STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055211	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idylwood Care Center	1002 W. Fremont Avenue Sunnyvale, CA 94087

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained dignity and respect for two of 32 residents when: 1. Maintenance staff intervened while staff attempted to de-escalate Resident 62's angry outburst. 2. Resident 88's urinal was on his bedside table next to food items. These failures had the potential to affect the emotional well-being of the residents. Findings: 1. During an observation on 4/7/25 at 1:31 p.m., there were two maintenance staff working on a handrail in the hallway, close to the nurse's station. Resident 62 was in his wheelchair banging on the door to the nurse's station. One of the maintenance workers, maintenance staff M (MS M) was repeatedly telling Resident 62 to stop banging on the door. MS M stood up from his position fixing the handrail, walked to Resident 62 at the nurse's station, and stood behind Resident 62's wheelchair. MS M continued to tell Resident 62 to stop banging on the door. MS M then grabbed Resident 62's wheelchair and pulled the resident backward. Resident 62 swung his right arm behind him and hit MS M in the face. Review of Resident 62's face sheet indicated he was admitted to the facility with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making). Review of Resident 62's care plan indicated he has repetitive anxious concerns/complaints, demands juice, burritos, popsicles, and does not allow ample time for staff to accommodate requests. The care plan also indicated Resident 62 bangs on office and nurse's station doors. The care plan interventions included to explain all procedures to the resident before starting and allow the resident time to adjust to changes. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the report sent to the Department on 4/11/25 indicated the following: On 4/7/2025, at approximately [1:30 p.m.], staff observed Resident 62 repeatedly banging on the . nursing station window. While CNA [certified nursing assistant] was assisting Resident 62, one maintenance staff intervened and loudly verbalized to [Resident 62] to stop banging on the window. Maintenance staff attempted to redirect [Resident 62] by pulling [Resident 62]'s wheelchair backward towards [his] room. Maintenance staff was behind [Resident 62]'s wheelchair. [Resident 62] responded to maintenance staff by suddenly punching staff using his [Resident 62] right fist to hit the staff member's right eye. Two nurses remained with Resident 62 until he [calmed] down . During an interview on 4/7/25 at 1:45 p.m. licensed vocational nurse N (LVN N) stated he saw the incident with Resident 62. LVN N stated Resident 62 is constantly banging on the window. He stated he saw MS M try to take the resident back to his room and Resident 62 hit MS M on the right side of his face. During an interview on 4/10/25 at 1:43 p.m., the maintenance supervisor O (MS O) stated he heard about the incident with Resident 62 and MS M. The MS O stated he supervises four staff members. He stated he expects maintenance staff to be considerate to residents. The MS O stated if there was a situation related to nursing, he would expect maintenance staff to find someone appropriate to help. When asked about whether maintenance staff should be involved in a resident's disruptive behavior, the MS O stated maintenance staff do not get involved in those types of interactions. When asked what he thought about MS M pulling backwards on Resident 62's wheelchair from behind, the MS O stated, I don't feel that that was the best approach. During an interview on 4/11/25 at 3:38 p.m. with the administrator (ADM) and director of nursing (DON), the DON stated Resident 62 has a behavior of banging on the door of the nursing station. She stated staff is aware how to handle Resident 62. The DON stated staff does not have to go close to Resident 62 to redirect him because he can get aggressive. She stated MS M attempted to redirect Resident 62 and pulled his wheelchair backwards. The DON stated Resident 62's reaction to his wheelchair being moved was to swing and Resident 62 hit MS M's right eye. Both the DON and ADM stated MS M should not have been involved in that type of situation. Review of the facility's policy and procedure, Adequate Staffing/Workplace Composition, revised 8/2023 indicated, Staff will participate in de-escalation training. Review of Crisis Prevention Institute's Nonviolent Crisis Intervention Training Participant Workbook, (training the facility provides) indicated, Always respond with respect, empathy, and compassion. The workbook also indicated, Interpret distress behaviors and address the cause of the behavior to de-escalate the situation and Manage your own emotional responses to distress behavior. 