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	12/03/2025

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. (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
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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to provide services according to professional standards for one of two sampled residents (Resident 1) when: 1. Licensed vocational nurse A (LVN A) crushed all of Resident 1's morning medications, mixed them with oatmeal, and left them at Resident 1's bedside; and 2. Certified nursing assistant B (CNA B) administered crushed medications, mixed with oatmeal to Resident 1. These failures had the potential to affect Resident 1's care, health, and well-being.Findings:1.Review of Resident 1's clinical record titled, admission Record, dated 9/25/2025, it indicated Resident 1 was admitted to the facility with diagnoses including myocardial infarction (heart attack), paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days), chronic systolic heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension (HTN - high blood pressure).Review of Resident 1's annual minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], it indicated Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Further review indicated Resident 1 was dependent on eating.During an interview with licensed vocational nurse C (LVN C) on 9/25/2025 at 10:40 a.m., LVN C confirmed Resident 1 would take his medications whole by mouth and he had no problem in swallowing. LVN C stated Resident 1 never requested his medications to be crushed and he took them whole with a sip of water. LVN C further stated that if a resident requested for the medications to be crushed, he would not crush them, and would rather call the physician first to get an order, may crush medications, and refer the resident to a speech therapist (ST) as needed.During an interview with registered nurse E (RN E) on 9/25/2025 at 11:38 a.m., RN E confirmed a medication error had happened with Resident 1's morning medications on 9/6/2025. RN E further confirmed LVN A crushed all of Resident 1's morning medications and mixed them with Resident 1's oatmeal. RN E stated some medications like the extended release (ER) should not be crushed because they won't work or would not be the same. RN E further stated Resident 1 was aware that his medications were mixed with his oatmeal and complained about his food tasted bad, and he called FM AA.Review of Resident 1's medication administration record (MAR - a record of medications given), month of September 2025, it indicated the following medications were crushed and administered to Resident 1 on 9/6/2025:a. Amiodarone hydrochloride (a medication that prevents and treats an irregular heartbeat) 200 milligram (mg - unit of measurement) tablet;b. Amlodipine Besylate 10 mg tablet (a medication that lowers blood pressure);c. Aspirin enteric coated (EC - a special coating to resist the stomach's acid and not dissolve until it reaches the small intestine81 mg tablet (an over-the-counter medication used to reduce pain, fever, inflammation and act as a blood thinner);d. Atorvastatin calcium 80 mg tablet (a medication used to lower cholesterol and fats in the blood);e. Clospidogrel bisulfate 75 mg tablet (an antiplatelet drug to prevent blood clots);f. Cyanocobalamin 1000 microgram tablet (a vitamin B12 used to treat and prevent vitamin B12 deficiency);g. Dilantin 30 mg, 2 capsules (brand name for the generic drug phenytoin, an anticonvulsant medication used to control and prevent certain types of seizures);h. Donepezil HCl 10 mg tablet (a medication used to treat symptoms of dementia in people with Alzheimer's disease [a disease characterized by a progressive decline in mental abilities]);i. Folic acid 1 mg tablet (a synthetic B vitamin that helps the body make new cells);j. Isosorbide mononitrate extended release (ER or XR - a medication designed to slowly release the active drug into the body over an extended period of time) 60 mg tablet (a medication used to prevent chest pain);k. Multivitamin one tablet;l. Pantoprazole sodium delayed release 40 mg tablet (a prescription medication that reduces the amount of acid produced in the stomach);m. Levetiracetam 750 mg tablet (an anti-seizure medication used to prevent and control various types of seizures);n. Metoprolol tartrate 100 mg tablet (a medication used to treat high blood pressure);o. Phenytoin sodium extended capsule 100 mg (used to treat and prevent various types of seizures);p. Sennosides 8.6 mg tablet (a medication used to treat constipation); andq. Hydralazine HCl 50 mg tablet (used to treat high blood pressure).During a phone interview with Resident 1's family member AA (FM AA) on 9/25/2025 at 11:53 a.m., FM AA stated Resident 1 called her to complain about his oatmeal tasted, awful. FM AA further stated she learned that LVN A crushed Resident 1's medications and mixed them on his oatmeal. FM AA confirmed that LVN A informed her that she asked CNA B to provide the oatmeal with medications to