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	03/28/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50855 Based on observation, interview, and record review, the facility failed to promote and maintain resident dignity during mealtime for one out of two residents (Resident 49) when Certified Nursing Assistant B (CNA B) was standing while providing feeding assistance to Resident 49 during meal. This failure had the potential for violation of the resident's dignity. During an observation in Resident 49's room on 3/24/25 at 12:33 p.m., with Certified Nursing Assistant B (CNA B), during lunch, CNA B was observed standing while providing feeding assistance to Resident 49. Resident 49 was lying on his bed, the head of the bed was elevated, the meal tray was on top of bedside table across the bed, Resident 49 was not at eye level with CNA B. CNA B was standing, holding the spoon with food and bringing to Resident 49's mouth. During an interview on 3/24/25 at 1:03 p.m., with CNA B, she confirmed the observation. CNA B stated she was standing because there was no chair inside Resident 49's room. During a review of Resident 49's clinical record indicated Resident 49 was admitted to the facility with diagnoses including Dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning). During a review of Resident 49's clinical record Task GG (a standardized functional assessment used in post-acute care settings to measure self-care and mobility abilities): eating, Question 1 ability to use utensils to bring food and/or liquid to the mouth . indicated, Resident 49 was dependent on 18 occasions from 3/1/25 to 3/26/25. During an interview on 3/26/25 at 4:26 p.m., with the Director of Nursing (DON), the DON was asked in terms of dignity during meals for resident with feeding assistance. The DON stated they [staff] should be sitting when feeding the patients [residents], and should be at eye level. During a review of facility's Polciy & Procedure (P&P) titled, Promoting/Maintaining Resident Dignity During mealtimes, revised date 10/21/2024, the P&P indicated, . 1. All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during meals .5. All staff will be seated, if possible, while feeding resident .

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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 44583 Based on observation, interview, and facility's document review, the facility failed to maintain resident's rights to privacy and confidentiality to four of 18 sampled residents when Residents 35, 56, 91 and 2's personal information and care instructions were posted in the room visible to their roommate's visitors. This failure had the potential to compromise resident's rights. Findings: 1. During an observation on 3/24/2025 at 9:12 a.m., inside Resident 35's room, Resident 35 was sharing a room with two other residents. Resident 35 was asleep and there were two care instructions posted at the wall: a. one care instruction was posted at the wall above Resident 35's head of bed (HOB) indicated, Mr. [Resident 35's initials] PLEASE HAVE HIM SIT UP IN WHEELCHAIR DAILY FROM 2 - 4 PM IN ACTIVITIES b. and the second care instruction was posted at the wall located to the left side of Resident 35's bed beside his picture indicated, Attention Staff:) Please assist resident down to Activities on the following days. >Tuesday at 2 pm for social & movie & popcorn. > Fridays at 9:30am for morning social Thank you, Activity Staff:) During a concurrent observation and interview with licensed vocational nurse E (LVN E) on 3/25/2025 at 8:40 a.m., inside Resident 35's room, the care instructions were still posted. LVN E confirmed above observation and stated the postings of Resident 35's care instruction should be covered. 2. During an observation on 3/24/2025 at 9:16 a.m., inside Resident 56's room, Resident 56 was in bed asleep, and observed a posting of his care instruction at the wall above his HOB. The posting indicated, Please Remove the ACE wrap when patient is ready for sleep. Thank you! Treatment Nurses. Resident 56 was sharing a room with two other residents. During a concurrent observation and interview with registered nurse H (RN H) on 3/24/2025 at 12:50 p.m., in Resident 56's room entrance, the posting above his HOB could easily be seen just at his room entrance. RN H confirmed above observation and stated she was not the one who posted the care instruction. RN H further stated the care instruction posted above Resident 56's HOB should be covered. 3. During an observation on 3/24/2025 at 11:25 a.m., inside Resident 91's room, Resident 91 was sharing the room with one resident. Resident 91 was seated on his wheelchair and observed a posting of his care instruction posted at the wall above his HOB. It indicated, [Resident 91's room number and full name], FLUID RESTRICTION. During a concurrent observation and interview with certified nursing assistant I (CNA I) on 3/25/2025 at 8:58 a.m., inside Resident 91's room, Resident 91 was in bed, and CNA I was providing Resident 91's morning care to get him ready for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). CNA I confirmed the care instruction posted and stated, should it be there? (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the director of nursing (DON) on 3/28/2025 at 8:39 a.m., the DON stated resident's care instruction should be covered to provide resident's privacy. 50135 4. During an observation on 3/24/2025 at 11:10 a.m., inside Resident 2's room, Resident 2 was awake and sitting in the wheelchair next to her bed. Resident 2 was sharing a room with two other residents. There were two pink sheets of paper labeled, Care Instructions, posted on the wall above Resident 2's head of bed. There were no care instructions located underneath both pink sheets of paper. There were two white sheets of paper posted on the wall on the right side of Resident 2's bed. One sheet indicated care instructions for enteral tube feedings (deliverance of liquid nutrition directly to the stomach through a tube) for Resident 2 and the second sheet indicated care instructions for positioning of Resident 2 while sitting in the wheelchair. During a concurrent observation and interview on 3/27/25 at 11:11 a.m., in Resident 2's room with the DON, the DON stated it was best practice to cover all care instructions for all residents to protect their privacy. During a review of the facility's policy and procedure titled, Dignity-Promoting/Maintaining Dignity, dated 10/2022, indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity .13. Maintain resident privacy .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview, and record review, the facility failed to complete a comprehensive minimum data set (MDS - a federally mandated resident assessment tool) admission assessment and the required discharge (DC) assessment in a timely manner for two of two residents (Residents 39 and 81). This failure resulted in Residents 39 and 81's admission and discharge assessment not completed within the time requirement and had a potential to result in inappropriate care planning and intervention. Findings: 1.Review of Resident 39's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a medical condition that affects brain function, leading to a wide range of symptoms like confusion, drowsiness, difficulty concentrating, seizures, and muscle weakness), type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar), and unspecified dementia (decline in mental capacity affecting daily function), severe, with other behavioral disturbance. Review of Resident 39's list of MDS assessments indicated the following: - Admission/5-day assessment dated [DATE], indicated it was completed and signed by registered nurse (RN) on 12/4/2024; and - DC assessment-return anticipated dated 11/18/2024, indicated it was completed and signed by RN on 12/8/2024. During a concurrent interview with the minimum data set coordinator (MDSC) and record review on 3/26/2025 at 10:23 a.m., the MDSC reviewed Resident 39's Admission/5-day assessment and DC assessment return anticipated. MDSC confirmed both assessments were completed late. The MDSC stated Resident 39's Admission/5-day assessment should have been completed on 11/27/2024, which was the thirteenth day from Resident 39's admission. The MDSC confirmed she should have just completed a combined 5-day and DC assessment return anticipated instead of completing them separately since Resident 39 stayed at the facility for only 5 days. The MDSC stated the DC assessment should have been completed on 12/2/2024, which was the fourteenth day of Resident 39's DC. The MDSC further stated, she was on vacation on November 2024, and it was the other MDS nurse who completed both assessments. 2. Review of Resident 81's clinical record titled, Admission Record, dated 3/27/2025, indicated, Resident 81 was admitted to the facility on [DATE] with diagnoses including hypo-osmolality (refers to a low concentration of solutes [a substance that is dissolved in a solution] in the body's fluids, particularly the blood), and hyponatremia (when the amount of sodium in the blood is too low), and parkinsonism (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance and posture). Review of Resident 81's list of MDS assessments indicated the following: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was no DC MDS assessment completed for Resident 81 when Resident 81 discharged on [DATE]. - Admission assessment dated [DATE] was completed and signed by RN on 11/28/2024. During a concurrent interview with MDSC and record review on 3/25/2025 at 10:31 a.m., MDSC reviewed the list of Resident 81's MDS assessments and confirmed there was no DC MDS assessment completed. MDSC stated there should have been a DC assessment completed and it should be dated on 11/25/2024. MDSC continued to review Resident 81's Admission assessment and confirmed it was completed late. MDSC stated the admission assessment should have been completed on 11/20/2024 which was the thirteenth day from Resident 81's admitted . MDSC stated she was on vacation in November and came back on December 2024. Review of Center for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (CMS's LTCF RAI - a guide for facility staff to existing coding and transmission) Manual 3.0 Version 1.19.1, dated 10/2024, indicated, Admission (Comprehensive) - MDS Completion Date No Later Than - 14th calendar day of the resident's admission (admitted + 13 calendar days) . Discharge Assessment-return anticipated - MDS Completion Date No Later Than - discharge date + 14 calendar days.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure a significant change in status assessment (SCSA) was completed within 14 days after a significant change in the resident's physical or mental condition had been determined for one of 18 sampled residents (Resident 11). This failure had the potential of not providing the appropriate care and services to Resident 11. Findings: Review of Resident 11's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 11 was admitted to the facility with diagnoses of nondisplaced supracondylar fracture without intracondylar extension of lower end of left femur (broken thigh bone [femur] just above the knee, where the bone is broken but remains in its normal alignment, and the fracture doesn't extend into the knee joint), type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar), dementia(a group of symptoms affecting thinking and social abilities interfering with daily functioning), other chronic (something that continues over an extended period of time) pain, and retention of urine (a condition in which the patient is unable to empty all the urine from the bladder). Review of Resident 11's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation - an assessment tool used to facilitate prompt and appropriate communication of a problem]-Fall Report, dated 1/11/2025, it indicated Resident 11 had an un-witnessed fall. Further review, there was an interdisciplinary (IDT, team composed of members from different departments involved in resident's care) follow up which revealed, Resident found lying on the floor inside his room. He said he is trying to get his wallet. Denies hitting head. No injury noted. Review of Resident 11's clinical record titled, ED [emergency department] Provider Notes, dated 1/16/2025, it indicated, Resident 11 was transferred to ED. Further review indicated, BIBA [brought in by ambulance] for c/o [complained of] bilateral [both] femur fractures. Both fractures above the knee Per EMS [emergency medical services] report .Pt [patient] had a fall on Saturday and noted swelling and pain the next morning (Sunday) Xray showed fractures per EMS report . Resident 11 was transferred back to the facility on [DATE] with diagnoses including closed nondisplaced supracondylar fracture of distal end of left and right femur without intracondylar extension and acute (severe, or intense) pain of both knees. During a concurrent observation and interview with Resident 11 inside his room on 3/24/2025 at 9:08 a.m., Resident 11 was in bed, with urine bag hanged at the lower part of the bed, and a floor mat was located at the left side of his bed. Resident 11's bed was positioned in a regular height. Resident 11 stated he was okay. During another observation on 3/25/2025 at 8:33 a.m., inside Resident 11's room, Resident 11 was in bed, asleep, urine bag was hanged at the lower part of the bed, floor mat was located at the left side of the bed, and the bed was positioned in a regular height. During an interview with licensed vocational nurse E (LVN E) on 3/25/2025 at 8:35 a.m., LVN E confirmed Resident 11 used to attend group activities prior to his diagnosis of fracture. LVN E stated they allowed Resident 11 to stay in bed for comfort. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/2025 at 1:36 p.m., inside Resident 11's room, Resident I1 was in bed, intermittently (on and off) screaming with eyes closed. Resident 11's bed was positioned about this writer's waist level. During an interview with certified nursing assistant J (CNA J) on 3/26/2025 at 1:39 p.m., CNA J stated Resident 11 used to attend activities in the social dining room. CNA J further stated Resident 11 preferred to stay in bed after the fall. During a concurrent interview with the director of nursing (DON) and record review on 3/27/2025 at 9:43 a.m. , the DON reviewed Resident 11's SBAR on 1/11/2025, ED report, and 1/2025 medication administration record (MAR). DON confirmed Resident 11 had a fall on 1/11/2025 and sustained fractures to bilateral lower part of his femur. The DON further confirmed on 1/28/2025, there was an increased in Resident 11's Methadone (an opioid to treat moderate to severe pain) order from 2.5 milligram (mg - unit of measurement) twice daily to 5 mg twice daily and new order of hydrocodone-acetaminophen (a potent controlled medication for pain) 10-325 mg one tablet every 6 hours due to pain on his knees. During an interview with therapy director (TD) on 3/27/2025 at 10:19 a.m., TD stated Resident 11 was totally dependent with most of activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) even prior to the fall. TD confirmed Resident 11 required a hoyer lift (a mechanical device used to lift and/or transfer a person from place to place) transfer prior to the fall and could tolerate sitting up on a wheelchair. During a concurrent interview with the minimum data set coordinator (MDSC) and record review on 3/28/2025 at 10:30 a.m., the MDSC reviewed Resident 11's list of minimum data set (MDS - a federally mandated resident assessment tool) assessments and confirmed there was no SCSA completed since January 11, 2025. The MDSC stated they would complete a SCSA if there were at least 2 or more decline or improvement in resident's mobility or status. MDSC stated Resident 11 had no change in his functional mobility but due to his new fractures in January, increased pain and inability to attend group activities, the MDSC confirmed they should have completed a SCSA. The MDSC further stated, Resident 11's changes should have been discussed with the IDT when he came back from the hospital. During an interview with the activity assistant (AA) on 3/28/2025 at 1:11 p.m., the AA confirmed Resident 11 used to attend their morning activities but lately, they were just doing room visits. The AA stated Resident 11 couldn't tolerate when seated on a wheelchair. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Center for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (CMS's LTCF RAI - a guide for facility staff to existing coding and transmission) Manual 3.0 Version 1.19.1, dated 10/2024, indicated, The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline .A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met. After the IDT has determined that the resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50855 Based on interview and record review, the facility failed to ensure a baseline care plan was completed within 48 hours of admission for one of two residents (Resident 50). This failure had the potential for the resident and/or responsible party (RP) to be unaware of the plan of care. Findings: During a review of Resident 50's clinical record, it indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance and posture) and history of falling. During a review of Resident 50's care plan Admission Baseline it was initiated on 3/25/25. The admission baseline care plan was developed six days after Resident 50 was admitted to the facility on [DATE]. During a review of Resident 50's interdisciplinary team (IDT- a group of health care professionals from diverse fields who work toward a common goal for residents) admission assessment dated , 3/20/25 was incomplete, there were missing Resident signature, and representative signature. During a concurrent interview and record review on 3/28/25 at 2:43 p.m., with the Director of Nursing (DON), the DON reviewed Resident 50's care plan Admission Baseline and IDT admission assessment. The DON confirmed Admission Baseline was initiated on 3/25/25, 6 days after Resident 50 was admitted and the IDT admission assessment was incomplete. The DON stated baseline care plan or admission baseline plan should be done within 48 hours upon admission. