STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055800	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Health and Rehabilitation	350 DE Soto Drive Los Gatos, CA 95032

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper drying of cooking/serving equipment, when a large baking pan and three steam table pans were stacked while still wet. This failure had the potential to cause foodborne illness (illness resulting from contaminated food) for 67 residents who received food from the kitchen. Findings:During an initial inspection of the kitchen, 1 large baking pan was observed wet in the stack of baking pans that had been put away for storage, 1 steam table pan in a stack of steam table pans which had been put away for storage, and three other steam table pans in a different stack of steam table pans which had been put away for storage.During an interview with the dietary manager (DM) on 7/28/25 at 8:53 a.m., he acknowledged that there were one large baking pan and four steam table pans which had been stacked for storage and were still wet.During a review of the facility's undated policy and procedure (P&P) titled, Dish Washing, the P&P indicated .5. Dishes are to be air dried in racks before stacking and storing.

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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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure that alternatives were attempted and documented prior to using side rails (devices attached to the side of a bed) for 32 of 68 sampled residents (Residents 1, 4, 6, 12, 16, 17, 18, 25, 26, 31, 32, 33, 43, 48, 50, 51, 56, 59, 70, 82, 83, 84, 86, 87, 88, 89, 93, 94, 95, 96, 100, and 101) reviewed for side rail use.Findings:During multiple observations on 7/28/25 between 9:00 a.m. and 3:00 p.m., Residents 1, 4, 6, 12, 16, 17, 18, 25, 26, 31, 32, 33, 43, 48, 50, 51, 56, 59, 70, 82, 83, 84, 86, 87, 88, 89, 93, 94, 95, 96, 100, and 101 were observed with both upper side rails raised.Review of the Alternative Measures Tried section on the facility's Siderails Screening Tool showed no evidence that alternatives were attempted or documented prior to using side rails for all 32 residents reviewed.During an interview with the Director of Nursing (DON) on 7/30/25 at 11:10 a.m., when asked what alternatives were tried before using side rails, the DON stated that on admission, the charge nurse asked the resident if they want the side rails up or down. The DON stated that the use of side rails were based on resident's preference. The DON stated that nurses documented the alternatives in the Alternative Measures Tried section of the Siderail Screening Tool.During concurrent record review of the facility's Siderail Screening Tool with the DON for one resident, the DON confirmed the section was blank. The DON acknowledged this section should have been completed and stated she would address the issue.During a interview with the Assistant Director of Nursing (ADON) on 7/30/25 at 3:10 p.m., the ADON stated that on admission, staff informed the residents that side rails were considered enabler (a device that helps a resident move or reposition) or were used for repositioning. If residents agreed to have side rails, they are used.During a concurrent record review with the ADON of the Siderail Screening Tool of 68 sampled residents, the ADON confirmed the Alternative Measures Tried section of the Side rails Screening Tool were blank for the 32 residents with side rails. The ADON stated that this section should have been completed.Review of the facility's policy, Proper Use of Side rails revised 12/2016, indicated Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of siderails.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program to prevent the spread of infections as evidenced by:1. Licensed nurses did not know the process to disinfect a glucometer (blood glucose meter to measure and display the amount of sugar [glucose] in your blood) according to manufacturer's instructions;2. Resident 52's urinary catheter bag (a bag that is attached to a tube that is connected to the bladder) was touching the floor; and3. The Certified Nursing Assistant (CNA) did not perform hand hygiene after removing her gloves and prior handling the new clean bed linens.These failures had the potential to compromise resident's health and safety in the facility.1. During a medication administration observation on 7/28/25 at 11:40 a.m. with Registered Nurse (RN) A, RN A completed a blood sugar check on Resident 48. RN A used a disinfectant “Sani-Cloth” wipe and wiped the front and back of glucometer device for 4 seconds and then placed the glucometer in a small plastic basket. When RN A was asked what the contact time (the amount of time disinfectants need to remain wet on surfaces to properly disinfect) was, she stated “5 seconds.” A review of the product labeling for the Sani-Cloth disinfectant wipes used by RN A indicated “Disinfects in 2 minutes” and further label information indicated “Contact time: Use wipe to thoroughly wet surface. Allow surface to remain visibly wet for two (2) minutes. Let air dry.” RN A read the label on the disinfectant Sani-Cloth wipes and confirmed the contact time was 2 minutes, not 5 seconds. During an interview on 7/30/25 at 7:18 a.m. with