STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056069	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clara Post Acute	991 Clyde Avenue Santa Clara, CA 95054

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, an assessment tool) for two of 39 sampled residents (Residents 68 and 50). Failure to accurately assess had the potential to compromise the facility's ability to develop care plans and provide interventions to meet the residents' needs. Findings: Review of Resident 68's medical record indicated Resident 68 was admitted on [DATE] and had diagnoses including cerebral infarction (damage to the brain caused by lack of blood flow and oxygen), hemiplegia (a condition in which one side of the body is paralyzed), paraplegia (a condition in which the legs and lower body are paralyzed), and weakness. Review of Resident 68's Order Summary Report indicated Resident 68 had a physician's order, dated 11/27/23, to have one quarter bed rails (metal or plastic bars attached to the bed ranging in size from full to one-half, one quarter, or one-eighth lengths) as an enabler for turning and repositioning. Review of Resident 68's MDS, dated [DATE], indicated Resident 68 was dependent (unable to perform without full staff assistance) with bed mobility (moving around in bed) and transfers. Section P0100 of the MDS (section designated to indicate that restraints were used on a resident) indicated bed rails were used daily on Resident 68. During an interview and concurrent record review with Minimum Data Set Coordinator A (MDSC A) on 5/6/24 at 11:33 a.m., MDSC A reviewed Resident 68's 4/5/24 MDS and confirmed bed rails were coded as restraints in section P0100. MDSC A confirmed that for Resident 68, bed rails were not considered restraints because they did not restrict freedom of movement and did not restrict access to the resident's own body. MDSC A explained that even though bed rails were not considered restraints for Resident 68, they were coded as restraints in section P0100 because it was the only place in the MDS to code bed rails. During a follow-up interview with MDSC A on 5/8/24 at 12:54 p.m., MDSC A stated the facility was using Resident 68's bed rails as a mobility enabler and the bed rails did not meet the definition of restraints. MDSC A confirmed bed rails should not have been coded as restraints on Resident 68's 4/5/24 MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2023, indicated for section P0100, If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. The RAI manual further indicated, Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories. 38087 Review of Resident 50's medical record indicated Resident 50 was admitted on [DATE] and had diagnoses including end stage renal disease (kidney failure, kidneys no longer function to meet the body's needs), and dependence on renal dialysis (dialysis: a procedure in which a machine filters wastes and fluid from the blood). Review of Resident 50's medical record indicated Resident 50 traveled to a dialysis center and received dialysis treatments on Monday, Wednesday, and Friday of each week. Review of Resident 50's MDS dated [DATE], Section O0110J1: Dialysis was left blank. Section O0110 titled Special treatments, Procedures, and Programs indicated to check all of the following treatments, procedures, and programs that were performed. Review of Resident 50's Hemodialysis Communication Record, dated 4/17/24, 4/19/24, and 4/22/24, indicated Resident 50 attended the dialysis center for his hemodialysis treatments. During an interview and concurrent record review with Minimum Data Set Coordinator K (MDSC K) on 5/10/24 at 12:39 p.m., MDSC K reviewed Resident 50's 4/23/24 MDS and confirmed Section O0110J1, Dialysis, was left blank. MDSC K confirmed Resident 50 attended dialysis treatments three times a week and stated the dialysis treatments should be reflected on Resident 50's 4/23/24 MDS. The RAI Manual, dated 10/2023, Section O0110: Special Treatments, Programs, and Procedures indicated The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods. Section O0110J1, Dialysis, indicated to code renal dialysis which occurs at another facility. The RAI manual further indicated coding instructions to Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, resident-centered and specific care plans for three out of 39 sampled residents (Residents 162, 55 and 26), when: 1. There were no care plans developed for Resident 162's diagnoses; 2. For Resident 55, there was no care plan to address Resident 55's diabetes, use of insulin, depression and use of antidepressant medication; and 3. For Resident 26, the interventions in her activity care plan did not mention about the room visits and the activities provided during