

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>49345</p> <p>Based on observation, interview and record review, the facility failed to ensure care was provided in accordance with professional standards of quality for one (Resident 13) out of three sampled residents when Resident 13 had an unnecessary and improper blood sugar check done.</p> <p>This failure resulted in a potentially inaccurate blood sugar result and an additional finger prick which can be painful.</p> <p>Findings:</p> <p>During an observation on 10/21/24 at 11:47 a.m. with Licensed Vocational Nurse (LVN) A, LVN A cleaned Resident 13's left ring finger with an alcohol swab and immediately pricked Resident 13's finger. LVN A then placed the blood</p> <p>sugar strip connected to the glucometer (device used to check blood sugar) to the pricked finger to catch the drop of blood for the blood sugar test. After obtaining the blood sugar result of 136 milligram/deciliter (mg/dl, a unit of measurement; normal range is 80-110 mg/dl), LVN A stated I am going to hold her insulin right now. I am going to feed her at 2 p.m. She has a G-tube (a flexible, hollow tube that is inserted into the stomach through the abdominal wall). I will give it with her food. LVN A also stated that he will check Resident 13's blood sugar again before feeding.</p> <p>During an interview on 10/21/24 at 2:13 p.m. with LVN A, LVN A stated that part of the process for checking blood sugar is waiting for the alcohol to dry out before pricking the finger with lancet (a sharp point needle that is used to obtain blood for testing blood sugar). LVN A also stated, he was following the order to check blood sugar at 12 p.m. LVN A stated he should have checked it before feeding Resident 13 instead.</p> <p>During a concurrent interview and record review on 10/22/24 at 12:50 p.m. with the Director of Nursing (DON), DON stated they should wait for the alcohol to dry before poking the resident's finger during blood sugar check. DON verified there is no specific physician order to check blood sugar at 12 p.m. for Resident 13. DON also verified that blood sugar documentation is part of physician orders for insulin (a medication used in the treatment of high blood sugar).</p> <p>A review of Resident 13's Physician orders indicated, Enteral Feed Order every 8 hours .1 Can (250ml/cc) + 4 OZ SF Healthshake 2 pm It also indicated, Admelog Injection Solution 100 unit/ml (Insulin Lispro) Inject 3 units subcutaneously every 6 hours</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 13's Medication Administration Record for October 2024 indicated Enteral feed was scheduled daily at 6 a.m., 2 p.m. and 10 p.m. It also indicated, Admelog Injection was scheduled daily at 12 a.m., 6 a.m., 12 p.m., and 6 p.m.</p> <p>A review of facility's policy and procedure (P&P) titled Obtaining a Fingerstick Glucose Level revised October 2011, the P&P indicated 8. Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results .12 .If alcohol wipes are used, make sure the area is dry before taking blood sample</p> <p>A review of Daily Med from National Library of Medicine (www.dailymed.nlm.nih.gov), a nationally recognized source for drug label information, indicated, Administer the dose of ADMELOG subcutaneously within fifteen minutes before a meal or immediately after a meal</p> <p>A review of facility's undated P&P entitled Administering Medications, the P&P indicated, 3. Medications must be administered in a timely manner and in accordance with the attending physician's written/verbal orders .12. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR (Medication Administration Record) space provided for that particular drug .</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>44185</p> <p>Based on observation, interview, and record review, the facility failed to ensure that appropriate care and services were provided to one out of twelve sampled residents, (Resident 8), when the restorative nursing assistant (RNA) totally assisted Resident 8 in feeding instead of set-up help only.</p> <p>This failure had the potential, for the resident, not to maintain or achieve the highest level of self-care or independence in feeding.</p> <p>Findings:</p> <p>During the concurrent dining observation and interview with RNA on 10/21/2024 at 12:20 p.m., RNA was spoon-feeding Resident 8, totally assisting him with feeding. RNA acknowledged for totally assisting Resident 8 in feeding and for not checking the feeding care plan of Resident 8 prior to assisting him.</p> <p>During the interview with the Infection Preventionist (IP), who was overseeing the lunch dining area of the residents, on 10/21/2024 at 12:27 p.m., IP verified that Resident 8 had specialized adaptive utensils to help with grip and would help encourage self-feeding and should not be totally assisted with feeding.