RN B, she stated she has 16 residents who require blood sugar checks in the morning before breakfast. RN B stated she uses a shared (used for multiple residents) glucometer to check the resident's blood sugar levels. When asked what the contact time was for disinfecting a shared glucometer, RN B stated “30 seconds.” RN B stated she uses Sani-Cloth disinfectant wipes to disinfect the glucometer. RN B read the label on the disinfectant Sani-Cloth wipes and confirmed the contact time was 2 minutes, not 30 seconds. During an interview with the Infection Director of Staff Development/Infection Preventionist (DSD/IP) on 8/1/25 at 8:15 a.m., she was asked about the contact time for disinfecting shared glucometers. The DSD/IP stated the facility uses the product “Sani-Cloth” wipes, which has a contact time of 2 minutes. She further stated all staff should know the contact times for disinfectants to ensure proper use of the product for disinfecting. Review of the facility's policy titled “Obtaining a Fingerstick Glucose Level,” revised October 2011, indicated “Clean and disinfect reusable equipment between uses according to manufacturer's instructions and current infection control standards of practice.” 2. During a concurrent observation and interview on 7/28/25 at 10:01 a.m. with Certified Nursing Assistant (CNA) D in Resident 52's room, CNA D showed Resident 52's urinary catheter bag, which was positioned behind the wheelchair, covered with a white pillowcase and touching the floor. During an interview with CNA D on 7/30/2025 at 2:57 p.m., CNA D confirmed that the urinary catheter bag of Resident 52 was touching the floor following Resident 52's care on Monday, 7/28/25. During an interview with the Director of Staff Development/Infection Preventionist (DSD/IP) on 7/31/25 at 10:01 a.m., the DSD/IP stated, The catheter bag should be off the floor, even if it's covered with a pillowcase. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated September 2014, the P&P indicated, Be sure the catheter tubing and drainage bag are kept off the floor. 3. During an observation on 7/29/25 at 9:15 a.m. in Resident 26's room, CNA E was observed wearing gloves while assisting Resident 12 to the bathroom. While Resident 12 was in the bathroom, CNA E changed the bed linens, bundled the soiled bed linens in a plastic bag, and disposed them in the dirty bin outside the room. Subsequently, CNA E removed her gloves without performing hand hygiene, and proceeded to grab clean bed linens from the rack in the hallway, which she then placed on Resident's bed. During an interview on 7/29/25 at 10:26 a.m. with CNA E, CNA E confirmed that she did not perform hand hygiene after removing her gloves and prior to handling the new clean bed linens. CNA E further stated that it was not okay to remove gloves and touch anything without first performing hand hygiene. An interview with the DSD/IP on 7/31/2025 at 3:17 p.m., the DSD/IP stated that staff were expected to practice hand hygiene before putting on gloves and after taking them off, and that no staff should wear gloves while in the hallway. During an interview on 7/31/25 at 3:32 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that staff were expected to wash their hands or use hand sanitizer before and after using gloves to avoid cross-contamination. A review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised August 2015, the P&P indicated that the facility considers hand hygiene the primary means to prevent the spread of infection - use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations include: after removing gloves .

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and facility document review, the facility failed to maintain resident's rights to privacy and confidentiality to one of 17 sampled residents (Resident 72) when Resident 72's personal information and care instruction was posted in the room visible to roommates and visitors. This failure had the potential to compromise residents' rights and dignity.Findings:During an initial observation on 7/28/25, at 10:01 a.m. in Resident 72's room, an ENT [ear, nose, and throat] Doctor note was observed posted on the wall above Resident 72's head of bed (HOB). The note, which was written in blank ink, indicated a request from Resident 72's daughter for the ENT doctor to examine Resident 72's ears. The note also provided Resident 72's full name and identified Resident 72's diagnosis of bilateral (affecting two sides) hearing loss due to Cerumen [earwax] impaction.During an interview with the Assistant Director of Nursing (ADON) on 7/31/25 at 3:30 p.m., the ADON confirmed that the note titled ENT Doctor which was posted to the wall above Resident 72's HOB contained Resident 72's full name and diagnosis. The ADON mentioned that Resident 72 shares a room with other residents who often have visitors, thereby allowing the visitors the opportunity to view the note. Furthermore, the ADON explained that the note should be covered if requested by the family.A review of the facility's policy and procedure (P&P) titled, Dignity, revised August 2009, the P&P indicated, in number 9. Staff shall maintain an environment in which confidential clinical information is protected, for example: Signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room. Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door). and in number 10. Staff shall promote, maintain and protect resident privacy .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to document the status of Advance Directive for two of 24 residents (Resident 8 and 44), when no advance directive was located in the electronic records, nor was section D of the POLSTs filled out. This failure had the potential of the facility not following the wishes of the residents in the event of incapacitation and need for life saving treatment. Findings:1. During a record review of Resident 8's advance directive status, no advance directive was located, nor any documentation of whether Resident 8 had one or not. On Resident 8's POLST (physician's order for life sustaining treatment), section D had no check marks pertaining to the status of Resident 8's advance directive. There were three check boxes for: 1) Advance Directive dated; 2) Advance Directive not available; and 3) No Advance Directive. All of these check boxes were blank.During an interview with the Assistant Director of Nursing (ADON) on 7/31/25 at 1:33 p.m., she acknowledged there were no boxes check related to advance directive in section D of Resident 8's POLST form, and there should have been.2. During a record review of Resident 44's advance directive status, no advance directive was located, nor any documentation of whether Resident 44 had one or not. On Resident 44's POLST (physician's order for life sustaining treatment), section D had no check marks pertaining to the status of Resident 44's advance directive. There were three check boxes for: 1) Advance Directive dated ___; 2) Advance Directive not available; and 3) No Advance Directive. All of these check boxes were blank.During an interview with the ADON on 7/31/25 at 1:37 p.m., she acknowledged there were no boxes check related to advance directive in section D of Resident 44's POLST form, and there should have been.During a review of the facility's policy and procedure (P&P) titled Advance Directives, revised December, 2016, the P&P indicated1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure that resident's enteral feeding (liquid nutrition directly delivered to the stomach using a tube) bottle was properly labeled for one of three sampled residents (Resident 2). This failure had the potential to cause an error during administration of the enteral feeding formula for Resident 2.Findings:Review of Resident 2's clinical record indicated she had diagnoses including dysphagia (difficulty of swallowing) and presence of a gastrostomy tube (GT, a device surgically inserted into the stomach through the abdomen used to supply nutrition or liquid medication). Resident 2's physician order dated 7/28/25 indicated Jevity 1.2 (liquid nutrition) at 70 milliliters (ml, unit of measurement) per hour for 12 hours from 9 p.m. to 9 a.m. via a feeding pump.During an observation in Resident 2's room on 7/30/25 at 8:05 a.m., there was a GT formula bottle with formula running via an enteral feeding pump attached to a pole next to Resident 2's bed. The feeding formula bottle indicated a net volume of 1500 ml and the reading on the pump indicated the volume of formula delivered was 792 ml. Resident 2's GT formula bottle was not labeled or dated.During a follow-up observation and concurrent interview with Registered Nurse A (RN A) on 7/30/25 at 8:10 a.m., RN A confirmed Resident 2's GT formula bottle was unlabeled and undated. RN A stated the bottle should have been labeled with the resident's name, the rate at which the formula was to be administered, and the date and time the feeding was initiated.During an interview with the Director of Nursing (DON) on 7/31/25 at 7:55 a.m., she confirmed GT feeding formula bottles should be labeled with the resident's name and date the formula is started. The DON further stated the label should indicate the tube feeding order and rate on the label.Review of the facility's policy titled Enteral Tube Feeding via Continuous Pump, revised November 2018, indicated On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure intravenous (IV) therapy (the administration of parenteral fluids or medications through an IV catheter to treat a condition) was labeled for one of four sampled residents (Resident 31).This deficient practice had the potential to compromise Resident 31's health and well-being.Findings:During an initial observation on 7/28/25 at 9:51 a.m., in Resident 31's room, Resident 31 was observed receiving IV therapy with 0.45% Sodium Chloride (a parenteral solution containing sodium chloride in water for injection intended for IV administration). The IV fluid did not have labels indicating Resident 31's name, the start date and time, medication instructions, and the initials of the nurse who administered.During a concurrent observation and interview on 7/28/25 at 10:15 a.m. with Registered Nurse (RN) A in Resident 31's room, RN A confirmed that the IV fluid containing 0.45% Sodium Chloride (also known as half normal saline, a hydrating solution) administered to Resident 31 lacked the necessary labels, including the Resident's name, the date and time the IV was initiated, medication instructions or IV rate, and the initials of the administering