room visits. These failures had the potential to result in the residents, not receiving the interventions necessary to maintain their highest level of well-being. Findings: 1. Review of Resident 162's medical record indicated Resident 162 was admitted on [DATE] and had diagnoses including Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and Post-Traumatic Stress Disorder (PTSD, a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock) Further review of Resident 162's medical record indicated there were no care plans developed to address Resident 162's Bipolar disorder or PTSD. During an interview with Minimum Data Set Coordinator A (MDSC A) on 5/9/24 at 9:13 a.m., MDSC A stated resident care plans should be completed within 14 days from the date of admission. MDSC A confirmed that all the resident's diagnoses and interventions should be included in the care plan. MDSC A stated Resident 162 should have a comprehensive care plan to address interventions in placed, for the diagnoses of PTSD and Bipolar disorder, to ensure Resident 162's mental health was addressed. 37686 2. Review of Resident 55's medical record indicated Resident 55 was admitted on [DATE] and had diagnoses including diabetes (a disease that impairs the body's ability to control blood sugar) and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 55's Order Summary Report indicated Resident 55 had the following physician's orders, dated 1/24/24, for diabetes: 1. Insulin aspart (medication used to lower blood sugar) 100 units per milliliter (unit/ml, dose measurement) inject 14 units subcutaneously (SQ, under all layers of the skin) before meals; and 2. Insulin NPH (medication used to lower blood sugar) 100 unit/ml inject 7 units SQ two times a day. The Order Summary Report indicated Resident 55 also had a physician's order, dated 1/24/24, for venlafaxine (medication used to treat depression) 37.5 milligrams (mg, dose measurement) give 1 capsule by mouth one time a day for depression manifested by verbalization of sadness. Further review of Resident 55's medical record indicated, there was no care plan to address Resident 55's diabetes and use of insulin. There was also no care plan to address Resident 55's depression and use of antidepressant medication. During concurrent record review and interview with MDSC A on 5/8/24 at 12:43 p.m., MDSC A stated resident care plans should be completed within 14 days from the date of admission. MDSC A confirmed that all the resident's diagnoses and interventions should be included in the care plan. During an interview and concurrent record review with MDSC B on 5/10/24 at 7:39 a.m., MDSC B reviewed Resident 55's medical record and confirmed there was no care plan to address Resident 55's diabetes and use of insulin. MDSC B also confirmed there was no care plan to address Resident 55's depression and use of antidepressant medication. 44185 3. During an observation of Resident 26 on 5/6/24 at 12:43 p.m., Resident 26 was in her room, laying in her bed, alert and verbally responsive. She appeared calm and comfortable. Review of Resident 26's admission record indicated, Resident 26 was admitted to the facility on [DATE] with diagnoses including unspecified fracture (a partial or complete break of the bone) of left pubis (pubic bone or pelvic girdle, one of the three main bones that make up the pelvis), subsequent encounter for fracture with routine healing, history of falling and other reduced mobility (decreased or limited movement). During an interview with Registered Nurse M (RN M), on 5/9/24 at 10:30 a.m., RN M verified that Resident 26 was non-ambulatory (unable to walk) and she was wheelchair bound (person is restricted, bound and completely defined by their wheelchair). RN M further verified that Resident 26 would participate in group activities sometimes, but most of the time, she usually would stay in her room. During an interview with the Activity Director (AD), on 5/9/24 at 1:40 p.m., the AD verified that Resident 26 does not participate in group activities. The AD then stated that activity staffs visit Resident 26 in her room twice per week, providing hand massage, exercises and playing music in the tablet (portable touch-screen device that can play music, videos and games). Review of the active physician orders of Resident 26 as of 5/8/24 indicated, Resident 26 may participate in activity and general conditioning program as desired, ordered on 2/20/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the activity care plan of Resident 26 indicated that the interventions in the activity care plan of Resident 26 did not mention about the room visits twice per week and the activities that were provided during room visits. The activity care plan of Resident 26 was