STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Drive Post Acute	2500 Country Drive 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities for one resident of 23 sampled residents (Resident 266) based on assessment and care plan, preferences, and in a manner designed to meet the resident's needs. This failure placed Resident 266 at risk for isolation and boredom and may negatively impact his psychosocial well-being. Findings: A review of Resident 266's admission record indicated Resident 266 was admitted on [DATE] with diagnoses that included pneumonia, weakness, and difficulty in walking. During an observation on the intial tour, on 4/21/25 at 10:45 a.m., Resident 266 was lying in bed, awake, alert. Resident 266 had in his hands a plastic syringe used for his Gastrostomy tube (G Tube- A medical device inserted into the stomach to deliver food and liquids) and played with it. Resident 266 unable to talk when spoken to. No TV or music was playing in the room.When alerted, CNA 1 entered Resident 266's room and took the syringe from Resident 266 and placed it on his nightstand and picked the paper cover for the syringe from the floor by Resident 266's bed and trashed it. During an observation on 4/22/25 at 9:20 a.m. Resident 266 was lying in bed, awake alert. Resident's GT was connected to his stomach and GT feed was running via the GT pump. No TV or music was playing in the room. Resident 266 responded to greeting with a smile, but did not talk when spoken to. A review of the Minimum Data Set (MDS - an assessment tool used to direct care) Section C - Cognitive Patterns indicated Resident 266 with short- and long-term memory problem and Cognitive skills for Daily Decision Making indicated Modified independence - some difficulty in new situations only. During an interview on 4/22/25 at 12:26 p.m. with the Activity Director (AD), AD stated Resident 266 was not getting out of bed and they did in-room visits for him. AD could not state what activities they provided during room visits. AD stated she would go and check. The activity care plan for Resident 266 was requested from AD. AD did not return until around 2 p.m. During a review of Resident 266's electronic medical record on 4/22/25 at around 1:28 p.m. there was no activity care plan found on record. (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the MDS Section F, Preference for Customary Routine and Activities, F0800 Staff Assessment for Daily and Activity Preferences dated 3/31/25, indicated no resident's choice and preferences for Resident 266. During a concurrent interview and record review on 4/23/25 at 9:30 a.m. with AD, AD acknowledged there was no individualized activity assessment for Resident 266 because she left a message for the family/significant other regarding resident's preferences for activity. AD stated she did not follow up with them since 4/4/25 and just did yesterday 4/22/25. AD stated they have been doing in room visit for Resident 266 and they have the logs for visit and would provide them. She stated the logs were paper forms and not on the computer. AD stated they just anticipated what activities they would offer resident when they do room visit. She stated they were supposed to follow the plan and Resident 266 did not have a plan when he should have had one. AD stated the care plan was generated after the assessment was done on 4/22/25. AD stated the individual assessment needed to be done within five to seven days of resident's admission. AD stated it was important so that they assess and find out what residents like and don't like. During an interview on 4/23/25 at 9:54 a.m. with the Director of Nursing (DON), DON stated it was important they get an assessment so they can have a plan. She stated activity was important to know what the residents like, to get them engaged. During a review of the facility's policy and procedure (P&P) titled, Individual Activities and Room Visit program dated Revised 2018, the P&P indicated, Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so . Individualized activities are offered reflective of the resident's activity interests, as identified in the Activity Assessment, .and the resident's Comprehensive Care Plan . During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/5/21 indicated, An individualized comprehensive care plan that incudes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident . The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS) .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one out of 29 sampled residents (Resident 220), an ongoing and consistent collaboration with dialysis center for Resident 220 was established. Resident 220's dialysis communication binder did not contain the current physicians orders, no follow up for recommended medication to be discontinued, and facility staff was noting inconsistent assessment on the dialysis access site. These failures had the potential to affect Resident 220's health and safety due to lack of coordination with dialysis center. Findings: During a review of facility's admission Record indicated Resident 220 was admitted on [DATE], with diagnoses that included severe kidney disease and hypertensive emergency. Resident 220's physician orders indicated Clonidine (medication used to treat high blood pressure) transdermal patch weekly 0.3 milligram (mg)/24 hour. Apply two patches transdermally one time a day every seven days related to essential hypertension. Resident 220's Minimum Data Set (MDS - resident assessment tool) dated 04/15/2025, indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score of 13, (BIMS score of 13 - 15, cognitively intact). During a review of Resident 220's Dialysis Communication Record (DCR), dated 4/14/25 indicated Resident 220's dialysis access site was