STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055315	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grant Cuesta Sub-Acute and Rehabilitation Center	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)
F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prepare and ensure a safe and appropriate discharge for one of three residents (Resident 1) when:1. Resident 1's fall risk level was not updated;2. Resident 1's discharge minimum data set (MDS, a clinical assessment tool) was not accurately coded;3. The facility did not provide discharge notice (a written notice in advance to the resident and the resident's representative in a language and manner they understand and an opportunity to appeal) to Resident 1 and/or her son (Resident 1's co-health care decision maker). Resident 1 also did not have a discharge care plan and did not have discharge notes on the day of her discharge; and4. The facility did not verify the license and the care capabilities of the discharge placement facility.These failures resulted in Resident 1 who had severe cognitive impairment (a significant decline in a person's ability to think, learn, remember, use judgement, and make decisions that can lead to a point where the individual is incapable of living independently because of the inability to plan and carry out activities of daily living [ADL, the tasks of everyday life] and apply judgment), poor recent memory, poor insight and judgment, mental illness, required a Preadmission Screening and Resident Review Level 2 (PASRR Level 2, a comprehensive, person-centered evaluation conducted for individuals identified by a Level 1 screening as having or potentially having a Serious Mental Illness [SMI], Intellectual Disability [ID, a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently], Developmental Disability [DD, a group of conditions due to an impairment in physical, learning, language, or behavior areas], or related condition), and required moderate to maximal assistance or dependent on the staff for ADL was discharged to an unlicensed Room and Board (Independent Living, living accommodations and dining services) on 5/22/25. Resident 1 fell at the discharge placement facility and was sent to acute care on 6/11/25. Findings:1. Review of Resident 1's admission Record indicated she was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (cancer, an abnormal growth of cells) of left breast, diabetes (high blood sugar levels), protein-calorie malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it gets), hyperlipidemia (high level of fats in the blood), hypertension (HTN, high blood pressure), reduced mobility (limitations in movement), muscle weakness, osteoporosis (a disease that weakens the bones; it makes the bones thinner and less dense than they should be), and depression (a persistent feeling of sadness and loss of interest and can interfere with the daily life).Review of Resident 1's clinical record indicated she did not have quarterly fall risk assessments from 8/22/24 to the day of her discharge on [DATE] (two quarterly assessments).During an interview with the director of nursing (DON) on 7/28/25, at 4:10 p.m., he reviewed Resident 1's clinical record and confirmed that Resident 1 did not have quarterly fall risk assessments from 8/22/24 to the day of her discharge on [DATE]. The DON stated the resident fall risk assessment should be done every quarter.2. During an interview with certified nursing assistant A (CNA A) on 7/30/25, at 1:40 p.m., CNA A stated before the discharge of Resident 1 was dependent on staff for shower and upper and lower body dressing and needed maximal assistance (the helper does more than half the effort) for personal hygiene.During an interview with certified nursing assistant B (CNA B) on 7/30/25, at 2 p.m., CNA B stated before the discharge Resident 1 was dependent on staff for shower, upper and lower body dressing, and personal hygiene.During an interview with certified nursing assistant C (CNA C) on 7/30/25, at 2:15 p.m., CNA C stated before the discharge Resident 1 was dependent on staff for shower and upper and lower body dressing and needed maximal assistance for personal hygiene.During an interview with certified nursing assistant D (CNA D) on 7/30/25, at 3:20 p.m., CNA D stated before the discharge Resident 1 needed moderate assistance (the helper does less than half the effort) for upper and lower body dressing and needed maximal assistance for shower and personal hygiene.During an interview with certified nursing assistant E (CNA E) on 7/30/25, at 3:50 p.m., CNA E stated before the discharge Resident 1 needed a lot of help; Resident 1 was dependent on staff for shower, upper and lower body dressing, and personal hygiene.Review of Resident 1's 5/2025 Document Survey Report V2 (Resident 1's Daily ADL status reported by the CNAs) indicated that for the last three days of her stay (from 5/20/25 to 5/22/25) at the facility she needed maximal assistance for bathing and needed moderate to maximal assistance for upper and lower body dressing and personal hygiene.However, review of Resident 1's discharge MDS on 5/22/25 indicated it was coded that Resident 1 needed moderate assistance for bathing and supervision for upper and lower body dressing and personal hygiene.During an interview with the MDS director (MDSD) on 7/30/25, at 2:45 p.