not comprehensive and was not specific about the room visits. During a concurrent review of Resident 26's activity care plan and further interview with the AD, on 5/9/24 at 1:52 p.m., the AD verified that Resident 26 activity care plan did not mention room visits and the activities provided during room visits. The AD further verified that the activity care plan of Resident 26 was not comprehensive and was not specific about the room visits and will update her activity care plan. During an interview with the Director of Nursing (DON) on 5/9/24 at 4:30 p.m., the DON verified that Resident 26 activity care plan should have interventions about the room visits and the activities done during room visits. The DON further verified that the activity care plan of Resident 26 was not comprehensive and was not specific about the room visits and should be updated. The facility's policy titled Care Plan Comprehensive, effective date 8/25/21, indicated, an individualized comprehensive care plan shall be developed for each resident. The policy further indicated, each resident's comprehensive care plan is designed to incorporate identified problem areas, reflect treatment goals, timetables, objectives in measurable outcomes and includes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record reviews, the facility failed to ensure, a complete monitoring and documentation of the change of condition for one out of six residents investigated, (Resident 179), when nurses did not have complete documentation and monitoring for Resident 179's change of condition. These failures had the potential to affect the resident's care and could compromise the resident's health and well-being. Findings: During an observation of Resident 179 on 5/6/24 at 11:54 a.m., Resident 179 was sitting in his wheelchair, eating his lunch. He was able to eat by himself. Resident 179 was alert, oriented, verbally responsive and appeared comfortable. Review of Resident 179's admission record (document created when a resident is admitted to a healthcare facility) indicated, Resident 179 was readmitted on [DATE] with diagnoses including urinary tract infection (UTI, an illness in any part of the urinary tract, the system of organs that makes urine), site not specified, generalized muscle weakness (lack of physical or muscle strength) and other cerebral infarction (ischemic stroke, occurs as a result of disrupted blood flow to the brain) due to occlusion (blockage) or stenosis (narrowing) of small artery (arteriole, very small blood vessel that branches off from the artery and carries blood away from the heart, to the tissues and organs). Review of Resident 179's medication administration record (MAR, report detailing the medications administered to the resident by a healthcare professional at a facility), for 5/1/24 to 5/31/24, indicated, Resident 179 had an order of Keflex (an antibiotic, used to treat a wide variety of bacterial infections) oral capsule, 250 milligrams (mg, measure of weight), give 1 capsule by mouth every 8 hours for UTI, for 5 days and the order was taken on 5/3/24. Review of Resident 179's current care plan related to UTI, one of the interventions indicated, to monitor and document for probable cause of each pain episode and to remove and limit causes, where possible. Review of Resident 179's progress notes from 5/1/24 to 5/10/24 indicated, that nurses did not do a complete documentation and monitoring for Resident 179's change of condition, when he was taking Keflex oral capsule antibiotic for UTI. The nurses did not document every shift, every time, Keflex oral capsule antibiotic for UTI was given to Resident 179. The last dose of Keflex oral capsule antibiotic was given at 2 p.m., on 5/8/24 and the nurse did not document after it was given. During an interview with Registered Nurse M (RN M) on 5/9/24 at 10:32 a.m., RN M verified, that for a change of condition, nurses should notify the physician and the resident's representative (main contact of the resident), document the change of condition, do the care plan for the change of condition and then do the 72 hours monitoring and documentation for the change of condition like the use of antibiotic and another three days, post-antibiotic documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of Resident 179's clinical records and interview with Registered Nurse N (RN N) on 5/9/24 at 11:10 a.m., RN N verified that there was incomplete documentation and monitoring of Resident 179's change of condition, when he was taking Keflex oral capsule antibiotic for UTI. RN N further verified that documentation should be done, even after Resident 179 was done with the antibiotic. During an interview with the Director of Nursing (DON) on 5/9/24 at 4:30 p.m., the