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, revised date 9/18/2024, the P&P indicated, 1. The baseline care plan will: a. Be developed within 48 hours of resident's admission .3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed . 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview, and record review, the facility failed to develop and implement individualized, resident-centered, care plans for seven of 18 sampled residents (Residents 62, 11, 68, 91, 40, 59, and 98) when: 1. Resident 62's diagnosis of Post Traumatic Stress Disorder was not addressed; 2. Resident 11's new diagnosis of closed nondisplaced supracondylar fracture of distal end of left and right femur without intracondylar extension (broken thigh bone [femur] just above the knee, where the bone is broken but remains in its normal alignment, and the fracture doesn't extend into the knee joint), was not developed and implemented since 1/17/2025, and fall care plan intervention was not implemented; 3. Bed rail (also known as side rail, a barrier attached to the side of bed, designed to prevent falls or assist with mobility) care plan used for Resident 68 was not developed; 4. Resident 91's fall care plan intervention was not implemented; 5. Resident 40's Left and Right heel pressure injury (also known as bedsores, pressure sores, or pressure ulcers, are areas of skin and underlying tissue damage caused by prolonged pressure, often occurring over bony prominences.) care plans were not developed; 6. Resident 59's care plan for pressure injury was not patient centered; and 7. Resident 98's MASD (MASD (Moisture-Associated Skin Damage, a term referring to inflammation and/or erosion of the skin caused by prolonged exposure to moisture sources) care plan were not developed. These failures had the potential to result in the inability to identify the resident's individualized care issues and implement person-centered care plans to address their respective identified needs. Findings: 1. A review of Resident 62's clinical record indicated she was admitted on [DATE] with diagnosis including Post Traumatic Stress Disorder (PTSD). A review of Resident 62's Minimum Data Assessment (MDS - an assessment tool) dated 3/3/25, indicated PTSD under Psychiatric/Mood Disorder in Section I - Active Diagnoses. A review of Resident 62's care plans indicated there was no care plan developed to address the diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review with the minimum data set coordinator (MDSC) on 3/8/25 at 1:25 p.m., Resident 62's MDS was reviewed. The MDSC confirmed that Resident 62 had a PTSD diagnosis listed on her admission record facesheet (document containing resident's key information.) The MDSC reviewed Resident 62's care plans and confirmed a PTSD care plan had not been developed and she stated a care plan should have been created. The MDSC stated a care plan should be developed to implement actions and interventions to address Resident 62's psychological needs. 44583 2a. Review of Resident 11's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 11 was admitted to the facility with diagnoses of nondisplaced supracondylar fracture without intracondylar extension of lower end of left femur, type 2 diabetes mellitus (DM - a condition which affects the way the body processes blood sugar), dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), other chronic (something that continues over an extended period of time) pain, and retention of urine (a condition in which the patient is unable to empty all the urine from the bladder). Review of Resident 11's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation - an assessment tool used to facilitate prompt and appropriate communication of a problem]-Fall Report of Incident, dated 1/11/2025, it indicated Resident 11 had an un-witnessed fall. Further review, there was an interdisciplinary (IDT, team composed of members from different departments involved in resident's care) follow up which revealed, Resident found lying on the floor inside his room. He said he is trying to get his wallet. Denies hitting head. No injury noted. Review of Resident 11's clinical record titled, ED [emergency department] Provider Notes, dated 1/16/2025, it indicated, Resident 11 was transferred to ED. Further review indicated, BIBA [brought in by ambulance] for c/o [complained of] bilateral [both] femur fractures. Both fractures above the knee Per EMS [emergency medical services] report .Pt [patient] had a fall on Saturday and noted swelling and pain the next morning (Sunday) Xray showed fractures per EMS report . Resident 11 was transferred back to the facility on [DATE] with diagnoses including closed nondisplaced supracondylar fracture of distal end of left and right femur without intracondylar extension and acute (severe, or intense) pain of both knees. During an interview with licensed vocational nurse E (LVN E) on 3/25/2025 at 8:35 a.m., LVN E confirmed Resident 11 used to attend group activities prior to his diagnosis of fracture. LVN E stated they allowed Resident 11 to stay in bed for comfort. During an interview with certified nursing assistant J (CNA J) on 3/26/2025 at 1:39 p.m., CNA J stated Resident 11 used to attend activities in the social dining room. CNA J further stated Resident 11 preferred to stay in bed after the fall. During a concurrent interview with the director of nursing (DON) and record review on 3/27/2025 at 9:43 a.m. , the DON reviewed Resident 11's SBAR on 1/11/2025, ED report, and list of care plans. The DON confirmed Resident 11 had a fall on 1/11/2025 and sustained fractures to bilateral lower part of his femur. Further review, the DON confirmed there was no care plan developed for the new diagnosis of fracture when Resident 11 came back from the hospital on 1/17/2025. The DON stated there should have been a new care plan developed for staff to know how to manage Resident 11's new condition. (continued on next page)

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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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the minimum data set coordinator (MDSC) and record review on 3/28/2025 at 10:30 a.m., the MDSC reviewed Resident 11's list of minimum data set (MDS - a federally mandated resident assessment tool) assessments and care plans. The MDSC confirmed there was no care plan developed for Resident 11's new fracture since 1/17/2025. The MDSC stated the IDT should have discussed Resident 11's new condition when he came back from the hospital for them to develop the care plan. 2b. During a concurrent observation and interview with Resident 11 inside his room on 3/24/2025 at 9:08 a.m. , Resident 11 was in bed, with urine bag hanged at the lower part of the bed, and a floor mat was located at the left side of his bed. Resident 11's bed was positioned in a regular height. Resident 11 stated he was okay. During another observation on 3/25/2025 at 8:33 a.m., inside Resident 11's room, Resident 11 was in bed, asleep, urine bag was hanged at the lower part of the bed, floor mat was located at the left side of the bed, and the bed was positioned in a regular height level. During an observation on 3/26/2025 at 1:36 p.m., inside Resident 11's room, Resident 11 was in bed, intermittently (on and off) screaming with eyes closed. Resident 11's bed was positioned about this writer's waist level. During a concurrent observation and interview with registered nurse K (RN K) on 3/28/2025 at 3:32 p.m., inside Resident 11's room, Resident 11's bed was positioned in a regular height level. RN K confirmed above observation and stated Resident 11's bed was not in the lowest level. RN K stated Resident 11 was a fall risk and his bed should always be positioned in the lowest level as planned. During a review of Resident 11's actual fall care plan dated 9/19/2019, one intervention indicated, Bed in the lowest position. 3. Review of Resident 68's clinical record titled, Admission Record, dated 3/26/2025, indicated Resident 68 was readmitted to the facility with diagnoses including dementia, severe, with other behavioral disturbance (unusual, disruptive, or problematic behaviors that deviate from typical patterns and cause distress or impairment in daily functioning), epilepsy (a brain disorder characterized by recurrent, unprovoked seizures) , and delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined). Review of Resident 68's clinical record titled, Bed Rail Safety Assessment, dated 11/8/2024, revealed Resident 68 had an indication for bed rail use. During observations inside Resident 68's room on 3/24/2025 at 9:37 a.m., Resident 68 was seated on a wheelchair, and her bed was observed with two upper bed rails installed and in upright position. During a concurrent observation and interview with LVN E on 3/26/2025 at 8:41 a.m., inside Resident 68's room, Resident 68 was in bed with two upper bed rails in upright position. LVN E confirmed above observation and stated Resident 68 used the bed rails for repositioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with DON and record review of Resident 68's list of care plans on 3/28/2025 at 8:24 a.m., DON confirmed there was no care plan developed for Resident 68's bed rail used. DON stated there should have been a care plan developed for Resident 68's bed rail use since it was determined it was indicated to assist in repositioning. 4.Review of Resident 91's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), type 2 DM with diabetic neuropathy (with nerve damage), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dependence on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). Review of Resident 91's clinical record titled, Fall Risk Assessment, dated 1/11/2025, it indicated Resident 91 had a score of 55 (Morse Fall Scoring: High Risk 45 and higher; Moderate Risk 25-44 and Low Risk 0-24). Review of Resident 91's clinical record titled, SBAR-Fall Report of Incident, dated 3/5/2025, it indicated Resident 91 had an un-witnessed fall in his room. Further review revealed Resident 91 was found sitting on the floor next to his bed and did not sustain any injury. During a concurrent observation and interview with Resident 91 on 3/28/2025 at 10:50 a.m., inside Resident 91's room, Resident 91 was in bed and was observed he wearing a yellow band to his left wrist which indicated, FALL RISK. Resident 91's bed was positioned in a regular height level, which was about this writer's waist level. Resident 91 stated he fell on e time, and he was okay. During a concurrent observation and interview with registered nurse H (RN H) on 3/28/2025 at 11:01 a.m., inside Resident 91's room, RN H confirmed above observation and stated Resident 91's bed should be in a lowest position. RN H confirmed Resident 91 was a fall risk resident. During a review of Resident 91's care plan titled, At risk for falls and injuries . dated 1/11/2025, one of the interventions indicated, Low Bed. Date Initiated: 03/25/2025. During a review of the facility's policy and procedure titled, Care Plan, Comprehensive, dated 12/2017, indicated, It is the policy of this facility to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs. 50855 5. During a review of Resident 40's clinical record indicated Resident 40 was admitted to the facility with diagnosis including Peripheral artery disease (PAD a condition where the arteries that carry blood away from the heart to the limbs (usually the legs) become narrowed or blocked). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's physician's order, it indicated an order for Left heel stage 4: Cleanse w/ Dakins (wound care products), pat dry, apply Santyl (used to remove damaged tissue from chronic skin ulcers and severely burned areas)to wound bed, cover the eschar w/ betadine soaked gauze and cover the heel with gauze Kerlex (bulky gauze bandage primarily used for wound dressing) daily, dated 2/27/25 During a review of Resident 40's physician's order, it indicated an order for Right heel stage 4 dressing: Cleanse w/ Dakins, apply Santyl to wound bed, cover w/ ca (calcium) alginate (a water-insoluble, gelatinous substance used in various applications, including wound dressing) wound and eschar area, and pad, kerlex roll daily, dated 2/27/25. During a review of Resident 40's clinical record, it indicated there were no care plans developed for Resident 40's left and right heel pressure injury stage 4. During a concurrent interview and record review on 3/26/25 at 4:11 p.m., with the Director of Nursing (DON), the DON reviewed Resident 40's care plan. The DON confirmed there were no care plan develop for Resident 40's left and right heel stage 4 pressure injury. The DON further stated, Resident 40 should have care plans for left and right heel stage 4 pressure injury. During a review of facility's P&P titled, Care Plan, Comprehensive, dated 12/2017, the P&P indicated, . PROCEDURE; 1. Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .5. Each plan should include measurable goals and associated time-frames and responsibility.6. Individualized Care Plans should be accessible to all caregivers . 6.During a review of Resident 59's clinical record indicated Resident 59 was admitted to the facility with diagnoses including malignant neoplasm (abnormal growth of cells that invade and spread to other parts of the body) and muscle weakness. During a review of Resident 59's physician's order, it indicated an order for Stage 2 pressure injury to R (right) buttock: cleanse w/ (with) NSS (normal saline), part dry and apply triad (Wound Dressing is for the local management of pressure) paste then cover with foam dressing, dated 3/10/25. During a review of Resident 59's clinical record, it indicated a care plan, dated 3/10/25, The resident has stage 2 pressure injury to R buttock the intervention indicated, Treatment per order. During a concurrent interview and record review on 3/28/25 at 9:31 a.m., with the Director of Nursing (DON), the DON reviewed Resident 59's care plan. The DON confirmed there is only one intervention for Resident 59's stage 2 pressure injury to right buttock. The DON stated it's not a patient centered, there should have more interventions on care plan for Resident 59's stage 2 pressure injury to right buttock. During a review of facility's P&P titled, Care Plan, Comprehensive, dated 12/2017, the P&P indicated, . PROCEDURE; 1. Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .5. Each plan should include measurable goals and associated time-frames and responsibility.6. Individualized Care Plans should be accessible to all caregivers . DOCUMENTATION GUIDELINES, Document may include: . Resident specific focus, goals and interventions . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During a review of Resident 98's clinical record indicated Resident 98 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar). During a review of Resident 98's physician's order indicated an order for Sacrococcyx (The sacrum and coccyx are two bones located at the base of the spine) scattered MASD Cleanse w/ NS (normal saline), apply Triad and foam dressing daily, dated 3/13/25. During a review of Resident 98's clinical record indicated there were no care plans developed and implemented for Resident 98's Sacrococcyx scattered MASD. During a concurrent interview and record review on 3/28/25 at 9:34 a.m., with the DON, the DON reviewed Resident 98's care plan. The DON confirmed there was no care plan develop for Resident 98's Sacrococcyx scattered MASD. The DON further stated there should have care plan develop for Resident 59's Sacrococcyx scattered MASD. During a review of facility's P&P titled, Care Plan, Comprehensive, dated 12/2017, the P&P indicated, . PROCEDURE; 1. Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .5. Each plan should include measurable goals and associated time-frames and responsibility.6. Individualized Care Plans should be accessible to all caregivers .