</p> <p>During the concurrent record review of the most recent minimum data set (MDS, a standardized, comprehensive assessment tool used to evaluate the health of residents in nursing homes) of Resident 8, dated 9/13/24, and interview with the director of nursing (DON) on 10/24/24 at 8:45 a.m., indicated that Resident 8 was coded 05, for his MDS, Section GG0130A: Eating, indicating, Set-up or clean-up assistance. The helper would provide assistance prior to or following the feeding activity. DON acknowledged the discrepancy between Resident 8's assessed needs in feeding and the assistance provided to him. DON further acknowledged that Resident 8 was not provided with the appropriate assistance in feeding by the RNA and will remind the staffs about providing the proper assistance to residents.</p> <p>51580</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49345</p> <p>Based on observation, interview and record review, the facility had a medication error rate of 12.12% when four medication errors occurred out of 33 opportunities for four residents (Resident 27, Resident 12, Resident 46, and Resident 154):</p> <ol style="list-style-type: none"> 1. For Resident 27, the nursing staff did not confirm the exact dose as ordered by the physician for the medicine Lamotrigine (a medicine used for seizure). 2. For Resident 12, the nursing staff administered the medication Metformin (a medicine used to lower the blood sugar) without a meal. 3. For Resident 46, the nursing staff did not administer Lidocaine 5% Patch (used to alleviate pain). 4. For Resident 154, the nursing staff did not administer an inhalation solution in accordance with the facility procedure. <p>These failures resulted in medications not given in accordance to the manufacturer's instructions and/or physician's order and had the potential for residents not receiving the full therapeutic effects of medications.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a medication pass observation on 10/21/24 at 4:13 p.m., Licensed Vocational Nurse (LVN) B, took out a blister pack of lamotrigine 100 milligrams (mg, unit of measure) whole tablets and a blister pack of lamotrigine 100 mg in half tablets. LVN B took one whole tablet and another half tablet. <p>At 4:15 p.m., LVN B administered a whole tablet of lamotrigine 100 mg and a half tablet of lamotrigine 100 mg to Resident 27.</p> <p>A review of Resident 27's physician order on 10/24/23 indicated, Lamotrigine Oral tablet 150 mg, give 1.5 tablet by mouth two times a day related to epilepsy (seizure disorder).</p> <p>During a concurrent observation, interview, and record review on 10/22/24 at 12:50 p.m. with the Director of Nursing (DON), DON verified the order for lamotrigine for Resident 27 and stated that a total 225 mg twice a day of lamotrigine should be given as written in the order. DON verified the stock doses of lamotrigine for Resident 27 in the medication cart were a blister pack of whole tablets of lamotrigine 100 mg and a blister pack of half tablets of lamotrigine 100 mg.</p> <p>During a concurrent interview and record review over the phone on 10/23/24 at 10:15 a.m. with the Consultant Pharmacist (CP), CP interpreted the order of lamotrigine for Resident 27 as a total of 225 mg two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 27's hospital summary documents prior to admission indicated a physician's order, Lamotrigine 150 mg tab twice a day</p> <p>A review of facility's undated policies and procedures (P&P) entitled Administering Medications, the P&P indicated, .8. The individual administering the medication must ensure that the right medication, right dosage . are verified before the medication is administered.</p> <p>2. During a medication pass observation on 10/21/24 at 4:38 p.m., LVN B administered metformin 500 mg tablet to Resident 12. There was no visible food or any snack on Resident 12's bedside table.</p> <p>During an interview with Resident 12 on 10/25/24 at 1:16 p.m., Resident 12 stated that dinner comes at 5:40 p.m. or sometimes 6:00 p.m.</p> <p>During an interview on 10/25/24 at 1:25 p.m. with Registered Dietician (RD), RD stated dinner is served at 5:30 p.m. RD showed the signage of meal times in the bulletin board that indicated, Meal Service Times . Dinner 5:30 p.m.</p> <p>During a concurrent interview, and record review on 10/22/24 at 12:50 p.m. with the DON, the DON verified the physician's order of metformin for Resident 12 indicated to be given with breakfast and dinner.</p> <p>A review of Resident 12's physician order indicated, Metformin Hcl tablet 500 mg, give 1 tablet by mouth two times a day for diabetes with breakfast and dinner. The order was dated 4/11/23.</p> <p>A review of Daily Med from National Library of Medicine (www.dailymed.nlm.nih.gov), a nationally recognized source for drug label information, indicated, Metformin hydrochloride should be given in divided doses with meals.</p> <p>A review of facility's undated policies and procedures (P&P) entitled Administering Medications, the P&P indicated, .3. Medications must be administered in a timely manner and in accordance with the attending physician's written/verbal order.