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	07/29/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38087 Based on interview and record review, the facility failed to provide care in accordance with professional standards of practice for two of three sampled residents (Resident 1 and 2) when: 1. Staff did not complete an SBAR (situation, background, assessment, recommendation, a communication tool) and did not notify the physician and the responsible party (RP, person designated to make decisions on behalf of a resident) when an altercation occurred between Resident 1 and Resident 2; 2. Licensed nurse did not do a skin assessment for Resident 1 when Resident 2 threw coffee on Resident 1; 3. Licensed nurses did not put Resident 1 and Resident 2 on alert charting (nurses on each shift closely monitor and document in the medical record for 72 hours about a specific condition) when an altercation between Resident 1 and Resident 2 occurred; 4. Staff did not follow up with Resident 2 following a room change. These failures had the potential to result in inadequate monitoring of the resident's conditions, and the potential to negatively affect the residents' health, safety and well-being. Findings: Review of facility's document titled SOC 341 (Document for reporting suspected dependent Adult/Elder Abuse), dated 1/11/24, indicated at approximately 8:17 a.m., it was reported that Resident 2 threw cold coffee on roommate, Resident 1. A facility's untitled document, dated 1/15/24, contained a summary of the findings regarding the SOC. The summary indicated on 1/11/24 the certified nursing assistant (CNA) noticed that coffee had been spilled on Resident 1. The document further indicated Resident 1 informed the CNA that her roommate Resident 2 had thrown cold coffee on her. Upon interview with Resident 2, Resident 2 admitted to throwing coffee at Resident 1 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an interview with the director of nursing (DON) on 7/11/24 at 2:45 p.m., she reviewed the clinical records of Resident 1 and Resident 2 and confirmed there was no SBAR done on 1/11/24 when the incident occurred between Resident 1 and Resident 2. The DON acknowledged an SBAR should have been completed and stated in addition the facility must notify a resident's physician and responsible party if there is an altercation between 2 residents. The DON reviewed Resident 1 and Resident 2's clinical records and confirmed there was no documentation that the physicians and RPs of the residents had been notified. The DON acknowledged the facility should have notified the physicians and the RPs about the altercation between Resident 1 and Resident 2. Review of the facility's policy titled Change of Condition. Revised 11/18/21, indicated The licensed nurse will document the following: Date, time, and pertinent details of the incident and subsequent assessment in the Resident's chart. In addition, the policy indicated the licensed nurse will notify the resident's physician, legal representative or appropriate family member when there is an incident or accident involving the resident. 2. During an interview with licensed vocational nurse A (LVN A) on 7/11/24 at 1:00 p.m., she stated when there is a physical altercation between two resident the licensed nurse must complete a skin assessment and document any findings in the resident's clinical record. LVN A reviewed Resident 1's clinical record and confirmed there was no documentation that a skin assessment had been performed on Resident 1 on 1/11/24 after Resident 2 had thrown coffee on Resident 1. LVN A stated Resident 1 should have a full skin assessment performed to assess for any injury. Review of the facility's policy titled Abuse Prevention and Management, dated 2022, indicated .6. Immediate Actions . b. The resident will be assessed by the licensed nurse for any physical or emotional distress. Notify the physician and provide treatment as ordered, if applicable. Notify the responsible party of the incident and result of assessment findings. 3. During an interview with the DON on 7/11/24 at 2:45 p.m., she reviewed the clinical records of Resident 1 and Resident 2 and confirmed licensed nurses did not document in the days following the incident between Resident 1 and Resident 2 on 1/11/24. The DON stated the licensed nurse should document every shift for 3 days after the incident to assess and record any adverse effects from the altercation. The DON acknowledged there was no follow-up documentation by the licensed nurses and stated there should be. Review of the facility's policy titled Change of Condition. Revised 11/18/21, indicated when there is an incident or accident involving the resident the Licensed nurse will document each shift for at least 72 hours on Resident. 4. Review of Resident 2's clinical record indicated that on 1/11/24 she had a room change and was no longer roommates with Resident 1. There was no documentation in Resident 2's record to indicate any follow up was done to assess the transition to the new room. There was no documentation to indicate if Resident 2 was getting along with her new roommate or was having any adverse effects to the room change. During an interview with the DON on 7/11/24 at 2:45 p.m., she reviewed the clinical record of Resident 2 and confirmed there was no documentation to indicate any follow up was conducted to assess Resident 2's adjustment to the new room location. The DON stated staff should document for 3 days after a room change to monitor any adverse effects. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Room or Roommate Change, revised March 2018, indicated Social Service or designee will make a follow up visit to assess the resident's adjustment to the change.