DON verified that for the change of condition of Resident 179, for taking Keflex oral capsule antibiotic for UTI, nurses should do documentation and monitoring every shift for 72 hours and after his antibiotic was done as well and she will remind nurses to do a complete documentation. Review of the facility's policy and procedure titled, Change of Condition: Notification of Changes, Charting and Documentation, revised February 2021, indicated, Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. The nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on interview, and record review the facility failed to ensure significant weight loss was monitored and assessed for one of five sampled residents (Resident 165) when staff did not address significant weight losses, did not initiate weekly weights, and did not convene an interdisciplinary team (IDT, team members from different departments involved in a resident's care) meeting regarding Resident 165's significant weight losses. These failures had the potential to result in Resident 165's further unplanned weight loss. Findings: A review of Resident 165's face sheet (document that supplies pertinent resident information) indicated she had an initial admitted [DATE] and a readmitted [DATE] to the facility. Resident 165's diagnoses included type 2 diabetes (a condition which affects blood sugar), congestive heart failure (heart cannot pump enough blood to meet the body's needs), fracture of the left femur (upper bone of the leg), anemia (low levels of healthy red blood cells), hypertension (increase in blood pressure), muscle weakness, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident 165's Nutritional Assessment - Admission/Readmission, dated 3/14/24, indicated, Registered Dietitian (RD) documented Per chart review, no admit weight or recent weight to assess weight changes. Will recommend to weigh patient and continue weekly weight x 1 month given new admit. Review of Resident 165's Weights and Vitals Summary document indicated Resident 165's weight was taken once a month., there were no weekly weights recorded with the exception of during the initial admission month of December 2023. A review of Resident 165's Weights and Vitals Summary, indicated the following weights: 2/5/24 = 156.2 lbs; 3/18/24 = 147.4 lbs; 4/17/24 = 126.6 lbs and 5/1/24 = 112.8 lbs. The Weight and Vitals Summary document contained a column titled Warnings and indicated: 3/18/24 147.4 lbs: -7.5% change [comparison weight 12/23/2023, 173.2 lbs, -14.9%, -25.8 lbs] and 4/17/24 126.6 lbs: -7.5% change [comparison weight 2/5/24, 156.2 lbs, -19%, -29.6 lbs] -5% change over 30 days. [Comparison weight 3/18/24, 147 lbs, -13.6%, -20.0 lbs]. Review of the above weights indicated Resident 165 was weighed one time during the month of March on 3/18/24 and had a significant weight loss of 8.8 lbs in one month, and weighed once in the month of April on 4/17/24 and had a significant weight loss of 20.8 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the RD on 5/9/24 at 10:21 a.m., the RD stated a significant change in weight would be considered if a resident lost 5 lbs in one month. During a concurrent interview with the RD, she reviewed Resident 165's Weights and Vitals Summary and confirmed there was an 8.8 lb weight loss in March and a 20.8 lb weight loss in April for Resident 165 which were significant weight losses. The RD stated when the resident was readmitted on [DATE] she should have been weighed weekly for one month. In addition, the RD stated a resident would be put on weekly weights if they had a significant weight loss. The RD confirmed Resident 165 was not being weighed weekly in the month of March or April and stated that she should have been weighed weekly when the significant weight losses were identified. When asked if there had been any IDT meetings to discuss Resident 165's significant weight losses in March and April, the RD stated there was no IDT meetings and there should have been IDT weight variance meetings to discuss Resident 165's weight loss and identify interventions to prevent further weight loss. Review of Resident 165's care plan indicated Resident 165 was at nutritional risk. Interventions in the care plan included, weigh and alert the dietician and physician to any significant loss or gain and an entry dated 3/14/24 indicated Continue weekly weights x 1 month given new admit. During an interview with the Director of Nursing (DON), on 5/9/24 at 11 a.m., she stated the resident's weights are taken and recorded by the rehabilitation nursing assistants. The DON stated The RD will assess for weight changes and provide the nursing department with her recommendations. If there are significant weight losses, the RD will