</p> <p>3. During a medication pass observation on 10/22/24 at 7:50 a.m., LVN C stated that Resident 46's due medications included lidocaine 5% patch. LVN C stated that lidocaine 5% patch was not available.</p> <p>During a concurrent interview, and record review on 10/22/24 at 12:50 p.m. with the DON, the DON verified Resident 46's Medication Administration Record for 10/22/24 indicated that Lidocaine 5% patch was not given at 9 a.m. as ordered.</p> <p>A review of Resident 46's physician's orders indicated, Lidocaine Patch 5% apply to right shoulder topically one time a day for pain management r/t neuropathy apply to right shoulder or affected area, apply at 9am and remove at 9pm and remove per schedule The order was dated 8/29/24.</p> <p>A review of facility's undated policies and procedures (P&P) entitled Administering Medications, the P&P indicated, 3. Medications must be administered in a timely manner and in accordance with the attending physician's written/verbal order .7. Medications .must be administered within one hour of their prescribed time .</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a medication pass observation on 10/22/24 at 8:15 a.m., LVN C explained the indication of the medication budesonide and formoterol fumarate dihydrate (used to control or prevent difficulty in breathing) inhalation solution to Resident 154. LVN C shook the inhaler (device for giving medicines in the form of a spray that is inhaled) and asked Resident 154 to open his mouth. Resident 154 opened his mouth, LVN C inserted the mouthpiece in Resident 154's mouth, gave 1 puff and visible mist came out of Resident 154's mouth. LVN C instructed and assisted Resident 154 to gargle with water.</p> <p>During an interview on 10/22/24 at 9:30 a.m. with LVN C, LVN C was asked how to correctly administer an inhaled medication via inhaler. LVN C stated she should have asked Resident 154 to tightly close his lips onto the inhaler mouthpiece.</p> <p>During an interview with the DON on 10/22/24 at 12:50 p.m., the DON stated that when administering a medication via inhaler, resident must be instructed to exhale, then they inhale the medication as it is given and hold it for a few seconds and then exhale.</p> <p>A review of facility's policies and procedures (P&P) entitled Administering Medications through a Metered Dose Inhaler revised October 2010, the P&P indicated, Administer Medication: .d. Ask the resident to inhale and exhale deeply for a few breath cycles. On the last cycle, instruct the resident to exhale deeply. e. Place the mouthpiece in the mouth and instruct resident to close his or her lips to form a seal around the mouthpiece g. Instruct the resident to inhale deeply and hold for several seconds. H. Remove the mouthpiece from the mouth and instruct the resident to exhale slowly through pursed lips.</p> <p>A review of facility's undated policies and procedures (P&P) entitled Administering Medications, the P&P indicated, 8. The individual administering the medication must ensure the right medication.and right method of administration are verified before the medication is administered.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>44185</p> <p>Based on observation, interview and record review, the facility failed to ensure that the recipe (a set of instructions on how to prepare or make a particular food) for making vegetable puree (smooth, crushed, or blended food that has the consistency of a creamy paste or liquid) was being followed when the lead cook did not follow the recipe for making carrot puree. This failure had the potential to result in decreased palatability that could lead to decrease in food intake for the 6 residents with puree consistency diet order out of the skilled nursing facility census of 48.</p> <p>Findings:</p> <p>During the observation of making vegetable puree with the lead cook (LC), on 10/22/24 at 10:55 a.m., LC was making vegetable puree using carrots, good for 12 servings. LC put 48 ounces (oz, unit of weight) of carrots, 4 oz per serving, good for 12 servings, into the blender, added 2 cups (cooking measure of volume) of milk and then pureed them. LC then checked the consistency of the pureed carrots, added 1 cup of milk, then added food thickener and pureed them again. LC then set aside the pureed carrots in the oven after.</p> <p>Review of the facility's recipe: Pureed (IDDSI, international dysphagia diet standardization initiative, Level 4, level of food texture) Vegetables, dated 2024 indicated, Pureed on low speed to a paste consistency before adding any liquid. For 12 servings, add 1/4 cup to 3/4 cup of warm fluid such as milk .If needed: stabilizer: . commercial instant food thickener .Serve on trayline at the recommended temperature . The recipe did not indicate to add any liquid before pureeing. The recipe did not also indicate to add 2 cups of milk for 12 servings of pureed vegetables. The recipe indicated, to only add 1/4 cup to 3/4 cup of warm fluid such as milk, for 12 servings of pureed vegetables. The recipe did not indicate as well to add 1 cup of milk after pureeing.