STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055562	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niles Canyon Post Acute	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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 2) had physician orders for hemoglobin A1C (a blood test that shows average level of blood glucose, also called blood sugar, over the past two to three months) monitoring every 6 months and or blood glucose capillary/fingerstick assessments (a rapid diagnostic method used to measure blood sugar found in the bloodstream, serving as the body's main source of energy for cells, tissues, and the brain) at least twice weekly. This failure resulted in Resident 2 having weakness and elevated blood glucose above 800 mg/dL. During record review of admission record, printed on 2/9/26, Resident 2 was admitted on [DATE].During record review of Resident 2's Minimum Data Set (MDS, an assessment used to guide care) dated 2/14/25, indicated Resident 2's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 6 out of 15, indicated Resident 2 had severe cognitive impairment. MDS indicated Resident 2 had a diagnosis of malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and type 2 diabetes (a chronic condition causing high blood sugar because the body cannot properly produce or use insulin, a hormone needed to turn food into energy).During an interview on 2/10/25, at 1:57 p.m., the Director of Nursing (DON) stated a physician's order is needed to perform a blood glucose capillary/fingerstick, but Resident 2 had no physician orders for blood glucose monitoring. DON stated it was important to assess Resident's blood glucose to determine blood sugar status and monitor resident's treatment plan.During an interview on 2/11/26, at 07:55 a.m., the Attending Provider (MD) stated residents receiving oral diabetic medication with a stable diabetic diagnosis should have an order set (a pre-defined, standardized group of medical orders such as labs, medications, imaging, nursing instructions) used in electronic medical record (EHR; a comprehensive, digital, and real-time version of a patient's paper chart, containing medical history, diagnoses, medications, treatment plans, immunization dates, allergies, and lab results) for hemoglobin A1C monitoring every 6 months.During a record review and concurrent interview on 2/11/26, at 2:39 p.m., DON stated Resident 2 was admitted in March 2024 with a diagnosis of diabetes, received orders for oral sitagliptin (an oral prescription-only medication used to lower blood sugar levels in adults with type 2 diabetes), but did not have an order for hemoglobin A1C monitoring every 6 months. During a record review and concurrent interview on 2/13/26, at 10:46 a.m., MD stated hemoglobin A1C monitoring every 6 months was a standard order set that was automatically placed by MD on admission for residents with type 2 diabetes and on oral diabetic medication, but was unsure why Resident 2 did not receive the order set. MD stated they review all orders and placed new orders based on communication from nurses. During a record review and concurrent interview on 2/13/26, at 1:15 p.m., Medical Records (MR) and Administrator (Admin) stated MD had access to the EHR, but used personal electronic medical record system, where MR uploaded SOAP notes (Subjective, Objective, Assessment and Plan; a structured, standardized method of clinical documentation used by (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healthcare providers to record patient encounters efficiently), history and physical (a formal, comprehensive, and essential document in healthcare created by a clinician upon a patient's admission to a hospital or during a new consultation), laboratory results, past medical history, and current medications from hospital medical records for MD review. MR stated they upload relevant documents monthly into MD's personal EHR for record review, per request. During a review of Resident 2's Order Listing Report, there was no ordered hemoglobin A1C monitoring every 6 months by MD initiated at admission.During a review of Resident 2's Weights and Vitals Summary, there were no blood sugar assessments between admission, 3/11/24, and 3/18/25.During a review of Resident 2's Facesheet from the General Acute Care Hospital (GACH), dated 3/9/2025, Resident 2 was admitted to GACH on 3/9/25 at 3:47 p.m. with altered mental status, including lethargy, confusion, partial responsiveness, and weakness. During a review of Resident 2's Labs from the GACH, dated 3/9/25 at 6:26 p.m., Resident 2's blood glucose was greater than 800 mg/dl. During a review of the facility's policy and procedure (P&P) titled, Diabetes Clinical Protocol, the P&P indicated, The provider will order desired glucose targets and monitoring regimens, as well as parameters for reporting information related to blood sugar management.the provider will adjust treatments based on these results and other factors such as glycosuria, weight gain or loss, hypoglycemic episodes, etc. Assess glycemic status by A1C measurement, blood glucose monitoring by capillary/fingerstick devices. Examples of blood glucose monitoring for various situations might include the following: For the resident on oral medication(s) who is well controlled monitor blood glucose levels at least twice weekly (or more frequently if there is a change in drugs or drug dosages); monitor A1C on admission (if no results from a previous test are available) or when diabetes is diagnosed and every 6 months thereafter.