initiate an IDT care conference and the resident will be weighed weekly to monitor the weight loss. The DON stated The nursing department will document a change of condition (COC) and will notify the doctor and the responsible party if there are significant weight losses. The DON confirmed Resident 165 was only weighed once a month in March, April, and May. She stated Resident 165 should have been weighed weekly when the significant weight losses were identified. The DON was asked if there were any IDT meetings or COCs documented when Resident 165 had significant weight loss in March and April. The DON stated resident 165's weight losses in March and April should have triggered a significant weight loss and she confirmed there was no documentation to indicate the significant weight losses were addressed in an IDT meeting or CC and the DON said these should have been done. The DON stated there is no documentation the physician or the responsible party were informed of the significant weight losses. Review of the facility's policy, Weight Management, dated 8/5/21, indicated to obtain baseline weight and identify significant weight change and to determine possible causes of significant weight change . In the event of a patterned or significant, unplanned weight loss/gain if at least 2% in a week (+/-3 lbs), 5% in 30 days (+/-5 lbs, 7.5% in 90 days or 10% in 180 days, the following interventions will be carried out: Notification of attending physician and family member/responsible party by nursing staff .The dietetics professional will assess the resident, document the assessment, and make recommendations in the resident's medical record. A review of the facility's Dietician Job Description signed by RD on 2/15/24 indicated to maintain an adequate liaison with families and residents . assist in developing diet plans for individual residents . develop a dietary plan of care that identifies the dietary needs of the resident . review nurses notes to determine if the dietary care plan was being followed .discuss problem areas with the director of nursing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935 Based on observation, interview and record review, the facility failed to ensure proper care was provided to one of two sampled residents receiving oxygen (Resident 48) when Resident 48 did not have a physician order for her oxygen use. This failure had the potential to compromise Resident 48's health and well-being. Findings: Review of Resident 48's admission record (document created when a resident is admitted to a healthcare facility) indicated, Resident 48 was initially admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia (difficulty breathing with low oxygen levels), chronic obstructive pulmonary disease (COPD, a disease affecting breathing and the lungs) and type 2 diabetes (disorder in regulation of blood sugar levels). Review of Resident 48's Minimum Data Set (MDS, a required assessment tool) Section C indicated Resident 48 had a brief interview for mental status (BIMS, screening tool used to assess cognitive impairment in nursing homes and other long-term care facilities) score of 13 (13-15 is considered cognitively intact). Review of Resident 48's MDS Section O indicated Resident 48 received oxygen therapy. During an observation on 5/6/24 at 10:10 a.m., Resident 48 was seen sitting in a motorized wheelchair wearing a nasal cannula (a type of oxygen delivery device through the nostrils). The oxygen canister located at the back of the wheelchair, the oxygen rate was set to 3 liters (L, amount of oxygen delivered from an oxygen delivery device per minute). During a second observation on 5/10/24 at 9:30 a.m., Resident 48 was seen lying in bed with eyes closed. The oxygen meter located in the portable oxygen tank sitting beside Resident 48's bed indicated, the oxygen rate was set to 3.5 liters. Review of Resident 48's physician orders indicated there was no physician order for oxygen administration. During an interview with the Director Of Nursing (DON) on 5/10/24 at 9:41 a.m., the DON stated, there should be a physician order for administering oxygen to residents, for both intermittent use and continuous use. The DON also stated, Resident 48 had an order for oxygen, but it was discontinued when Resident 48 was admitted to the hospital and was not ordered again by the physician when she returned to the facility. Review of facility policy and procedure titled Oxygen Administration-F695, dated 1/31/23, indicated, Verify that there is a physician's order for this procedure or facility protocol for oxygen administration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38087 Based on observation, interview, and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse and addiction) when random controlled medication use audit for three of eight residents (Residents 64, 173, and 183) did not reconcile. The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate they were administered to the residents. The failure resulted in inaccurate accountability and had the potential for misuse or diversion of controlled medications. Findings: A review of Resident 64's clinical record indicated he had a physician's order, dated 12/5/23, for Norco (hydrocodone-acetaminophen, a controlled medication for pain) 5/325 milligrams (mg, unit of measurement) 1 tablet by mouth every 6 hours as needed for mild pain and two tablets by mouth every 6 hours as needed for severe pain. Review of Resident 64's CDR for Norco 5/325 mg indicated two tablets of the medication were signed out for use on 5/7/24 at 9:27 p.m. There was documentation in Resident 64's May MAR that indicated only one tablet of Norco 5/325mg was administered to Resident 64 on 5/7/24 at 9:27 p.m. During a concurrent interview and record review with the DON on 5/10/24 at 10:09 a.m., a review of Resident 64's CDR for Norco 5/325 mg and the May 2024 MAR was conducted. The DON confirmed the CDR indicated the nursing staff removed and signed out two tablets on 5/7/24 at 9:27 p.m. but Resident 64's MAR indicated only one tablet was administered. The DON confirmed one Norco tablet was unaccounted for. The DON stated any time a resident requested a PRN (as needed) controlled medication, the nurse removes the medication from the locked compartment in the medication cart, signs it out on the CDR, administers it to the resident, and then documents the administration on the resident's MAR. Review of Resident 173's clinical record indicated a physician's order, dated 4/12/24, for oxycodone 5 mg one tablet every 4 hours as needed for moderate pain and two tablets every 4 hours as needed for severe pain. Review of Resident 173's CDR for oxycodone indicated two tablets of the medication were signed out for use on 5/1/24 at 5 a.m. There was documentation in Resident 173's May 2024 MAR that indicated only one tablet of oxycodone 5 mg was administered to Resident 173 on 5/1/24 at 5 a.m. In addition, Resident 173's CDR for oxycodone indicated two tablets of the medication were signed out for use on the same date of 5/1/24, at 6 a.m. There was no subsequent documentation in Resident 173's May 2024 MAR that indicated oxycodone was administered to Resident 173 on 5/1/24 at 6 a.m. (continued on next page)

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	056069	A. Building B. Wing	05/10/2024

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Santa Clara Post Acute	991 Clyde Avenue Santa Clara, CA 95054

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the DON on 5/10/24 at 10:09 a.m., a review of Resident 173's CDR for oxycodone and the May 2024 MAR was conducted. The DON confirmed the CDR indicated the nursing staff removed and signed out two tablets on 5/1/24 at 5 a.m. and two tablets on 5/1/24 at 6 a.m. The DON stated Resident 173's MAR indicated only one tablet was administered on 5/1/24 at 5 a.m. and there was no documented evidence that Resident 173 received oxycodone at 6 a.m. on 5/1/24 at 6 a.m. The DON confirmed three oxycodone tablets were unaccounted for. Review of Resident 183's clinical record indicated a physician's order, dated 4/4/24, for oxycodone (a potent narcotic for pain) 5 mg one tablet every 6 hours as needed for moderate pain. Review of Resident 183's CDR for oxycodone indicated one tablet of the medication was signed out for use on 5/3/24 at 4:30 a.m. and on 5/5/24 at 6:00 a.m. There was no subsequent documentation in Resident 183's May MAR that indicated oxycodone was administered to Resident 183 on 5/3/24 at 4:30 a.m. and on 5/5/24 at 6 a.m. During a concurrent interview and record review with the DON on 5/10/24 at 10:09 a.m., a review of Resident 183's CDR for oxycodone and the May 2024 MAR was conducted. The DON confirmed the CDR indicated the nursing staff removed and signed out 1 tablet on 5/3/24 at 4:30 a.m. and on 5/5/24 at 6 a.m. The DON confirmed there was no documented evidence on the MAR that Resident 183's received oxycodone at 4:30 a.m. on 5/3/24 and at 6 a.m. on 5/5/24. The DON confirmed two oxycodone tablets were unaccounted for. A review of the facility's Policy and Procedure titled Preparation and General Guidelines - Controlled Medications dated 4/2008, indicated When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 48935 Based on observation, interview and record review, the facility failed to ensure, staff performed their job functions competently according to standards of practice when one cook did not properly verbalize the cool down process for cooking