

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2025
NAME OF PROVIDER OR SUPPLIER Grant Cuesta Sub-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1949 Grant Road Mountain View, CA 94040	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an assessment for self-administration of medications was completed for one of 3 residents (1) when Resident 1 administered lidocaine (used to relieve pain) liquid to his right hip himself and did not have a self-administration of medication assessment and did not have an order from the physician to do so. This failure resulted in duplication of administered medications and had the potential for improper, unsafe medication administration and not addressing the clinical condition of the resident. Findings:Review of Resident 1's admission Record indicated he was admitted to the facility on [DATE].Review of Resident 1's Minimum Data Set (MDS, a clinical assessment tool), dated 3/25/25, indicated his cognition was intact.During an observation with registered nurse A (RN A) on 6/17/25, at 4:15 p.m., an Aspercreme Lidocaine Liquid Roll-On applicator was on the floor at the foot of the bed of Resident 1.During a concurrent interview with Resident 1, he stated the Aspercreme Lidocaine Liquid Roll-On applicator was his, and he applied it to his right hip himself.During an interview with RN A on 6/17/25, at 4:20 p.m., she reviewed Resident 1's clinical record and confirmed that Resident 1 did not have physician orders for Lidocaine Liquid Roll-On applicator and for self-administration of medication. RN A also confirmed that currently Resident 1 had a physician order for Aspercreme Lidocaine Patch 4% apply to right hip topically every day, on for 12 hours, off for 12 hours.During an interview with the director of nursing (DON) on 6/17/25, at 4:25 p.m., he stated he would keep Resident 1's Lidocaine Liquid Roll-On applicator and would talk with the physician about Resident 1's self-administration of it.Review of Resident 1's clinical record indicated he did not have an assessment on self-administration of medication.During an interview and review record with the DON on 7/14/25, at 11:35 a.m., the DON reviewed Resident 1's clinical record and confirmed that currently Resident 1 had a physician order for self-administration of Lidocaine External Cream 4% to right hip topically one time a day, starting on 6/18/25, but Resident 1 still did not have an assessment on self-administration of medication.Review of the facility's policy, Resident Self-Administration of Medication, dated 6/26/24, indicated . A resident may only self-administration medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to provide the residents with a safe environment when one of 8 resident beds was not stable; 5 of 8 toilet seats were not stable as it was wubly; 5 of 6 toilet-seat risers were not stable; and the toilet tank in room [ROOM NUMBER] did not have a proper size and shape lid. These failures had the potential to compromise the health and safety of the residents. Findings:During an observation with the maintenance director (MD) on 6/17/25, at 1:30 p.m., the following were observed:a. The bed in room [ROOM NUMBER]A was still movable even though its wheels were braked.b. The toilet seats in Rooms 18, 20, 28, 31, and 34 were not stable.c. The toilet-seat risers in Rooms 2, 18, 20, 28, and 40 were not stable.d. A smaller and different shaped lid was lying on top of the open toilet tank in room [ROOM NUMBER].During an interview with Resident 2 on 6/17/25, at 1:50 p.m., she stated her portable toilet-seat riser was not stable. She had to carefully position it again and again to make sure it was stable before she sat down on it.During an interview with the MD on 6/17/25, at 1:55 p.m., he stated the smaller and different shaped lid which was lying on top of the open toilet tank in room [ROOM NUMBER] was an accident hazard for the residents and staff, and it should not be there.During an interview with the MD on 6/17/25, at 2:20 p.m., he acknowledged that unstable bed, unstable toilet seats, and unstable toilet-seat risers were not safe for the residents, and he would fix them.Review of the facility's policy, Safe, Clean, Comfortable, and Homelike Environment, dated 6/2023, indicated In accordance with residents' rights, the facility will strive to provide a safe, clean, comfortable, and homelike environment .Review of the facility's policy, Toileting Equipment Policy, dated 6/11/25, indicated Toilet risers and other adaptive toileting devices . must be maintained in safe working condition, . 5. All equipment must be inspected for cracks, corrosion, loose fittings, or other hazards.Review of the facility's policy, Bed Wheel Locking Policy, dated 6/11/25, indicated To ensure resident safety and prevent falls or unintended bed movement by requiring all beds to be locked (wheel brakes engaged) when not being actively relocated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices when:1. Certified nursing assistant B (CNA B) did not remove her gloves and carried Resident 3's soiled linen out of her room and in the hallway;2. A soiled pillowcase was left on the floor in room [ROOM NUMBER]; and3. Certified nursing assistant C (CNA C) did not put on a gown when doing incontinent care for Resident 4 who was on Enhance Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, a germ that is resistant to many antibiotics] in nursing homes). These failures had the potential to spread the infection to residents, staff, visitors, and throughout the facility. Findings:1. During an observation on 6/16/25, at 1:15 p.m., CNA B carried soiled linens out of Resident 3's room with her gloved hands and walked in the hallway. One piece of the soiled linens dropped down on the hallway floor. CNA B picked it up and continued walking in the hallway to the double door beside Resident 5's room, opened the double door to throw the soiled linen in the hamper which was parked outside.During a concurrent interview with CNA B, she stated she should remove her gloves in the resident room and should not carry soiled linens out of the resident room and in the hallway. CNA B stated she should place the soiled linens in a plastic bag and throw the bag in the hamper. 2. During an observation with the maintenance director (MD) on 6/17/25, at 1:45 p.m., a soiled pillowcase was on the floor behind the open door in room [ROOM NUMBER].During a concurrent interview with registered nurse D (RN D), she stated one of the residents in room [ROOM NUMBER] was moved to a different room, and the other resident was discharged . RN D stated the staff prepared the room for new residents this morning, and the soiled pillowcase should not be left on the floor.Review of the facility's undated policy, Glove Use, indicated . B. Used gloves should be discarded into the nearest waste receptacle inside the room.Review of the facility's policy, Handling Soiled Linen, dated 6/11/25, indicated . 3. Linen should not be allowed to touch the uniform or floor . 4. Used or soiled linen shall be collected at the bedside or point of use and placed in a linen bag or designated lined receptacle. 3. During an observation on 6/17/25, at 3:45 p.m., CNA C was cleansing Resident 4 who was on EBP and did not wear a gown. CNA C only had gloves on.During an interview with CNA C on 6/17/25, at 3:50 p.m., he stated Resident 4 had bowel movement, so he cleansed her and changed her brief. CNA C observed the EBP sign that was posted on Resident 4's room door and stated he should put on a gown and gloves when cleansing Resident 4 and changing her brief.During an interview with the infection preventionist (IP) on 6/20/25, at 9:20 a.m., she stated the staff should remove their gloves in the resident room and should not carry soiled linens out of the resident room and in the hallway. The IP stated soiled linens should not be let touch the floor, and the CNAs should put on gowns and gloves when providing incontinent care to residents who were on EBP.Review of the facility's posting sign, Enhanced Barrier Precautions, indicated . Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: . Changing briefs or assisting with toileting .</p>		