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure care plans were reviewed and updated by the interdisciplinary team (IDT, a group of health care professionals from diverse fields who work in a coordinated fashion toward the common goal for the resident for two of 18 sampled residents (Residents 11 and 68) when: 1. Resident 11's fall, activity and pain care plans were not updated after a significant change in status; and 2. Resident 68's care plan for antipsychotic (a type of drug used to treat symptoms of psychosis) use was not updated. This deficient practice had the potential to compromise resident's health, safety and psychosocial well-being. Findings: 1. Review of Resident 11's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 11 was admitted to the facility with diagnoses of nondisplaced supracondylar fracture without intracondylar extension of lower end of left femur (broken thigh bone [femur] just above the knee, where the bone is broken but remains in its normal alignment, and the fracture doesn't extend into the knee joint), type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar), dementia(a group of symptoms affecting thinking and social abilities interfering with daily functioning), other chronic (something that continues over an extended period of time) pain, and retention of urine (a condition in which the patient is unable to empty all the urine from the bladder). Review of Resident 11's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation - an assessment tool used to facilitate prompt and appropriate communication of a problem]-Fall Report, dated 1/11/2025, it indicated Resident 11 had an un-witnessed fall. Further review, there was an interdisciplinary (IDT, team composed of members from different departments involved in resident's care) follow up which revealed, Resident found lying on the floor inside his room. He said he is trying to get his wallet. Denies hitting head. No injury noted. Review of Resident 11's clinical record titled, ED [emergency department] Provider Notes, dated 1/16/2025, it indicated, Resident 11 was transferred to ED. Further review indicated, BIBA [brought in by ambulance] for c/o [complained of] bilateral [both] femur fractures. Both fractures above the knee Per EMS [emergency medical services] report .Pt [patient] had a fall on Saturday and noted swelling and pain the next morning (Sunday) Xray showed fractures per EMS report . Resident 11 was transferred back to the facility on [DATE] with diagnoses including closed nondisplaced supracondylar fracture of distal end of left and right femur without intracondylar extension and acute (severe, or intense) pain of both knees. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 11 inside his room on 3/24/2025 at 9:08 a.m., Resident 11 was in bed, with urine bag hanged at the lower part of the bed, and a floor mat was located at the left side of his bed. Resident 11's bed was positioned in a regular height. Resident 11 stated he was okay. During another observation on 3/25/2025 at 8:33 a.m., inside Resident 11's room, Resident 11 was in bed, asleep, urine bag was hanged at the lower part of the bed, floor mat was located at the left side of the bed, and the bed was positioned in a regular height. During an interview with licensed vocational nurse E (LVN E) on 3/25/2025 at 8:35 a.m., LVN E confirmed Resident 11 used to attend group activities prior to his diagnosis of fracture. LVN E stated they allowed Resident 11 to stay in bed for comfort. During an observation on 3/26/2025 at 1:36 p.m., inside Resident 11's room, Resident 11 was in bed, intermittently (on and off) screaming with eyes closed. Resident 11's bed was positioned about this writer's waist level. During an interview with certified nursing assistant J (CNA J) on 3/26/2025 at 1:39 p.m., CNA J stated Resident 11 used to attend activities in the social dining room. CNA J further stated Resident 11 preferred to stay in bed after the fall. During a concurrent interview with the director of nursing (DON) and record review on 3/27/2025 at 9:43 a.m. , the DON reviewed Resident 11's SBAR on 1/11/2025, ED report, list of care plans and 1/2025 medication administration record (MAR). the DON confirmed Resident 11 had a fall on 1/11/2025 and sustained fractures to bilateral lower part of his femur. The DON further confirmed on 1/28/2025, there was an increased in Resident 11's Methadone (an opioid to treat moderate to severe pain) order from 2.5 milligram (mg - unit of measurement) twice daily to 5 mg twice daily and new order of hydrocodone-acetaminophen (a potent controlled medication for pain) 10-325 mg one tablet every 6 hours due to pain on his knees. The DON confirmed Resident 11's fall and pain care plans were not reviewed and updated. The DON stated the mentioned care plans should have been revised or updated based on Resident 11's changed in condition. During an interview with the therapy director (TD) on 3/27/2025 at 10:19 a.m., The TD stated Resident 11 was totally dependent with most of activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) even prior to the fall. TD confirmed Resident 11 required a hoyer lift (a mechanical device used to lift and/or transfer a person from place to place) transfer prior to the fall and could tolerate sitting up on a wheelchair. During a concurrent interview with the minimum data set coordinator (MDSC) and record review on 3/28/2025 at 10:30 a.m., the MDSC reviewed Resident 11's fall, pain and activity care plans and confirmed they were not updated. The MDSC stated these were missed because they (IDT) missed to discussed Resident 11's condition when he came back from the hospital. During an interview with the activity assistant (AA) on 3/28/2025 at 1:11 p.m., the AA confirmed Resident 11 used to attend their morning activities but lately, they were just doing room visits. The AA stated Resident 11 couldn't tolerate when seated on a wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with activity manager (AM) from another facility on 3/28/2025 at 2:58 p.m., AM stated the activity care plan should have been revised especially Resident 11 was unable to attend the group activities anymore. During a review of Resident 11's activity care plan, it indicated an intervention initiated on 12/20/2016 and revised on 2/27/2020, revealed, Will encourage and assist resident to be out of bed at least 2x a week to attend the group activity. 2. Review of Resident 68's clinical record titled, Admission Record, dated 3/26/2025, indicated Resident 68 was readmitted to the facility with diagnoses including dementia, severe, with other behavioral disturbance (unusual, disruptive, or problematic behaviors that deviate from typical patterns and cause distress or impairment in daily functioning), epilepsy (a brain disorder characterized by recurrent, unprovoked seizures) , and delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined). During an observation inside Resident 68's room on 3/24/2025 at 9:37 a.m., Resident 68 was seated on a wheelchair, and was talking to self. Another observation and concurrent interview with Resident 68's family member (FM) at 12:38 p.m., Resident 68 was eating lunch with FM's assistance and supervision. FM stated, my mom has grade 7 dementia, During a concurrent observation and interview with certified nursing assistant L (CNA L) on 3/25/2025 at 8:50 a.m., inside Resident 68's room, Resident 68 was seated on a wheelchair and continuously talking. CNA L was observed seated on a chair in front of Resident 68. CNA L stated she was the sitter (a caregiver who provides companionship and supervision to patients who need constant observation or assistance, often due to medical conditions or behavioral issues that could pose a risk) for Resident 68 because she was at risk of falling. During an interview with licensed vocational nurse E (LVN E) on 3/26/2025 at 8:41 a.m., LVN E stated Resident 68 had an aggressive behavior and used to wander at the facility. LVN E confirmed Resident 68 had a sitter to prevent her from wandering and elopement (the act of a patient leaving a healthcare facility without authorization or supervision). Review of Resident 68's clinical record titled Order Summary Report, date ordered 3/10/2025, indicated, QUEtiapine Fumarate [an antipsychotic drug] Tablet 50 MG Give 1 tablet by mouth two times a day for Mood disorder m/b [manifested by] yelling, striking out. Review of Resident 68's care plan for use of quetiapine, date initiated 11/9/2024, indicated an intervention, Monitor behavior for anti-psychotic Seroquel [brand name of quetiapine] for dx [diagnosis] mood/behavior M/B: aggressive behavior, getting out of bed and Tally Q [every] Shift. During a concurrent interview with DON and record review of Resident 68's order summary report and care plan for quetiapine use on 3/26/2025 at 2:17 p.m., DON confirmed the care plan for quetiapine use was not updated when the order was changed on 3/10/2025. DON stated Resident 68's target behavior should also reflect in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Care Plan, Comprehensive, dated 12/2017, indicated, Plans are reviewed and revised by the IDT at least quarterly, following completion of the MDS [minimum data set - federally mandated resident assessment tool] assessment or following an assessment for a significant change of condition .Resident progress is regularly evaluated, and approaches revised or updated as appropriate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice when: 1. Resident 89 did not have documentation for the care of her cast (is a device used to support healing by surrounding and immobilizing the area of the fracture) located in her extremity. 2. Resident 54 and Resident 156 did not have physician orders for PICC ((PICC, a thin, soft, long catheter [tube] that is inserted into a vein in arm, leg or neck and the tip of the catheter is positioned in a large vein that carries blood into the heart) line managment; 3. Residents 62, 73, 89, 153, and 156 did not have physician orders for use of side rails; 4. Resident 68's physician was not notified of resident's phenytoin test (to measure and monitor phenytoin [a drug used to treat or prevent seizures or convulsions that may be caused by epilepsy, brain surgery, or treatment for brain cancer] in the blood and to determine whether drug concentations are in the therapeutic range) result; 5.Resident 68 and Resident 91 did not have physician orders for bed/side rails used; 6. Residents 40, 38, 50, and 98 - did not have physician orders for side rails prior to use; 7. Resident 64 did not have a physician order for side rails. These failures had the potential to compromise the residents' health and well-being. Findings: 1. Review of Resident 89's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including fracture of the lower end of the radius (one of the 2 bones that make up the forearm, located on the thumb side), closed fracture (broken bone does not penetrate the skin) with routine healing, dementia (a decline in mental capacity affecting daily function). During an observation on 3/25/25 at 12:34 p.m., a hard cast was noted on Resident 89's right forearm. The cast extended from Resident 89's right hand, just below the fingers, to her right elbow. The integrity of the cast was compromised with shredded gauze visible, protruding from the edges of the cast along the length of the forearm. Review of Resident 89's Order Summary Report indicated there was no physician order for care and treatment of Resident 89's right forearm cast. Review of Resident 89's clinical record indicated there was no documentation addressing Resident 89's right forearm arm, and there was no care plan developed for the fractured radius and the presence of a cast on Resident 89's forearm. (continued on next page)

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	03/28/2025

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review with registered nurse G (RN G) on 3/26/25 at 8:30 a.m., she stated Resident 89 has a cast on her right forearm. RN G stated licensed nurses should check circulation, sensation, and color of an extremity that is casted. RN G reviewed Resident 89's physician orders, medication and treatment records and stated there were no orders to monitor Resident 89's casted right forearm. RN G reviewed Resident 89's care plans and stated there was no care plan addressing Resident 89's fractured right radius and presence of a cast. RN G stated there should be physician orders and a care plan for Resident 89's casted right forearm During an observation, interview and concurrent record review with the director of nursing (DON) on 3/26/25 at 8:30 a.m., he inspected Resident 89's casted right forearm and confirmed the cast integrity was compromised with shredded gauze visible protruding from the edges of the cast. The DON stated licensed nurses should monitor the casted extremity for sensation, color, signs and symptoms of impaired circulation and infection. The DON reviewed Residents 89's clinical record and confirmed there was no documentation related to resident's casted right arm: no care plan, no monitoring of the cast, no physician orders for cast care and treatment. The DON stated there should be orders and monitoring in place and a care plan addressing Resident 89's fracture right radius and presence of a cast. Review of the facility policy titled Cast Care, of Resident with Plaster Cast dated 2006, indicated documentation guidelines that included observations for circulation, irritation, pain and edema and notification of physician for any untoward signs or symptoms. The policy further indicated care plan documentation guidelines that included identifying the problem that necessitated application of a cast, indicating infection prevention measures, instructions for care of the cast, and type and frequency of peripheral circulation monitoring. 2a. During an observation on 3/27/25 at 2:48 p.m., Resident 54 had a PICC line with a transparent dressing on her right upper arm that was dated 3/21/25. A review of Resident 54's medication administration record (MAR), it indicated Resident 54 received intravenous Meropenem Solution (antibiotic used to treat infections caused by bacteria) twice a day in February from 2/19/25 to 2/2/25 and twice a day in March from 3/11/25 to 3/25/25. During an observation and concurrent interview with the director of nursing (DON) on 03/27/25 at 3:15 p.m., the DON confirmed the presence of a PICC line in Resident 54's upper right arm. The DON stated residents who have PICC lines require physician orders for insertion and care of the PICC line, and a care plan developed for PICC line care. The DON stated PICC line management included physician orders for changing the dressing every 7 days, monitoring the site for signs and symptoms of infection, and flushing the catheter before and after medications were given. During a concurrent record review of Resident 54's clinical record, the DON confirmed Resident 54 had received intravenous antibiotic as stated on the above dates in February and March. The DON confirmed there was no physician orders in place for Resident 54's PICC line. The DON further stated there were no physician orders for dressing changes, monitoring signs and symptoms of infection, or flushing the PICC line, and no care plan had been developed for Resident 54's PICC line. 2b. During an observation on 3/24/25 at 2:08 p.m., Resident 156 was observed with a PICC line in the right upper arm. The PICC line had a transparent dressing dated 3/23/25. Resident stated she was receiving intravenous antibiotic (drug used to treat infection) one time a day for an infection in her left foot. (continued on next page)

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 03/28/2025

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 156's clinical record indicated she was admitted on [DATE] with diagnoses including surgical amputation with acquired absence of left foot, acute osteomyelitis (infection in the bone) of left ankle and left foot, diabetes mellitus (inadequate control of blood levels of glucose). Review of Resident 156's physician orders indicated ceftriaxone sodium (antibiotic used to treat infections caused by bacteria) 2 Gram (unit of measure) intravenously in the evening for osteomyelitis until 4/11/25. Another physician order indicated to flush PICC with 10 milliliters (ml, a unit of measure) NS (normal saline) after med every shift. Catheter patency must be verified prior to each access. Resident 156's 3/2025 intravenous administration record (IAR) was reviewed. The IAR indicated the physician order to flush the PICC line was not documented as completed for 31 occasions during the month of March. There were no licensed nurse's initials on the IAR: 12 times on the day shift, 15 times on the evening shift, and 4 times on the night shift when the IAR was left blank for the flushing Resident 156's PICC line. During an interview with the DON on 3/27/25 at 2:00 p.m., he reviewed Resident 156's IAR and confirmed the PICC line flushes were not documented as completed on the above dates. The DON confirmed if the nurses performed the flushes, they should have documented in Resident 156's IAR. The DON acknowledged that if the flushes were not documented, they were not done. Review of Resident 156's clinical record indicated she had a PICC line in her right upper arm. There was no physician order to change the PICC line dressing. There was no documentation in Resident 156's clinical record to indicate dressing changes were being done. During an interview and concurrent record review with the DON on 3/27/25 at 2:00 p.m., he stated residents who have PICC lines require physician orders for care of the PICC line which includes changing the PICC line dressing every 7 days. The DON confirmed there were no physician orders to change Resident 156's PICC line dressing every 7 days, and he stated there should be dressing change orders. 3. During initial tour observations on 3/24/25 from 9:25 a.m. to 10:08 a.m., Residents 62, 73, 89, 153, and 156 were observed with upper quarter-length side rails (cover a portion of the bed, typically one fouth the length) on the bed. The side rails were fixed in the upright position. Review of Resident 62's, 73's, 89's, 153's, and 156's clinical records indicated there were no physician orders for the use of side rails. During an interview and concurrent record review with the director of nursing (DON) on 3/28/25 at 8:00 a.m., he confirmed Residents 62, 73, 89, 153, and 156 were using side rails on their beds. The DON confirmed there were no physician orders for the use of quarter-length side rails for Residents 62, 73, 89, 153, and 156 and he stated residents who have side rails in use should have a physician order. 