

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Saratoga Retirement Community Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14500 Fruitvale Avenue Saratoga, CA 95070	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>52203</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure physician's orders were followed related to supplemental oxygen administration for 1 (Resident #12) of 1 sampled resident reviewed for respiratory care.</p> <p>Findings included:</p> <p>A facility policy titled, Oxygen/Respiratory Therapy & Safety, last revised 01/2020, revealed, Policy: It is the policy of the Company that: a. Oxygen/respiratory equipment will be operated, cleaned and maintained to optimize functions, safety and prevent infections. b. Oxygen therapy is provided in accordance with physician orders. Procedure: Obtaining orders and documentation: 1. All oxygen and oxygen saturation orders and/or parameters are clarified on admission. 2. Oxygen orders and saturation documentation will be documented on the resident's Medication & Treatment Record.</p> <p>An Admission Record revealed the facility admitted Resident #12 on 11/18/2021. According to the Admission Record, the resident had a medical history that included Alzheimer's disease and chronic obstructive pulmonary disease (COPD).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2024, revealed Resident #12 had a Staff Assessment for Mental Status (SAMS), which indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living and used oxygen therapy</p> <p>Resident #12's care plan, included a focus area initiated 11/23/2023, that indicated the resident had altered respiratory status related to COPD, seasonal rhinitis, and chronic rhinitis. Interventions specified the resident's supplemental oxygen setting should be at 2 liters per minute (LPM) by way of nasal canula (NC), continuous and may be increased to 3-4 LPM if the resident's oxygen saturation level fell below 93%.</p> <p>Resident #12's Order Summary Report, which contained active orders as of 01/06/2025, revealed an order dated 06/24/2024, for continuous, supplemental oxygen at 2 LPM by way of a NC and could be increased to 3-4 LPM, if the resident's oxygen saturation level fell below 93%.</p> <p>During an observation on 01/06/2025 at 1:06 PM, Resident #12's supplemental oxygen concentrator was set to provide 1.5 LPM.</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
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 01/07/2025 at 8:19 AM, Resident #12's supplemental oxygen concentrator that was located at the resident's bedside was set to provide 1.5 LPM. Certified Nurse Aide #2, who was present in the resident's room, verified the resident's supplemental oxygen concentrator was set at 1.5 LPM.</p> <p>On 01/07/2025 at 8:22 AM, the Infection Preventionist (IP) accompanied the surveyor in Resident #12's room and acknowledged the resident's supplemental oxygen concentrator was set at 1.5 LPM. The IP stated it was her expectation that the supplemental oxygen setting be checked once a shift and confirmed the resident's supplemental oxygen concentrator should be set to provide 2 LPM. The IP sated Licensed Vocational Nurse (LVN) #1 was the nurse assigned to the resident's care.</p> <p>During an interview on 01/07/2025 at 2:15 PM, LVN #1 confirmed Resident #12 was on supplemental oxygen by way of a NC and the physician's order was for 2 LPM. LVN #1 said he was informed by another staff member during the morning hours on 01/07/2025, that resident's supplemental oxygen was set at 1.5 LPM. LVN #1 stated after he checked the physician's orders, he corrected the resident's supplemental oxygen flow rate. LVN #1 stated he checked the residents he was assigned to when he arrived on shift, to include their supplemental oxygen settings, but did not have time on 01/07/2025. LVN #1 reported, I was busy with another resident. LVN #1 confirmed a resident's supplemental oxygen should be administered according to the physician's order.</p> <p>During an interview on 01/08/2025 at 8:27 AM, the Director of Nursing (DON) stated she was informed Resident #12's supplemental oxygen was set incorrectly on 01/07/2025. The DON stated the process was nurses should check the physician's orders to ensure supplemental oxygen was administered according to the physician's order. The DON stated she expected the physician's orders to be followed, and supplemental oxygen should be administered at the flow rate ordered.</p> <p>During an interview on 01/08/2025 at 8:49 AM, the Health Services Director confirmed it was her expectation that physician's orders were followed.</p>