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the physician failed to provide laboratory orders for routine monitoring of one of two sampled Residents' (Resident 2) who was ordered oral sitagliptin (an oral prescription-only medication used to lower blood sugar levels in adults with type 2 diabetes).This failure resulted in Resident 2 having weakness and elevated blood glucose above 800 mg/dL. During record review of admission record, printed on 2/9/26, Resident 2 was admitted on [DATE].During record review of Resident 2's Minimum Data Set (MDS, an assessment used to guide care) dated 2/14/25, indicated Resident 2's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 6 out of 15, indicated Resident 2 had severe cognitive impairment. MDS indicated Resident 2 had a diagnosis of malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and type 2 diabetes (a chronic condition causing high blood sugar because the body cannot properly produce or use insulin, a hormone needed to turn food into energy).During a record review and concurrent interview on 2/11/26, at 2:39 p.m., with the Director of Nursing, the Lab Results Report was reviewed. DON stated Resident 2 was admitted in March 2024 with a diagnosis of type 2 diabetes and received orders for oral sitagliptin. DON stated the Lab Results Report with reported date of 3/16/2024 at 2:31 p.m., ordered by Attending Provider (MD), indicated hemoglobin A1C (a blood test that shows your average level of blood glucose, also called blood sugar, over the past two to three months) was 10.8%, and estimated average glucose (estimated average of your blood glucose levels over a period of 2 to 3 months) was 263 mg/dL. DON stated lab results should have been communicated to MD via fax. DON stated the lab results report was reviewed by Assistant Director of Nursing (ADON), which indicated ADON opened lab results report in EHR. During a record review and concurrent interview on 2/13/26, at 10:46 a.m., MD stated they relied on nursing staff to communicate abnormal lab reports to MD by phone or text message. MD stated the Lab Results Report with reported date of 3/16/2024 at 2:31 p.m., ordered by MD, indicated hemoglobin A1C was 10.8%, and estimated average glucose was 263 mg/dL, which was elevated, very high and warranted additional orders. MD stated 3/16/2024 lab report was not reviewed by MD. MD stated Comprehensive Metabolic Panel (a common, 14-substance blood test that evaluates overall health, including kidney and liver function, blood glucose, calcium levels, protein levels, and electrolyte balance) collected on 2/21/2025 at 1:55 p.m., ordered by MD, indicated glucose was 273 mg/dL, was high and warranted MD notification for additional orders. MD stated it was the nurses' responsibility to call MD with abnormal lab results. MD stated he does not follow up on ordered lab results, only relied on nurses to communicate abnormal results. MD stated it was important for abnormal lab results to be communicated to MD for proper interventions.During a record review and concurrent interview on 2/13/26, at 1:15 p.m., Medical Records (MR) and Administrator (Admin) stated MD had access to the electronic medical record (EHR; a comprehensive, digital, and real-time version of a patient's paper chart, containing medical history, diagnoses, medications, treatment plans, immunization dates, allergies, and lab results), but used personal electronic medical record system, where MR uploaded SOAP notes (Subjective, Objective, Assessment and Plan; a structured, standardized method of clinical documentation used by healthcare providers to record patient encounters efficiently), history and physical (a formal, comprehensive, and essential document in healthcare created by a clinician upon a patient's admission to a hospital or during a new consultation), laboratory results, past medical history, and current medications from hospital medical records for MD review. MR stated uploads relevant documents monthly into MD's personal EHR for record review, per MD's request. During a review of Resident 2's Facesheet from the General Acute Care Hospital (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(GACH), dated 3/9/2025, Resident 2 was admitted to GACH on 3/9/25 at 3:47 p.m. with altered mental status, including lethargy, confusion, partial responsiveness, and weakness. During a review of Resident 2's Labs from the GACH, dated 3/9/25 at 6:26 p.m., Resident 2's blood glucose was greater than 800 mg/dl. During a review of the facility's policy and procedure (P&P) titled, Diabetes Clinical Protocol, the P&P indicated, The provider will order desired glucose targets and monitoring regimes. The provider will individualize monitoring frequency based on the complexity of the resident's regimen combined with the risk of hypoglycemia.Assess glycemic status by A1C measurement, blood glucose monitoring by capillary/fingerstick devices. During a review of the facility's P&P titled, Lab and Diagnostic Test Results-Clinical, the P&P indicated, The physician will identify and order diagnostic and lab testing based on resident's diagnostic and monitoring needs.