44583 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident 68's clinical record titled, Admission Record, dated 3/26/2025, indicated Resident 68 was readmitted to the facility with diagnoses including dementia, severe, with other behavioral disturbance (unusual, disruptive, or problematic behaviors that deviate from typical patterns and cause distress or impairment in daily functioning), epilepsy (a brain disorder characterized by recurrent, unprovoked seizures[a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) , and delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined). Review of Resident 68's clinical record titled, Order Summary Report, date ordered 11/8/2024, indicated an order of Phenytoin Sodium 100 milligrams (mg - unit of measurement) two capsules in the morning and one capsule at bedtime for seizure. Review of Resident 68's recent diagnostic test results, dated 3/17/2025, it indicated Resident 68's phenytoin level was 3.0 (normal value 10.0-20.0) which was low. During a concurrent interview with the DON and record review of Resident 68's phenytoin level on 3/17/2025 and nursing progress notes on 3/26/2025 at 2:17 p.m., the DON confirmed Resident 68's phenytoin level was low and there was no documentation from nurses that the physician was notified. The DON stated nurses should have documented they notified the physician about Resident 68's low phenytoin level and the physician's answer or order, if any. During a review of the facility's policy and procedure titled, Provision of Physician Ordered Services, dated 2/5/2025, indicated, Qualified nursing personnel will receive and review the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Ordering Provider will be notified or results upon receipt if deemed critical and/or require immediate attention. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record. 5a. During an observation inside Resident 68's room on 3/24/2025 at 9:37 a.m., Resident 68 was seated on a wheelchair, and her bed was observed with two upper bed rails installed and in upright position. During a concurrent observation and interview with licensed vocational nurse E (LVN E) on 3/26/2025 at 8:41 a.m., inside Resident 68's room, Resident 68 was in bed with two upper bed rails in upright position. LVN E confirmed above observation and stated Resident 68 used the bed rails for repositioning. During a concurrent interview with the DON and record review of Resident 68's list of care plans and physician's order on 3/28/2025 at 8:24 a.m., the DON confirmed there was no physician's order for Resident 68's bed rail used. The DON stated the nurses should have obtained an order from Resident 68's physician prior to installation and used of bed rails. 5b. During an observation inside Resident 91's room on 3/24/2025 at 11:25 a.m., Resident 91 was seated on a wheelchair and his bed was observed with two upper bed rails installed and in upright position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with certified nursing assistant I (CNA I) on 3/25/2025 at 8:58 a.m., inside Resident 91's room, Resident 91 was in bed, and CNA I was providing Resident 91's morning care to get him ready for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Resident 91's bed had two upper bed rails installed and in upright position. CNA I confirmed observation and stated Resident 91 held on to the bed rails when she cleaned him. During a concurrent interview with the DON and record review of Resident 91's physician's order on 3/28/2025 at 8:38 a.m., the DON confirmed there was no physician's order for Resident 91's bed rail used. The DON stated there should have been a physician's order obtained first prior to installation and bed rail used. 50855 6a. During an observation in Resident 40's room on 3/24/25 at 10:51 a.m., Resident 40 was in bed. Resident 40's bed had bilateral (both) upper quarter side rails. During a review of Resident 40's clinical record indicated Resident 40 was admitted to the facility on [DATE]. During a review of Resident 40's order summary report, dated 3/27/25 at 09:52 PT (Pacific Time Zone) indicated there were no order for bilateral upper quarter side rails. During a concurrent interview and record review on 3/28/25 at 2:46 p.m., with the Director of Nursing (DON), the DON confirmed Resident 40 was using bilateral side rails. The DON reviewed Resident 40's order summary report and he stated there were no order for bilateral upper quarter side rails. The DON further stated Resident 40 should have a physician's order prior to use of side rails. 6b. During an observation in Resident 38's room on 3/24/25 at 12:23 p.m., Resident 38 was in bed. Resident 38's bed had bilateral upper quarter side rails. During a review of Resident 38's clinical record indicated Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's order summary report dated 3/27/25 at 09:41 PT indicated there were no order for bilateral upper quarter side rails. During a concurrent interview and record review on 3/28/25 at 2:48 p.m., with the Director of Nursing (DON), the DON confirmed Resident 38 has bilateral side rails in bed. The DON reviewed Resident 38's order summary report and he stated there is an order for bilateral upper quarter side rails, dated 3/28/25. The DON stated Resident 38 side rails order was just today. The DON further stated Resident 38 should have a physician's order prior to use of side rails. 6c. During an observation in Resident 50's room on 3/24/25 at 3:57 p.m., Resident 50 was lying in bed. Resident 50's bed had both upper quarter side rails. During a review of Resident 50's clinical record indicated Resident 50 was admitted to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 50's order summary report dated, 3/28/25 at 14:13 PT indicated there were no order for bilateral upper quarter side rails. During a concurrent interview and record review on 3/28/25 at 2:39 p.m., with the Director of Nursing (DON), the DON confirmed Resident 50 has bilateral side rails in bed. The DON reviewed Resident 50's order summary report and he stated there is an order for bilateral upper quarter side rails, dated 3/28/25. The DON stated Resident 50 side rails order was just today. The DON further stated Resident 50's side rails should be in physician's order upon admission. 6d. During an observation in Resident 98's room on 3/25/25 at 9:38 a.m., Resident 98 was lying in bed. Resident 98's bed had bilateral upper quarter side rails. During a review of Resident 98's clinical record indicated Resident 98 was admitted to the facility on [DATE]. Review of Resident 98's order summary report, dated 3/27/25 at 08:52 PT indicated there were no order for bilateral upper quarter side rails. During a concurrent interview and record review on 3/28/25 at 2:44 p.m., with the Director of Nursing (DON), the DON confirmed Resident 98 has bilateral side rails in bed. The DON reviewed Resident 98's order summary report and he stated there is an order for bilateral upper quarter side rails, dated 3/28/25. The DON stated Resident 98 side rails order was just today. The DON further stated the physician's order for Resident 98's side rails should be upon admission. 50135 7. During an observation on 3/24/25 at 9:45 a.m., inside Resident 64's room, 1/4 bilateral side rails were observed on the bed of Resident 64. Medical record review for Resident 64 indicated Resident 64's initial admission to the facility was on 12/19/22 and readmitted on [DATE]. During a concurrent interview and record review on 3/27/25 at 11:35 a.m., with the DON, the DON reviewed Resident 64's physician order and confirmed Resident 64 did not have an order for the use of bed rails prior to installation and use. The DON stated Resident 64 had been hospitalized a several times and the physician orders were not updated upon readmission to the facility. During an interview on 3/28/25 at 1:32 p.m., with the DON, the DON stated residents must be offered alternatives to bedrails, an informed consent for use of bedrails, a care plan, an assessment and a physician's order before bedrails are installed. During a review of the facility's policy and procedure titled Proper Use of Bed Rails, dated October 2022, indicated, Policy Explanation and Compliance Guidelines: .8 .the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50855 Based on observation, interview, and record review, the facility failed to inspect and ensure the Sharps container (a puncture-resistant container designed for the safe disposal of sharp medical instruments like needles, syringes, and scalpels, to prevent accidental injuries and ensure proper waste management.) were not overfilled for one of four medication carts (medication cart 4). When medication cart 4 was overfilled with syringes. This failure has the potential to cause injury to staff and residents in the facility. Finding: During an observation on 3/25/25 at 9:49 a.m., medication cart 4 was parked outside in the hallway near room [ROOM NUMBER], where residents were observed walking in the hallway. Medication cart 4's Sharps container was observed overfilled. Two used syringes with needles attached were outside the Sharps container door and the lid was open. During a concurrent observation and interview on 3/25/25 at 9:50 a.m., with Registered Nurse G (RN G), RN G was asked if the Sharps container was overfilled on medication cart 4. RN G checked the Sharps container, tried to close the Sharps container lid, but couldn't close the lid and the used syringes were not falling inside the Sharps container. RN G confirmed the Sharps container was overfilled. During a concurrent observation and interview on 3/25/25 at 9:54 a.m., with the Director of Nursing (DON), in the hallway. The DON checked the Sharps container on medication cart 4, and confirmed it was full of used syringes. The DON stated it is the routine of the medication nurse to check the level of the Sharps container. The DON stated that when the objects inside the Sharps container reaches the indicator line on the container it should be replaced. The DON further stated the Sharps container should not be overfilled. The DON stated this is to protect the staff and residents from needle pricks (a puncture made by a needle or similar sharp object, potentially causing pain or, in the case of a needlestick injury, a risk of infection from bloodborne diseases), especially those residents with dementia who might come in contact with the Sharps container. During a review of the facility's Policy & Procedure (P&P) titled HANDLING OF BIOHAZARDOUS WASTE, Revision date 1/1/14, the P&P indicated, .Containers used for biohazard waste shall be so secured as to deny access to unauthorized persons The following items shall be considered biohazardous and disposed of according to this procedure:. Three-quarters (3/4) full needle and syringe rigid impervious collection containers .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview and record review, the facility failed to ensure the proper care and treatment services for oxygen (O2, a colorless, odorless gas) use was provided for four of seven sampled residents (Residents 42, 155, 303, and 40) when: 1. Resident 42's O2 concentrator's (a device which concentrates the oxygen from ambient air) filter had a grayish substance build-up and there was no Oxygen in Use/No Smoking sign posted at the entrance or door of Resident 42's room; 2. Resident 155's oxygen concentrator's filters were dusty; 3. Resident 303's door or entance there was no sign posted for Oxygen in Use/No Smoking; and 4. Resident 40's door or entance there was no sign posted for Oxygen in Use/No Smoking. These deficient practices had the potential for the residents to have complication related to improper treatment while receiving O2 therapy. Findings: 1. Review of Resident 42's clinical record titled, Admission Record, dated 3/28/2025, indicated Resident 42 was admitted to the facility with diagnoses including parkinsonism (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance and posture), sleep apnea (a sleep disorder characterized by pauses in breathing during sleep), heart failure (HF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), unspecified, and shortness of breath. During a concurrent observation and interview with certified nursing assistant M (CNA M) on 3/25/2025 at 9:11 a.m., at Resident 42's bed side, Resident 42 was in bed, receiving O2 therapy at 2 liters per minute (lpm) thru a nasal cannula (a device used to deliver supplemental oxygen or airflow) connected to an O2 concentrator. The O2 concentrator's filter located at the right lower side, was observed to have a grayish substance build-up. CNA M confirmed the observation, and her eyes opened wide when she saw the build-up in the O2 filter. Both this writer and CNA M walked towards Resident 42's entrance door and observed there was no Oxygen in Use/No Smoking sign posted. CNA M confirmed the observation. During a concurrent interview with registered nurse F (RN F) and record review of Resident 42's physician order for O2 use on 3/25/2025 at 9:22 a.m., RN F confirmed Resident 42 had an order for oxygen use, as needed only. RN F stated the O2 filter had to be changed at night shift every 72 hours or as needed. During an interview with the director of nursing (DON) on 3/26/2025 at 2:30 p.m., the DON stated the O2 filter should be changed or washed weekly, or at least every Sunday. The DON confirmed there should be a sign posted by the door indicating, Oxygen in Use for those residents receiving O2 therapy. The DON further confirmed they have smokers (residents). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Oxygen Safety, date revised 3/19/2025, indicated, It is the policy of this facility to provide a safe environment for residents, staff, and the public. Further review indicated, No Smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply, and will remain in place until oxygen administration has been discontinued. 2. Review of Resident 155's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a disease that causes airflow blockage and breathing-related problems) and dependence on supplemental oxygen. Review of Resident 155's physician order, dated 3/22/25, it indicated she had an order for oxygen at 2 liters per minute continuously. During an observation on 3/25/25 at 1:55 p.m., Resident 155 was receiving oxygen via nasal cannula (a tubing used to deliver oxygen) being delivered via an oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to a resident in need of supplemental oxygen). The filters on both sides of the concentrator machine were dusty, with an accumulation of whitish gray substances on the filter sponge. During an observation and concurrent interview with registered nurse G (RN G) on 3/25/25 at 2:05 p.m., she confirmed both filters on Resident 155's concentrator were dirty, and she stated the filters should be changed. During an interview with the director of nursing (DON) on 3/26/25 at 8:30 a.m., he stated the concentrator filter should be cleaned every week and replaced as needed. Review of the facility's policy Oxygen Concentrator dated 12/3/24, indicated Care of the Concentrator: a. Follow manufacturer recommendations for the frequency of cleaning filters . Review of the Platinum Series XL, 5, 10 operator's manual indicated the following for routine maintenance of the cabinet filters: Remove each filter and clean at least once a week. 3. During an observation on 3/24/25 at 9:12 a.m., Resident 303 was lying in bed with oxygen concentrator in use at 2L/min (L, metric unit of volume) /minutes via nasal cannula (NC, device placed in the nostril used to deliver oxygen) at the bedside. There was no oxygen signage posted on Resident 303's door. During a review of Resident 303's physician's order, it indicated an order, dated 3/24/25 May give O2 @ (at) 1LPM (Liter per minute) via nasal cannula for SOB (shortness of breath), chest pain, Oxygen saturation (the percentage of oxygen in the blood) less than 90% as needed May titrate up to 4LPM to keep O2 saturation 90% and Notify MD (Medical Doctor). During an interview on 3/25/25 at 4:08 p.m., with the Director of Nursing (DON), the DON confirmed there was no Oxygen in use or No smoking sign posted outside Resident 303's door. The DON further stated they should have sign outside the door if they have oxygen concentrator is inside the room even the order for oxygen is as needed for safety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 3/24/25 at 10:51 a.m., Resident 40 was lying in bed with oxygen concentrator in used at 2 LPM via nasal cannula at the bedside. There was no oxygen signage posted on Resident 40's door. During a review of Resident 40's physician's order, dated 3/22/25 indicated Start Oxygen at 2L/min (Liter per minute) for SOB, Chest Pain, O2 sat (saturation) < (less than) 90% and Notify MD. During an interview on 3/25/25 at 4:10 p.m., with the Director of Nursing (DON), the DON confirmed there was no Oxygen in use or No smoking sign posted outside Resident 40's door. The DON further stated there should be a sign outside the door if they have oxygen concentrator is inside the room even the order for oxygen is as needed for safety. During a review of the facility's policy and procedure titled, Oxygen Safety, date revised 3/19/2025, indicated, It is the policy of this facility to provide a safe environment for residents, staff, and the public. Further review indicated, No Smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply, and will remain in place until oxygen administration has been discontinued.