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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055562 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/05/2026 |
| NAME OF PROVIDER OR SUPPLIER Niles Canyon Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 38650 Mission Boulevard Fremont, CA 94536 | |

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) |
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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>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow doctor's orders to perform STAT (immediately or without delay) X-ray (imaging of inside of body) for over 10 hours for one of three sampled residents (Resident 1) after a fall at the facility. Resident 1 was later diagnosed with fracture (broken bone) of the Right Tibia (shin) and Fibula (calf bone) related to the fall. This failure resulted in Resident 1 to stay in pain/discomfort for over 10 hours and caused a delay in treatment. During a review of Resident 1's admission record printed on 1/8/26, the record indicated Resident 1 was admitted to the facility on [DATE]. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment used to create individualized care plan) dated 5/2/25, the assessment indicated Resident 1's Brief Interview for Mental Status (BIMS, short-term memory screening tool), score was nine (9) out of 15, indicating moderately impaired thinking or memory. The assessment indicated Resident 1 required staff supervision or touching assistance with toileting transfer. During an interview on 1/5/26 at 12:50 p.m. Certified Nursing Assistant (CNA) 1, CNA 1 stated she assisted Resident 1 for toileting on 7/8/25, while Resident 1 used a bedside commode (a portable toilet). CNA 1 stated after toileting, Resident 1 got up from the commode, got stuck, couldn't turn or walk to the bed, and she ended up assisting Resident 1 onto the floor. During an interview on 1/5/26 at 1:15 p.m., Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was the assigned nurse for Resident 1 when she fell on 7/8/25 at 2:00 pm. LVN 1 stated Resident 1 complained of three out of 10 pain (mild pain) after the fall incident on 7/8/25 and was given Tylenol for pain management. During a phone interview on 1/6/26 at 11:31 a.m. LVN 2, LVN 2 stated she was the evening shift (3:00 p.m.- 11:00 p.m.) nurse on 7/8/25 for Resident 1. LVN 2 stated Resident 1 had non-verbal cues of pain and she gave her another dose of Tylenol. LVN 2 stated she noticed an increase in swelling on Resident 1's right ankle and called the doctor. LVN 2 stated around 4:00 pm, the doctor ordered a STAT x-ray for Resident 1's bilateral knees and right ankle. LVN 2 stated STAT orders should be completed within four (4) hours, however Resident 1's X-ray was not completed even until end of her shift. During a record review of Resident 1's progress notes dated 7/8/25 the progress notes indicated, at 3:40 p.m. LVN 2 noted bilateral (both) knee and right ankle swelling with complaint of three out of 10 pain and at 4:00 p.m. Resident 1's doctor was notified who ordered STAT x-ray. During a record review of Resident 1's Order Listing Report (Doctor's orders) printed on 1/6/26, the order report indicated to complete STAT X-ray on bilateral (both) knee and right ankle for swelling [related to fall on 7/8/25]. During a phone interview on 1/8/26 at 2:05 p.m., LVN 3 stated she was the assigned night shift nurse (11:00 pm on 7/8/25 through 7:00 am on 7/9/25) for Resident 1. LVN 3 stated she noted swelling, pain and purple discoloration on Resident 1's right ankle. LVN 3 since the STAT X-ray for bilateral knee and right ankle was still not conducted until she came on shift, she notified Resident 1's doctor at 11:39 p.m. and got an order to send Resident 1 to an acute care hospital for further evaluation. During a record review of Resident 1's Medication</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 055562 | If continuation sheet Page 1 of 2 |

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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>Administration Record (MAR) for July 2025, the MAR indicated on 7/8/25 Resident 1 required pain management after the fall and received two tablets of Acetaminophen (Tylenol) 325 milligrams (mg) (a total of 650 mg) at 2:27p.m, 3:10p.m, and 9:30p.m.During a record review of Resident 1's progress notes dated 7/8/25, LVN 3 documented Resident 1 was sent to acute hospital -Emergency department at 12:49 am on 7/9/25.During a record review of Resident 1's acute hospital Discharge summary dated [DATE], indicated fracture of tibia/fibula (shin and calf bone) related to the fall at the facility on 7/8/25.During a phone interview on 1/6/26 at 2:12 p.m., the Director of Nursing (DON) stated that STAT orders need to be followed through within four hours the order was received. The DON also stated if facility was unable to meet the timeline for a STAT order, the doctor needed to be notified to rule out any significant change, or to transfer to an acute care hospital.During a review of facility's Policy and procedure (P&P) titled Acute Condition Changes - Clinical Protocol dated 03/2018, the P&P indicated, The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less) . If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, Emergency Room.</p> |