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	06/19/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and communicate which licensed nurse was responsible for providing care to one of three sampled residents (Resident 1) on the evening shift (3:00 p.m. to 11:00 p.m.) of 4/9/25. This failure resulted in Resident 1 not receiving scheduled medications in a timely manner, and had the potential to result in other care needs not being met. Findings: Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including, but not limited to dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertensive heart disease (a heart condition that develops from chronic high blood pressure), and heart failure (a condition in which the heart does not pump blood as well as it should). Review of Resident 1's medication administration record (MAR), dated 4/2025, indicated Resident 1 was scheduled to receive the following evening medications: 1.) Lactobacillus oral capsule (a supplement that contains beneficial bacteria) at 5:00 p.m.; 2.) Metformin (a medication used to treat DM) 500 milligrams (mg, unit of dose measurement) at 5:30 p.m.; 3.) Metoprolol (a medication used to treat high blood pressure and heart failure) 25 mg at 5:00 p.m.; and 4.) Insulin Lispro injection (medication used to treat DM) 100 units per milliliter (u/ml, unit of dose measurement) per sliding scale (amount to be administered depends on blood sugar reading) at 5:00 p.m. For lactobacillus, metformin, and metoprolol, the MAR did not specify what time the medications were given on 4/9/25. However, for the insulin lispro injection, the MAR indicated the medication was administered by licensed vocational nurse A (LVN A) at 6:59 p.m. (almost two hours after the scheduled administration time) on 4/9/25. The facility's monthly nursing assignment, dated 4/2025, was reviewed. The monthly nursing assignment indicated licensed vocational nurse B (LVN B) was scheduled to provide care to Resident 1's area of the facility on 4/9/25. (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

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	06/19/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 6/19/25 at 10:44 a.m., LVN A stated there was an evening shift during which there was confusion about the licensed nurse assignment for Resident 1. LVN A stated he was the nurse supervisor on this particular evening shift. LVN A explained that LVN B was usually scheduled to provide care to Resident 1's area of the facility on the evening shift, but it had been requested that LVN B not provide care to Resident 1. LVN A further explained that since LVN B could not provide care to Resident 1, licensed vocational nurse C (LVN C) was supposed to take on that responsibility. LVN A confirmed LVN C was not informed that she was supposed to provide care to Resident 1 on this particular evening shift. LVN A stated he or LVN B should have communicated this to LVN C. LVN A confirmed that on this particular evening shift, he was the one who administered Resident 1's scheduled 5:00 - 5:30 p.m. medications at around 7:00 p.m. LVN A confirmed these medications were administered late, as they should have been administered within one hour before or after the scheduled times. The facility's undated document, titled LVN Staff Nurse Job Description, indicated the LVN was responsible for giving and receiving nursing reports upon beginning and ending of their assigned shift. It also indicated the LVN was responsible for reviewing and assisting in revision of nursing assignments. The facility's policy titled Medication - Administration, revised 1/1/2012, indicated, Medications may be administered one hour before or after the scheduled medication administration time.