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 91) who received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment received care in accordance with professional standards of practice when: 1. Staff did not follow Resident 91's fluid restriction (limiting liquids) order; 2. There was no documentation of Resident 91's fluid intake each shift for staff to determine if Resident 91 have met the fluid restriction order; and 3. There was no record of Resident 91's intake and output (I&O - the measurement of the fluids and food that enter [intake] and leave [output] the body) monitoring. This deficient practice had the potential to result in Resident 91's fluid overload (a condition where there is an excessive amount of fluid in the body) or dehydration (a condition that occurs when the body loses more fluids than it takes in, resulting in a lack of water in the body). Findings: 1. Review of Resident 91's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), type 2 DM with diabetic neuropathy (with nerve damage), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Review of Resident 91's Admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], it indicated Resident 91's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 13 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During an observation on 3/24/2025 at 11:25 a.m., inside Resident 91's room, Resident 91 was sharing the room with one resident. Resident 91 was seated on his wheelchair and observed a posting of his care instruction posted at the wall above his HOB. It indicated, [Resident 91's room number and full name], FLUID RESTRICTION. During a concurrent observation and interviews with certified nursing assistant I (CNA I) and Resident 91 on 3/25/2025 at 8:58 a.m., inside Resident 91's room, Resident 91 was in bed, and CNA I was providing his morning care to get him ready for dialysis. A pitcher of water about 3/4 full and a cup of water were observed on top of Resident 91's overbed table. CNA I confirmed the observation and stated she was aware of Resident 91's fluid restriction order, but it was night shift staff who left the pitcher of water on the overbed table. Resident 91 stated he could reach the pitcher of water if he needed to drink. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 91's clinical records, titled Medication Administration Record [MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for 3/2025, it indicated an order on 1/17/2025, Fluid Restriction 1200 ml [milliliters - volume of measurement] Total per 24 hrs. as follows: Dietary Dept: 600 ml on meal trays: (BKFT [breakfast], 240 ml, Lunch 120 ml, Dinner 240 ml) Nursing Dept: 480 ml: (Days 250 ml, PM's [evening shift] 250 ml, Noc [night shift]100 ml) every shift. Further review indicated nurses would just initial their names in each shift without documentation of the exact amount of fluids Resident 91 consumed in each shift. 3. Review of Resident 91's clinical records, titled Order Summary Report, date ordered 1/11/2025, indicated, Bumetanide (a diuretic [medicine that help reduce fluid buildup in the body] medicine) Tablet 2 MG (milligrams - unit of measurement) Give 1 tablet by mouth two times a day for fluid retention (it occurs when part of the body swell due to a build-up of trapped fluid). Further review indicated Resident 91 had an order for dialysis every Tuesday, Thursday and Saturday. During a concurrent interview with the registered dietitian (RD) and record review on 3/26/2025 at 3:25 p.m., the RD reviewed Resident 91's dietary notes and the order summary report and confirmed Resident 91 had an order for fluid restriction, dialysis three days a week and was on bumetanide. The RD admitted Resident 91 was at risk of dehydration and confirmed there was no documentation I&O were being monitored. The RD stated it was not his responsibility to recommend I&O monitoring for residents on dialysis, fluid restriction and taking diuretics. The RD further stated his role was just to let the nurses know about the fluid breakdown of fluid restriction. During a concurrent interview with the director of nursing (DON) and record review on 3/28/2025 at 8:42 a.m. , the DON reviewed Resident 91's order summary report, assessments, progress notes, and 3/2025 MAR. The DON confirmed Resident 91 was on dialysis three days a week, fluid restriction and on diuretics. The DON stated Resident 91 should not have a pitcher of water on top of the overbed table and nursing staff should follow the allowed fluids each shift to prevent fluid overload. The DON confirmed nurses did not document the exact amount of fluids Resident 91 consumed on each shift. The DON stated the amount of fluids Resident 91 had consumed should be documented in the MAR. The DON admitted Resident 91 was at risk of dehydration and the I&O should have been monitored and documented. The DON stated RD can recommend getting an order for I&O monitoring during his dietary review on Resident 91 if resident did not have one. During a review of the facility's policy and procedure titled, Hemodialysis, dated 12/2/2024, indicated, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan .to meet the special medical, nursing .needs of resident receiving hemodialysis. During a review of the facility's policy and procedure titled, Fluid Restriction, dated 3/26/2024, indicated, The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluids per 24 hours to be distributed between the food and nutrition department and nursing department, and will be recorded on the medication record or other format as per facility protocol .Water will not be provided at the bedside unless calculated into the daily total fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Intake and Output (I&O), dated 8/2014, indicated, BASIC RESPONSIBILITY Nursing Staff POLICY * It is the policy of this facility to monitor intake and output and accurately document when it is determined that monitoring is necessary to evaluate hydration status, compliance with fluid restrictions, or to assist in the assessing and managing fluid needs. Potential resident may include (but are not limited to) .b. Residents who are determined to be at risk for dehydration. c. Residents on fluid restriction .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on interview, and document review, the facility failed to ensure the licensed nursing staff employed at the facility had appropriate competencies, and skill sets related to intravenous (IV, to deliver a medication into a vein) therapy to ensure the residents with peripherally inserted central catheter (PICC, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart, used for long term IV medication administration) lines received safe and appropriate medical care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. There were 2 residents with PICC lines admitted to the facility at the time of the survey. This failure could compromise the safety and quality of care for the two residents. Findings: During an interview on 3/28/25 at 9:07 a.m., the DON stated he had been working at the facility for five weeks. The DON stated he was responsible for competency evaluations and the ongoing education program through in-services for licensed nurses at the facility. However, he had not completed any in-services or competency evaluations regarding IV and PICC line care since he started working at the facility. He also stated there were a few residents with PICC lines at the facility and residents were occasionally admitted to the facility from hospitals to complete their medication therapy. The DON stated it was important and beneficial to evaluate nurses' performance for best nursing practice in providing quality resident care. During a review of the in-service binder titled In-services 2024, indicated that discussions and trainings were provided for the facility's licensed nursing staff. There were no records found to indicate in-services for IV and PICC line management and care were conducted, or any evaluations of the facility staff's competencies and skills sets for these special care treatments. During an interview on 3/28/25 at 10:31 a.m., with the Regional Director of Clinical Operations (RDCO), the RDCO stated the Director of Nursing (DON) was responsible for conducting licensed nurses' competency/skills evaluations and in-services since the Director of Staff Development (DSD) had retired and a new DSD had not been hired at the facility. The RDCO stated she conducted an in-service for the licensed nursing staff a few months prior but did not provide any documentation of in-services, training or competency skills validation for PICC line management/care. During an interview on 3/28/25 at 3:00 p.m., with Registered Nurse O (RN O)), RN O stated she had experience caring for residents with PICC lines from her previous employment but did not have a competency skills validation by the DON or the Director of Staff Development (DSD) when hired at the facility. RN O stated she had not attended any in-services for PICC management since being hired. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's assessment policy, titled, Grant [NAME] Nursing and Rehab Center Facility Assessment Policy, revised 1/2025, indicated, .4. The Facility Assessment will be used to: a. Inform staffing decisions to facilitate sufficient numbers of staff with the appropriate competencies and skill sets necessary to care for resident needs as identified through resident assessment and plan of care . 2.4 Staff training/education and competencies: California training requirements for Licensed Nurses upon hire; offered annually; PRN (as needed) based on changes in clinical guidance or staff performance evaluations- PICC line management (site care, dressing changes, flushing, aseptic technique, infection prevention).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50855 Based on interview and record review, the facility failed to ensure accurate accountability of controlled drugs (medications that can be easily abused and are under strict government control) and document medication administration in accordance with the facility policy and procedures (P&P) for three out of four residents (Resident 38, Resident 56, and Resident 59). This failure had the potential for medication errors and controlled drug abuse or diversion (when healthcare providers obtain or use prescription medicines illegally). Findings: 1. During a review of Resident 38's clinical record, it indicated Resident 38 was admitted to the facility with diagnoses including bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making). During a review of Resident 38's physician's order, dated 2/18/25, it inlcuded order for morphine sulfate (controlled medication for pain) tablet 15 mg (milligram, unit of measurement), 1 tablet by mouth every 12 hours as needed for severe pain. During a concurrent interview and record review on 3/26/25 at 3:51 p.m., with the Director of Nursing (DON), a review of Resident 38's Controlled Drug Record (CDR) for morphine sulfate 15 mg tablet and the March 2025 Medication Administration Record (MAR) indicated, on 3/15/25 at 10:18 and 3/23/25 at 2:51 p.m., the nursing staff signed out one tablet on CDR but did not document their administration on the MAR. The DON confirmed the findings and stated the nurse should sign the MAR after the medication administration. 2. During a review of Resident 56's clinical record, it indicated Resident 56 was admitted to the facility with diagnoses including malignant neoplasm of thymus (a cancerous tumor that originates in the thymus gland, located in the upper chest behind the breastbone). During a review of Resident 56's physician's order, dated 7/4/24, it included Percocet (controlled medication for pain) 5-325 mg (milligram, unit of measurement), 1 tablet by mouth every 8 hours as needed for severe pain. During a concurrent interview and record review on 3/26/25 at 3::56 p.m., with the Director of Nursing (DON), a review of Resident 56's Controlled Drug Record (CDR) for Percocet 5-325 mg and the March 2025 Medication Administration Record (MAR) indicated, on 3/16/25 at 10:00 a.m. and 3/23/25 at 8:00 a.m., the nursing staff signed out one tablet on CDR but did not document their administration on the MAR. The DON confirmed the findings and stated the nurse should sign the MAR and CDR after medication administration. 3. During a review of Resident 59's clinical record indicated Resident 59 was admitted to the facility with diagnoses including malignant neoplasm (abnormal growth of cells that invade and spread to other parts of the body) and muscle weakness. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59's physician's order dated 2/20/2025, it included oxycodone (a potent controlled medication for pain)5 mg (milligram, unit of measurement), 1 tablet by mouth every 4 hours as needed for severe pain During a concurrent interview and record review on 3/26/25 at 4:00 p.m., with the DON, a review of Resident 59's Controlled Drug Record (CDR) for oxycodone and the February and March 2025 Medication Administration Record (MAR) indicated, on 2/26/25 at 0000, 3/2/25 at 2330, and 3/23/25 at 0560, the nursing staff signed out one tablet on CDR but did not document their administration on the MAR. The DON confirmed these findings and stated the nurse should sign the MAR and CDR after medication administration. During a review of facility's Policy & Procedure (P&P) titled, Inventory of Controlled Substances, revised 8/1/24, the P&P indicated, 1 .1.3 .1.3.3 The facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Controlled Substance Verification/shift Count Sheet to the medication administration record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on interview and record review, the facility failed to act upon the facility's Consultant Pharmacist's (CP) recommendations during the Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) to address the recommendation/ irregularities for the month of December 1, 2024 to January 31, 2025's MRR for 2 of 4 sampled residents (Resident 2 and 32). This deficient practice had the potential to result in adverse medication outcomes and for potential unnecessary medications for Resident 2 and Resident 32. Findings: 1. During a review of Resident 2's medical record, it indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making), gout (painful form of arthritis), hyperlipidemia (high levels of fat particles [lipids] in the blood), and atrial flutter (a very fast heart rhythm that can lead to an increased risk of stroke due to blood clot formation). Review of Resident 2's physician order dated 1/1/25 indicated an order for risperidone (drug used to treat bipolar disorder) oral tablet 0.5 mg (milligram-unit of measurement), give 1 tablet at bedtime, and orders dated 12/2/24 for allopurinol (used to treat gout) oral tablet 100 mg give one tablet by mouth in the morning, and atorvastatin calcium (medication used to lower fat levels in the blood) oral tablet 40 mg give one tablet by mouth at bedtime. On 12/2/24 Resident 2 was also prescribed Eliquis (used to prevent and treat blood clots) oral tablet 2.5 mg give 1 tablet by mouth two times a day. During a review of the MRR for Resident 2, dated 12/1/24-1/31/25, the MRR indicated the CP's acknowledgment of Resident 2 receiving risperidone and its association with dyslipidemia (abnormally high levels of fats in the blood) but did not have documentation of a fasting (not eating food or drink for a period of time) lipid panel (a blood test that measures levels of fats in the bloodstream) recorded in the medical records within the previous twelve months. The CP noted the physician's orders for atorvastatin and allopurinol with a fasting lipid panel was last monitored in October 2023. The CP's recommendation for monitoring of uric acid (a waste product left over from normal chemical process in the body), and fasting lipid panel was signed off by the facility's physician but not dated. The CP requested clarification of concerns about the medication administration record, prescriber order sheets and recommendation to monitor bleeding for Resident 2 were also not signed and dated by the facility's physician and/or nursing staff. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 32's medical record indicated Resident 32 was admitted on [DATE] with diagnoses including depression disorder (a mood disorder that causes persistent feelings of sadness or loss of interest), and dysphagia (difficulty swallowing food or liquids). Further review of the record indicated Resident 32 had a physician's order dated 2/6/25, for duloxetine (medication used to treat depression) 30 mg one capsule by mouth one time a day. Review of the MRR for Resident 32, dated 12/1/24-1/31/25, it indicated a recommendation to the attending physician to discontinue duplicate orders of glycolax and Miralax, to clarify items on the medication administration record (MAR) and prescriber order sheet, to identify and monitor side effects and target behaviors for duloxetine. The facility's physician and nursing staff did not provide a response to the recommendations. The portions of the report designated for the physician and nursing staff to provide a response were left blank. During an interview and concurrent record review on 3/26/25 at 12:12 p.m. with the Director of Nursing (DON), the DON reviewed the MRR's dated 12/1/24-1/31/25 for Resident 2 and Resident 32. The DON stated the physician and nursing staff did not complete the documents in response to the CP's recommendations. The DON stated the CP's reports are forwarded to the physician for review, but the physician failed to sign and date the reports for both residents. The DON could not provide a MRR binder for the year 2024/2025 for review and stated paper copies of the MRR for 2024 and monthly visits by the CP could not be located anywhere in the facility. The DON also verified CP reports were uploaded into the electronic medical records periodically for residents at the facility during the year of 2024. During an interview on 3/26/25 at 12:30 p.m., with the Regional Director of Clinical Operation (RDCO), the RDCO stated the MRR binder and all the documents of the CP's monthly visits for the year 2024 and previous years were somewhere in the facility but could not find them. During a telephone interview on 3/28/2025 at 1:45 p.m., with the facility's CP, the CP stated medication record reviews and visits were done monthly. The CP stated reports were faxed to the DON and recommended the facility review the monthly MRR report and notify resident's physician of any irregularities and recommendations as indicated on the monthly MRR report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility Policy and Procedure titled, Medication Regimen Review, revised 6/5/2024, indicated: .9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. 