38087 2. Review of Resident 88's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including depression, anxiety, and need for assistance with personal care. Review of Resident 88's minimum data set (MDS, an assessment tool), dated 3/20/25, indicated his cognition was moderately impaired and he needed partial/moderate assistance for toileting hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/7/25 at 9:47 a.m., Resident 88's bedside table had several drink items on the table including a glass of milk, a cup of coffee, and a glass with a pink liquid. Next to the drinks, on Resident 88's bedside table, was a plastic urinal that contained a yellow liquid. When Resident 88 was asked about the items on his bedside table he stated, That's the remnants of my breakfast I am finishing. Resident 88 further stated he does not like the urinal next to his food but stated, I can't do anything about it. During an observation on 4/7/25 at 9:50 a.m., the activities director (AD) was removing Resident 88's urinal from his bedside table. During a concurrent interview with the AD, he stated, It should not be on the bedside table next to the food. The AD removed the urinal and returned with a plastic urinal holder which he placed on the left side of Resident 88's bedframe. During an interview with the director of nursing (DON) on 4/10/25 at 7:30 a.m., she stated a urinal should not be placed on the bedside table during the meal service or when any food items are on the bedside table. The DON further stated staff should empty urinals after each use and then store in holders on the side of the resident's bed. Review of the facility's policy titled, Use of Bedpans and Urinals indicated, Avoid storing on any surface used for eating, such as the rolling bedside table.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 38573 Based on observation, interview and record review, the facility failed to maintain proper infection control practices when: 1. Resident 77 had an opened plastic bag with gastrostomy (GT, a surgical opening into the stomach for administration of nutrition and medications) syringe dated [DATE] and his urinary catheter attached to urinary catheter drainage bag (a urinary catheter is a thin, flexible tube used to drain urine from the bladder) was not properly positioned; 2. Resident 5's and 31's room had an opened and unlabeled GT syringe; 3. Resident 32 had an opened unlabeled plastic bag with enteral feeding tube (used to deliver nutrients directly into the stomach or small intestine, bypassing the mouth and swallowing process); 4. Resident 100's used spirometer (an apparatus for measuring the volume of air inspired and expired by the lungs that measures ventilation, the movement of air into and out of the lungs) mouthpiece had a dried yellowish substance and was touching the inside part of a wash basin; 5. A dirty plastic garbage bag was touching a box of clean gloves on top of Resident 100's bed and Dakin's solution (used to clean wounds) was not cleaned before storing in the treatment cart; 6. Nasal cannulas (NC, a tubing used to deliver oxygen) for Residents 43 and 40 were not in the resident's nostrils and were not stored properly; 7. A nurse was wearing an N95 (personal protective mask that filters out at least 95% of airborne particles, designed to form a seal around nose and mouth) face mask below her nose and mouth; 8. Resident 17's foley catheter (F/C, thin, flexible tube used to drain urine from bladder) drainage bag (urine collection bag) was on the floor; 9. The enteral feeding tubing for Residents 56, 28, and 17 were not dated; 10. The filters in Resident 27's concentrator were dirty. 11. A nurse did not sanitize a stethoscope after use. These failures had the potential to result in the transmission and spread of infection throughout the facility. Findings: 1. During the initial tour observation of the facility on [DATE] at 9:50 a.m., Resident 77's bedside table has plastic bag with GT syringe dated [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial tour observation of the facility on [DATE] at 9:51 a.m., Resident 77's had a urinary catheter attached to a urinary catheter drainage bag. The position of the tubing of the urinary catheter was above the level of the bladder and was kinked. During a concurrent observation and interview on [DATE] at 9:52 a.m., with licensed vocational nurse Q (LVN Q) she acknowledged the above observation and stated the GT syringe should not be there. During a concurrent observation and interview on [DATE] at 9:55 a.m., with LVN Q, she confirmed the above observation and stated the position of the tubing was above the level of the bladder, urine was going back to the bladder, and it should not have been kinked. During a concurrent interview and record review on [DATE] at 8:57 a.m., with the assistant director of nursing (ADON), the ADON reviewed Resident 77's clinical records and stated that Resident 77 was readmitted to the facility on [DATE] and had a suprapubic catheter (small flexible tube surgically inserted into the bladder through an incision in the lower abdomen) insertion procedure on [DATE] due to diagnosis of obstructive and reflux uropathy. The ADON further stated that the care plan for suprapubic catheter was initiated on [DATE] and indicated that one of the interventions was to position catheter bag and tubing below the level of the bladder and away from the entrance room door. 2. During the initial tour observation of the facility on [DATE] at 10:06 a.m., a room was shared by two residents, Resident 5 and Resident 31. There was a bedside table in the middle of the room. On top of the bedside table there was an opened and unlabeled GT syringe. During a concurrent observation and interview on [DATE] at 10:10 a.m., with LVN Q, she confirmed the above observation and stated it should have been labeled because both residents are on isolation precautions. 