STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056116	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Altos Post-Acute	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services according to professional standards for one of one resident (Resident 1) when:1.Licensed nurses did not administer Resident 1's Vancomycin (a powerful prescription antibiotic used to treat serious bacterial infections) as ordered within 60 minutes prior to or after scheduled time and three doses were missed in May 2026;2.Resident 1 received only two doses of Mounjaro (brand named of tirzepatide, a prescription medication taken as a weekly injection to help control blood sugar with type 2 diabetes mellitus [DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) since it was ordered on 5/4/2026;3.Licensed nurses did not follow physician's order to check Resident 1's finger-stick blood sugar (FSBS - a quick method of checking a person's sugar level using a small device called a glucometer) for five days; and4.Certified nursing assistant A (CNA A) did not provide Resident 1's lunch tray on 6/11/2026.These failures had the potential to affect Resident 1's care, health, and well-being.Findings:1a. Review of Resident 1's clinical record titled, admission Record, dated 6/11/2026, indicated Resident 1 was admitted at the facility on 5/4/2026 with diagnoses including cellulitis (a common, potentially serious bacterial infection of the deep layers of the skin and underlying tissues) of right lower limb (or lower extremity, consists of the hip, thigh, knee, leg, ankle and foot), type 2 DM with other skin complications, osteomyelitis (an infection and inflammation of the bone), right ankle and foot, and unspecified protein-calorie malnutrition (a potentially life-threatening condition caused by inadequate intake of protein, calories or both).Review of Resident 1's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).During a phone interview with Resident 1 on 6/11/2026 at 8:29 a.m., Resident 1 stated nurses were not giving his antibiotics (Vancomycin) on time and sometimes nurses were not giving it to him. Resident 1 stated his last day of antibiotics was on 6/4/2026.Review of Resident 1's order listing report, dated 5/4 - 6/30/2026, indicated an order of Vancomycin 1.25 grams (unit of weight and mass) intravenously (IV - inside a vein, a medical method used to give fluids, nutrients, or medications directly into a person's bloodstream using a needle or flexible tube) every 12 hours for bacteremia (presence of bacteria in the bloodstream) until 6/4/2026, order revised on 5/8/2026.Review of Resident 1's May 2026 medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), indicated the Vancomycin IV dose was scheduled at 9:00 a.m. and 9:00 p.m. daily. Further review indicated the date and time the Vancomycin was given late to Resident 1:5/15/2026, 9:00 a.m. dose was given at 12:37 p.m. and 9:00 p.m. dose was given on 5/16/2026 at 6:49 a.m.5/16/2026, 9:00 a.m. dose was given at 10:43 a.m.5/17/2026, 9:00 p.m. dose was given at 11:18 p.m.5/22/2026, 9:00 a.m. dose was given at 10:11 a.m.5/23/2026, 9:00 p.m. dose was given on 5/24/2026 at 1:45 a.m.5/27/2026, 9:00 a.m. dose was given at 1:33 p.m.Review of Resident 1's June 2026 MAR, indicated Resident 1 received the Vancomycin late on:6/1/2026, 9:00 p.m. dose was given (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:23 p.m.6/3/2026, 9:00 p.m. dose was given at 10:15 p.m.During a concurrent interview with minimum data set nurse (MDSN) and record review of Resident 1's 5/2026 MAR on 6/11/2026 at 3:47 p.m., MDSN confirmed the above late administration of Resident 1's Vancomycin. 1b. During a concurrent interview with MDSN and record review of Resident 1's May 2026 physician's order, MAR, and nursing progress note on 6/11/2026 at 4:19 p.m., MDSN confirmed Vancomycin was not administered to Resident 1 on 5/24, 5/25 and 5/27/2026 for 9:00 p.m. dose. MDSN stated as indicated in the progress note, Vancomycin was not administered on 5/25/2026 due to registered nurse (RN) availability. MDSN further stated there was no RN available to administer the IV Vancomycin and that was not an excuse. MDSN stated, It should have been given. Further review, MDSN confirmed there was no documentation on why Vancomycin was missed on 5/24, and 5/27/2026. MDSN stated licensed nurses should document in resident's MAR after they administered the medication, when it was missed and the reason why it was missed.During an interview with licensed vocational nurse B (LVN B) on 6/11/2026 at 2:45 p.m., LVN B stated medications should be given one hour before or one hour after the scheduled time and should be documented in residents' MAR. LVN B further stated licensed nurses should notify the physician, resident or responsible party the reason when a certain medication was not given.During a concurrent phone interview with the director of nursing (DON) and record review of Resident 1's 5/2026 MAR and nursing progress notes on 6/18/2026 at 12:15 p.m., the DON confirmed the above late administration and missed doses of Vancomycin. The DON stated the medication should be administered an hour before and an hour after the dosing time and as ordered by the physician. The DON confirmed the order for Resident 1 was to administer the Vancomycin every 12 hours. The DON stated they had some RNs who worked on 5/25/2026, that the assigned nurse should have informed them to administer Resident 