| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055318 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Skyline Healthcare Center - San Jose | 2065 Forest Avenue<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review, the facility failed to prevent abuse for one of three residents (Resident 1) when Licensed Vocational Nurse A (LVN A) hit and punched Resident 1's wound with his fist. This failure resulted in pain to Resident 1 and affected the resident's psychosocial well-being.Findings: Review of Resident 1's Face Sheet indicated the resident was admitted to the facility with diagnoses including osteomyelitis (bone infection) of the vertebra (backbone). Review of Resident 1's Minimum Data Sheet (MDS, an assessment tool) indicated his Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 15, meaning he was cognitively intact. Review of Resident 1's Physician Order Report indicated he had treatment orders for a coccyx (tailbone, small bone at the base of the spine) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and a left buttocks open wound. The report indicated Resident 1's treatment order, dated 2/24/26 indicated to cleanse the coccyx pressure injury with normal saline (a saltwater solution), apply Santyl ointment (used for wound care to help remove dead tissue), moistened gauze, and cover with foam dressing twice a day or as needed if soiled. The report also indicated Resident 1's treatment order, dated 2/24/26 indicated to cleanse the left buttocks wound with Dakins solution (used to clean wounds), apply Santyl ointment, collagen (protein used to encourage tissue growth for wound healing), and calcium alginate (absorbent dressing), cover with foam dressing twice a day or as needed. Review of a fax from the facility, Report of Suspected Dependent Adult/Elder Abuse, dated 2/25/26 indicated Resident 1 alleged a nurse providing treatment for his wound hit his wound with his hand a few days ago. During an interview on 3/26/26 at 9:42 a.m., the administrator (ADM) stated Resident 1's allegation was substantiated. The ADM stated Resident 1 provided a video recording of the incident which showed LVN A hitting Resident 1's wound. The ADM stated they were going to terminate LVN A, but LVN A decided to resign. The ADM stated LVN A has been reported to the Board of Nursing. During a concurrent review of Resident 1's video recording on the ADM's phone showed LVN A standing on left side of Resident 1's bed while Resident 1 was lying on the bed face down. LVN A had gloves on both hands and was using his fingers on both hands to press down the tape around the wound dressing. LVN A used the back side of the fingers of his right hand to smooth out the tape on the dressing. Then LVN A made a fist with his right hand and punched Resident 1's wound on top of the dressing. Resident 1 screamed out in pain and shouted obscenities. LVN A pulled Resident 1's underwear and pants over his dressing. During an interview on 3/26/26 at 11:49 a.m., Resident 1 described how LVN A hit or punched him on his wound site when providing treatment for his wound. He stated prior to setting up the video recording on his cellphone, LVN A punched his wound three or four times. Resident 1 stated other times, LVN A would slap his wound. He stated he was afraid to report LVN A hitting his wound. Resident 1 stated another resident also witnessed LVN A hitting his wound multiple times. Resident 1 stated he told LVN A to stop and warned him, but LVN A still proceeded. Resident 1 stated sometimes LVN A would do his wound treatment and just leave. Resident 1 stated his pants would be down and LVN A would leave the curtain open and the door open, which would be humiliating. During an<br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on 3/26/26 at 11:55 a.m., Resident 2 explained that he witnessed LVN A hitting Resident 1's wound. He stated LVN A would hit Resident 2 across the backside. Resident 2 stated LVN A would also squeeze Resident 1's wound or slap Resident 1's wound. He stated he cannot put a number on how many times LVN A abused Resident 1 because he did not want to lie. Review of the facility's undated policy, Abuse Prevention Program indicated, Our residents have the right to be free from abuse . It also indicated the administration will protect residents from abuse from anyone including staff, residents, family members, visitors, or any other individual. |