

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Gilroy Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8170 Murray Avenue Gilroy, CA 95020	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure to provide care and services to meet professional standards for one of three sampled resident (Resident 1) when license nursing staff failed to follow medical doctor's (MD, a licensed healthcare professional who practices medicine to diagnose, treat, and prevent illnesses, injuries, and other medical conditions for residents) order to notify the MD when Resident 1's blood glucose (BG, sugar level in blood) level were more than 300 (mg/dl, milligrams per deciliter, standard unit of measuring BG) for 14 times across nine days in two months. These failures had the potential to affect plan of care, medical condition and well-being for Resident 1. Findings: Review of resident 1's face sheet (FS, document that gives resident's information at a quick glance) indicated Resident 1 was admitted to facility on 9/29/2025. Review of Resident 1's FS also indicated Resident 1's diagnoses included diabetes type 2 (a chronic medical condition of body not able to maintain normal blood sugar levels). Review of Resident 1's order summary report indicated an order for blood glucose fingerstick (minimally invasive medical procedure involves pricking the finger with a small needle to draw a few drops of blood to verify blood glucose level) monitoring QID (quarter in die, a Latin phrase meaning four times a day) before breakfast, lunch, dinner, & HS (every night at bed time). Call MD if BS (blood sugar/glucose) is under 70 or over 300. This order was started on 9/29/2025 and was discontinued on 11/10/2025. Review of Resident 1's electronic medication administration record (EMAR, a digital version of documentation for medications administration) for October 2025 indicated following: On 10/11/2025, Resident 1's BG was 314 at 11:30 a.m., 378 at 4:30 p.m., 389 at 9:30 p.m. On 10/12/2025, 391 at 6:30 a.m., 385 at 4:30 p.m., 309 at 9:30 p.m. On 10/15/2025, 338 at 9:30 p.m. On 10/17/2025, 366 at 6:30 a.m., 358 at 11:30 a.m. On 10/19/2025, 350 at 4:30 p.m. On 10/23/2025, 352 at 4:30 p.m. On 10/25/2025, 342 at 4:30 p.m. On 10/26/2025, 315 at 4:30 p.m. Review of Resident 1's EMAR for November 2025 indicated on 11/1/2025, BG level was 327 at 6:30 a.m. (According to American Diabetes Association [nation's leading voluntary health nonprofit organization fighting to prevent, manage, and cure diabetes], normal range of BG level 80 to 130 with diagnosis of DM.) Further review of Resident 1's clinical documentation indicated there was no documented evidence that license nursing staff notified the MD for the above times and dates when Resident 1's BG level exceeded 300 for 14 times across nine days in two months period. During an interview with facility's assistant director of nursing B (ADON B) on 6/24/2026 at 12:11 p.m., ADON B confirmed Resident 1's MD's order for notification MD for BG more than 300 level. ADON B also confirmed there was no documented evidence that license nursing staff informed the MD when Resident 1's BG was more than 300. ADON B stated license nursing staff should have followed MD order and informed MD when BG level was noted more than 300 for Resident 1. During an interview with facility's director of nursing (DON) on 6/24/2026 at 12:49 p.m., DON stated license nursing staff should have followed the MD's order and informed MD when BG level more than 300 for Resident 1. DON also stated risk for Resident 1's plan of care and medical condition if license nurse did not follow MD's order to notify high BG levels. Review of facility's policy and procedure (P&P) titled, Nursing Care of the Older Adult with Diabetes Mellitus, revised November 2020, the P&P indicated, Establish provider notification protocols, for example: b. Call as soon as possible when: 2. blood glucose values are >250 mg/dl., more than once within a 24-hr period; 3. blood glucose values are >300mg/dl., more than once over two consecutive days.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055797

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to follow their policy and procedure (P&P) for prevention of pressure injuries (localized damage to the skin and underlying soft tissue when exposed to prolonged or intense pressure) for one of three sampled resident (Resident 1) when there was no documented evidence indicated for Resident 1's braden assessment (a standardized, evidence-based clinical tool used by healthcare professionals to predict a resident's risk of developing pressure injuries) completed upon admission to the facility on 9/29/2025. This failure had the potential to affect pressure injury management for Resident 1. Findings: Review of resident 1's face sheet (FS, document that gives resident's information at a quick glance) indicated Resident 1 was admitted to facility on 9/29/2025. Review of Resident 1's FS also indicated Resident 1's diagnoses included fibromyalgia (a medical condition characterized by widespread body pain, fatigue, sleep problems and cognitive distress), paraplegia (a medical condition with partial or complete loss of motor and sensory function in the lower half of the body, typically including both legs), diabetes type 2 (a chronic medical condition of body not able to maintaining normal blood sugar levels), pressure ulcer (pressure injury) of unspecified site, and anemia (a medical condition with lack of enough healthy red blood cells). Review of Resident 1's electronic clinical record indicated there was no documented evidence indicated Resident 1 had braden assessment on 