9.1. For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined by the State Operations Manual Appendix PP. 9.2 The attending physician should document in the resident's health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 9.2.1. If the attending physician/prescriber has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record . 13. The attending physician/prescriber should address the consultant pharmacist's recommendations no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations. 14. Facility should maintain readily available copies of MRRs on file in Facility as part of the residents' permanent health record and should be readily available for review. 15. If documentation of the consultant pharmacist's findings is not in the active record, it is maintained within the facility and is readily available for review.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50855 Based on observation, interview, and record review, the facility had a medication error rate of 6.67% when two medication errors occurred out of 30 opportunities during the medication administration for two out of nine residents (Resident 26 and Resident 155). The failures resulted in the nursing staff not following physician's orders and the facility's policy and procedures (P&P), which had the potential for the residents not receiving the medications full therapeutic effects, and could also result to complications of the medications. Findings: 1. During the medication administration observation on 3/24/25 at 4:42 p.m., Registered Nurse H (RN H) was observed preparing and administering 2 medications, tablet and one liquid supplement to Resident 26. Included in the medications was carvedilol (class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure) 3.125 mg (milligram, unit of measurement). RN H checked the blood pressure (BP) on Resident 26's right arm using manual BP apparatus (a machine that measures blood pressure) after checking, RN H handed the medication to Resident 26 then Resident 26 took the medications with water. RN H did not check Resident 26's pulse rate (PR) prior to medication administration. During a concurrent interview and record review shortly after the observation, on 3/24/25 at 9:53 p.m., RN H clicked the carvedilol on Resident 26's Medication Administration Record (MAR), it indicated a requirement for BP and PR. When RN H was asked if the PR was checked for Resident 26, RN H stated the PR was not checked before administering the carvedilol. RN H confirmed carvedilol has the requirements on the MAR to check the BP and PR before administering. Review of Resident 26's March 2025 MAR, it indicated a physician order, dated 7/27/24, for carvedilol 3.125 mg 1 tablet by mouth BID (two times a day) with meals for hypertension (high blood pressure) and also indicated on the MAR, BP and PR were being checked. During an interview on 3/28/25 at 9:54 a.m., with the Director of Nursing (DON), the DON stated for BP medications the nurse should have checked the BP and PR prior to administering medications. The DON further stated it's a standard of practice. During a review of facility's P&P titled, Medication Administration, revised date 3/38/2025, the P&P indicated, Medication are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice .8. Obtain and records vital signs, when applicable . 2. During the medication administration observation on 3/24/25 at 4:42 p.m., Registered Nurse G (RN G) was observed preparing and administering 5 medications including Breo Ellipta (medication to treat breathing problems) inhaler to Resident 155. RN G took the box of Breo Ellipta inhaler from the medication cart. RN G stated the Breo Ellipta inhaler had no open date. RN G stated it should have an open date. RN G further stated the pharmacy needed to be called to make sure it was still okay to administer the Breo Ellipta inhaler to Resident 155. (continued on next page)

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Grant Cuesta Sub-Acute and Rehabilitation Center	1949 Grant Road Mountain View, CA 94040

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow interview on 3/26/25 at 3:28 p.m., with RN G, RN G stated the Breo Ellipta inhaler was not given to Resident 155. RN G further stated the medication would be delivered by the pharmacy. During a review of Resident 155's Medication Administration Record (MAR) for March 2025 indicated and order dated 3/17/25, for Breo Ellipta inhalation 200-25 mcg/act (measured in micrograms (mcg) per actuation) 1 puff inhale orally in the morning (0900) for COPD (Chronic obstructive pulmonary disease is a group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs, making it difficult to breathe). RN G signed the MAR with the code 9= Other/See Progress Notes. Review of Resident 155's progress notes dated, 3/26/25 at 17:17 indicated RG G documented Breo not given and awaiting for pharmacy to deliver. During an interview on 03/26/25 at 4:30 pm., with the Director of Nursing (DON), the DON stated, the inhaler was delivered on 3/17/25 and that Resident 155 should have received the Breo Ellipta inhaler. During a review of facility's P&P titled, Medication Administration, revised date 3/38/2025, the P&P indicated, Medication are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice .10. Ensure that the six right of medication administration are followed: .e. Right time . 12 .b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50855 Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when one expired insulin vial was not removed from active stock and opened multi-dose vials/inhalers had no open date. These failures had the potential for residents to receive medications with reduced efficacy. Findings: 1. On [DATE] at 11:39 a.m., an inspection of the medication cart 1 with Licensed Vocational Nurse C (LVN C) identified one opened multi dose vial of insulin dated [DATE]. LVN C confirmed this finding and stated the insulin vial opened date [DATE] should be discarded after 28 days. A review of the manufacturer's label for the insulin Novolin N vial indicated Storage conditions and expiration dates, in-use (opened) room temperature 42 days. During an interview on [DATE] at 4:03 p.m., with the Director of Nursing (DON), the DON stated, the insulin opened, date [DATE] should not be used and should be discarded because of the effectiveness. During a review of the facility's P&P titled 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, Revision date [DATE], the P&P indicated, .10. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer/supplier; . are stored separate from other medications until destroyed or returned to the pharmacy or supplier . 2. During a medication administration observation in medication cart 4 on [DATE] at 10:22 a.m., with Registered Nurse G (RN G), identified a fluticasone furoate (medication to treat breathing problems) Ellipta was undated with the open date. RN G stated it should have an open date and stated the pharmacy would be called to confirm if the fluticasone furoate could still be given. A review of the manufacturer's label indicated to discard 6 weeks after opening the tray. During an interview on [DATE] at 3:45 p.m., with the DON, the DON stated fluticasone should have an open date and stated some inhalers are discard after 6 weeks of opening. During a review of the facility's Policy & Procedure (P&P) titled 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, Revision date [DATE], the P&P indicated, .11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e , vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38087 Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety when: 1. Insulated food covers used for food service were stacked and stored wet; 2. There were unlabeled and undated food items in the reach-in refrigerator. These failures had the potential to cause food contamination and food-borne illness to 89 of 90 residents who received their food from the kitchen. Findings: 1. During an initial tour of the kitchen on 3/24/25 at 9:15 a.m., accompanied by the dietary manager (DM), there were 36 insulated plate covers observed to be stacked on a metal wire rack. The insulated plate covers were stacked inside of one another and were wet inside and outside of the plate covers' surfaces. The DM confirmed the insulated plate covers were wet and she stated they should have been air dried before being stacked and stored. According to the 2022 Food and Drug Administration (FDA) Food Code, Section 4-901.11 Equipment and Utensils, Air-Drying Required, After cleaning and sanitizing, equipment and utensils: shall be air-dried . According to the FDA Food Code 2022 4-903 Storing, Clean equipment and utensils shall be stored in a self-draining position that allows air drying. 2. During an observation on 3/24/25 at 9:29 a.m., accompanied by the DM, there were 3 brown bags that were unlabeled and undated in the reach-in refrigerator. There was the word Tuna marked on the outside of each bag and a blank label affixed to the bags. The bags each contained a tuna sandwich wrapped in plastic wrap with no identified markings or date. The DM stated the lunches were prepared in the morning for dialysis residents who are not in the facility over the lunch meal service. The DM confirmed the label was blank and stated the bag lunch and the tuna sandwich should be dated and labelled. A review of the facility policy titled Food Safety in Receiving and Storage indicated food that is repackaged will be labeled with the name of the contents and dated with the date it was transferred to the new container.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview and facility's document review, the facility failed to implement infection control measures when: 1. Resident 73's nebulizer equipment was left uncovered and undated; 2. Certified nursing assistant L (CNA L) was wearing gloves in the hallway after resident care; 3. Certified nursing assistant N (CNA N) was wearing gloves in the hallway after resident care; 4. Resident's used basins were unlabeled and stored on top of bathroom toilet's tank; 5. There was no enhance barrier precautions (EBP - an infection control strategy, focusing on the targeted use of gown and gloves during high-contact resident care activities [such as dressing, bathing, transferring, changing linens, etc.] to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) signage by the door and no isolation cart right outside Resident 11's door entrance; 6. Resident 15's urine bag (also called urine drainage bag, is a bag connected to a catheter or sheath that collects urine drained from the bladder) was found on the floor; 7. The Restorative nursing assistant (RNA - a healthcare professional who helps residents maintain or regain functional abilities and independence through restorative care programs) did not follow the contact precaution (measures taken in healthcare settings to prevent the spread of infections that can be transmitted through direct or indirect contact with a patient or their environment, such as touching contaminated surfaces or body fluids) posted in Resident 301 and Resident 98's door; 8. Certified Nursing Assistant A (CNA) was wearing gloves in hallway after resident care; 9. Two Nurses did not place barrier on table before placing glucometer tray and did not sanitize the tray after performing finger stick blood sugar (FSBS-a test where a small amount of blood is pricked from the fingertip to measure blood sugar levels.); and 10. CNA N did not follow Resident 2's EBP. These failures had the potential to result in the spread of infection and compromise the health and safety of the residents and staff in the facility. Findings: 1. Review of Resident 73's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including pneumonitis (inflammation of the lungs). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 73's physician order, dated 3/18/25, it indicated an order for albuterol sulfate inhalation nebulization solution (opens the airways) 2.5 milligrams (mg, a metric unit of mass)/3 milliliters (ml, a metric unit of volume) via nebulizer (a machine that turns liquid medicine into a fine mist inhaled into the lungs, mist comes through a tube that is attached to a facemask) The physician order indicated to inhale orally every six hours prn (as needed) for cough. During an observation and interview with registered nurse (RN F) on 3/24/25 at 1:12 p.m., Resident 73's nebulizer was laying on top of the bedside cabinet, uncovered and undated. RN F confirmed the nebulizer was uncovered and the tubing was not dated. RN F stated the nebulizer and tubing should be dated and covered. RN F further stated staff should wash the nebulizer after each use, air dry it and then store it in a plastic bag. Review of the facility policy titled Respiratory Services - Aerosol Delivery Device, dated 1/1/2014, indicated Respiratory Care Practitioner Responsibilities: . proper use, maintenance and cleaning of equipment . 44583 2a. During an observation on 3/24/2025 at 9:10 a.m., in the facility's hallway, CNA L stepped out of Room AA, wearing gloves on both hands and was carrying one plastic filled with garbage to left hand and one plastic of dirty linens to right hand. CNA L lifted the lid of the garbage bin at the hallway with used gloves and dumped the plastic of garbage. CNA L went forward to go to the laundry basket at the hallway, lifted the laundry basket lid with used gloves and dumped the bag of dirty linen to the laundry basket. 2b. Another observation on 3/24/2025 at 11:10 a.m., in the same facility hallway, CNA L stepped out of Room BB, wearing gloves on both hands and was carrying a plastic of dirty linens, walked towards Shower room [ROOM NUMBER], touched the shower room's doorknob with used gloves, and went inside the shower room. CNA L stepped out of Shower room [ROOM NUMBER] not wearing gloves anymore. During a follow-up interview with CNA L on 3/24/2025 at 11:11 a.m., CNA L confirmed above observations and stated she should have removed the used gloves prior to exiting Rooms AA and BB and performed hand hygiene (the practice of cleaning hands to prevent the spread of germs and infections, which can be achieved through washing hands with soap and water or using alcohol-based sanitizers). 3. During an observation on 3/24/2025 at 11:12 a.m., in the facility's hallway, certified nursing assistant N (CNA N) stepped out of Room CC wearing gloves and carrying a bag of dirty linens with right hand. CNA N removed the glove in the left hand while walking towards Shower room [ROOM NUMBER], did not perform hand hygiene before touching the shower room's doorknob with left hand to open the door. CNA N went inside Shower room [ROOM NUMBER]. During a follow-up interview with CNA N on 3/24/2025 at 11:15 a.m., CNA N confirmed above observation, and stated she should have discarded the used gloves before she exited Room CC. CNA N further stated she should not wear gloves in the hallway. During an interview with the director of nursing (DON) on 3/28/2025 at 8:42 a.m., the DON stated gloves should not be worn at the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4a. During an observation on 3/24/2025 at 9:22 a.m., inside Room DD's bathroom, there were two used unlabeled basins seen on top of the toilet's tank. Room DD's bathroom was being shared by three residents. During a concurrent observation and interview with the infection preventionist (IP) on 3/24/2025 at 9:33 a.m., inside Room DD's bathroom, two unlabeled basins were still on top of the toilet's tank, the IP confirmed above observation and stated resident's used basins should be labeled. The IP was not able to state where to store the used basins and what should be written on it. 4b. During a concurrent observation and interview with CNA L on 3/24/2025, inside Room EE's bathroom, there were basins stocked up on top of the toilet's tank. CNA L confirmed there were four basins stocked up on top of the toilet's tank, two of them were labeled with resident's room number and bed, and the two were unlabeled. Room EE's bathroom was being shared by three residents. CNA L stated the used basins should be labeled and stored under the resident's bedside drawer. During an interview with the DON on 3/28/2025 at 8:56 a.m.,the DON stated resident's used basins should be labeled with resident's name and should have been stored inside the resident's bedside drawer. During a review of the facility's undated policy and procedure titled, Labeling Critical and Non-Critical Personal Belongings, indicated, All personal belongings of residents as well as items supplied by the facility (such as urinals, bedpan, etc.) will be labeled .Store all items in appropriate place. 