3. During an observation on [DATE] at 10:27 a.m., Resident 32's bedside table had an opened plastic bag with enteral feeding tube inside. The bag was undated, unlabeled, and touching an opened package of A and D ointment (used to moisturize skin). During a concurrent observation and interview on [DATE] at 10:30 a.m., with LVN Q, she confirmed the above observation and stated it should have been labeled and dated. She further stated that A&D ointment that was used and opened should have been discarded to prevent contamination. 4. During the initial tour observation of the facility on [DATE] at 10:00 a.m., Resident 100's used spirometer mouthpiece had a dried yellowish substance and was touching the inside part of the pink wash basin. The spirometer was stored together with string, lotion, plastic and paper. During a concurrent observation and interview on [DATE] at 10:02 a.m., LVN Q confirmed the above observation and LVN Q stated that the spirometer apparatus mouthpiece should not be touching the pink wash basin. LVN Q further stated that after using the spirometer apparatus, it should have been cleaned and put it inside a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's undated policy and procedure, titled, Cleaning and Disinfection of Resident-Care Items and Equipment indicated, Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard . Disinfection necessary for items used in resident care . Semi-critical items consist of items that may come in contact with mucus membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. 5. During wound dressing change observation on [DATE] at 10:05 a.m., with the TX N, there was a dirty plastic garbage bag on top of Resident 100's bed that contained used gauze, used dressings, and used gloves. The garbage bag was touching and covering more than half of an opened box of clean gloves. The TX N was holding a Dakin's solution bottle with his left gloved hand with the same glove that was used during Resident 100's wound dressing change. The TX N stored the Dakin's solution bottle inside the treatment cart without cleaning the bottle. During an interview on [DATE] at 10:15 a.m., with TX N, he confirmed the above observations. Review of the facility's policy and procedure dated [DATE], titled, Dressing, Non-Sterile and Sterile indicated, Non-sterile (clean) dressing changes are applied in a clean and comfortable manner . Example of Wounds: Pressure Ulcers, Chronic Wounds, Skin tears, Less Invasive Wounds . Clean technique means free of dirt, marks, or stains . Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Review of the facility's undated policy and procedure, titled, Personal Protective Equipment - Gloves indicated gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. 46552 6. Review of Resident 43's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 43 was admitted to the facility on [DATE]. Resident 43's FS also indicated diagnoses included chronic obstructive pulmonary disease (COPD, a progressive lung disease causes airflow limitations and lung tissue destruction) and respiratory failure with hypoxia (a condition with low oxygen [O2, a colorless, odorless, and tasteless gas essential to living organisms] blood levels due to lungs unable to adequately oxygenate the blood). Review of Resident 43's physician orders, dated [DATE] indicated, Administer continuous oxygen at 2 LPM [liters per minute, flow rate of oxygen delivery] via nasal cannula. During an initial observation of Resident 43's room on [DATE] at 10:00 a.m., Resident 43's NC was laying on the bed's left side rail and was connected to an oxygen concentrator (a medical device that concentrates oxygen from environmental air and delivers it to a resident in need of supplemental oxygen). Resident 43's oxygen concentrator was on. During an interview with licensed vocational nurse B (LVN B) on [DATE] at 10:17 a.m., LVN B confirmed Resident 43's NC was not in the resident's nostril and was left on the side rail. LVN B stated the NC should not have been left on the side rail due to infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 40's FS indicated Resident 40 was admitted to the facility on [DATE]. Resident 40's FS also indicated diagnoses included thrombocytopenia (low levels of platelets [type of blood cells to help to stop bleeding] in blood) and venous insufficiency (a condition when blood flow problems sending from legs back up to heart). Review