9/29/2025. During a concurrent record review of Resident 1 for braden assessment and interview with facility's assistant director of nursing A (ADON A) on 6/23/2026 at 2:24 p.m., ADON A confirmed there was no braden assessment completed and documented upon admission to facility on 9/29/2025 for Resident 1. ADON A stated license nursing staff were responsible to screen and document braden assessment for Residents upon admission. ADON A also stated license nursing staff should have completed and documented braden assessment for Resident 1 upon admission on [DATE]. During an interview with facility's director of nursing (DON) on 6/24/2026 at 12:49 p.m., DON stated license nursing staff should have screened and documented braden assessment for Resident 1 upon admitted to facility on 9/29/2025 for skin management and prevent new pressure injuries while in facility. Review of facility's undated P&P titled, Prevention of Pressure Injuries, the P&P indicated, Residents will be assessed for pressure injury risk using Braden or other standardized tool: o Upon admission.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from unnecessary medication. Resident 1 received insulin (a man- made medication used to treat high blood glucose [BG, sugar in blood] level) without documented evidence of adequate monitoring for signs and symptoms (s/s) of hypoglycemia (a medical condition with blood glucose drops to dangerous low levels) and hyperglycemia (a medical condition with high blood glucose level) on routine basis for Resident 1. These failures had the potential to affect health condition, well-being and necessary use of insulin for Resident 1. Findings: Review of resident 1's face sheet (FS, document that gives resident's information at a quick glance) indicated Resident 1 was admitted to facility on 9/29/2025. Review of Resident 1's FS also indicated Resident 1's diagnoses included diabetes type 2 (DM2, a chronic medical condition of body not able to maintain normal blood sugar levels). Review of Resident 1's order summary dated 9/29/2025 indicated an order for insulin aspart (a fast acting man- made medication used to treat DM2) 100 units/ml (units per milliliter, measurements of liquid concentration) 5 units inject subcutaneously (SQ, a method of administering medication under the skin) before meals for DM. Review of Resident 1's order summary dated 9/29/2025 also indicated another order for insulin glargine (a long acting man- made medication used to treat DM2) 100 units/ml, inject 34 units SQ at bed time for DM. Review of Resident 1's clinical record indicated, there was no documented evidence that facility adequately monitored for s/s of hypoglycemia (such as intense hunger, confusion and mild shakiness) and hyperglycemia (excessive thirst, frequent urination, blurred vision, and extreme fatigue) for Resident 1. Review of Resident 1's order summary report indicated an order for, Blood Glucose Fingerstick (minimally invasive medical procedure involves pricking the finger with a small needle to draw a few drops of blood to verify blood glucose level) monitoring QID (quarter in die, a Latin phrase meaning four times a day) before breakfast, lunch, dinner, & HS (every night at bed time). Call MD if BS (blood sugar/glucose) is under 70 or over 300. This order was dated 9/29/2025 and was discontinued on 11/10/2025. Review of Resident 1's electronic medication administration record (EMAR, a digital version of documentation for medications administration) for October 2025 indicated following: On 10/11/2025, BG was Resident 1's 314 at 11:30 a.m., 378 at 4:30 p.m., 389 at 9:30 p.m. On 10/12/2025, 391 at 6:30 a.m., 385 at 4:30 p.m., 309 at 9:30 p.m. On 10/15/2025, 338 at 9:30 p.m. On 10/17/2025, 366 at 6:30 a.m., 358 at 11:30 a.m. On 10/19/2025, 350 at 4:30 p.m. On 10/23/2025, 352 at 4:30 p.m. On 10/25/2025, 342 at 4:30 p.m. On 10/26/2025, 315 at 4:30 p.m. Review of Resident 1's EMAR for November 2025 indicated on 11/1/2025, BG level was 327 at 6:30 a.m. (According to American Diabetes Association [nation's leading voluntary health nonprofit organization fighting to prevent, manage, and cure diabetes], normal range of BG level 80 to 130 with diagnosis of DM) Further review of Resident 1's clinical documentation indicated there was no documented evidence of license nursing staff notified MD with above times and dates with BG level more than 300, 14 times across nine days in two months period. There was no documented evidence that facility monitored and documented s/s of hyperglycemia for above 14 times across nine days in two months when Resident 1's BG levels exceeded 300. During an interview with facility's assistant director of nursing B (ADON B) on 6/24/2026 at 12:40 p.m., ADON B confirmed MD's order for insulin and diagnosis of DM 2 for Resident 1. ADON B also confirmed there was no documented evidence of license staff monitored Resident 1 for s/s of hypo or hyperglycemia. ADON B stated license staff should have monitored and documented every shift for s/s of hypoglycemia and hyperglycemia based on Resident 1's medical condition and variable blood glucose levels. During an interview with facility's director of nursing (DON) on 6/24/2026 at 12:49 p.m., DON stated license nursing staff should have monitored and documented s/s of hyperglycemia and hypoglycemia every shift for Resident 1. Review of facility's policy and procedure (P&P) titled, Nursing Care of the Older Adult With Diabetes mellitus, Revised November 2020, indicated, Older adults with diabetes should be regularly screened for cognitive impairment. Cognitive decline is associated with increased risk of hypoglycemia.		