STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555214	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROFESSIONAL POST ACUTE CENTER	**81 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0551 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility staff failed to follow the delegation of resident rights to designated resident representatives of two out of three sampled residents, Resident 1 and Resident 2, when these two residents were administered with Covid-19 (Coronavirus disease 2019 is an infectious disease caused by severe acute (sudden onset) respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2) tests without prior consents from their designated resident representatives. These failures prevented the designated resident representatives for Resident 1 and Resident 2, to decide on behalf of the residents, which could have a potential impact on future important healthcare decisions for Resident 1 and Resident 2 when the facility does not treat the decisions of the representative as the decisions of the resident to the extent required by the court or delegated by the resident. Findings: During an interview on 8/20/2020, at 1:10 p.m., with Resident Representative for Resident 1, the resident representative stated the facility did not report to her that there was an outbreak of Covid-19 at the facility. Resident 1's representative stated she learned about the outbreak at the facility from a news article that she read. She stated she got confirmation when she called and spoke to Administrative Staff A. Resident 1's representative stated the facility did not call her to ask for consent prior to administering the Covid-19 test to Resident 1. During an interview on 8/27/2020, at 8:47 a.m., with Licensed Staff B, Licensed Staff B was asked for the facility's procedure when a resident becomes symptomatic (showing signs of illness, e.g. fever, shortness of breath, cough) of Covid-19, Licensed Staff B stated she will protect herself first and made sure she has the proper PPE (Personal Protective Equipment), assess the resident, if a resident will have elevated temperature, the physician and the responsible party will be notified and the resident will be sent out to the Emergency Department for further evaluation. Licensed Staff B stated the floor nurses do not administer the Covid-19 test and do not ask for consent from families regarding Covid-19 testing. During an interview on 8/27/2020, at 9:55 a.m., with Administrative Staff C, Administrative Staff C stated she administers Covid-19 testing for the staff and the residents. When Administrative Staff C was asked how does she get consents prior to testing for Covid-19 if the resident was not their own decision maker, Administrative Staff C stated, that the facility sent a letter to all families regarding Covid-19 and suggested that this was a form asking for consent. Administrative Staff C stated she will be able to provide a copy of that letter. During an interview on 8/27/2020, at 11:03 a.m., with Resident Representative for Resident 2, the resident representative stated the facility did not call to report to him that his sister, Resident 2, had tested positive for Covid-19. The resident representative stated he spoke to Resident 2 and Resident 2 told him that she was transferred to a different room. The resident representative called the facility and spoke to a staff, whose name he could not recall, to ask why was Resident 2 transferred to a different room. The facility staff informed the representative that Resident 2 had tested positive for Covid-19. The resident representative for Resident 2 stated the facility did not ask him for a consent to administer the Covid-19 test to Resident 2, and have not received any communication by mail from the facility regarding Covid-19 testing. During an interview on 8/27/20, at 11:40 a.m., with the Director of Nursing (DON), the DON was asked if a consent from a resident representative was needed prior to administering a Covid-19 diagnostic test if the resident was not his/ her own responsible party, the DON stated that she was unsure about the facility's policy as she had been with the facility for only two weeks. The DON stated that she will send the policy and procedure via faxed message as soon as she can get a hold of a facility policy and procedure for Covid-19 testing. On 8/27/2020, at 2:28 p.m., the DON sent a faxed message to the California Department of Public Health, a policy statement pertaining to culture test not on Covid-19 diagnostic test. Handwritten by the DON on the culture test policy statement indicated, Pertains to Covid Outbreak. During a review of a sample document provided by the Administrator, titled,Covid-19 Update, dated March 12, 2020, Administrative Staff C stated that this was the letter that was sent to the families of residents asking for consent prior to the Covid-19 testing. A review of this document did not indicate that it was asking families for consent prior to Covid-19 testing.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow its policy and procedure on change of condition notification for two of three sampled residents, Resident 1 and Resident 2, when Resident 1 and Resident 2's representatives were not notified of positive COVID-19 (Coronavirus disease 2019 is an infectious disease caused by severe acute (sudden onset) respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2) diagnosis. These failures had the potential to result in a decline in the respiratory function for Resident 1 and Resident 2 and endanger their health, if their representatives were not informed of their health status, and consistent with their authorities, make the required decisions on how to proceed with the care for Resident 1 and Resident 2. Findings: During an interview on 8/20/2020, at 1:10 p.m., with Resident Representative for Resident 1, the resident representative stated the facility did not report to her that there was an outbreak of Covid-19 at the facility. Resident 1's representative stated she learned about the outbreak at the facility from a news article that she read. She stated she got confirmation when she called and spoke to Administrative Staff A. Resident 1's representative stated the facility did not call her to ask for consent prior to administering the Covid-19 test to Resident 1. During an interview on 8/27/2020, at 8:47 a.m., with Licensed Staff B, Licensed Staff B was asked for the facility's procedure when a resident becomes symptomatic (showing signs of illness, e.g. fever, shortness of breath, cough) of Covid-19, Licensed Staff B stated she will protect herself first and made sure she has the proper PPE (Personal Protective Equipment), assess the resident, if a resident will have elevated temperature, the physician and the responsible party will be notified and the resident will be sent out to the Emergency Department for further evaluation. Licensed Staff B stated the floor nurses do not administer the Covid-19 test and do not ask for consent from families regarding Covid-19 testing. During an interview on 8/27/2020, at 9:55 a.m., with Administrative Staff C, Administrative Staff C stated she administers Covid -19 testing for the staff and the residents. When Administrative Staff C was asked how does she get consents prior to testing for Covid-19 if the resident was not their own decision maker, Administrative Staff C stated, that the facility sent a letter to all families regarding Covid-19 and suggested that this was a form asking for consent. Administrative Staff C stated she will be able to provide a copy of that letter. During an interview on 8/27/2020, at 11:03 a.m., with Resident Representative for Resident 2, the resident representative stated the facility did not call to report to him that his sister, Resident 2, had tested positive for Covid-19. The resident representative stated he spoke to Resident 2 and Resident 2 told him that she was transferred to a different room. The resident representative called the facility and spoke to a staff, whose name he could not recall, to ask why was Resident 2 transferred to a different room. The facility staff informed the representative that Resident 2 had tested positive for Covid-19. The resident representative for Resident 2 stated the facility did not ask him for a consent to administer the

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

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Covid-19 test to Resident 2, and have not received any communication by mail from the facility regarding Covid-19 testing. During a review of a sample document provided by the Administrator, titled,Covid-19 Update, dated March 12, 2020, Administrative Staff C stated that this was the letter that was sent to the families of residents asking for consent prior to the Covid-19 testing. A review of this document did not indicate that it was asking families for consent prior to Covid-19 testing. During an interview on 8/27/2020, at 11:40 a.m., with the Director of Nursing (DON), The DON was asked if a resident was not his or her own decision-maker, and was assessed to have a change of condition, should their representatives be notified, the DON stated, Yes. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated September 2013, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).