</p> <p>During a concurrent review of the recipe for making puree vegetables and interview with LC on 10/22/24 at 10:57 a.m., LC verified that the recipe for making puree carrots was not followed. He further verified that he would check and follow the recipe next time.</p> <p>During a concurrent review of the recipe for making puree vegetables and interview with registered dietitian (RD) on 10/22/24 at 11:00 a.m., RD verified that the lead cook should have followed the recipe for making puree carrots, but it was not followed. RD further verified that the recipe for making vegetable puree should be followed next time.</p> <p>Review of the facility's policy and procedure titled, Food Preparation, dated 2023 indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. The facility will use approved recipes, standardized to meet the resident census .Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44185</p> <p>Based on observation, interview and record review, the facility failed to ensure, infection prevention and control practices were implemented when:</p> <ol style="list-style-type: none"> 1. a laundry cart with clean linens was left in the passageway of the laundry room where the carts with dirty linens pass by; 2. laundry staff did not sanitize the laundry cart from outside before placing the clean linens in the cart; 3. a large bucket, full of soiled linens, was left open without cover; 4. there were missing logs in the laundry dryer cleaning inspection logs; 5. 2 out of 3 kitchen staffs did not know the sanitizer testing procedure; 6. cleaning chemicals were kept in the emergency food storage area and 7. a silverfish bug and a disposable spoon were found in the sink inside the medicine storage room. <p>These failures had the potential to spread infection that could affect the 48 residents residing in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the concurrent laundry room area observation and interview with the environmental services supervisor (EVSS) on 10/24/24 at 9:09 a.m., there was a rack full of clean clothes of residents and not covered, in the passageway where the dirty linens pass by, going to the washer. EVSS acknowledged that the uncovered rack full of clean clothes of residents should not be left there for infection control. EVSS further verified that those clean clothes should have been brought back right away to the residents. <p>During an interview with the infection preventionist (IP) on 10/25/24 at 11:00 a.m., IP verified that the rack full of clean clothes of residents and not covered, should not be left in the passageway where the dirty linens pass by, going to the washer, for infection control. They should have been brought back to the residents right away after they are washed and dried.</p> <p>Review of the facility's policy titled, Laundry and Bedding, Soiled: Storage, dated 2001 indicated, Clean linen is stored separately, away from soiled linens, at all times Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. During the concurrent laundry room observation and interview with laundry staff G (LS G) on 10/25/24 at 9:35 a.m., LS G brought inside the laundry room, a laundry cart from outside, to put in the clean resident clothes that were ready to be distributed back to the residents. LS G did not sanitize the laundry cart from the outside and he was about to put in the clean resident clothes in there. LS G was asked if he needed to sanitize the laundry cart first and he acknowledged that the laundry cart that was brought from outside should be sanitized first before putting in the clean clothes of the residents there. LS G then sanitized the laundry cart before putting in the clean resident clothes.</p> <p>During the interview with EVSS on 10/24/24 at 9:38 a.m., EVSS verified that LS should have sanitized the laundry cart from outside first before putting in the clean clothes of the residents for infection control.</p> <p>During an interview with IP on 10/25/24 at 11:00 a.m., IP verified that LS should have sanitized the laundry cart that was brought from outside first, before putting in the clean clothes of residents. IP further verified that she will remind the staffs about this.</p> <p>Review of the facility's policy titled, Laundry and Bedding, Soiled: Transport, dated 2001 indicated, Linen carts are cleaned and disinfected whenever visibly soiled and according to the established schedule</p> <p>3. During the concurrent laundry room observation and interview with EVSS on 10/24/24 at 9:45 a.m., there was a bucket full of dirty and soiled linens near the washer area that was left there uncovered. EVSS acknowledged that the bucket full of dirty and soiled linens near the washer area should not be left uncovered, when they were not washed yet.</p> <p>During an interview with IP on 10/25/24 at 11:00 a.m., IP verified that dirty and soiled linens in the laundry room should be covered and will remind the staffs about it.