located on L-perm cath [left chest permacatheter - catheter used for short-term dialysis treatment. The catheter is placed inside a blood vessel in your neck or just under your collarbone and through the right side of the heart]. The dialysis center noted Can you please give us her home med [medication] list? Section Post Hemodialysis Assessment indicated Resident 220's access site was RUA [right upper arm], and the access site had bruit (swooshing sound of a dialysis fistula caused by the high-pressure flow of blood through the fistula), and thrill (vibration caused by blood flowing through the fistula). Resident 220 would not have bruit and thrill since her dialysis access site was a permacatheter on her left chest. Resident 220's DCR dated 4/18/25 Post Hemodialysis Assessment dialysis access site was RUA, with bruit and thrill present. Further, the DCR indicated a post dialysis notes from the dialysis center per nephrologist Dr . discontinue Clonidine patches. During a review of Resident 220 medication administration record (MAR) for the month of April 2025 indicated Resident 220 attended dialysis three times a week on Monday, Wednesday, and Friday. Resident 220's MAR indicated Clonidine Transdermal patch weekly 0.3 mg/24 HR, apply 2 patches transdermally one time a day every seven days. Clonidine 0.3 mg patches were applied on 4/19/25. During a concurrent observation and interview on 04/22/25 at 07:36 A.M., in Resident 220's room with Resident 220 lying down on her bed. Resident 220 stated she went to the dialysis center the previous afternoon. Resident 220 stated the dialysis center would like to have a list of her medications, because it was not in the communication binder. Resident 220 stated access site for her dialysis was on the left side of her chest. Resident 220 stated she had the Clonidine patches on her both sides of her upper back. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 04/23/25 at 7:45 A.M., with Director of Staff Development (DSD), DSD stated the physicians order had to be in the dialysis communication binder. DSD reviewed Resident 220's dialysis binder and there was no copy of the medication list. DSD reviewed Resident 220's Resident 220's DCR dated 4/18/25, which indicated to discontinue Clonidine patches, and dialysis access site located at right upper arm with bruit and thrill. DSD stated that Resident 220's dialysis access site was on her left upper chest would not have bruit and thrill because she had permacatheter. DSD stated she would notify Resident 220 about the Clonidine patches. During a review of facility's policy and procedure titled Dialysis Care with effective date 08/25/2021, indicated I. Purpose. To provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments III Procedure 4. Communication and Collaboration. a. The Nursing Staff, Dialysis Provider Staff, and the Attending Physician (Dialysis Staff) will collaborate on a regular basis concerning the resident's care as follows: i. Nursing staff will communicate the following information in writing to the Dialysis Staff: The resident's current vital signs. Any changes of condition specific to the resident with each treatment. ii. The dialysis Provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required. iii. Nursing Staff will keep the Attending Physician, the resident and the resident's family informed of any change in condition. iv. Nursing Staff may use the Hemodialysis communication record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, and record review the facility failed to ensure a minimum of 3.5 Direct Care Service Hours Per Patient Day (DHPPD - refers to the minimum number of direct care service hours a facility is required to provide to each resident per day) and a minimuim of 2.4 Certified Nursing Assistant (CNA) DHPPD on ten weekend days. This failure had the potential to result insufficient nursing staff and inadequate nursing care for the facility residents. Findings: During an interview on 4/23/25, at 9:53 a.m., with Staff Developer Assistant (SDA), SDA stated they completed the daily staffing schedule and were required to staff for a minimum of 3.5 DHPPD and 2.4 CNA DHPPD. During an interview on 4/23/25, at 10:28 a.m., with Director of Staff Development (DSD), DSD stated staffing effected patient care, and patient care was a top priority. During a concurrent interview and record review on 4/23/25, at 11:11 a.m. with Payroll Coordinator (PC), the Facility's Census and Direct Care Service Hours Per Patient Day (DHPPD) reports between 5/1/24 through 6/30/24 were reviewed. PC stated the following Census and Direct Care Service Hours Per Patient Day (DHPPD) reports indicated low DHPPD and low CNA DHPPD on the following days: 5/1/24 DHPPD was 3.49 and CNA DHPPD was 2.23 5/30/24 DHPPD was 3.42 and CNA DHPPD was 2.19 6/1/24 DHPPD was 3.18 and CNA DHPPD was 1.84 6/2/24 DHPPD was 3.07 and CNA DHPPD was 1.86 6/9/24 DHPPD was 3.20 and CNA DHPPD was 2.04 6/15/24 DHPPD was 3.38 and CNA DHPPD was 1.99 6/16/24 DHPPD was 3.12 and CNA DHPPD was 1.99 6/22/24 DHPPD was 3.11 and CNA DHPPD was 1.93 6/23/24 DHPPD was 3.27 and CNA DHPPD was 2.07 6/30/24 DHPPD was 3.18 and CNA DHPPD was 1.79 During a review of the facility's Staffing Waiver dated 6/20/23, the Waiver indicated, The facility shall provide no less than 3.5 direct care service hours per patient day.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure accurate medication administration for 2 of 25 medications observed during a medication pass, resulting in a medication error rate of 8%, which exceeds the acceptable federal threshold of 5%. This failure created the potential for subtherapeutic treatment, adverse side effects, and inadequate symptom control for Resident 38. Findings: On 4/2/125, at approximately 1:16 PM, the surveyor conducted a medication administration observation with Registered Nurse (RN) 1. During this observation, RN 1 administered Lantus Insulin, 17 units subcutaneously (SC), and Novolog Insulin, 4 units SC, to Resident 38. During the administration of Novolog Insulin, the surveyor observed that RN 1 failed to follow proper technique by not holding the insulin pen in place for the full manufacturer-recommended time following injection. The needle was held in place for approximately 2 to 3 seconds before being withdrawn. According to manufacturer package insert, insulin pens must be held in place for at least 5 to 10 seconds to ensure full delivery of the medication and to prevent insulin leakage, which could lead to underdosing and ineffective glycemic control. Each instance of incorrect administration of a different insulin medication is counted as a separate medication error. Therefore, the incorrect technique affected both Lantus and Novolog administration and constitutes two medication errors during the single observation period. These errors contributed to a medication error rate of 8%-a rate which exceeds the maximum allowable error rate of 5% as defined by federal standards. During a follow-up interview conducted immediately after the observation on 4/2/125, at approximately 1:16 PM, RN 1 was asked about the technique used during insulin administration. She said she forgot and will do better next time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure that prescription medications were properly labeled and stored as evidenced by: 1. This failure was identified during the inspection of one of three medication carts and had the potential to result in medication errors, including the risk of incorrect administration, diversion, or harm to residents receiving medications from that cart when multiple medications were found without a prescription label. 2. The facility stored multiple medications in a medication refrigerator that was operating at a temperature of 14°F, significantly below the required refrigeration range of 36°F to 46°F. This deficiency created the potential for insulin degradation, rendering the medication ineffective or unsafe for resident use. The failure to maintain proper storage conditions compromised the integrity of medications administered to multiple residents. Findings: 1. During an observation on 4/21/25, at approximately 2:00 PM, it was observed alongside Registered Nurse (RN 1). During the inspection, it was observed multiple medications within the cart drawers that lacked prescription labels and any identifying resident information. Among the items found was a Humalog (insulin lispro) KwikPen, which did not have a prescription label or any indication of which resident it was intended for. Additionally, a pink circular pill organizer containing a mixture of various oral tablets-differing in size, shape, and color-was present. The only marking on this organizer was the handwritten number 157 in black ink; it lacked any resident name, prescription label, or clear medication identifiers. Also present was an Albuterol Sulfate Inhaler that displayed only the product name and usage directions, but did not include any labeling from a pharmacy or the name of the resident for whom it was prescribed. These medications were not separated from other facility-stocked medications and were stored in a manner that failed to prevent potential medication administration errors. The lack of segregation and secure storage increased the likelihood that medications could be given to the wrong resident or accessed inappropriately, thereby compromising resident safety. During an interview on 4/21/25 at 2:00 PM, RN 1 acknowledged that the medications were brought in by a resident and admitted that they had not been properly labeled. She stated, They were brought in by the resident. I know they're supposed to be labeled. They should have been. RN 1 confirmed that she was aware these items were stored in the cart and further acknowledged that they should not have been in use or available for administration without proper pharmacy labeling and verification. This deficient practice indicates a systemic failure to adhere to established medication management policies and compromises the facility's obligation to ensure safe and accurate pharmaceutical care for all residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation 4/22/25 at 1:50 PM, the surveyor observed the medication refrigerator located in the facility's medication storage area. The thermometer inside the unit displayed a temperature of 14°F, indicating that the contents of the refrigerator were exposed to freezing conditions. Multiple insulin vials and pens were observed inside the refrigerator, all of which were clearly labeled with manufacturer stickers stating, Refrigerate until used. Once in use, store at room temperature. According to the manufacturers and current pharmaceutical standards, insulin must never be frozen, as freezing compromises its molecular structure and can result in the loss of therapeutic efficacy and safety. During an interview 4/22/25 at 1:50 PM, the facility's nursing supervisor 1 acknowledged the issue. When asked about the temperature reading, she stated, I wasn't aware it was out of range. That's not appropriate. We'll start monitoring and have maintenance look at it. This admission confirmed that staff had not previously identified or addressed the unsafe storage condition. There was no indication that the affected insulin had been evaluated for safety or removed from circulation. The facility's failure to ensure appropriate storage of refrigerated medications placed residents at risk for receiving medications that may have been rendered ineffective or harmful due to improper handling.