nurse. During an interview with the Nurse Supervisor (NS) on 7/28/25 at 10:54 a.m., the NS indicated that nurses were expected to label IV fluids, including the start date and time, as well as the initials of the administering nurse. The NS mentioned that the nurse on the night shift had initiated Resident 31's IV fluids but it was not labeled and dated.A review of Resident 31's Medication Administration Record (MAR), dated 7/1/2025 - 7/31/2025, the MAR indicated, on 7/27/25 at night shift, Sodium Chloride IV Solution 0.45% for hydration was administered.A review of the facility's policy and procedure (P&P) titled, General Policies for IV Therapy, dated March 2023, the P&P indicated, Nurses shall not alter any prescription label prepared by the pharmacy with the exception of the IV rate. With an MD order, rate may be changed when accompanied by the date and nurse's initial. All additive labels will be completed by the nurse administering the IV fluid/medication and are to include the nurse's initials, date and time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide adequate monitoring for three of 17 sampled residents (Resident 72, 52, and 31) when:Resident 72 was not monitored for psychotropic side effects on abnormal involuntary movement based on Medication Regimen Review (MRR); andResident 52 and 31 were not monitored for signs and symptoms of hypo/hyperglycemia (too low/high blood sugar) as indicated in the care plan.These failures had the potential for side effects to go undetected or recognized for timely interventions.Findings:During a concurrent interview and record review on 8/1/25 at 10:10 a.m. with Licensed Vocational Nurse (LVN) C, Resident 72's Medication Administration Record (MAR) was reviewed. LVN C confirmed that there were no tardive dyskinesia (repetitive movements mostly affecting the face) monitoring indicated in Resident 72's antipsychotic side effect monitoring.During a concurrent interview and record review on 8/1/25 at 10:27 a.m. with Registered Nurse (RN) A, Resident 72's MAR was reviewed and no tardive dyskinesia included in the antipsychotic side effect monitoring. RN A explained that the side effect of antipsychotic medication includes mouth dryness, dehydration, and tardive dyskinesia. RN A agreed that tardive dyskinesia should be part of the antipsychotic side effect monitoring. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 8/01/2025 at 10:15 a.m., the ADON explained that the MRR process involves notifying the doctor and considering nursing measures. The ADON further explained that these measures include monitoring medication side effects, resident behavior, and black box warnings. The ADON confirmed that tardive dyskinesia had not been included in Resident 72's antipsychotic side effect monitoring.During a follow-up interview with the ADON on 8/1/25 at 2:58 p.m., the ADON stated that assessments were conducted based on the side effect monitoring conducted by the nurses.A review of Resident 72's clinical record indicated Resident 72 was admitted to the facility on [DATE] with diagnosis including Schizophrenia, unspecified (a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others).A review of Resident 72's Order Summary Report, active order as of 7/31/25, the medication order dated 1/3/25 indicated, Resident 72 had been receiving risperidone (a type of antipsychotic medication that treats mental health conditions schizophrenia) oral tablet, 0.5 milligram (mg, unit of measurement) by mouth at bedtime for SCHIZOPHRENIA.A review of Resident 72's Order Summary Report active order as of 7/31/25, the monitoring order for the side effect of antipsychotic medication (Risperdal) dated 1/3/25 and 2/24/25 did not reflect the tardive dyskinesia monitoring such as tremors, muscle rigidity, and other abnormal motor movements.A review of facility's Consultant Pharmacist's Medication Regimen Review (MRR), dated 2/1/2025 to 2/25/2025 and 3/1/25 to 3/31/25, the MRR indicated missing psychotropic monitoring behavior.A review of Resident 72's Care Plan focused on Alteration in Behavior pattern R/T [related to] (Schizophrenia) M/B [manifested by] angry outburst such as yelling, date initiated 2/24/25, the Care Plan interventions indicated Monitor side effect of Anti-psychotic medication: extrapyramidal reaction [group of side effects that affect the movement usually cause by antipsychotic], . Special Attention for: Tardive dyskinesia .A review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports, effective date April 2008, the P&P indicated, Recommendations are acted upon and documented by the facility staff and or the prescriber. The director of nursing or designated licensed nurse addresses and documents recommendations that do not require a physician intervention . A review of the facility's policy and procedure (P&P) titled Antipsychotic Medication Use, revised December 2016, the P&P indicated, The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications; Nursing staff shall monitor for and report any of the following side effects and adverse consequences of the antipsychotic medication to the Attending Physician: Neurologic (Akathisia [a movement disorder that makes it hard for you to stay still], dystonia [a movement (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder that causes involuntary contractions of your muscles], extrapyramidal effects [drug-induced movement disorders], akinesia [inability to perform a clinically perceivable movement] ; or tardive dyskinesia, stroke or TIA [Transient Ischemic Attack (a temporary blockage of blood flow to the brain, causing stroke-like symptoms]. 