STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056376	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Grace Sub Acute & Skilled Care	1250 S. Winchester Boulevard San Jose, CA 95128

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 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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacy services were provided to meet the needs of one of three sampled residents (Resident 1) when medications were not available to be administered as ordered. This failure had the potential to compromise the resident's health and safety.Findings:Review of Resident 1's medical record indicated he was readmitted to the facility on [DATE] and had diagnoses including traumatic brain injury and epilepsy (a brain disorder that causes seizures [bursts of electrical activity in the brain that can cause changes in behavior, movements, and levels of consciousness]).Review of Resident 1's physician's orders indicated he had the following medication orders, dated 7/1/25: 1.) Clobazam (medication used to treat seizures) oral suspension 2.5 milligrams per milliliter (mg/ml, unit of dose measurement) give 8 ml via gastrostomy tube (GT, a tube inserted through the abdomen and into the stomach) two times a day; and 2.) Lacosamide (medication used to treat seizures) oral solution 100 mg/ml give 20 ml via GT two times a day. Resident 1 also had an order, dated 7/2/25, for Zonisamide (medication used to treat seizures) oral suspension 100 mg/5 ml give 15 ml via GT one time a day.Review of Resident 1's medication administration record (MAR), dated 7/2025, indicated Clobazam and Lacosamide were not documented as administered on 7/1/25, 7/2/25, and 7/3/25. Further review of the MAR indicated Zonisamide was not documented as administered on 7/2/25 and 7/3/25.Review of Resident 1's progress notes, dated 7/1/25 to 7/3/25, indicated the above medications were not available and that the facility was waiting for the medications to be delivered from the pharmacy.During an interview with licensed nurse A (LN A) on 7/10/25, at 3:21 p.m., LN A verified the above medications were not administered to Resident 1 because they had not been delivered to the facility from the pharmacy.During an interview with the consultant pharmacist (CP) on 8/14/25, at 1:20 p.m., the CP explained there was a delay in the delivery of the above medications because Clobazam and Lacosamide were controlled medications (medications regulated by the government due to their potential for abuse and addiction) and the pharmacy was waiting for the required triplicates (signed prescriptions from the physician or other valid prescriber). The CP further explained that Lacosamide was a high-cost medication for which the pharmacy requested delivery authorization from the facility, but the facility had not replied.An email from the CP, dated 8/15/25, was reviewed. The email contained documentation that the pharmacy faxed a request for triplicates for Clobazam and Lacosamide to Resident 1's physician on 7/2/25 at 12:31 p.m., but did not receive these triplicates until after 7/3/25. The email also contained documentation that the pharmacy faxed a high-cost medication delivery authorization request for Zonisamide to the facility on 7/2/25 at 2:54 a.m., but did not receive authorization from the facility until after 7/3/25.The facility's policy titled Pharmacy Services Overview, revised 4/2019, indicated, Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.The facility's policy titled Medication Ordering and Receiving from Pharmacy Provider, dated 1/2025, indicated, Medications and related products are received from the provider pharmacy on a timely basis. The policy further indicated, The Drug Enforcement Agency (DEA) requires that a pharmacy must have a valid prescriber signed prescription in order to dispense controlled substances.