5. During a concurrent observation and interview with Resident 11 inside his room on 3/24/2025 at 9:08 a.m., Resident 11 was in bed, with urine bag hanged at the lower part of the bed, and a floor mat was located at the left side of his bed. Resident 11's bed was positioned in a regular height. Resident 11 stated he was okay. Further observation at Resident 11's door, there was no EBP sign posted and there was no isolation cart available. During a concurrent observation and interview with IP on 3/24/2025 at 9:30 a.m., in front of Resident 11's door, there was no EBP sign posted, and no isolation cart was observed. IP confirmed above observation. IP confirmed Resident 11 had foley catheter (a catheter which is inserted into the bladder, thru the urethra and remains in place to drain urine) and he was at risk of infection. IP stated Resident 11 should have been on EBP, and a sign should be posted at his door for staff to be aware about the precaution and should have implemented it. IP confirmed they did not have enough isolation cart and would purchase more of it soon. During an interview with the DON on 3/28/2025 at 8:54 a.m., the DON confirmed Resident 11 should have EBP signage because of his foley catheter use. The DON stated Resident 11 was at risk for infection related to foley catheter use. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated revised 2/5/2025, indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e. wound irrigation, tracheostomy care). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Centers for Disease Control and Prevention's (CDC - a federal agency under the United States Department of Health and Human Services that focuses on protecting public health by preventing and controlling diseases, injuries, and disabilities) undated letter to facilities titled, Help Keep Our Residents Safe - Enhanced Barrier Precautions in Nursing Homes, indicated, Enhanced Barrier Precautions requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO. These include the following residents: .Residents with indwelling medical device including central venous catheter, urinary catheter .HOW will I know when to use Enhanced Barrier Precautions? We will be posting signs on the doors of residents for whom EBP are recommended. The signs will also include reminders of the activities during which a gown and gloves should be worn. 6. During an observation on 3/24/2025 at 9:07 a.m., inside Resident 15's room, Resident 15 was asleep in bed, and his urine bag was on the floor. Resident 15's urinary tubing was observed filled with urine not fully drained to the urine bag. During a concurrent observation and interview with the IP on 3/24/2025 at 9:27 a.m., inside Resident 15's room, the urine bag was still on the floor. The IP confirmed above observation and stated she was sorry; the urine bag should not be on the floor. The IP stated the urine bag should be hanged at the lower part of Resident 15's bed frame. The IP confirmed Resident 15 was also on EBP. During an interview with the DON on 3/28/2025 at 8:51 a.m., the DON confirmed resident's urine bag should not be placed on the floor to prevent contamination or infection. During a review of Resident 15's care plan titled, Resident is at risk for Urinary Tract Infection [UTI - an infection in the bladder/urinary tract] due to: indwelling urinary catheter (Foley) . date initiated 2/28/2020, indicated in one of the interventions, Ensure catheter tubing and drainage bag are properly positioned to prevent urinary back-flow or contamination. Further review of the care plan's intervention, date initiated 8/28/2023, indicated, Keep foley catheter bag off the floor. During a review of the facility's policy and procedure titled, Catheter Care, date revised 12/2/2024, indicated, It is the policy of this facility to ensure that resident s with indwelling catheters receive appropriate catheter care . 7. Record review of Resident 301's Admission Record and Order Summary Report indicated, Resident 301 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of skin graft (a surgical procedure where a piece of healthy skin is taken from one area of the body (the donor site) and transplanted to another area to cover damaged or missing skin) infection, with peripherally inserted central catheter (PICC - a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) line, on EBP for wound care management and had wounds located in the right upper thigh (donor site), left lower extremity (LLE) and mid part of the abdomen. Resident 301 was on two different antibiotics (medications that kill or inhibit the growth of bacteria) for the LLE Methicillin-resistant Staphylococcus aureus (MRSA - a type of bacteria that is resistant to the antibiotic methicillin and other similar antibiotics) infection until 4/22/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 98's Admission Record and Order Summary Report indicated, Resident 98 was admitted to the facility on [DATE] with diagnosis of cellulitis (a common bacterial infection of the skin and underlying tissues) of left and right lower limb. Further review of Resident 98's Order Summary Report, it indicated Resident 98 was on antibiotics for MRSA infection until 4/4/2025 and it revealed an order dated 3/22/2025, Contact Precautions for MRSA infection until antibiotic therapy completed. During an observation on 3/26/2025 at 9:20 a.m., outside Resident 301 and Resident 98's shared room, a sign was posted at the room door that showed Contact Precautions, with a large red stop sign and A and B were written and circled at the top of the sign. The sign showed, Everyone must clean hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect resuable equipment before use for another person. Another sign was observed posted on the door and showed a table with the column heading of A with orange colored cell in the row below and another column heading for B with yellow colored cell below. During an observation on 3/26/2025 at 9:31 a.m., in front of Resident 301 and Resident 91's room, RNA opened the room door, put on a gown while talking to Resident 301. RNA removed her gloves, stepped out of the room and performed hand hygiene. While RNA was outside the room, the call light (a device, typically a button or switch near a patient's bed, that patients use to signal staff when they need assistance) turned on. RNA re-entered the shared room of Resident 301 and Resident 98 without donning (putting on) gloves or gown and went to Resident 98's bedside. RNA turned off the call light and moved Resident 98's clothing from closet to bed, and touched Resident 98's wheelchair, RNA's personal walker, and Resident 98's overbed table. During an interview with certified nursing assistant A (CNA A) on 3/26/2025 at 9:36 a.m., CNA A stated the staff should wear a gown and gloves whenever they entered Resident 301 and Resident 98's room and removed their gown and gloves when they exited the room. When asked about the table with the orange for A and yellow for B, CNA A stated orange meant staff should need to wear gown and gloves to provide care, and yellow meant staff should wear gown and gloves whenever they enter the room, but since both residents were sharing one room, staff should wear both gown and gloves whenever they enter the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the RNA and IP on 3/26/2025 at 10:16 a.m., the RNA stated gown, and gloves should be worn before entering Resident 301 and Resident 98's shared room. When asked if this was needed for both residents in the room, The RNA stated gown and gloves were needed for Resident 301 only, but stated that this was the first time she saw the signs on residents' door. The IP stated the orange and yellow cell posted at the door shouldn't be there because it was confusing staff. IP stated that both residents were on contact precautions and staff should be wearing gown and gloves when they entered the room and removed when exiting. The RNA stated that she needed to wear gown and gloves for Resident 301 whenever she entered the room but she only needed to wear gown and gloves for Resdient 98 whenever care was provided. The IP stated staff should not have to wear gown or gloves if they would only see Resident 98 as long as they did not touch the resident or her belongings. The RNA confirmed she moved Resident 98's clothing and turned off her call light but was not aware that she touched Resident 98's wheelchair and overbed table. The IP stated that since the RNA touched Resident 98's things in the room, the RNA should have worn gown and gloves at that time. The IP clarified and stated that gown and gloves should be worn whenever staff would enter into the room. The RNA apologized and stated that she didn't know she was supposed to do that. During a review of CDC's Infection Control Basics titled, Transmission-Based Precautions, dated 4/3/2024, indicated, Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission .Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon entry and properly discarding before exiting the patient room is done to contain pathogens. 50855 8. During an observation on 03/24/25 at 10:00 a.m. outside room [ROOM NUMBER], CNA A was observed coming out of room [ROOM NUMBER] wearing pair of gloves on both hands and walking in the hallway holding the linen inside a plastic bag and putting the plastic bag inside a hamper located next to room [ROOM NUMBER]. CNA A went back inside room [ROOM NUMBER] wearing the same pair of gloves. During an interview on 3/24/25 at 10:02 a.m., with CNA A, CNA A confirmed wearing gloves in the hallway when placing dirty linen in the hamper outside the room. CNA A stated the gloves should not have been worn in the hallway and should have been removed before leaving the room and put a clean pair of gloves on before re-entering the room. During an interview on 3/25/25 at 11:55 a.m., with the Infection preventionist (IP), the IP stated, no gloves are allowed in the hallway and the staff should not wear gloves in the hallway. The IP further stated the gloves might be contaminated and possibly spread infection. During a review of facility's Policy and Procedure (P&P) titled, Infection Prevention Manual for Long Term Care Center revised date 10/2022, the P&P indicated, Enhanced Standard Precautions . Gowns and gloves should always be removed inside the room when the care activity is complete. Gowns and gloves should not be worn outside of the room when resident care is not being performed . (continued on next page)

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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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9a. During the medication administration observation on 3/25/225 at 11:41 a.m., Licensed Vocational Nurse D (LVN D), was observed doing the fasting blood sugar (FBS, measurement of sugar levels in the blood after a period of not eating food or drinking fluid except water) check for Resident 86. When finished, LVN D placed the glucometer (an instrument for measuring blood sugar) on Resident 86's overbed table without placing a barrier (such as a clean paper towel) first and did not clean the table afterwards. During an interview shortly after the observation, on 3/25/25 at 11:45 a.m., LVN D was asked if a barrier should have been placed on the table before placing the glucometer machine on it and if Resident 86's overbed table should have been cleaned after use. LVN D confirmed a barrier was not placed on the overbed table before placing the medication tray and glucometer machine on it and not cleaning the table after use. During an interview on 3/25/25 at 11:52 a.m., with the Infection Preventionist (IP), the IP stated they [nurse] should use a medication tray and barrier on the table or sanitize the table before placement of the medication tray and glucometer. During a review of facility's P&P titled, Infection Prevention Manual for Long Term Care Center revised date 10/2022, the P&P indicated, .10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment . 9b. During the medication administration observation on 3/26/225 at 11:36 a.m., Licensed Vocational Nurse E (LVN E), was observed doing the FBS check for Resident 86. LVN E placed the medication tray containing a glucometer on Resident 86's overbed table without placing a barrier then placed the medication tray on top of medication cart 1 when finished. LVN E proceeded to place the medication tray inside medication cart 1 without sanitizing the tray. During a concurrent observation and interview on 3/26/25 at 11:42 a.m., LVN E was observed placing the medication tray inside the medication cart 1. LVN E was asked if he placed a barrier and sanitized the glucometer tray afterwards. LVN E stated a barrier was not used and the medication tray was not sanitized before placing it back inside the medication cart . LVN E stated the medication tray should have been sanitized for infection control. During an interview on 3/28/25 at 9:52 a.m., with the Director of Nursing (DON), the DON stated they [nurses] should sanitize the edication tray before putting it back in the cart to prevent the spread of infection. During a review of facility's P&P titled, Infection Prevention Manual for Long Term Care Center revised date 10/2022, the P&P indicated, .10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment . 50135 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of Resident 2's clinical record indicated she was admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing food or liquids), gastrostomy tube (GT tube, a surgical opening into the stomach for administration of nutrition and medications directly into the stomach) status, and diabetes (a condition which affects the way the body processes blood sugar). Review of Resident 2's physician's order, dated 1/24/24, it indicated enteral feed (supplying nutrition directly into the stomach or intestines through a tube) every 6 hours. Further review of the order dated 3/24/25, it indicated Resident 2 was to be on enhanced barrier precaution (EBP) for GT feeding. During an observation on 3/24/25 at 11:10 a.m., in the room of Resident 2, Certified Nurse Assistant N (CNA N) was observed finishing with the placement and positioning of Resident 2 into a wheelchair without wearing a gown or gloves. An orange poster was observed on Resident 2's room door. The orange poster read, ENHANCE BARRIER PRECAUTIONS . PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities . Dressing . Bathing/Showering .Transferring . Changing Linens . CNA N left the room briefly and returned without performing hand hygiene and not wearing a gown and gloves. CNA N proceeded to change the bed linens of Resident 2's bed. During the interview on 3/24/25 at 12:48 p.m., after being shown the poster on the door of Resident 2, CNA N confirmed she should have cleaned her hands and worn a gown and gloves before entering the resident's room if she was going to provide care to the resident and while changing the bed linens. During an interview on 3/27/25 at 11:11 a.m., in the room of Resident 2 with the Director of Nursing (DON), the DON stated, for residents on EBP, the staff providing care, such as bathing, transferring and bed linen changes, must wear a gown and gloves before entering the room. A review of the facility's P&P titled Enhanced Barrier Precautions, revision date 2/5/2025, indicated, 3. Implementation of Enhanced Barrier Precautions: b. Personal Protective Equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include . b. Bathing c. Transferring . e. Changing linens.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 44583 Based on observation, interview, and record review, the facility failed to follow their Antibiotic Stewardship Program for two of 18 sampled residents (Residents 68 and 301) when: 1.Resident 68 received two different antibiotics (medications that kill or inhibit the growth of bacteria) to treat pneumonia (an infection/inflammation in the lungs) and urinary tract infection (UTI- an infection in the bladder/urinary tract) without provider's full assessment and the diagnostic test performed indicated Resident 68 was negative for the mentioned infections; and 2. Resident 301 was prescribed with topical (medication or treatment applied directly to the skin or body surfaces) antibiotics without a stop date. These failures had the potential to increase the prevalence of multi-drug resistance organism or bacteria. Findings: 1.Review of Resident 68's clinical record titled, Admission Record, dated 3/26/2025, indicated Resident 68 was readmitted to the facility with diagnoses including dementia, severe, with other behavioral disturbance (unusual, disruptive, or problematic behaviors that deviate from typical patterns and cause distress or impairment in daily functioning), epilepsy (a brain disorder characterized by recurrent, unprovoked seizures , and delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined). During observations inside Resident 68's room on 3/24/2025 at 9:37 a.m., Resident 68 was seated on a wheelchair, and was talking to self. Another observation and concurrent interview with Resident 68's family member (FM) at 12:38 p.m., Resident 68 was eating lunch with FM's assistance and supervision. FM stated, my mom has grade 7 dementia, During a concurrent observation and interview with certified nursing assistant L (CNA L) on 3/25/2025 at 8:50 a.m., inside Resident 68's room, Resident 68 was seated on a wheelchair and continuously talking. CNA L was observed seated on a chair in front of Resident 68. CNA L stated she was a sitter (a caregiver who provides companionship and supervision to patients who need constant observation or assistance, often due to medical conditions or behavioral issues that could pose a risk) for Resident 68 because she was at risk of falling. During an interview with licensed vocational nurse E (LVN E) on 3/26/2025 at 8:41 a.m., LVN E stated Resident 68 had an aggressive behavior and used to wander at the facility. LVN E confirmed Resident 68 had a sitter to prevent her from wandering and elopement (the act of a patient leaving a healthcare facility without authorization or supervision). