or particulate and lint on the back of one pipe extending from machine and the set PVC pipe laying on the sides of the was that was lifting away stated terminal ofee once a week and the machines is not cle concerns about the the washing machine the washing machine.	vation and concurrent E, in the dirty laundry room, on behind the washing machine usty electrical conduit leading g to the washing machines, wall under the detergent and degradation resulting in in the wall with plaster accumulating on the floor, and washing machine was a PVC if an opening in the back of the accommunity machine had a the floor. The area around shers had limbeum flooring y from the cement. A.S. E uning of the laundry occurs is back of the washing aned. He stated he had no condition of the area behind les impacting the cleanliness in the front of the washing				

	RS FOR MEDICAR TOF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1		, , , , , , , , , , , , , , , , , , , ,		(<u>OMB NO</u>	APPROVE 0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. HUILDU	ng	NSTRUCTION		,	(X3) DAY	MPLETED TE GURYEY	
		5559 5	B. WING_					144	H <i>RION</i> 40	
name of 1	PROVIDER OR SUPPLIER				ET AUDRESS, 1		3, ZIP CODE 11/16/20			
KINDRE		ARE AND REHAD - SMITH RANG	;H		Silveira Paj Rafael, C/					
(X4) ID PREFIX TAG	i (each dericiend	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDE (PACH CO) OROSS-REFE	ER'S PLAN OF TRECTIVE AC PRENCED TO DEFICIEN	TION SHOUL THE APPRO	D. FIE	(XII) COMPLETION DATE	
F 880	Continued From pa	age 34	F 88	во		•				
	Services) - Laundr	rtmental (Environmental y and Linen," revised 2014, Guidelines Standard			1			•		
	Precautions 2, V solled linen and be Consider all solled	Vesh hands after handling fore handling clean linen, 3. finen to be optentially			·				, 	
	Sorting Solled Line Washing linen mus	die with standard precautions In 1. Employees sorting or It wear a gown and Linen and other Solled								
!	items12. Wash t linen (i.e., when m	ands before handling clean owing from washer to dryer, to sorting table, and through								
!	2014, indicated "10 wear gloves and go	ridium Difficile," revised July). a. Healthcare workers will owns upon entering the room					•	•		
•	will remove gowns room, 11, When o	ith C.Difficule infection, and and gloves prior to exiting the aring for resident with distribes caused by C. Difficile, staff	,					,	<u> </u>	
	wili maintain vigilar when caring for red infection, washing	nt hand hygiene. 12. Glove use sidents with D. difficile hands with soap and water								
	upon exiting the ro infection AND strict general is consider	om of a resident with C. difficile t adherence to hand hygiene in ed best practice."				•				
	During a review of Disease Control ar Hand Hygiene in H	a document titled "Centers for ad Prevention, Guideline for ealthcare Settings					·			
•	Recommendations Control Practices A HICPAC/SHEA/AP	of the Healthcare Infection Advisory Committee and the IC/IDSA Hand Hygiene Task				•				
	"Recommended He	4, indicated for Hand Hyglene, and Hyglene includes; Wear when treating patients with C.								

TATEMEN	OF DEHICIENCIES	(X1) PROVIDER/SUPPLIFR/CLIA	(X2) MULTIPLE	CONSTRUCTION		. 0938-039		
ND MAN C	OF CONRECTION	(DENTIFICATION NUMBER:	A BUILDING			E SURVITY MPI ETED		
		556595	B, WING		11/15/201			
NAME OF	PROVIDER OR SUPPLIES		ST	REET ADDRESS, CITY, STATE, ZIP CODE	ODE 11/16/201			
KINDRE	TRANSITIONAL C	ARE AND REHAB - SMITH RANCE	1	50 SILVEIRA PARKWAY NN RAFAEL, CA 94903				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTING (EACH CORRECTIVE ACTION SHOULD CROSS-RUTERENCED TO THE APPRODEFICIENCY)	DBE	(X6) COMPLUTIO DATE		
F880	does not kill C. diff washing works be alone, thus the im- contact with the re immediate environ	ng short visits. Hand sanitizer ficile, and although hand tter, it still may not be sufficient portance of glovesany isident or surfaces in their ment can contaminate the red hands as well as clothing	F 880	DECEIV L JAN 0 4 2019 BY:				