

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Skyline Healthcare Center - San Jose		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 Forest Avenue San Jose, CA 95128	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>36623</p> <p>Based on interview and record review, the facility failed to ensure the physician orders of one of three residents (Resident 1) were followed when a nurse did not perform a blood sugar check, administer insulin, and administer the correct dose of medication to Resident 1 timely. These failures had the potential to affect the health of Resident 1.</p> <p>Findings:</p> <p>Review of Resident 1's face sheet indicated the resident was admitted with diagnoses including nausea with vomiting and Type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>Review of Resident 1's Physician Order Report, from 11/16/24 - 12/9/24 indicated the resident had orders for the following:</p> <ul style="list-style-type: none"> - Admelog SoloStar (insulin lispro [a short acting medication to helps to lower sugar in the blood]) 100 unit/ milliliter (mL, unit of measurement), per sliding scale for DM before meals 6:45 a.m., 11:45 a.m., 4:45 p.m., dated 12/4/24; - Myfortic (mycophenolate sodium [medication used to prevent the body from rejecting an organ transplant] tablet, delayed release, 360 mg (milligrams, unit of measurement), 3 tables, oral twice a day; 9 a.m., 9 p.m. <p>Review of Resident 1's Diabetes Administration History, from 11/26/24 - 12/7/24 indicated on 12/3/24, insulin lispro was administered late.</p> <p>Review of Resident 1's Progress Note, dated 12/3/24 indicated, Writer was notified by supervisor and charge nurse that the resident missed 2 tabs of his Mycophenate [sic] medication which is supposed to be 3 tabs .</p> <p>Review of Resident 1's Progress Note, dated 12/4/24 indicated, Writer was informed about the late administration of blood glucose check yesterday 12/3/24 and insulin per sliding scare. LN [licensed nurse] at new station checked resident's blood glucose as soon as nurse received report that it was not done at the previous station .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Risk Meeting Notes Weekly, dated 12/4/24 indicated, MD has an order of Mycophenolate 360 mg 3 tabs BID (9am and 9pm). It was reported that charge nurse only administered 1 out of 3 tabs at 12:20PM . Charge nurse also missed checking blood sugar at 11:45AM before lunch and therefore was not given insulin on time .</p> <p>During an interview on 1/17/25 at 10:57 a.m., the director of nursing (DON) stated she interviewed the nurse (Registered Nurse A [RN A]). The DON stated RN A only gave one tablet of mycophenolate to Resident 1. The DON stated Resident 1 was given the other two tablets within six hours. The DON stated medications are supposed to be given one hour before or one hour after the scheduled time. The DON stated later they found out in the afternoon that RN A did not check Resident 1's blood sugar before lunch. The DON confirmed the blood sugar check and insulin administration was delayed. The DON stated the physician orders written in the chart should be followed.</p> <p>Review of the facility's Medication Administration General Guidelines, dated 1/23 indicated, Medications are administered in accordance with written orders of the prescriber . Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on meal times.</p> <p>Based on interview and record review, the facility failed to ensure the physician orders of one of three residents (Resident 1) were followed when a nurse did not perform a blood sugar check, administer insulin, and administer the correct dose of medication to Resident 1 timely. These failures had the potential to affect the health of Resident 1.</p> <p>Findings:</p> <p>Review of Resident 1's face sheet indicated the resident was admitted with diagnoses including nausea with vomiting and Type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>Review of Resident 1's Physician Order Report, from 11/16/24 - 12/9/24 indicated the resident had orders for the following:</p> <ul style="list-style-type: none"> - Admelog SoloStar (insulin lispro [a short acting medication to helps to lower sugar in the blood]) 100 unit/ milliliter (mL, unit of measurement), per sliding scale for DM before meals 6:45 a.m., 11:45 a.m., 4:45 p.m., dated 12/4/24; - Myfortic (mycophenolate sodium [medication used to prevent the body from rejecting an organ transplant] tablet, delayed release, 360 mg (milligrams, unit of measurement), 3 tables, oral twice a day; 9 a.m., 9 p.m. <p>Review of Resident 1's Diabetes Administration History, from 11/26/24 - 12/7/24 indicated on 12/3/24, insulin lispro was administered late.</p> <p>Review of Resident 1's Progress Note, dated 12/3/24 indicated, Writer was notified by supervisor and charge nurse that the resident missed 2 tabs of his Mycophenate [sic] medication which is supposed to be 3 tabs .</p> <p>(continued on next page)</p>		

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