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 68's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2025, it indicated Resident 68 received Levofloxacin (an antibiotic medication) 500 milligram (mg - unit of measurement) on 3/1, 3/2, and 3/3/2025 for pneumonia. Further review indicated, Resident 68 received nitrofurantoin (an antibiotic medication) 100 mg twice a day from 3/4/2025 to 3/17/2025 for UTI. During an interview with LVN E on 3/27/2025 at 1:21 p.m., LVN E confirmed Resident 68 had antibiotics for UTI due to her increased aggressiveness, but there was no fever. LVN E stated they did not follow any checklist regarding a possible infection before they called the doctor. LVN E further stated they only have the SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents). LVN E confirmed Resident 68 received levofloxacin for pneumonia. LVN E stated Resident 68 had dry cough and no fever when she was prescribed with levofloxacin. During an interview with the infection preventionist (IP) on 3/27/2025 at 1:43 p.m., the IP confirmed Resident 68 did not meet the McGeer (a standard surveillance used in long-term care to identify UTI [look for signs like suprapubic pain, new or increased incontinence, urgency, or frequency, along with fever] and respiratory tract infections [look for fever, chills, new or increased cough, sore throat, and muscle pain]) and Loeb Minimum Criteria (a set of minimum standards for initiating antibiotics in long-term care settings) and received both levofloxacin and nitrofurantoin. The IP further confirmed Resident 68's chest x-ray (a diagnostic test used to generate images of tissues and structures inside the body) result was negative for pneumonia and there was no urine culture performed to confirm the diagnosis of UTI. The IP stated she did not communicate these concerns to the provider who prescribed the antibiotics. During a review of the facility's policy and procedure titled, Antibiotic Stewardship Program, date revised 6/2023, indicated, The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Attending Physicians - prescribe appropriate antibiotics in accordance with standard of practice and facility protocols .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. A. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection prior to notifying the physician. Ii. Laboratory testing shall be in accordance with current standards of practice. Iii. The facility uses the McGeer criteria to define infections. Iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. 2. Record review of Resident 301's clinical record titled, Admission Record, indicated, Resident 301 was admitted to the facility with diagnosis of skin graft (a surgical procedure where a piece of healthy skin is taken from one area of the body (the donor site) and transplanted to another area to cover damaged or missing skin) infection. Review of Resident 301's Order Summary Report, indicated an order dated 3/17/2025, Neosporin Original Ointment [topical antibiotic] .Apply to left flap wound topically in the morning for wound care. Further review of the order indicated there was no stop date and revealed the duration of the medication was indefinitely. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with the IP and record review of Resident 301's Order Summary Report on 3/27/2025 at 2:49 p.m., the IP confirmed there was no stop date for Resident 301's topical antibiotic use. The IP stated nurses should have asked the doctor for the stop date of the antibiotics prescribed. During a review of the facility's policy and procedure titled, Antibiotic Stewardship Program, date revised 6/20/23, indicated, v. Prescriptions for antibiotics shall specify the dose, duration, and indication for use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44583 Based on interview, and document review, the facility failed to ensure the designated Infection Preventionist (IP - infection control nurse) had completed the required specialized training in infection prevention and control. This deficient practice had the potential for inadequate infection control measures and could result in mismanagement of infections among residents, staff, and community. Findings: During a review of IP's credentials titled, CDC TRAIN (a Centers for Disease Control and Prevention accredited program for Nursing Home Infection Preventionist Training Course), it indicated the IP completed Module 1 (Infection Prevention & Control Program) and 2 (The Infection Preventionist) on 12/26/2024 and Module 3 (Integrating Infection Prevention and Control into the Quality Assurance Performance Improvement Program) on 12/27/2024. During a concurrent interview with the IP and document review of the IP's CDC Train certificates on 3/27/2025 at 8:30 a.m., the IP confirmed she only completed three modules of the 15 modules to be certified as an IP. The IP stated she was busy with her orientation at the facility and was not able to complete the whole course of the IP certification. The IP further stated she stopped the training course after she completed Module 3 in 12/2024. The IP confirmed she did not have any other trainings related to her role as an IP. During an interview with the director of nursing (DON) on 3/28/2025 at 8:58 a.m., the DON confirmed he did not know the IP did not complete the training requirements before she assumed the position as the facility's IP. During a review of the facility's undated job description job title, Infection Preventionist, indicated, Must have training in infection prevention and control in accordance with federal requirements. During a review of CDC TRAIN titled, Nursing Home Infection Preventionist Training Course, indicated, Program Description: This course will provide infection prevention and control (IPC) training for individuals responsible for IPC programs in nursing homes so they can effectively implement their programs and ensure adherence to recommended practices by front-line staff. The course will include information about the core activities of an effective IPC program, with a detailed explanation of recommended IPC practices to prevent pathogen transmission and reduce healthcare-associated infections and antibiotic resistance in nursing homes. Additionally, this course will provide helpful implementation resources (e.g., training tools, checklists, signs, and policy and procedure templates) .What Topics Are Addressed? (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Nursing Home Infection Preventionist Training Course is made up of 24 modules and submodules addressing a variety of topics including an overview of the IPC program and the role of the infection preventionist, infection surveillance and outbreak management, infection prevention practices such as hand hygiene, and antibiotic stewardship.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 91) received pneumococcal (common bacteria that can affect different parts of the body) vaccination. This failure resulted in Resident 91's positive chest x-ray (a diagnostic test used to generate images of tissues and structures inside the body) result of pneumonia (an infection/inflammation in the lungs) during the facility stay. Findings: Review of Resident 91's clinical record titled, Admission Record, dated 3/27/2025, indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), type 2 DM with diabetic neuropathy (with nerve damage), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Review of Resident 91's clinical record titled, Immunization Report, dated 3/28/2025, if indicated Resident 91's last pneumococcal vaccination was on 12/28/2021 with pneumococcal polysaccharide vaccine (PPSV23 - a type of pneumococcal vaccination). Review of Resident 91's clinical record titled, Immunization Informed Consent Record-Resident, dated 1/11/2025, indicated Resident 91 had provided a consent to accept a pneumococcal vaccine which was PCV20 (Prevnar20 - another type of pneumococcal vaccination). Further review indicated, the consent was signed and dated by Resident 91 and a nurse on 1/11/2025. Review of Resident 91's clinical record titled, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/2025, 2/2025, and 3/2025 revealed, Resident 91 did not receive the pneumococcal vaccine. Review of Resident 91's clinical record titled, Change in Condition Evaluation, dated 3/15/2025, indicated Resident 91 had dry cough with crackles (also known as rales, sounds heard in a lung field characterized by popping or rattling sounds and can indicate fluid in the lungs or other lung condition) at the left lower part of the chest. Further review indicated, Resident 91's physician was notified and had ordered a cough medication and a STAT (comes from Latin word, STATim which translate immediately and it means that the order should be prioritized first as it is needed urgently) chest x-ray. Review of Resident 91's chest x-ray result dated 3/16/2025, indicated Resident 91 had pneumonia in the right lower lobe of the lungs. Review of Resident 91's 3/2025 MAR indicated Resident 91 received antibiotics from 3/17/2025 to 3/24/2025 for pneumonia. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the infection preventionist (IP) on 3/27/2025 at 3:00 p.m., the IP confirmed Resident 91 did not receive pneumococcal vaccine since January 2025, had pneumonia in March 2025 and completed a full course of antibiotics for pneumonia. The IP stated they had a vaccination clinic (VC) and Resident 91 did not receive the vaccine because VC did not provide the pneumococcal vaccine due to Resident 91's insurance, which was not funded by Health Services Advisory Group (HSAG - a Medicare Quality Improvement Organization [QIO] in California, working to improve the quality and safety for beneficiaries and providers). The IP confirmed she did not contact Resident 91's insurance case manager or physician to obtain an order for administration of Resident 91's pneumococcal vaccine and for the insurance to provide the vaccine. During an interview with the director of nursing (DON) on 3/28/2025 at 8:42 a.m., the DON stated resident's insurance should not stop them from providing the pneumococcal vaccines to residents. The DON further stated they only needed to obtain resident's consent, and a physician's order of resident's vaccine. The DON confirmed they have a house supply of pneumococcal vaccines, and they did not have to wait for the VC's schedule to administer resident's vaccine. During a review of the facility's policy and procedure titled, Pneumococcal Vaccine (Series), date revised 8/2023, indicated, It is our policy to offer Residents immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention - the nation's leading science-based, data driven, service organization that protects the public's health) guidelines and recommendations. Each Resident will be assessed for pneumococcal immunization upon admission .the immunization may be administered in accordance with physician's order .A consent form shall be signed prior to administration of vaccine and filed in the individual's medical record. Type of pneumococcal vaccine . offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC recommendations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to ensure updated Coronavirus Disease 2019 (COVID-19, a highly contagious respiratory illness in humans capable of producing severe symptoms) 2024-2025 vaccination (a way to create immunity to [protection from] diseases) was offered to two of five sampled residents (Residents 15 and 35). This deficient practice placed Resident 15 and Resident 35 at risk for COVID-19 infection and had the potential to result in the spread of infection placing residents, staff, and visitors at risk to be infected with COVID-19. Findings: 1.Review of Resident 15's clinical record titled, Admission Record, dated 3/26/2025, indicated Resident 15 was readmitted to the facility on [DATE] with diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with other diabetic kidney complication, essential hypertension (HTN-high blood pressure), and schizophrenia (a mental illness that is characterized by disturbances in thought). Review of Resident 15's clinical record titled, Immunization Report, date ranged 12/28/202-3/31/2025, indicated Resident 15's latest COVID-19 vaccine was administered on 9/19/2024. Further review indicated the vaccine Resident 15 received was Comirnaty COVID-19 2023 Vaccine. During a concurrent interview with the infection preventionist (IP) and record review of Resident 15's Immunization report on 3/27/2025 at 2:26 p.m., the IP confirmed she missed to get a consent from Resident 15 which resulted to Resident 15's inability to received the COVID 19 2024-2025 vaccine. The IP further confirmed, the facility had a vaccination clinic (VC) held on 3/19/2025 where they provided the COVID-19 2024-2025 vaccine. During a review of the Centers for Disease Control and Prevention's (CDC - the nation's leading science-based, data driven, service organization that protects the public's health) guidelines titled, Staying Up to Date with COVID-19 Vaccines, dated 1/7/2025, indicated, WHAT TO KNOW The COVID-19 vaccine helps protect you from severe illness, hospitalization , and death .Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine .People ages 12-[AGE] years - You are up to date when you have received: *1 dose of the 2024-2025 .COVID-19 vaccine. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 35's clinical record titled, Admission Record, indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (also called stroke - loss of blood flow to a part of the brain) affecting left non-dominant side (the part of the body [like hand, foot or eye] that is less preferred nor used for tasks compared to its paired counterpart, which is the dominant side), type 2 DM, paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days), and hyperlipidemia (high cholesterol - an excess of lipids or fats in the blood). Review of Resident 35's clinical record titled, 'Immunization Report, date ranged 2/9/2022 - 3/31/2025, indicated Resident 35's latest COVID-19 vaccine was administered on 9/19/2024. Further review indicated the vaccine Resident 35 received was Comirnaty COVID-19 2023 Vaccine. During a concurrent interview with the infection preventionist (IP) and record review of Resident 35's Immunization report on 3/27/2025 at 2:39 p.m., the IP confirmed Resident 35 did not receive the COVID 19 2024-2025 vaccine during their VC on 3/19/2025. The IP stated she ran out of time collecting consents for the VC on 3/19/2025 and Resident 35 was one of the residents she missed. During a review of CDC's guidelines titled, Staying Up to Date with COVID-19 Vaccines, dated 1/7/2025, indicated, It is especially important to get your 2024-2025 COVID-19 vaccine if you are ages 65 and older, are at risk for severe COVID-19, or have never received a COVID-19 vaccine .People ages [AGE] years and older - You are up to date when you have received: * 2 doses of any 2024-2025 COVID-19 vaccine 6 months apart. While it is the recommended to get 2024-2025 COVID-19 vaccine doses 6 months apart, the minimum time is 2 months apart, which allows flexibility to get the second dose prior to typical COVID-19 surges, travel, life events, and healthcare visits.

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	03/28/2025

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

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation and interview, the facility failed to meet the requirement of having no more than four residents per room, when room [ROOM NUMBER] had six residents in the room. Having more than four residents in a room could potentially compromise the quality of life, care and services the residents receive. Findings: During observations on 3/24/2025 at 10:22 a.m. and 3/25/2025 at 9:10 a.m., room [ROOM NUMBER] was observed to accommodate six residents. room [ROOM NUMBER] was 800 square feet, and each resident had 133 square feet. The room had adequate space for the residents to move about and for care to be given. Each resident had a bed, privacy curtain, nightstand, and a closet. The bed did not block any closets, bathrooms, or exits. Two residents were observed to be able to wheel themselves inside the room without difficulty. One resident had an oxygen concentrator (a device which concentrates the oxygen from ambient air) at bedside and still observed to have enough space. There was no safety hazard or privacy concerns. During the survey, residents and staff were interviewed to determine if there were any concerns or issues with residing in room [ROOM NUMBER]. The residents and staff verbalized no complaints or concerns regarding six residents in room [ROOM NUMBER]. No quality of care or quality of life concerns were identified during resident and staff interviews regarding room size and number of resident occupants.