

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Los Altos Sub-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 Fremont Avenue Los Altos, CA 94024	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interviews, and record review, the facility failed to ensure two of two residents (Resident 1 and 2) received proper care and treatment services when:</p> <ol style="list-style-type: none"> 1. For Resident 1, there was no physician order and care plan regarding the use of left-hand splint; and 2. For Resident 2's treatment for the nephrostomy sites (an opening in the skin of the back where the tube is inserted to drain urine from the kidney), was not initiated until 4 days after admission and it was not documented in some days. <p>These failures could affect the residents' health and individualized care and services provided while in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including sepsis (blood poisoning due to an infection), urinary tract infection (UTI, an infection caused by a bacterium (germs) that gets into the bladder or kidneys) and Alzheimer's disease (a progressive disease that destroys memory and mental functions). <p>Review of Resident 1's physician progress note dated 6/18/2024, indicated Resident 1's son told the physician that his mother's left hand was painful at that time.</p> <p>Review of Resident 1's clinical record titled, SBAR [Situation, Background, Assessment and Recommendation, an assessment tool used to facilitate prompt and appropriate communication of a problem], dated 6/19/2024, indicated Resident 1 was transferred out at the hospital for probable septic [a life-threatening medical condition that occurs when an infection causes a body-wide reaction that leads to dangerously low blood pressure and organ failure] and dehydration [a harmful reduction in the amount of water in the body].</p> <p>Review of Resident 1's x-ray of left wrist dated 6/19/2024, indicated, Nondisplaced fracture (still broken bones, but the pieces weren't moved far enough during the break to be out of alignment) of the trapezium [a bone in the wrist below the base of the thumb]. Action required.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Los Altos Sub-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 Fremont Avenue Los Altos, CA 94024	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's History and Physical by a physician dated 6/25/2024, indicated Resident 1 was readmitted back to the facility on [DATE]. Further review indicated, Also found to have a new left trapezium fracture for which she was seen by ortho [orthopedist, a medical specialist who focuses on injuries and disease affecting the bones, muscles, joints and soft tissues] and placed in a splint [an external device that stabilizes and holds a part of the body in place to protect it and support it after an injury or to treat certain health condition] with plans for outpatient follow-up.</p> <p>During an interview with registered nurse A (RN A) on 7/10/2024 at 12:05 p.m., RN A confirmed Resident 1 had a left wrist splint in place. RN A stated she did not know the indication of Resident 1's splint use.</p> <p>During an interview with the certified nursing assistant B (CNA B) on 7/10/2024 at 2:20 p.m., CNA B confirmed Resident 1 did not fall and CNA B was not sure why Resident 1 was wearing a splint to left wrist.</p> <p>During a concurrent observation and interview with Resident 1 on 7/10/2024 at 2:25 p.m., inside Resident 1's room, Resident 1 was in bed, oxygen was in used, and left hand was observed swollen, with splint in place. Resident 1 stated she was okay, and did not complain of pain. Resident 1 confirmed she did not know how she hurt her left wrist.</p> <p>During a concurrent interview with both director of nursing (DON) and case manager (CM) and record review on 7/10/2024 at 4:14 p.m., DON and CM reviewed Resident 1's physician's orders, transfer records, and list of care plans. Both DON and CM stated they were not aware about Resident 1's fracture of left wrist. DON confirmed there was no order and no care plan developed for Resident 1's splint use. DON stated there should be a physician's order and care plan developed for splint use on Resident 1's left wrist.</p> <p>During an interview with licensed vocational nurse C (LVN C) on 8/1/2024 at 1:11 p.m., LVN C stated the admitting nurse should have called Resident 1's doctor to obtain a doctor's order for the splint use if it was still needed. LVN C further stated, the use of splint should have been care planned.</p> <p>During a review of the facility's policy and procedure titled, Admission Orders, dated 11/28/23, indicated, The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. The orders should provide information to maintain or improve the resident's functional abilities .</p> <p>During a review of the facility's policy and procedure titled, Care Plan, Comprehensive, dated Dec. 2017, indicated, Care Plans should be developed by the Interdisciplinary Team (IDT), which includes activities, dietary, nursing management, social services, and therapy and includes input from direct care staff including Licensed Nurses and Nursing Assistants .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .</p> <p>2. Review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including pyelonephritis (medical term for kidney infection), hydronephrosis (a condition that causes one or both kidneys to swell and stretch due to a buildup of urine), and encounter for attention to other artificial openings of urinary tract.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Los Altos Sub-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 Fremont Avenue Los Altos, CA 94024	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview with hospital's social work clinician (SWC) on 8/1/2024 at 8:49 a.m., SWC confirmed Resident 2 was admitted back at the hospital on 7/27/2024 with admitting diagnosis of UTI associated with nephrostomy catheter.</p> <p>During an interview with LVN C on 8/1/2024 at 1:21 p.m., LVN C stated, nurses should call the doctor if resident was admitted with nephrostomy tube to get a treatment order on its sites and other nephrostomy care. LVN C further stated, nurses should document after a treatment was completed.</p> <p>During an interview with registered nurse D (RN D) on 8/1/2024 at 1:40 p.m., RN D stated Resident 2 was alert and oriented to person, place, and time. RN D confirmed Resident 2 had a fever, and he was transferred to the hospital for further evaluation. RN D stated, admission nurses should call the doctor to obtain orders related to nephrostomy care. RN D further stated, nurses should document once they were done with the treatment as ordered.</p> <p>During a concurrent interview with nurse supervisor (NS) and record review on 8/1/2024 at 1:57 p.m., NS reviewed Resident 2's treatment administration record (TAR). NS confirmed Resident 2's treatment to nephrostomy sites just started on 5/21/2024, 4 days after his admission. NS confirmed the treatment to clean the nephrostomy sites, changed the dressings and to empty every shift were not documented as completed on: 7/6/2024, night shift; 7/17/2024, days shift; 7/18/2024, days shift; 7/24/2024, days shift; and 7/26/2024, evening shift. NS stated, treatment should be documented once it was done or completed.</p> <p>During an interview with DON on 8/1/2024 at 4:12 p.m., DON stated the admitting nurse should have called Resident 2's attending physician to obtain a treatment order for nephrostomy site and for nephrostomy care. DON further stated, nurses should document once the treatment is done.</p> <p>During an interview with assistant director of nursing (ADON) on 8/28/2024 at 10:18 a.m., ADON stated, if the treatment was not documented, it did not happen.</p> <p>During a review of the facility's policy and procedure titled, Wound Treatment Management, dated 4/1/2024, indicated, Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatments will be documented on the Treatment Administration Record. Electronic Medical Record or in the electronic health record.</p>