any hot foods such as meat dishes. This failure had the potential to expose 175 residents to food borne illnesses. Findings: During an observation on 5/7/24 at 9:39 a.m., Cook J was seen attending to pots and pans on the stove. During an interview on 5/7/24 at 9:39 a.m., Cook J was asked about the proper coo ldown process for cooked foods such as meat dishes. Cook J stated, the food was cooked to 165 degrees Fahrenheit (F, scale for measuring temperature), then cooled down to 145 degrees F in one hour. Cook J said, he did not know, what should be the temperature in two hours or after. During an interview with the Dietary Services Supervisor (DSS) on 5/8/24 at 1:55 p.m., the DSS stated, any hot foods should be cooled down to 140 degrees F in one hour, then cooled down to 70 degrees F in two hours, and then cooled down to 41 degrees F in four hours. The DSS also stated these were the correct temperatures and she expected Cook J to know that. Review of the 2022 Federal FDA Food Code, section 3-501.14, titled Cooling, indicated, Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 135 degrees F to 70 degrees F; and (2) Within a total of 6 hours from 135 degrees F to 41 degrees F or less.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935 Based on observation, interview and record review, the facility failed to follow a menu, approved by the facility's registered dietitian (RD) according to the facility's policy, for three out of three sampled residents, when a fruit cup was served instead of a snickerdoodle cookie for the consistent carbohydrate (CCD, eating the same amount of carbohydrates everyday, a nutritionally balanced diet to meet specific nutrition needs) renal diet and renal diet (diet that is low in sodium, phosphorous and protein). This failure had the potential to cause decreased food intake and compromise the resident's nutritional status. Findings: During an observation on 5/7/24 at 11:30 a.m., during the lunch time trayline process, three residents with either the CCD Renal diet or Renal Diet were seen getting a fruit cup in their tray. During an interview with the Regional Registered Dietitian (RRD) on 5/8/24 at 1:48 p.m., the RRD stated any menu substitutions need to be signed off by the facility's RD and placed on a log. The RRD also stated, a substitution was approved on 5/7/24 for the pork loin and brussel sprouts and recorded on the log, but not for the CCD Renal and Renal therapeutic diet dessert. During an interview with the Regional Dietary Manager (RDM) on 5/8/24 at 1:48 p.m., the RDM stated, Dietary Aide L (DA L) made the snickerdoodle cookies earlier in the day but the cookies did not turn out well. During an interview with the facility RD on 5/10/24 at 9:18 a.m., the RD stated if any food runs out, then the Dietary Services Supervisor (DSS) will alert her, and then she will sign off on a menu substitution log. The RD also stated the residents receiving a CCD Renal and Renal diet, not getting the snickerdoodle cookie, was more of an error. Review of the facility's policy titled Menus, last revised on 10/2022, indicated, Menus will be served as written unless a substitution is provided in response to preference, unavailability of an item, or a special meal. A menu substitution log will be maintained on file. Review of facility document titled Santa [NAME] Post Acute hcsg2west2023-2024 Diet Guide Sheet indicated the CCD Renal and Renal therapeutic diets were to receive Snickerdoodle cookie 1 ea for dessert.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on observation, interview, and record review, the facility failed to ensure hospice services were provided in accordance with professional standards of practice for one of three sampled residents (Resident 68) when Hospice Aide G (HA G) transferred Resident 68 with a Hoyer lift (mechanical lift, machine used to transfer immobile residents with a sling) without assistance from another person. This failure had the potential to compromise Resident 68's safety. Findings: Review of Resident 68's medical record indicated Resident 68 was admitted on [DATE] and had diagnoses including cerebral infarction (damage to the brain caused by lack of blood flow and oxygen), hemiplegia (a condition in which one side of the body is paralyzed), paraplegia (a condition in which the legs and lower body are paralyzed), and weakness. Review of Resident 68's Order Summary Report indicated there was a physician's order, dated 4/10/24, to admit Resident 68 to hospice services (a program that provides end-of-life care to individuals with terminal illnesses). Review of Resident 68's Hospice Certification and Plan of Care, dated 3/30/24, indicated Resident 68 required Hoyer lift assist with transfers. Review of Resident 