of Resident 40's physician orders, dated [DATE] indicated, Administer ,d+[DATE] liters of oxygen via nasal cannula to maintain oxygen level of > [greater than] 92% as needed. During an initial observation of Resident 40's room on [DATE] at 10:37 a.m., Resident 40's NC was laying on a humidifier (a medical device that adds moisture to the oxygen delivered to resident during oxygen therapy) and was connected to an oxygen concentrator. Resident 40's oxygen concentrator was on. During an interview with licensed vocational nurse P (LVN P) on [DATE] at 11:40 a.m., LVN P confirmed the above observation. LVN P stated the NC should be in Resident 40's nostril when oxygen is in use. LVN P also stated the NC should not have been left on the humidifier. During an interview with the facility's infection preventionist (IP) on [DATE] at 8:20 a.m., the IP stated nasal cannulas should be in resident's nostrils when oxygen is in use. The IP also stated NC should not have been left on a side rail or humidifier because it would be an infection control issue. Review of facility's policy and procedure (P&P) titled, Labeling of Oxygen Cannula/Tubing, dated [DATE], the P&P indicated, During Use: Place the cannula in the patient's nostrils, ensuring a comfortable and secure fit. 7. During an observation on [DATE] at 9:55 a.m., licensed vocational nurse B (LVN B) was preparing medications in front of the medication cart (movable equipment used in healthcare settings to store, transport, and dispense medications) in the hallway. LVN B's N95 (personal protective mask that filters out at least 95% of airborne particles, designed to form a seal around nose and mouth) face mask was below her nose and mouth. During a second observation on [DATE] at 10:11 a.m., LVN B's N95 face mask was below her nose and mouth while preparing medications in front of the medication cart in the hallway. During an interview with LVN B on [DATE] at 10:15 a.m., LVN B confirmed her N95 was below her nose and mouth. LVN B adjusted her N95 to cover her nose and mouth and stated her N95 should have covered her nose and mouth to form a tight seal. During an interview with the IP on [DATE] at 7:58 a.m., the IP confirmed all staff must wear N95 due to current influenza (a common, sometimes deadly viral infection of the nose, throat, and lungs) outbreak (a sudden and unexpected increase in number of cases) in the facility. The IP stated LVN B's N95 face mask should have covered her nose and mouth to prevent the spread of infection. Review of facility's P&P titled, Personal Protective Equipment, dated [DATE], the P&P indicated, PPE (personal protective equipment) required for transmission-based precautions is maintained outside and inside the resident's room, as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility's P&P titled, Personal Protective Equipment-Using Face Masks, dated [DATE], the P&P indicated, Be sure that face mask covers the nose and mouth. 8. Review of Resident 17's FS indicated Resident 17 was admitted to the facility on [DATE]. Resident 17's FS also indicated diagnoses included ureteral obstruction (blockage of the tubes that carry urine from kidneys [body organ that filter waste and excess water from blood, producing urine] to the bladder [body organ that stores urine]). Review of Resident 17's physician order, dated [DATE] indicated, Indwelling Foley catheter #18 F (size of F/C) with 10 cc [cubic centimeter, unit of measurement] [NAME] to bedside gravity drainage bag. During an observation on [DATE] at 9:30 a.m., Resident 17's F/C drainage bag was on the floor next to the right side of Resident 17's bed. During a concurrent observation and interview with certified nursing assistant T (CNA T) on [DATE] at 9:40 a.m., CNA T confirmed Resident 17's F/C drainage bag was on the floor. CNA T stated the F/C drainage bag should not have been on the floor due to infection control. CNA T also stated nursing staff should have placed the F/C drainage bag in a privacy bag anchored to Resident 17's bed frame. During an interview with LVN P on [DATE] at 10:02 a.m., LVN P stated Resident 17's F/C drainage bag should have been placed in a privacy bag and anchored to the bed frame below the bladder. LVN P also stated nursing staff should not have left F/C drainage bag on the floor for infection control and prevention. During an interview with the IP on [DATE] at 8:15 a.m., IP stated nursing staff should have placed Resident 17's F/C drainage bag in a privacy bag and should not have left the bag on the floor for infection control practice. Review of facility's P&P titled, Catheter Care, Urinary, dated [DATE], the P&P indicated, If drainage bag is packed separately, open package and attach bag to the bed frame. Use an alternate method to keep the drainage bag off the floor. 