1's Vancomycin. She further stated that the assigned nurse should have called her if an RN was needed.During a review of the facility's policy and procedure titled, Administering Medications, date revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.Sign MAR after administered.2. During a phone interview with Resident 1 on 6/11/2026 at 8:29 a.m., Resident 1 stated he was supposed to get his injectable medication for diabetes (Mounjaro) once a week, but he never got it weekly. He stated he could only remember getting it once.Review of Resident 1's order listing report dated 5/4 - 6/30/2026, indicated an order of Mounjaro auto-injector 2.5 milligrams (mg - unit of measurement)/0.5 milliliter (ml - volume of measurement) to inject 2.5 mg subcutaneously (SQ - to inject under the skin) one time a day every Wednesday for DM.Review of Resident 1's 5/2026 and 6/2026 MAR indicated, Resident 1 did not receive the Mounjaro injection on 5/6, 5/13, 6/3, and 6/9/2026.During a concurrent interview with MDSN and record review of Resident 1's 5/2026 and 6/2026 MAR and progress notes on 6/11/2026 at 3:47 p.m., she confirmed Resident 1's missed dose of Mounjaro. MDSN stated they were missed due to pending insurance authorization.During a phone interview with the DON on 6/18/2026 at 11:44 a.m., when asked what the facility should have done to provide Mounjaro to Resident 1 as ordered by the physician, the DON stated they would notify the physician, asked if there were any alternative medication and they would follow the physician's order. When asked if those were documented, the DON stated, I have to review the documentation. The DON did not get back to this writer.During a review of the facility's undated policy and procedure titled, Diabetes - Clinical Protocol, indicated, Based on the preceding assessment, including causes and complications, the provider will order individualized interventions.Treatments will be consistent with applicable guidelines.3. Review of Resident 1's 5/2026 MAR indicated an order of FSBS every morning and at bedtime with start date on 5/15/2026 and scheduled every 7:00 a.m. and at 9:00 p.m. Further review indicated licensed nurses did not complete Resident 1's FSBS on 5/15/2026 at 9:00 p.m.; 5/16/2026 at 7:00 a.m. and 9:00 p.m.; 5/17/2026 at 7:00 a.m. and 9:00 p.m.; 5/18/2026 at 7:00 a.m. and 9:00 p.m.; 5/19/2026 at 7:00 a.m. and 9:00 p.m.; and 5/20/2026 at 7:00 a.m.During a concurrent phone interview with the DON and record review of Resident 1's 5/2026 MAR, the DON confirmed the above list of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missed FSBS checked. The DON stated nurses should have documented the reason for the missed FSBS. The DON stated, I need to investigate.During a review of the facility's undated policy and procedure titled, Diabetes - Clinical Protocol, indicated, The provider will order desired glucose targets and monitoring regimens, as well as parameters for reporting information related to blood sugar management. The staff will incorporate orders and reporting parameters into the Medication Administration Record.4. During a phone interview with Resident 1 on 6/11/2026 at 8:29 a.m., Resident 1 stated there was a time when his breakfast would be delivered late or sometimes would not be provided to him.During a concurrent observation and interview with Resident 1 on 6/11/2026 at 1:32 p.m., inside Resident 1's room, Resident 1 was seated at the edge of his bed, waiting for his lunch tray to be delivered. Resident 1's roommate, Resident 2 had a lunch tray placed on his overbed table, and his lunch tray was already partly eaten. Resident 1 stated, . I still did not get lunch and look at the time. I guess they are retaliating since I complained.During an interview with Resident 1's assigned licensed nurse, LVN B on 6/11/2026 at 1:38 p.m., LVN B stated he did not know Resident 1 was not eating yet, and stated he would look for CNA A, who was assigned to Resident 1.During an observation at the hallway near Resident 1's room on 6/11/2026 at 1:41 p.m., LVN B was still looking for CNA A, other CNAs were already collecting finished lunch trays, and they stocked the used trays inside the parked meal cart at the hallway. LVN B found Resident 1's lunch tray still inside the parked meal cart and it was mixed with the used meal trays. LVN B stated he would order a new lunch tray for Resident 1 because the old lunch tray was already cold.During an interview with CNA A on 6/11/2026 at 1:54 p.m., CNA A confirmed he missed to deliver Resident 1's lunch tray today. CNA A stated he assisted Resident 1's roommate, Resident 2 with his lunch and he did not notice Resident 1 did not have his tray.During a phone interview with the DON on 6/18/2026 at 12:15 p.m., the DON stated the CNAs should let the nurses know if there was a problem with meal trays. The DON was unable to state the person responsible in checking to make sure all residents received their meal trays.During a review of the facility's policy and procedure titled, Frequency of Meals, date revised 7/2017, indicated, Each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes in the community, or in accordance with resident needs, preferences, requests and the plan of care. The facility will serve at least three (3) meals or their equivalent daily at scheduled times.The following meal times have been established by out facility for residents: Breakfast - 7:00 am, Lunch - 11:30 am, Dinner - 5:00 pm.