STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055315	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANT CUESTA SUB-ACUTE AND REHABILITATION CENTER	1949 GRANT ROAD MOUNTAIN VIEW, CA 94040

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on interview and record review, the facility failed to ensure 1. personal belongings for one of three residents (Resident 3) were not lost during her facility stay; and 2. Resident 2's responsible party's (RP) right to be informed of Resident 2's significant weight loss. These failures have the potential to result for emotional distress on Resident 3 and for RP unaware of Resident 2's change of condition. Findings: 1. During a record review on 9/4/2020 at 8:40 a.m., Resident 3's inventory of personal belongings done on 8/1/2020 indicated she had four blouses, one pajama, two socks and two underwear, and these items were not included in the signed and received personal inventory of belongings during her discharge on 8/10/2020. During a record review and concurrent interview on 9/4/2020 at 2:25 p.m., the social services director (SSD) upon review of Resident 3's medical record confirmed Resident 3's missing personal belongings when discharged from the facility. The SSD stated the facility had searched the laundry and other areas but did not find the missing items. During a follow-up interview on 9/5/2020 at 9:50 a.m., the SSD stated she contacted Resident 3 and informed her the facility would either pay or replace the lost items depending on her (Resident 3's) decision. 2. A review of Resident 2's facesheet indicated she had a responsible party (RP). The Weekly Weight Variance Note dated 8/28/2020 indicated a 2.7% significant weight loss in one week. During an interview and concurrent interview on 9/10/2020 at 3:00 p.m., the registered dietician (RD) and the director of nursing (DON) both reviewed Resident 2's medical record and confirmed no documentation had been found that indicated the responsible party was notified regarding resident's weight loss. The DON also stated significant weight loss was considered a change of condition that required a RP notification. A review of the facility's Resident Handbook, indicated the facility shall exercise reasonable care for the protection of resident's property from loss and theft. A review of the facility's October 2011 policy and procedure, Weight Management Standard, indicated physician and responsible party will be notified of significant weight variance.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically-related social services for one of three sampled residents (Resident 2) when the social services (a department aiming to promote the welfare of the residents in a facility) did not follow-up Resident 2's podiatry (a branch of medicine devoted to the study, diagnosis, and medical and surgical treatment of [REDACTED].(RP) request for hospice referral. These failures may to result in the facility's inability to appropriately address Resident 2's needs. Findings: A review of Resident 2's facesheet indicated she had a responsible party (RP), and included [DIAGNOSES REDACTED]. A review of Resident 2's physician's orders [REDACTED]. The social services referral list included Resident 2 as those to be seen by podiatrist in the monthly visit in July 2020. During an interview and concurrent record review on 9/10/2020 at 2:50 p.m., the social services assistant (SSA) confirmed Resident 2 was not seen by podiatrist during his monthly visits in July and August 2020, and no social services follow-up was done. The SSA also stated the podiatrist refused to see Resident 2 because he was at the Observation unit (unit to isolate residents on a 14-day observation for any signs and symptoms of respiratory infection). A review of Resident 2's interdisciplinary team (IDT, a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) Assessment and Progress Note dated 7/20/2020 indicated Resident 2's (RP) requested hospice care/referral during the care conference. During an interview on 9/10/2020 at 3:05 p.m., the minimum data set coordinator (MDSC) and SSA both confirmed the RP's request of hospice referral and found no documentation that a follow up was done. A review of the facility's December 2011 policy and procedure, Podiatry Positive Practice, indicated social services or nursing are the primary department responsible for referrals.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement infection control procedures to help prevent the spread of infection when: 1. Resident 1's stool specimen for [MEDICAL CONDITION] (c. diff, is a highly contagious disease caused by a spore-forming bacterium that can causes diarrhea and more serious symptoms ranging from diarrhea to life-threatening inflammation of the colon) was not collected and sent timely when ordered. 2. Resident 1's physician's orders to initiate and discontinue transmission-based precautions (TBP, type of isolation precautions to help prevent spread and transmission of illness/disease) were not taken. A change of condition (COC) note, notification of MD and responsible party was not done, and care plans for [DIAGNOSES REDACTED] isolation precautions and antibiotic use were not developed. 3. Resident 1's contact isolation (one type of TBP) was not initiated when Resident 1's positive c.diff test result was known and Resident 1's TBP was discontinued not in accordance with the Center for Disease Control (CDC) guidelines. 4. Residents 1 and 2's antibiotic use were not logged in the facility's infection log as part of their antibiotic stewardship program. These failures had the potential for transmission of infection to other residents, staff and visitors. Findings: 1. During a record review on 9/4/2020 at 11:30 a.m., Resident 1's physician's order dated 7/3/2020 included stool for [DIAGNOSES REDACTED] on 7/3 to 7/4/2020. During the record review and concurrent interview on 9/4/2020 at 11:30 a.m., the director of nursing (DON) upon review of Resident 1's bowel and bladder report from July 1 to 16, 2020 indicated the resident had passed stools on 7/3, 7/4, and 7/5/2020 but no specimen was collected and sent to the laboratory for analysis. The stool specimen was collected and sent on 7/6/2020 and the result came positive for [DIAGNOSES REDACTED] on the same day. 2. There was no physician's order to initiate contact isolation precautions. A COC note, MD and RP notification, and care plans for [DIAGNOSES REDACTED], isolation precautions and antibiotic use were missing. The DON stated staff should be consistent and make certain a physician's order be taken to initiate and discontinue TBP when required. 3. A review of Resident 1's infection notes dated 7/7/2020, indicated contact isolation initiated and an order dated 7/8/2020 for [MEDICATION NAME] HCL solution 25 mg./ml.(milligrams per milliliter, units of measurement) give 125 mg. by mouth four times a day for [DIAGNOSES REDACTED] x 14 days. A review of the Census List indicated Resident 1 was transferred to a private room (room [ROOM NUMBER]-P) on 7/9/2020 and transferred back to her old room (room [ROOM NUMBER]-D) with five other residents on 7/13/2020. During the record review and concurrent interview on 9/4/2020 at 1:10 p.m., the infection preventionist (IP) and licensed vocational nurse A (LVN A), nurse supervisor upon review of Resident 1's medical record, confirmed the resident was not placed on isolation precautions when the positive [DIAGNOSES REDACTED] result was known, and isolation precaution was discontinued while resident was still having episodes of diarrhea and on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) [MEDICATION NAME] treatment until 7/22/2020. Both the IP and LVN A stated, the TBP should continue while the resident was on antibiotics or free of diarrhea for at least 72 hours per CDC guidelines. 4. During a record review of the facility's July and August 2020 Infection Control Log on 9/10/2020 at 9:16 a.m., indicated antibiotic use for Residents 1 and 3 were missing. During the concurrent interview with the IP she stated any resident on antibiotics should be included in the Infection Surveillance Log as part of the facility's Antibiotic Stewardship Program to keep track on antibiotic use and look for trends in the possible spread of infection. A review of the facility's Infection Prevention Manual for Long Term Care, indicated for [MEDICAL CONDITION], infected residents should be placed in private room or cohorted while having diarrhea and remain on isolation precautions until they are asymptomatic(free of diarrhea for at least 72-hours).