2a. A review of Resident 52's clinical record indicated, Resident 52 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including Type 2 Diabetes Mellitus (DM) without complications (a disease in which your blood glucose [main source of energy], or blood sugar, levels are too high) without complications .A review of Resident 52's Order Summary Report, active order as of 7/31/25, the medication order dated 6/20/25 indicated, Resident 52 had been receiving insulin (a medication used in the treatment and management of diabetes) Lispro Injection Solution (a fast-acting type of insulin)100 UNIT/ML [milliliter] inject subcutaneously (insertion of medications beneath the skin) per sliding scale before meals and at bedtime for DM. The medication order revealed no monitoring of signs and symptoms of hypo/hyperglycemia 2b. A review of Resident 31's clinical record indicated, Resident 31 was admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes Mellitus without complications .A review of Resident 31's Order Summary Report, active order as of 7/31/25, the medication order dated 6/22/25 indicated, Resident 31 had been receiving insulin Lispro Injection Solution 100 UNIT/ML inject subcutaneously per sliding scale before meals and at bedtime for DM. The medication order revealed no monitoring of signs and symptoms of hypo/hyperglycemia During a concurrent interview and record review on 8/1/25 at 10:10 a.m. with LVN C. Resident 52 and 31 Medication Administration Record (MAR) were reviewed. LVN C confirmed that Resident 52 and 31 were both on insulin Lispro injection. LVN C indicated that there were no hypo/hyperglycemia monitoring indicated in the MAR. LVN C stated that signs and symptoms of hypo/hyperglycemia should be monitored.During a concurrent interview and record review on 8/1/25 at 10:27 a.m. with RN A. Resident 52 and 31 Medication Administration Record (MAR) were reviewed. RN A confirmed that Resident 52 and 31 were both on insulin and no hypo/hyperglycemia monitoring indicated in the MAR. RN A explained that, in addition to checking blood sugar levels, signs and symptoms of hypo/hyperglycemia include confusion and sweating, which should be included in the monitoring process.During a concurrent interview and record review on 8/1/25 at 10:15 a.m. with ADON. Resident 52 and 31 Medication Administration Record (MAR) were reviewed. The ADON confirmed that there were no hypo/hyperglycemia signs and symptoms monitoring for Resident 52 and 31. The ADON mentioned that nursing measure include monitoring of the side effect of the medication, resident behavior, and the black box warning. The ADON indicated that signs and symptoms of hypo/hyperglycemia should be included in the monitoring process.A review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised September 2014, the P&P indicated, Notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by the following the facility protocol for hypoglycemia management.A review of the facility's policy and procedure (P&P) titled, Nursing Care of the Resident with Diabetes Mellitus, revised December 2015, the P&P indicated the purpose is to prevent recurrent hyperglycemia/hypoglycemia and recognize, manage, and document the treatment of complications commonly associated with diabetes, and the Medication Management includes the nurse will closely monitor the diabetes management of cognitively impaired residents.According to the CDC's online publication named Living with Diabetes, dated 9/30/22, many causes such as insulin use, changes in diet or drinking, and illnesses could lead to hypo/hyperglycemia. Hypoglycemia symptoms may include fast heartbeat, sweating, nervousness or anxiety, irritability or confusion, dizziness, and hunger. Hyperglycemia symptoms included feeling very tired, thirsty, blurry vision, and needing to urinate more often. It indicated to monitor for signs and symptoms of diabetes complication and .catch low blood sugar early and treat it . Low blood sugar can be dangerous and should be treated as soon as possible. Regarding hyperglycemia, the publication indicated, Over time, high blood sugar can lead to long-term and serious health problems. (https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html; accessed 5/16/23)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055800	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Health and Rehabilitation	350 DE Soto Drive Los Gatos, CA 95032

