

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Skyline Healthcare Center - San Jose		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 Forest Avenue San Jose, CA 95128	

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>36623</p> <p>Based on observation, interview and record review, the facility failed to store medications in a safe manner when nursing staff left medications unattended on the bedside table in a resident room. This failure had the potential to allow residents and unauthorized staff to access medications.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated he was admitted to the facility with diagnoses including dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning) and anxiety disorder (a mental health condition characterized by fear and worry that is both intense and excessive).</p> <p>Review of Resident 1's physician orders indicated he had orders for cyanocobalamin (vitamin B-12) 1000 micrograms (mcg, unit of measurement) once a day and gabapentin (medication used to treat nerve pain) 100 milligrams (mg, unit of measurement) capsule once a day.</p> <p>During an observation in Resident 1's room on 12/11/24 at 10:18 a.m., there were medications in a medication cup on Resident 1's bedside table unattended. Resident 1 was not inside the room.</p> <p>During a concurrent interview, registered nurse A (RN A) stated she was assigned to care for patients in 15 rooms, which also included Resident 1's room. RN A was at the nurse's station preparing documents for another resident. When RN A went into Resident 1's room, she confirmed that she left Resident 1's medications on the bedside table. She stated Resident 1 was not in the room, so she left the medications. RN A stated the medications were vitamin B-12 and gabapentin. She stated she should not have left the medications unattended.</p> <p>Review of the facility's policy, Storage of Medication, dated 1/2023 indicated, The medication supply shall be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy also indicated that medications should be stored in a controlled environment, which includes medication carts, medication rooms, medication cabinets, or other suitable containers.</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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