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff contacted the physician on two occasions regarding one of two sampled Residents' (Resident 2) elevated blood sugar levels, but physician did not review the recorded laboratory results, talk to nurse regarding Resident's status or order changes to Resident 2's treatment regimen. This failure resulted in Resident 2 having weakness, and elevated blood glucose above 800 mg/dL. During record review of admission record, printed on 2/9/26, Resident 2 was admitted on [DATE].During record review of Resident 2's Minimum Data Set (MDS, an assessment used to guide care), dated 2/14/25, indicated Resident 2's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 6 out of 15, indicated Resident 2 had severe cognitive impairment. MDS indicated Resident 2 had a diagnosis of type 2 diabetes (a chronic condition causing high blood sugar because the body cannot properly produce or use insulin, a hormone needed to turn food into energy).During a record review and concurrent interview on 2/13/2026, at 12:46 p.m., the Director of Nursing (DON) stated labs were filed in electronic medical record (EHR; a comprehensive, digital, and real-time version of a patient's paper chart, containing medical history, diagnoses, medications, treatment plans, immunization dates, allergies, and lab results) by Medical Records (MR) after received and reviewed by nurses. DON stated physicians have access to EHR, but nurses were also responsible for placing lab results within paper chart. DON stated nurses also communicated with Attending Provider (MD) by phone or text and should write MD notified with date, time and signature on lab results after communicated with MD. During a record review and concurrent interview on 2/13/26, at 10:46 a.m., MD stated they relied on nursing staff to communicate abnormal lab reports to MD by phone or text message. MD stated the Lab Results Report resulted on 3/16/2024 at 2:31 p.m., ordered by MD, indicated hemoglobin A1C was 10.8%, and estimated average glucose was 263 mg/dL, which was elevated, very high and warranted additional orders. MD stated 3/16/2024 lab report was not sent or reviewed by MD. MD stated the Comprehensive Metabolic Panel (a common, 14-substance blood test that evaluates overall health, including kidney and liver function, blood glucose, calcium levels, protein levels, and electrolyte balance) resulted on 2/21/2025 at 3:16 p.m., ordered by MD, indicated glucose was 273 mg/dL, was high and warranted MD notification for additional orders. MD stated it was the nurses' responsibility to call or text MD with abnormal lab results. MD stated reviewed all orders and placed new orders based on communication from nurses during Resident assessments. MD stated important for abnormal lab results to be communicated to MD for proper interventions.During a record review and concurrent interview on 2/13/26, at 1:15 p.m., Medical Records (MR) and Administrator (Admin) stated MD had access to the EHR, but used personal electronic medical record system, where MR uploaded SOAP notes (Subjective, Objective, Assessment and Plan; a structured, standardized method of clinical documentation used by healthcare providers to record patient encounters efficiently), history and physical (a formal, comprehensive, and essential document in healthcare created by a clinician upon a patient's admission to a hospital or during a new consultation), laboratory results, past medical history, and current medications from hospital medical records for MD review. MR stated they uploaded relevant documents monthly into MD's personal EHR for record review, per request. During a review of Resident 2's Lab Results Report, with a result date of 3/16/2024 at 2:31 p.m., ordered by MD, indicated hemoglobin A1C (a blood test that shows your average level of blood glucose, also called blood sugar, over the past two to three months) was 10.8%, and estimated average glucose (estimated average of your blood glucose levels over a period of 2 to 3 months) was 263 mg/dL. The MD did not sign laboratory results to indicate results were reviewed or (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiate any new orders.During a review of facility's physician notification text messages, MD was notified of Resident 2's lab results on 3/17/2024 at 7:00 a.m. with three photos of Resident 2's laboratory results, in which MD did not respond via text message. During a review of Resident 2's Comprehensive Metabolic Panel (CMP), resulted on 2/21/2025 at 3:16 p.m., ordered by MD, indicated glucose was 273 mg/dL. Written on CMP was MD notified by Licensed Vocational Nurse (LVN) 1 on 2/21/25 at 10:58 p.m. The MD did not sign laboratory results to indicate results were reviewed or initiate any new orders. During a review of Resident 2's Facesheet from General Acute Care Hospital (GACH), dated 3/9/2025, Resident 2 was admitted to GACH on 3/9/25 at 3:47 p.m. with altered mental status, including lethargy, confusion, partial responsiveness, and weakness. During a review of Resident 2's Labs from GACH, dated 3/9/25 at 6:26 p.m., Resident 2's blood glucose was greater than 800 mg/dl. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems, the P&P indicated, The practitioner is responsible for.Responding in a timely manner to calls; especially regarding Immediate Notification problems.Communicating sufficient detail to appropriate staff about the assessment and management of the problem and the resident/patient.During a review of the facility's P&P titled, Lab and Diagnostic Test Results-Clinical, the P&P indicated, a Physician can be notified by phone, fax, voicemail, email, mail. Pager or telephone message to another person acting as the physicians agent.Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the progress notes section of the medical record and not on the lab results report. Alternatively, the staff and physician may also establish designated times during the day when they will review test results with physician by phone. A physician will respond within an appropriate time frame, based on the request from nursing staff and clinical significance of the information.A physician should respond within one hour regarding a lab result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response.