

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Stratford Villa Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 752 Holmes Street Livermore, CA 94550	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487</p> <p>Based on observation, interview and record review, the facility failed to ensure safe medication storage when the following medications were found in medication cart one:</p> <ol style="list-style-type: none"> 1. Resident 22 did not have an accurate medication card label for Colchicine that matched the order the physician had prescribed. (Colchicine is a medication used to prevent or treat gout attacks. Gout is a disease that causes severe pain, swelling, redness and tenderness in joints). 2. Three and one-half loose pills were not in a labeled container. <p>This failure had the potential for medication error and contamination.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of the admission record, dated 3/19/24, indicated Resident 22 was admitted on [DATE], with the diagnosis of gout. <p>During a medication administration observation on 3/19/24, at 8:21 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 gave Resident 22 one tablet of Colchicine 0.6 milligrams (mg) from Resident 22's medication card with a direction label that indicated to give Colchicine one tablet two times a day.</p> <p>During a concurrent interview and record review on 3/19/24, at 3:00 p.m., with LVN 1, Resident 22's physician's order, dated 3/19/24, was reviewed. The physician's order indicated to give one tablet of Colchicine 0.6 mg. once a day for gout. LVN 1 acknowledged Resident 22's medication card did not match the current physician's order, because the card indicated to give Colchicine one tablet two times a day. LVN 1 further stated having direction labels that did not match the current physician's order was a risk for medication administration error.</p> <p>During an interview on 3/21/24 at 9:05 a.m., with Registered Nurse 1 (RN 1), RN 1 stated the risk of having medication cards with direction labels that did not match Resident 22's current physician's order could be suffering an adverse (undesirable) effect of the medication.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated .The nursing staff must inform the pharmacy of any changes in physician's orders for a medication .</p> <p>2. During an observation and concurrent interview with RN 1, on 3/19/24, at 12:50 p.m., upon inspection of the medication cart 1, three and one-half loose tablets were found. RN 1 was unable to identify the loose tablets and stated loose tablets should not be in the medication cart and should have been disposed.</p> <p>During a review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated . Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents .</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>36593</p> <p>Based on observation, interview, and record review, the facility failed to ensure state requirements were met for a full-time registered dietitian or the person designated to serve as the director of food and nutrition services was hired on staff on a full-time basis (35+hours/week).</p> <p>This failure had the potential for food and nutrition services staff to be inadequately trained and supervised to carry out food and nutrition services for 26 out of 26 residents.</p> <p>Findings:</p> <p>During an interview on 3/19/24 at 8:39 a.m., with the Dietary Supervisor (DS) and Registered Dietician (RD), DS stated he did not work full time in the Kitchen. DS said he also worked next door at the sister facility. DS further stated he provided dietary staff training and checked their competencies. DS stated he did not work full time and works at least 20 hours a week for the facility. DS further stated he also worked at the sister facility next door for 20 hours a week. RD stated she works part time at the facility, between 8-16 hours a week.</p> <p>During an interview on 3/19/24 at 12:30 p.m., with the Administrator (Admin), Admin stated she was aware the facility did not have a full time DS or RD and Admin was working on it.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36593</p> <p>Based on observation, staff interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> 1. Hand washing sink was located right next to coffee machine and beverage dispenser. 2. Multiple food items opened with no use-by dates; bag of permecian gravy opened 3/5/24, bag of chicken gravy mix opened 3/2/24, carton of lactose free milk opened 3/12/24, cartoon of pineapple juice opened 3/10/24. There were five pounds of Monterey jack cheese opened 3/11/24, and a plastic container of apple sauce, dated 3/10/24. 3. Three-compartment sink was not operated according to instructions. 4. Ice machine had brownish whitish hard sticky substance on the right area on the outside difficult to wipe off. 5. Three kitchen air vents and one fly trap by the outside door with excessive blackish dust. 6. Floor drains and air gap by the ice machine and walk-in refrigerator had brownish black discoloration. 7. Dietary staff picked up trash from the kitchen floor and proceeded to distribute water from beverage cart without hand washing. <p>These failures increased the risk for food contamination and food borne illness for 26 residents who received food from the kitchen.</p> <p>Findings:</p> <p>During initial tour of the kitchen on 3/18/24 at 9:00 a.m., with Dietary Services Supervisor (DS), the following were observed: the container of coffee creamer was situated next to the coffee and beverage dispenser that was next to the hand washing sink. DS stated as long as the coffee dispenser is covered, he was not concerned about the water splashes from staff use of hand washing sink. Multiple food items in the refrigerator and walk-in refrigerator had an open date with no use-by date. DS stated the food items had no use-by date.</p> <p>During concurrent observation of the kitchen and interview on 3/18/24 at 9:34 a.m., with DS accompanied Registered Dietician (RD), the dishwashing machine was not operational. RD stated facility had been using the 3 compartment sink for dishwashing. The water in the 3-compartment sink had brownish discoloration. Dietary aide (DA1) stated he uses the 3 -compartment sink to wash pots and dishes, then rinse and immerse in the sanitizer for 5 minutes to sanitize. DA 1 further stated the water temperature was checked in the morning before starting wash and the temperature are recorded. DA 1 stated the water temperature and test strip result where not repeated or recorded every 30 minutes. RD stated the water temperature needs to be repeatedly checked every 30 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the emergency 3-compartment washing log posted on the wall indicated from 3/13/24 to 3/18/24, temperature of the 3 compartment sink and result of the sanitizer test strip were check with initial setup for each meal (breakfast, lunch and dinner), there was no record of the temperature and sanitizer test strip results documented every 30 minutes as instructed.