

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER Cupertino Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. 49345 Based on observation, interview and record review, the facility failed to ensure treatment and care provided were in accordance with professional standards of practice when one (Resident 1) out of three sampled residents was left with their oral medication to be taken unsupervised at bedside and was documented as given without confirmation. This failure resulted in inaccurate documentation of correct time of medication administration and had the potential for a missed dose. Findings: During a concurrent observation and interview on 12/17/24 at 11:39 a.m. with Resident 1 in her room, a medicine cup with two white capsules and a plastic cup of water were noted on her bedside table. Resident 1 stated that her nurse left it there for her to take. At 11:42 a.m., Certified Nurse Aide (CNA) B came in the room and verified the two capsules and stated she will call Resident 1's nurse. Licensed Vocational Nurse (LVN) A came in the room at 11:45 a.m. and confirmed she was Resident 1's assigned nurse and that she left the medications for Resident 1. LVN A stated It's not okay to leave medications at bedside. I should have watched her take her medications. LVN A also stated that the medication was Gabapentin (a medication to treat seizures and/or nerve pain). During a concurrent interview and record review with the Director of Nursing (DON) on 12/17/24 at 3:09 p.m., the DON stated that medications should not be left at bedside without an order for self-administration of medication from the doctor. The DON verified that Resident 1 had no order for self-administration of medication from the doctor. During a concurrent interview and record review of Resident 1's Medication Administration Record with LVN A on 12/17/24 at 3:45 p.m., LVN A verified the latest time stamp for the administration of Gabapentin on 12/17/24 was 11:24 a.m. LVN A confirmed she did not administer Gabapentin at 11:24 a.m. A review of Resident 1's clinical record indicated diagnoses of but were not limited to, Muscle Weakness, Paranoid Schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people) and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's Physician Order dated 11/8/24 indicated, Gabapentin Capsule 100 MG [milligram, a unit of measurement] Give 2 capsules by mouth three times a day for nerve pain. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055407	Facility ID: 055407 If continuation sheet Page 1 of 3

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER Cupertino Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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	A review of facility's Policy and Procedure (P&P) titled, Medication-Administration, revised January 1, 2012, the P&P indicated, .D. Medications must be given to the resident by the Licensed Nurse preparing the medication .IX. Documentation A. The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug or treatment. B. Recording will include the date, the time and the dosage of the medication or type of the treatment .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER Cupertino Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 49345 Based on interview and record review, the facility failed to ensure sufficient and appropriate social services were provided for two (Resident 7 and Resident 10) out of 12 sampled residents when psychosocial and emotional assessments were not done following a resident-to-resident altercation. This failure had the potential for psychosocial decline of the residents that can affect their overall health. Findings: During an interview on 12/17/24 at 1:47 p.m. with the Social Services Director (SSD), the SSD stated it was her duty to check on residents involved in altercations. The SSD also stated she must check on the residents for three consecutive days after an alleged event except on weekends. The SSD stated, I usually ask them what happened and if they are in pain. I also ask them if they're sad. The SSD also stated the assessment must be documented on the resident's electronic chart. During a concurrent interview and record review with the SSD on 12/17/24 at 2:02 p.m. of Resident 10's and Resident 11's progress notes, the DSD verified Resident 10 had an alleged altercation with Resident 11 on 8/15/24. The progress notes indicated Resident 10 was allegedly tapping Resident 11's legs. The SSD confirmed she had no documentation of psychosocial and emotional assessment for Resident 10 following the incident. The SSD stated, I don't know what happened. During a concurrent interview and record review with the Social Services Director (SSD) on 12/17/24 at 2:12 p.m. of Resident 5's and Resident 7's progress notes, the DSD verified that on 9/3/24, Resident 5 allegedly grabbed Resident 7's left wrist and kicked Resident 7's left ribs. The DSD verified there were no social services documentation of psychosocial and emotional assessment for Resident 7 following the alleged incident. During an interview with the Director of Nursing (DON) on 12/17/24 at 3:09 p.m., the DON stated there must be a 72-hour psychosocial status check done by the social services and must be documented on the resident's chart. A review of facility provided Job Description for Social Services Coordinator indicated, Principal Responsibilities Clinical/ Administrative .Assess the psychosocial, mental and emotional needs of residents . .Communicate needs and plan of care to resident, families, responsible parties and appropriate staff .		