</p> <p>Review of the facility's policy titled, Laundry and Bedding, Soiled: Handling, dated 2001 indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. All used laundry is handled as potentially contaminated using standard precautions Contaminated laundry is bagged or contained at the point of collection</p> <p>4. During the laundry room observation on 10/24/24 at 9:30 a.m., there were missing logs in the dryer cleaning log monitoring sheet that included the removal of the dryer lint (a collection of fine fabric and yarn pieces that accumulate in a dryer's filter while clothes were being dried).</p> <p>Review of the dryer cleaning log monitoring sheets of the laundry department, from 8/30/24 to 10/24/24 at 9:00 a.m., indicated that the 2 dryers were being checked that included the removal of the dryer lint, 5 times per day at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., and 3:00 p.m., and there were 124 missing signature logs by the laundry staffs.</p> <p>During the interview with EVSS on 10/24/24 at 9:32 a.m., EVSS verified the missing signature logs of the laundry staffs for the dryer cleaning log monitoring sheets of the laundry department that included the removal of the dryer lint. He further verified that there should be no missing signature logs of the laundry staffs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During the interview with IP on 10/25/24 at 11:00 a.m., IP verified that the dryer cleaning log monitoring sheets of the laundry department should have been completed and there should be no missing signature logs of the laundry staffs.</p> <p>Review of the undated facility's policy titled, Dryer Lint Policy, indicated, Proper care and maintenance of laundry equipment, including the management of dryer lint, are essential All staff involved in laundry operations will receive training on the importance of lint management and the procedures for proper removal and disposal. A log of lint removal and maintenance inspections will be maintained to ensure compliance with this policy</p> <p>5. During the concurrent observation of the three compartments sink and red bucket testing with sanitizer, using the sanitizer test strips and interview with the dietary aide H (DA H) on 10/22/24 at 1:25 p.m., DA H checked the sanitizer concentration level using the test strips. DA H was then asked the meaning of the test strip readings after they were dipped in the sanitizer. DA H could not tell the meaning of the test strip reading results, whether the concentration level of the sanitizer was okay for use.</p> <p>During another concurrent observation of the three compartments sink and red bucket testing with sanitizer, using the sanitizer test strips and interview with cook I (COOK I) on 10/24/24 at 11:05 a.m., COOK I checked the sanitizer concentration level using the test strips. COOK I was then asked the meaning of the test strip readings after they were dipped in the sanitizer. COOK I could not also tell the meaning of the test strip reading results, whether the concentration level of the sanitizer was okay for use.</p> <p>During the interview with the registered dietitian (RD) on 10/24/24 at 11:10 a.m., RD verified that kitchen staffs should know the effective concentration level of the sanitizer and should know how to read the results of the sanitizer testing strip. RD then stated that she would do an in-service about it.</p> <p>Review of the facility's policy titled, Quaternary Ammonium Log Policy, dated 2023 indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution The Food and Nutrition Services worker will place the solution in the appropriate bucket labeled for it's contents and will test the concentration of the solution</p> <p>6. During a concurrent observation of the emergency food storage room and interview with EVSS on 10/24/24 at 2:38 p.m., there were gallons and bucket of cleaning chemicals that were kept beside the plastic food containers. There were also food items stored in the emergency food storage room. EVSS acknowledged that the cleaning chemicals should not be stored in the emergency food storage room.</p> <p>During the interview with RD on 10/24/24 at 2:42 p.m., RD verified that the cleaning chemicals should be stored separately from the food items. RD further verified that she would remove the cleaning chemicals in the emergency food storage room and will store them separately.</p> <p>Review of the facility's policy titled, Storage of Food and Supplies, dated 2023 indicated, Food and supplies will be stored properly and in a safe manner Food storage areas should be used only for food. Items such as bleach, soap, and other cleaning supplies should be stored in entirely separate and specific areas</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>7. During an observation of the medication storage room on 10/20/24 at 2:43 p.m. with Licensed Vocational Nurse (LVN) D, a crawling silverfish bug and a white disposable spoon were found in the sink. The sink also had yellowish stains.</p> <p>During an interview on 10/22/24 at 1:06 p.m. with the Director of Nursing (DON), the DON stated that the medication room is cleaned daily by the housekeeper. DON also stated there is a log for the daily cleaning of the medication room.