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were appropriately stored and labeled during an inspection of randomly selected two of three medication storage when the following were found:1. An injectable medication pen was opened and used with no date.2. Medication that required refrigeration was stored inside the medication cart.These failures had the potential for the administration of expired or deteriorated medications or biologicals.Findings:1. During a random inspection of medication cart Y on Station BB with Registered Nurse A (RN A) on [DATE] at 1:35 p.m., an opened and undated multi-use Lantus insulin (long-acting insulin used to control high blood sugar) pen was observed. RN A confirmed the insulin was in use and there was no date on the pen indicating when the medication was opened. RN A stated there should be an open date. 2. During a random inspection of medication cart X on Station AA with Licensed Vocational Nurse C (LVN C) on [DATE] at 2:00 p.m., an unopened vial of Procrit (used to treat anemia [low levels of red blood cells]) was observed with a label that read KEEP MEDICINE IN REFRIGERATOR. LVN C verified the label and confirmed the medication should be refrigerated.During an interview with the Director of Nursing (DON) on [DATE] at 7:55 a.m., she was asked about the facility's policy for storage of medications. The DON stated medications requiring refrigeration should not be kept in the medication carts if the label/directions indicate to refrigerate. The DON further stated all insulin pens should be dated when opened and discarded per manufacturer's recommendations.A review of the facility's policy Medication Storage and Labeling, dated 3/2010, indicated to store and label medication for resident safety and pharmaceutical product integrity. The policy indicated that insulin should be dated and initialed when opened when currently in use.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure proper technique was used for checking the quaternary sanitizer (a group of chemicals used for a variety of purposes including as preservatives, surfactants, antistatic agents, and as active ingredients in disinfectants and sanitizers), when a kitchen staff member did not follow the instructions on the container for the test strips that were used. This failure had the potential of the strength of the sanitizer not being appropriate to kill any microbes, thus spreading food borne pathogens and illness to the facility occupants, which there were 67 of 68 residents who ate food from the kitchen. Findings:During an observation and subsequent interview in the kitchen on 7/29/25 at 1 p.m. with the Dietary Aide (DA F), she demonstrated how to check the strength of the quaternary (use as disinfectant) sanitizer, which is used in the three-compartment sink. The DA F dipped the sanitizer strip for 12.54 seconds. The DA F then compared the reagent square on the dip stick to the results picture on the container. The dip stick result read 400 ppm. The DA F stated she had held the dip stick in the sanitizer water for 10 seconds.During a review of the instructions on the container of Insta-Test Analytic: sanitized water test strips, QAC 50-400 ppm the container instructions indicated: 1. Dip and take out. 2. Shake off excess water. 3. Wait 5 seconds. 4. Compare.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure food preferences were honored for one of 17 sampled residents (Resident 90). This failure resulted in Resident 90 receiving food items she disliked.Findings:During a meal observation and interview on 7/28/25 at 12:54 p.m., in the resident's room, Resident 90 was seated in a wheelchair with a family friend, eating lunch. The meal included fish, carrots, and zucchini. Resident 90 stated she did not like zucchini but it was still served to her.During a concurrent review of Resident 90's meal tray ticket, zucchini was listed in Resident 90's dislikes.During an interview with the Dietary Manager (DM) on 8/1/25 at 1:45 p.m., the DM stated the resident's preferences should be followed.Review of the facility's policy Resident Food Preferences revised July 2017, indicated, Individual food preferences will be assessed upon admission, quarterly and as needed.when possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.if the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer pneumococcal vaccines (vaccines that help prevent serious infections caused by pneumonia, a lung infection) as required for two of five sampled residents (Residents 36 and 72). This failure had the potential to place residents at risk for preventable disease. Findings: 1. Review of Resident 36's clinical record indicated Resident 36 was admitted on [DATE]. The Pneumococcal Immunization Consent form, dated 6/17/24, indicated the resident/family refused the Pneumococcal vaccine.During a concurrent interview with the Director of Staff Development/Infection Preventionist (DSD/IP) on 7/31/25 at 4:50 p.m., the DSD/IP confirmed Resident 36 was not offered the pneumococcal vaccine again after admission. The DSD/IP stated that when offering the pneumococcal or flu vaccines, staff complete the consent form again or document the offer in the progress notes, but this was not done.2. Review of Resident 72's clinical record indicated resident was admitted on [DATE]. The Pneumococcal Immunization Consent form indicated the vaccine was refused on 6/27/24.During a concurrent interview and record review on 8/1/25 at 11:09 a.m., the DSD/IP acknowledged that Resident 72 was not offered the pneumococcal vaccine again after admission, as required by the facility's policy.Review of the facility's policy, Pneumococcal Vaccination revised 2/2022, indicated, .Pneumococcal and Influenza vaccine shall be offered and consent will be obtained on admission and quarterly, if eligible.