</p> <p>During a follow up tour of the kitchen on 3/19/24 at 9:32 a.m., with Maintenance Supervisor (MS) and Administrator (Admin), the ice machine had a brownish white hard, sticky substance on the right side of the wall which was difficult to wipe off. MS stated the build up on the ice machine could not be removed because the manufacturer did not want any chemical use on the outside of the machine. Three ceiling vents and fly trap above the exit door had excessive black dust. MS stated he missed cleaning the vents located in the kitchen ceiling. During further observation, the airgap/back flow area next to the ice machine and walk-in freezer were with brown-black discoloration. MS stated the air gaps area will be added to their maintenance cleaning schedule.</p> <p>During a concurrent observation and interview on 3/19/24 at 9:38 a.m., with RD and Admin, the coffee and beverage dispenser was next to the handwashing sink. RD stated there was a possible infection control concerns related to the coffee and beverage dispenser next to the sink. RD stated she was hired three months ago and had no documentation the kitchen sanitation checks were done.</p> <p>During tray line observation and concurrent interview on 3/19/24 at 11:56 a.m., DA 1 with gloved hands picked up a piece of trash from the kitchen floor and threw it in the trash can, using the same gloved hand to distribute water from the beverage cart. DA 1 stated he was supposed to change his gloves before he distribute cup of water from the beverage cart.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation dated 2023, the P&P indicated, the food and nutrition services (FNS) director is responsible for instructing employees in the fundamentals of sanitation in food service and for training employee to use appropriate techniques. The Maintenance Department will assist FNS as necessary in maintaining equipment and in doing janitorial duties which the FNS employees cannot do and maintain maintenance records on all equipments.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>36593</p> <p>Based on observation, interview, and record review, the facility failed to dispose of garbage and contain refuse properly when the dumpster was not closed.</p> <p>This failure had the potential of harborage and feeding of pests.</p> <p>Findings:</p> <p>During an observation on 3/19/24 at 8:39 a.m., with Dietary Services Supervisor (DS), one dumpster located by the side of the facility was full of trash bags and not closed or covered. There was no staff presence around the dumpster area.</p> <p>During an interview on 3/19/18 at 8:39 a.m., DS stated the dumpster was supposed to be closed.</p> <p>During an interview on 3/19/24 at 09:01 a.m., with Maintenance Director (MS) and Administrator (Admin), MS stated the dumpster was to be closed when not in-use.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Medical Waste, Handling of, revised September 2010, indicated outside compactor/dumpster must be locked when not in use and at night.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>36593</p> <p>Based on interview and record review, the facility failed to follow a written hospice (end-of-life) agreement that included joint responsibilities to develop and implement plan of care for one sampled resident (Resident 23) was admitted into the hospice program, when Resident 23 and Resident 23's representative (FM 1) were not included or participated in the development and implementation of Resident 23's hospice plan of care (POC).</p> <p>This failure had the potential to result in negative outcomes and lack of communication of a person-centered care needs for residents.</p> <p>Findings:</p> <p>Review of the Significant change in status-Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 2/24/24, indicated; Resident 23's diagnoses included Non-Alzheimer's Dementia (a group of diseases characterized by progressive deficits in behavior, executive function or language) and senile degeneration of the brain (Dementia). Resident 23's Basic Interview of Mental status (BIMS) score was 01 poor cognition). Resident 23 had a clear speech, usually understood and understood others.</p> <p>During a telephone interview on 3/18/24 at 11: 20 a.m., with Resident 23's representative (FM 1), FM 1 stated Resident 23 was admitted to hospice for terminal care. FM 1 stated the concern she had was that there was not enough communication with staff regarding Resident 23's care. FM 1 stated the care planning conference she was invited and participated was in June 2023 when Resident 23 was admitted to the facility. FM 1 stated Resident 23 and herself had not participated in Resident 23's hospice plan of care or in any other care planning.</p> <p>Review of Resident 23's hospice plan of care initiated 2/17/24 indicated Resident 23 was admitted to hospice care for senile degeneration of the brain interventions included to encourage participation to the extent the resident wishes to participate.</p> <p>Review of order summary report dated 2/17/24 indicated the physician admitted Resident 23 into hospice for senile degeneration of the brain.</p> <p>During a concurrent interview and review of the IDT (interdisciplinary team is comprised of different staff from different departments of the facility, like nursing, social services etc.) care planning conference records, on 3/20/24 at 9:26 a.m., with Social Services Director (SSD), Director of Nursing (DON) and Registered Nurse (RN 1), SSD stated Resident 23 and FM 1 had not been invited to participate in the development of Resident 23's hospice care plan. SSD stated she had not arranged for a care planning conference with Resident 23, FM 1, and the hospice provider. SSD further stated sometimes a quick care conference was done when FM 1 visited the facility. SSD could not provide documentation that Resident 23 and FM 1 was invited, included or participated in the hospice plan of care.</p> <p>Review of Resident 23's clinical records indicated the plan of care attended by Resident 23 and FM 1 was completed in June 2023 before Resident 23 was admitted into hospice.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/21/34 at 10:29 a.m., with Administrator (Admin) and DON, Admin stated hospice care planning was to be initiated when the resident was admitted into the hospice program. Admin stated the facility's policy was for SSD to coordinate with the facility staff and hospice provider.</p> <p>During a review of the Hospice Services Agreement (Agreement), dated 2/16/24, the Agreement indicated the Joint Responsibilities/Mutual Promises- Development and implementation of plan of care (POC). When a facility resident is authorized by hospice for admission to the Hospice Program, or when the facility admits a hospice patient to the facility, hospice and facility staff shall jointly develop and agree upon the patient's POC.</p> <p>{</p>		