68's activities of daily living (ADL) care plan, dated 10/27/23, indicated Resident 68 required two-person assistance with Hoyer lift transfers. During an observation on 5/6/24 at 11:12 a.m., HA G transferred Resident 68 from bed to wheelchair using a Hoyer lift. HA G performed the Hoyer lift transfer without assistance from another person. During an interview with HA G on 5/6/24 at 11:19 a.m., HA G confirmed there was no other person assisting with Resident 68's Hoyer lift transfer. During and interview with the Assistant Director of Nursing (ADON) on 5/8/24 at 10:16 a.m., the ADON stated Hoyer lift transfers must be done using two-person assistance. The ADON explained that one person should operate the Hoyer lift controls, while the other person stabilizes and guides the resident's body during the transfer. During an interview with the Director of Nursing (DON) on 5/8/24 at 1:22 p.m., the DON confirmed hospice aides were expected to follow facility policies when providing care to residents. The facility's policy titled Lifting Machine, Using a Mechanical, revised 7/2017 indicated, At least (2) nursing assistants are needed to safely move a resident with a mechanical lift. The facility's Hospice Services Contract, dated 9/26/17, indicated all services shall be provided in accordance with all applicable policies and procedures of Hospice and Facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49345 Based on observation, interview and record review, the facility failed to implement infection prevention and control practices for five out of 39 sampled Residents (Residents 5, 82, 37, 47, and 166,) when: 1. Residents 5 and 82 were fed at the same time by two Certified Nurse Aides without performing hand hygiene; and 2. For Residents 37, 47, and 166, their urine drainage bags (a bag that collect urine) were on the floor; These deficient practices had the potential to result in transmission and spread of infection to the residents and staff in the facility. Findings: 1. During an observation on 5/6/24 at 7:37 a.m., Certified Nurse Aide (CNA) H was feeding Resident 82 and assisting Resident 5 with her meal. Hand hygiene was not performed when CNA H went back and forth in between Residents 5 and 82. During an observation on 5/7/24 at 8:13 a.m. and 5/9/24 at 8 a.m., CNA I was feeding Resident 82. CNA I was also observed assisting Resident 5 with her meal without performing hand hygiene. CNA I did not perform hand hygiene when she went back to feed Resident 82. During an interview on 5/9/24 at 8:12 a.m. with CNA I, CNA I stated she should have performed hand hygiene in between assisting two residents. During an interview on 5/9/24 at 8:20 a.m. with the Assistant Director of Nursing (ADON), the ADON stated hand hygiene must be performed in between assisting residents. A review of the facility's undated Policies and Procedures (P&P) titled Feeding, the P&P indicated, Perform hand hygiene. 2. During an observation on 5/6/24 at 7:59 a.m. and on 5/7/24 at 8:22 a.m., Resident 37's urine drainage bag was on the floor. During a concurrent observation and interview on 5/8/24 at 9:39 a.m. with the ADON, the ADON stated, The urine bag is okay as long as it does not touch the floor. 50135 During an observation on 5/6/24 at 8:47 a.m., Resident 47 was lying in bed with urine drainage bag, enclosed in a dignity bag, was touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/6/24 at 8:47 a.m., Resident 166 was awake and lying in bed with urine drainage bag, enclosed in a dignity bag, lying flat on its side on the floor. During an interview with Licensed Vocational Nurse C (LVN C) on 5/8/24 at 11:07 a.m., LVN C stated he gave care to residents with indwelling foley catheters (a thin plastic tube inserted in the bladder connected into a collection bag outside of the body). LVN C stated enhanced precautions were taken during care of these residents. LVN C confirmed that collection bags should not be touching the floor, even when enclosed in a dignity bag. During an observation and concurrent interview with LVN D on 5/9/24 at 8:36 a.m., LVN D entered the room of Resident 166, noticed the dignity bag containing the urine drainage bag on the floor, and stated, That's not good. LVN D stated she was not ok with the dignity bag being on the floor and it should not be there. During an observation and concurrent interview with LVN D on 5/9/24 at 8:40 a.m., LVN D confirmed Resident 47's urine drainage bag and dignity bag were on the floor. LVN D acknowledged they should not have been on the floor. Review of the facility's policy and procedure titled, General Policy Guidelines: Urinary Catheter - Infection Control, dated 11/15/2021, indicated the catheter tubing and drainage bag are kept off the floor.