9. Review of Resident 56's FS indicated Resident 56 was admitted to the facility on [DATE]. Resident 56's FS also indicated diagnoses included gastrostomy (a surgical opening into the stomach, insert thin flexible tube to provided nutrition), and dysphagia (difficulty swallowing). Review of Resident 56's physician order dated [DATE] indicated, Enteral Feed Order every shift isosource [type of ready-to-use liquid nutrition formula] 1.5 at 70 ml/hr [milliliter/hour, metric unit of volume of fluid in one hour] via J-tube [jejunal tube, JT, soft plastic tube surgically inserted through skin into the small intestine to deliver nutrition and medications]. During an observation on [DATE] at 10:50 a.m., Resident 56's JT feeding was in use. The enteral feeding tube was attached to the ready-to-use feeding formula bag and the other end was attached to Resident 56's JT. Resident 56's enteral feeding tube was not dated. Review of Resident 28's FS indicated Resident 28 was admitted to the facility on [DATE]. Resident 28's FS also indicated diagnoses included gastrostomy and dysphagia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 28's physician order dated [DATE] indicated, Enteral Feed Order every shift isosource 1. 5 at 70ml/hr via J-tube. During an observation on [DATE] at 11:02 a.m., Resident 28's JT feeding was in use. The enteral feeding tube was attached to the ready-to-use feeding formula bag and the other end was attached to Resident 28's JT. Resident 28's enteral feeding tube was not dated. Review of Resident 17's FS indicated diagnoses included gastrostomy status and dysphagia. Review of Resident 17's physician order, dated [DATE] indicated, Enteral feed order every shift isosource 1. 5 at 5 ml/hr via G-tube [GT]. During an observation on [DATE] at 11:13 a.m., Resident 17's GT feeding was in use. The enteral feeding tube was attached to the ready-to-use feeding formula bag and the other end was attached to Resident 17's GT. Resident 17's enteral feeding tube was not dated. During an interview with LVN P on [DATE] at 11:33 a.m., LVN P confirmed the enteral feeding tubes were not dated when started for Resident 56, 28 and 17. LVN P stated nursing staff should have dated the residents' enteral feeding tubes. During an interview with IP on [DATE] at 8:10 a.m., the IP stated nursing staff should have labeled each enteral feeding tube with the date the feeding tube kit was opened. Review of manufacturer's recommendations for the enteral administration kit indicated, Discard administration set and transition connector when delivery is complete within a maximum of 48 hours. 38087 10. Review of Resident 27's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including COPD and pericardial effusion (build up of extra fluid in the space around the heart.) Review of Resident 27's physician order, dated [DATE], it indicated he had an order for continuous supplemental oxygen at 2 to 5 liters per minute. During an observation on [DATE] at 9:48 a.m., Resident 27 was receiving oxygen via nasal cannula being delivered via an oxygen concentrator. The filters on both sides of the oxygen concentrator machine were dusty, with an accumulation of whitish gray substances on the filter sponges. During an observation and concurrent interview with licensed vocational nurse A (LVN A) on [DATE] at 10:07 a.m., he confirmed both filters on Resident 27's concentrator were dirty and he stated the filters should be changed. During an interview with the director of nursing (DON) on [DATE] at 7:30 a.m., she stated the concentrator filter should be cleaned every week and replaced as needed. Review of the facility's policy Cleaning Resident Rooms and Equipment revised [DATE], indicated, . 5. For oxygen tanks, connectors and concentrators: b. Clean oxygen concentrator filters weekly. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Platinum Series XL, 5, 10 operator's manual indicated the following for routine maintenance of the cabinet filters: Remove each filter and clean at least once a week. 50855 11. During medication administration observation on [DATE] at 8:33 a.m., with Registered Nurse E (RN E), she was observed checking the gastrostomy tube (GT tube, a surgical opening into the stomach for administration of nutrition and medications) placement for Resident 34 using a stethoscope. After checking for placement, RN E placed the stethoscope inside the medication cart without sanitizing the stethoscope. During an interview shortly after medication administration on [DATE] at 8:57 a.m., RN E was asked whether she cleaned or sanitized the stethoscope after she used it and before placing it inside the medication cart. RN E stated, I did not sanitize it. She further stated for infection control it should be sanitized before and after use. During an interview on [DATE] at 3:38 p.m., with the Director of Nursing (DON), the DON stated the nurse should disinfect (clean something using chemicals that kill bacteria) the stethoscope after being used and before placing it back in the medication cart for infection control. During a review of facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated 2001, indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard . 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). 6. Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions.