Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055388	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Jose Healthcare & Wellness Center	75 N. 13th Street San Jose, CA 95112

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to ensure the Ombudsman (resident advocate) was notified of discharges for three of three residents (Residents 1, 2, and 3). This failure had the potential to result in the residents not having someone to advocate for their admission, transfer, and discharge rights. Findings: Review of Resident 1's medical record indicated she was admitted to the facility on [DATE]. Review of Resident 1's Progress Notes, dated 4/22/24, indicated the facility informed Resident 1 that her insurance issued a last covered date of 4/25/24 (this indicated the insurance would not pay for Resident 1's stay in the facility after 4/25/24). Review of Resident 1's Progress Notes, dated 4/26/24, indicated Resident 1 was discharged from the facility at 10:50 a.m. There was no documentation in the Progress Notes that indicated the facility notified the Ombudsman of Resident 1's discharge. During an interview with the director of nursing (DON) on 5/31/24 at 12:39 p.m., the DON stated the nurses were responsible for notifying the Ombudsman via fax when residents are discharged or transferred from the facility. When asked how to determine whether or not the information was actually faxed to the Ombudsman, the DON explained that the fax machine would print out a fax confirmation. The DON stated she would try to find documentation that indicated the facility notified the Ombudsman of Resident 1's discharge on 4/26/24. During an interview and concurrent record review with the DON on 5/31/24, at 1:27 p.m., the DON presented two documents. One of the documents was Resident 1's Notice of Proposed Transfer and Discharge, dated 4/26/24. The other document was a fax cover sheet, dated 4/26/24 and addressed to the Ombudsman. The subject line on the fax cover sheet was left blank, and there was no documentation that indicated the intended fax was regarding a discharge from the facility. Also, the fax cover sheet did not have a fax confirmation. The DON confirmed there was no indication that the Notice of Proposed Transfer and Discharge was actually faxed to the Ombudsman. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24, at 2:30 p.m., the administrator (ADM) presented a different fax cover sheet, dated 4/26/24 and addressed to the Ombudsman. This fax cover sheet did have a fax confirmation printed on the top. However, the subject line on the fax cover sheet was still blank, and there was no documentation that indicated the intended fax was regarding a discharge from the facility. During an interview with Ombudsman office representative B (OOR B) on 6/3/24, at 8:50 a.m., OOR B confirmed the Ombudsman office did not receive notification that Resident 1 was discharged from the facility on 4/26/24. OOR B added that the Ombudsman office actually had not received notifications of transfers and discharges from the facility since July of 2023. Review of Resident 2's medical record indicated she was admitted to the facility on [DATE]. Review of Resident 2's progress notes, dated 2/23/24, indicated Resident 2 was transferred to the acute hospital. There was no documentation in the medical record that indicated the facility notified the Ombudsman of Resident 2's hospital transfer. Review of Resident 3's medical record indicated he was admitted to the facility on [DATE]. Review of Resident 3's Progress Notes, dated 4/7/24, indicated Resident 3 was transferred to the acute hospital. There was no documentation in the medical record that indicated the facility notified the Ombudsman of Resident 3's hospital transfer. During an interview and concurrent record review with the DON on 6/11/24, at 12:11 p.m., the DON reviewed the medical records of Resident 2 and Resident 3. The DON confirmed these residents were transferred to the acute hospital on 2/23/24 and 4/1/24, respectively. The DON confirmed there was no documentation in the medical records that indicated the facility notified the Ombudsman of these residents' hospital transfers. The facility's policy titled Notice of Transfer/Discharge, revised 10/2017, indicated when a transfer or discharge is initiated by the facility, the facility will provide a Notice of Transfer and Discharge to the resident, responsible party, and Ombudsman 30 days prior to the transfer or discharge. The policy indicated if the resident requires immediate transfer due to medical needs, the Notice of Transfer and Discharge will be given as soon as practicable. The policy further indicated, A facility representative will retrieve the completed Notice of Proposed Transfer and Discharge form from the clinical record and mail/fax it to the resident, responsible party and Ombudsman, and document in the clinical record that the notice was mailed/fax[ed], to whom it was mailed/fax[ed] and the date of the mailing/fax. All Facilities Letter (AFL) 17-27, dated 12/26/17 and addressed to long-term care facilities, indicated, Effective January 1, 2018, AB 940 requires a LTC facility to notify the local LTC Ombudsman at the same time notice is provided to the resident or the resident's representatives when a facility-initiated transfer or discharge occurs. The facility must send notice to the local LTC Ombudsman for any transfer or discharge that is initiated by the facility, whether or not the resident agrees with the facility's decision. AFL 17-27 further indicated, The facility is required to provide a copy of the notice to the LTC Ombudsman as soon as practicable if a resident is subject to a facility-initiated transfer to a general acute care hospital on an emergency basis.

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NAME OF PROVIDER OR SUPPLIER San Jose Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13th Street San Jose, CA 95112	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on observation, interview, and record review, the facility failed to follow its Oxygen Therapy policy for two of three sampled residents (Residents 4 and 5) who used oxygen when: 1. Resident 4's nasal cannula (flexible tubing inserted into the nostrils and attached to an oxygen source) was unlabeled and undated; and 2. There was no No Smoking sign posted for Resident 5's room. These failures had the potential to compromise the residents' health and safety. Findings: 1. Review of Resident 4's medical record indicated she was admitted on [DATE] and had the diagnosis of chronic respiratory failure (a condition in which the respiratory system does not exchange oxygen and carbon dioxide properly). Review of Resident 4's Order Summary Report indicated she had a physician's order, dated 2/6/24, for oxygen to by administered via nasal cannula as needed. During observations on 5/31/24, at 11:52 a.m. and 1:23 a.m., Resident 4 was in her room receiving oxygen via nasal cannula. The nasal cannula was not labeled with a date. During an observation and concurrent interview with licensed nurse A (LN A) on 5/31/24, at 1:39 p.m., LN A entered Resident 4's room and confirmed Resident 4's nasal cannula was not labeled with a date. LN A stated nasal cannulas should be changed weekly and should be labeled with the date they were changed. The facility's policy titled Oxygen Therapy, revised 11/2017 indicated, Oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. The supplies will be dated each time they are changed. 2. Review of Resident 5's medical record indicated she was admitted on [DATE] and had the diagnosis of chronic respiratory failure. Review of Resident 5's Order Summary Report indicated she had a physician's order, dated 11/10/23, for oxygen to be administered via nasal cannula as needed. During an observation on 5/31/24, at 11:55 a.m., Resident 5 was in her room receiving oxygen via nasal cannula. There was no No Smoking sign posted at the entrance to, or anywhere inside Resident 5's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/31/24, at 1:20 p.m., Resident 5 was in her room sitting on her wheelchair. There was an oxygen concentrator (machine used to deliver oxygen) next to Resident 5's bed, and a portable oxygen tank attached to her wheelchair. There was still no No Smoking sign posted at the entrance to, or anywhere inside Resident 5's room. During an observation and concurrent interview with LN A on 5/31/24, at 1:39 p.m., LN A stated for residents who use oxygen, there should be a No Smoking sign posted at the entrance to their room. LN A went to Resident 5's room and confirmed there was no No Smoking sign posted. The facility's policy titled Oxygen Therapy, revised 11/2017 indicated, 'No Smoking' signs will be prominently displayed wherever oxygen is being stored or administered.