

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  The Reutlinger Community		STREET ADDRESS, CITY, STATE, ZIP CODE  4000 Camino Tassajara Danville, CA 94506	

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>44823</p> <p>Based on observation, interview and record review, the facility failed to ensure completion of a physician ' s order of stat (immediate) lab draw for one of the residents (Resident 1) for eight hours.</p> <p>This failure resulted in Resident 1 having a delay in the completion of a physician ' s order of stat blood draw which potentially impacted Resident 1 ' s treatment and well-being.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s face sheet, undated, Resident 1 was admitted in November 2022 with diagnoses of essential hypertension (high blood pressure without identifiable cause).</p> <p>During a record review of Progress Notes written on 11/16/22 at 1715 (5:15 p.m.), the note indicated a physician telephone order at 3:00 p.m. for stat blood draw for complete blood count (CBC-measures number and size of different cells in the blood), basic metabolic panel (BMP-measures glucose, calcium, sodium, potassium, carbon dioxide and chloride levels in the blood and kidney functioning), urinalysis (UA-detects urinary tract infections, kidney disease and diabetes) and culture &amp; sensitivity (C&amp;S-detects infection).</p> <p>During an interview on 8/21/23, at 1:10 p.m., with Laboratory Staff (LS) 1, LS 1 stated the facility called the lab for stat labs on 11/16/22 at 4:18 p.m. Per LS 1, dispatch notes at 11:45 p.m. indicated there was no lab tech available to go to the facility. LS 1 stated the facility contacted the lab and cancelled the lab order on 11/17/22 at 12:44 a.m. as Resident 1 was taken to the hospital.</p> <p>During an interview on 10/1/24, at 9:15 a.m., with the Director of Nursing (DON), the DON stated stat labs had to be done within four hours. Per DON, if in three hours still no lab, call the lab again to get lab draw expedited.</p> <p>During an interview on 10/17/24, at 8:55 a.m., with Licensed Vocational (LVN) 1, LVN 1 stated stat lab order is supposed to be completed within four to six hours. Per LVN 1, if there was still no lab tech, contact the lab ' s area manager to get a status and to get labs get done sooner.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Diagnostic Services, dated 5/24/13, the P&amp;P indicated, All requests for diagnostic services must be ordered by a physician and completed timely.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  The Reutlinger Community		STREET ADDRESS, CITY, STATE, ZIP CODE  4000 Camino Tassajara Danville, CA 94506	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44823</p> <p>Based on observation, interview and record review, the facility failed to provide accurate patient records when one resident (Resident 1) was transferred to a hospital.</p> <p>This failure resulted in Resident 1 not having the correct records at the hospital which potentially delayed identification and treatment.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s face sheet, undated, Resident 1 was admitted in August 2024 with diagnoses of urinary tract infection (UTI - an infection in the bladder/urinary tract) and unspecified atrial fibrillation (irregular, often heart rate that commonly causes poor blood flow).</p> <p>During a record review of Progress Notes: Health Status Note written on 8/17/24 at 1509 (3:09 p.m.), the note indicated Resident 1 was transported to the hospital at 12:30 p.m. for further evaluation as Resident 1 tested positive for Covid. Per the note, Resident 1 was lethargic (drowsy, not alert), had poor oral intake, and low blood pressure.</p> <p>During an interview on 9/10/24, at 10:29 a.m., with Unit Manager (UM), UM stated when Resident 1 was transferred to the hospital, the transfer packet documents that went with Resident 1 to the hospital was incorrect. Per UM, another nurse handed her an envelope with Resident 1 ' s name on it. UM added she saw a face sheet inside the envelope but did not verify face sheet information. UM stated she usually checked the face sheet. Per UM, the packet had an incorrect face sheet. UM stated it was her fault for not checking the contents of the envelope. Per UM, she knew about the incorrect transfer packet when ADM spoke to her about it as ADM was notified by the hospital.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Transfer, dated 10/1999, the P&amp;P indicated, The receiving community will be provided all pertinent medical and other information concerning a resident transferred from this community to assure continuity of care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2024
NAME OF PROVIDER OR SUPPLIER  The Reutlinger Community		STREET ADDRESS, CITY, STATE, ZIP CODE  4000 Camino Tassajara Danville, CA 94506	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44823</p> <p>Based on interview and record review, the facility failed to notify one resident ' s (Resident 1) emergency contact family member of a Covid outbreak at the facility.</p> <p>This failure resulted in Resident 1 ' s family member not receiving Covid exposure status of Resident 1. Resident 1 subsequently tested Covid positive and was hospitalized .</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s face sheet, undated, Resident 1 was admitted in August 2024 with diagnoses of urinary tract infection (UTI - an infection in the bladder/urinary tract) and unspecified atrial fibrillation (irregular, often heart rate that commonly causes poor blood flow).</p> <p>During an interview on 9/6/24, at 9:52 a.m., with Infection Preventionist (IP), IP stated when a resident tested Covid positive, notifications were made to family members listed on the face sheet. Per IP, Administrator (ADM) would send mass email notifications to residents ' family members.</p> <p>During a record review of the facility ' s Covid status tracking sheet, the Covid status tracking sheet indicated a Covid outbreak on 8/11/24. Resident 1 tested Covid positive on 8/17/24.</p> <p>During an interview on 9/6/24, at 10:25 a.m., with ADM, ADM stated he created the Covid 19 notification letter, and another staff sent out the emails. During an interview at 11:03 a.m., ADM added the facility used the face sheet to get email contact information. Per ADM, Resident 1 ' s family member was not notified of the outbreak as there was no email address on file. ADM stated he assumed everyone had email addresses.</p>