</p> <p>During a concurrent interview and record review on 10/24/24 at 3:29 p.m. with the Housekeeping Supervisor (HS), HS stated she cleaned the medication room that day 10/24/24. HS verified the document Med Room Cleaning/Disinfection Log, and stated it is not her signature on date 10/24/24. HS confirmed her signature was not in the document. HS stated there was no log for cleaning the medication room and it was the first time she saw the document.</p> <p>The facility provided a document entitled Med Room Cleaning/Disinfection Log, the document had seven columns corresponding to the months of June 2024 to December 2024. Written under each month were rows corresponding to the number of days of the month which indicated daily signatures except for 7/14/24. No other details were written in the document.</p> <p>A review of facility's policy and procedure (P&P) entitled Medication Labeling and Storage revised February 2023, the P&P indicated, .2. The nursing staff is responsible for maintaining medication and storage and preparation areas in clean, safe, and sanitary manner .</p> <p>49345</p> <p>51580</p>		

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NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>49345</p> <p>Based on observation, interview and record review, the facility failed to ensure equipment is in safe operating condition for four (Residents 8, 23, 26 and 38) out of eight sampled residents when a commode with noticeable rust was found in their shared toilet.</p> <p>This failure had the potential to put residents at risk for harm during their usage of the rest room.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 10/20/24 at 2:19 p.m. with LVN E, a commode with noticeable rust was positioned over the toilet bowl in the rest room shared by Resident 8, Resident 23, Resident 26, and Resident 38. LVN E stated we should have checked the commode before placing it in the resident's toilet.</p> <p>During an interview with the Maintenance Director/ Environment Services Supervisor (EVSS) on 10/23/24 at 1:49 p.m., EVSS stated that there is no log to monitor commodes. EVS also stated that nurses do the log for the commode maintenance and not the maintenance department.</p> <p>During a concurrent interview and record review on 10/23/24 at 1:55 p.m. with the Infection Preventionist (IP), the IP verified the Maintenance Log for October 2024 indicated there is no request to replace a commode.</p> <p>A review of facility's policy and procedure (P&P) entitled Maintenance Service revised December 2009, the P&P indicated, .1. The maintenance department is responsible for maintaining the .equipment in a safe and operable manner at all times .</p>		

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NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>35386</p> <p>Based on observation, interview, and record review, the facility failed to ensure multiple resident rooms with two beds (Rooms 101, 102, 103, 104, 105, 106, 107, 109, 110, 114, 115, 116, 117, 118, 120, and 121) measured at least 80 square feet per resident. Less than 80 square feet per resident in resident rooms could adversely affect resident health and safety.</p> <p>Findings:</p> <p>Room measurements indicated multiple resident rooms with two beds were less than 80 square feet per resident. Rooms 101, 102, 103, 104, 105, 106, 107, 109, 110, 114, 115, 116, 117, 118, 120, and 121 with two beds all measured 69.51 square feet per resident.</p> <p>None of the rooms were observed to inhibit the staff from providing care or the residents from receiving adequate care. The staff and the residents moved freely in the rooms. Wheelchairs and walkers were easily accommodated. The residents and the staff stated the square footage of the rooms was not a concern.</p> <p>Recommendation is for a continuance of the room waiver.</p> <p>44577</p>		

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NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>35386</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when two live cock roaches were observed in the social services office by health facilities evaluator nurses, during a recertification survey. This finding had the potential to put residents and staffs' health and safety at risk.</p> <p>Findings:</p> <p>During an observation on 10/24/24, at 2:30 p.m., in the social services office, a live cockroach was observed on the floor under the desk.</p> <p>During an observation on 10/24/24, at 2:47 p.m., in the social services office, a live cockroach was observed on top of the desk.</p> <p>During a concurrent interview and record review, on 10/25/24, at 2:32 p.m., with the administrator (ADM), the facility's policy and procedure (P&P) titled, Pest Control, revised May 2008, was reviewed. The P& P indicated, This facility maintains an effective pest control program so that the facility is free of pests and rodents. ADM acknowledged an effective pest control program was to ensure a pest free environment.</p> <p>44577</p>		