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	06/10/2024

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 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** 45853 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from abuse when the two residents were not separated after the incident. This failure resulted in Resident 1 was feeling terrified and was not able to sleep after the incident. Findings: During a review of Resident 1's face sheet (a document that gives a resident's information at a quick glance) dated 5/24/24, it indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of aftercare following joint replacement surgery due to displaced right patella (kneecap) fracture. During an interview on 3/13/24 at 3:10 p.m. with Resident 1, Resident 1 stated on the first night after he was admitted to the facility, his roommate (Resident 2) grabbed his left leg, the facility staff did not separate the two of them after incident, he was not able to sleep and stayed up all night, because he was terrified. Resident 2 grabbed his leg again the next morning, the facility did not move Resident 2 to another room until later that morning. During an interview on 3/13/24 at 4:25 p.m. with the Director of Nursing (DON), the DON stated the residents should have been separated, when she got the notification in the morning [3/6/24], Resident 1's room change was initiated right away. During a concurrent interview and record review on 5/23/24 at 2:23 p.m. with the Nursing Supervisor (NS), NS reviewed Resident 1's progress notes (PN); PN dated 3/6/24 at 6:58 a.m. indicated, Patient started yelling at 3AM wanting to be moved. He was unhappy about his roommate [Resident 2] spitting all night. 630 [a.m.] patient was upset because his roommate touched his leg. Patient called 911, 911 arrived at 645 [a.m.] and spoke to him. Patient wants to be moved asap [as soon as possible]. PN dated 3/6/24 at 7:30 a.m. indicated, He stated that his roommate grabbed his leg, I [writer] asked the CNA [certified nursing assistant] to get the other resident up and out of bed to avoid conflict. PN on 3/6/24 at 9:24 a.m. indicated, Currently looking for room change for the Pt [patient]. The NS stated staff did not separate the two residents right away, the room change was initiated in the morning after the IDT [Interdisciplinary Care Team, a group of healthcare professionals with different disciplines] meeting. (continued on next page)

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	During a review of the facility's policy and procedure (P&P) titled Abuse and Neglect dated 11/18/21, the P&P indicated, III. Immediate Action A. the Administrator (or designated representative) will provide for a safe environment for the Resident, as indicated by the situation i. If the suspected perpetrator is another Resident, they will be separated so they do not interact with each other until circumstances of the incident can be clarified.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on observation, interview, and document review, the facility failed to implement strategies to prevent the spread of coronavirus 2019 (COVID-19, a strain of virus that can cause mild to severe respiratory illness) when one of one resident (Resident 3) was not isolated after testing positive for COVID-19. This failure had the potential to result in the spread of COVID-19 in the facility. Findings: During an interview on 3/13/24 at 3:10 p.m. with Resident 1, Resident 1 stated there was a COVID positive resident who ran out of the room and went into the rehab gym over the weekend. One of the rehab staff was mad that staff let that resident came out of the room. During an interview on 3/13/24 at 3:33 p.m. with Occupational Therapist (OT) A, OT A stated Resident 3 came out of the room without a mask, went into the rehab gym, and staff had to ask her to put on a mask and she got escorted back to her room. During an interview on 3/13/24 at 3:45 p.m. with Physical Therapy Assistant (PTA) B, PTA B stated on 3/10/24, Resident 3 was in the gym all morning, the resident had a male sitter, and the sitter was just outside the gym while the resident was inside, the resident was there for a while. The resident was not removed from the gym until PTA B complained about it. PTA B was frustrated because staff had to sanitize whatever the resident touched in the gym. PTA B further stated if a resident was positive with COVID, they were not allowed to come out of the room. Rehab department provided services to positive COVID residents either in their room or in the courtyard. During an interview on 3/13/24 at 4:16 p.m. with the Infection Preventionist (IP), the IP stated Resident 3 was combative, and non-compliant and IP contacted the county infection prevention consultant, the consultant recommended Resident 3 should still be on isolation for 10 days since the day of admission, which was until 3/16/24. During a review of Resident 3 ' s face sheet (a quick glance of a resident ' s information), it indicated Resident 3 was admitted on [DATE] with diagnoses cerebral ischemia (a common mechanism of acute brain injury that results from impaired blood flow to the brain), psychosis (a mental disorder characterized by a disconnection from reality). Review of Resident 3 ' s admission COVID test dated on 3/7/24, indicated the resident was positive with COVID upon admission. Review of Resident 3 ' s physician order dated 3/7/24, indicated Maintain Contact/Droplet precautions X [times] 10 days for asymptomatic positive Covid rapid test upon admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review the facility ' s policy and procedure (P&P) titled IPC406 Management of COVID-19 dated 10/28/22. The P&P indicated, Patient care 20. Patients on Transmission-Based Precaution [the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission, including contact, droplet, and airborne precautions] are restricted to their room except for medically necessary purposes. a. If a patient must leave his/her room, he/she must wear a facemask or cloth face covering perform hand hygiene, limit movement in the center, and perform social distancing.