STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Avenue Cupertino, CA 95014

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35386 Based on interview and record review, the facility failed to ensure a resident's drug regimen was free from unnecessary medications when nursing staff did not accurately transcribe (transfer or copy information) from the physician's order to the medication administration record (MAR) for one of two sampled residents (Resident 1). For Resident 1, an order for milk of magnesia (MOM, a laxative used to treat constipation) was incorrectly transcribed onto the MAR and was administered daily instead of every third day. This failure resulted in Resident 1 receiving unnecessary doses of MOM and had the potential to compromise Resident 1's health and safety due to overuse. Review of Resident 1's Face Sheet (document that contains a summary of personal and demographic information), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure (inability of the respiratory system to meet oxygenation requirements) and hypoxia (low levels of oxygen). Review of Resident 1's Physician's Order, dated 10/18/23, indicated to give 30 milliliters (ml, a metric unit of volume) of MOM suspension 400 milligrams (mg, a metric unit of measurement)/5 ml by mouth every third day as needed for constipation if no bowel movement. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 10/25/23, for bowel continence (ability to control bowel function) indicated Resident 1 was always incontinent (inability to control bowel movements) and constipation was not present. Review of Resident 1's MAR for the period, 10/1/23 through 10/31/23, indicated Resident 1 received MOM daily on 10/19/23, 10/20/23, 10/21/23, 10/24/23,10/25/23 and 10/27/23 for a total of seven doses. Review of Resident 1's IDT Care Conference Note (IDT, interdisciplinary team meeting to discuss care), dated 10/26/23, indicated Resident 1 had an unwitnessed fall on 10/26/23. IDT further indicated Resident 1 was found on the floor near the bathroom with feces (stool) smeared on the floor. Review of Resident 1's Change of Condition Evaluation Note (a tool used to facilitate communication), dated 10/28/23, indicated Resident 1 was administered MOM daily since admission and upon reviewing the medication list Resident 1 was only to receive MOM PRN (according to or on an as needed basis). (continued on next page)

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
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's IDT, dated 10/30/23, indicated the doctor and the pharmacist were notified, and orders were given to monitor Resident 1 for signs and symptoms of adverse reactions to MOM. Review of Resident 1's Care Plan (written document that identifies nursing needs), revised on 10/30/23, indicated Resident 1 was at risk for diarrhea and complications due to a medication error when MOM was given routinely x 7 days. Care plan intervention was to discontinue the MOM and monitor for diarrhea or complications. Review of Resident 1's Health Status Note (written documentation detailing clinical status), dated 11/1/23, indicated physician orders were to discontinue all bowel medications and to call for any constipation. During an interview, on 12/1/23 at 1:35 p.m., with licensed vocational nurse A (LVN A), LVN A stated she was notified the resident had a fall on 10/26/23 and there was poop on the floor from his bed to the bathroom. LVN A further stated he may have slipped in his own poop. LVN A also stated he was getting MOM daily for constipation. LVN A further stated MOM is typically given PRN. During an interview, on 12/1/23 at 2:00 p.m., with licensed vocational nurse B (LVN B), LVN B stated the director of nursing (DON) notified me there was a medication error regarding the MOM. LVN B further stated the admitting nurse put the order in incorrectly on admission. During an interview on 4/18/24 at 11:00 a.m., with the DON, the DON stated after the incident we now have a system in place where the supervisors review all the medications with the floor nurse for accuracy. Review of the facility's August 21, 2020, policy Physician Orders indicated to have a process to verify that all physician orders are complete and accurate.