

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 02/12/2026
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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to ensure one (Resident 1) out of 6 sampled residents was free from physical abuse when a staff physically hit Resident 1 on the face. This failure resulted in a slap on the right side of the face of Resident 1 by CNA A which was witnessed by CNA B. This failure had the potential to put Resident 1 in psychosocial distress. FINDINGS: A review of Resident 1's medical record indicated an admission date of 10/30/25. Resident 1's diagnoses included but were not limited to muscle weakness, bipolar disorder (a mental health condition that causes extreme mood swings) and fracture of one rib, right side, sequela (residual effect that persists after the acute phase of an illness has resolved). A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 11/6/25, indicated a brief interview for mental status score of 5 (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident; a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). A review of Resident 1's Nurse's Notes dated 1/3/26 at 10:14 p.m. indicated, Resident is on COC [Change of Condition] monitoring for swelling to the left radial wrist and skin discoloration on the left inner thigh. A review of Resident 1's Nurse's Notes dated 1/4/26 indicated, Received x-ray [an imaging study] results for left wrist noted with mild degenerative joint disease of the left wrist. A Facility Reported Incident (FRI) sent by the facility to California Department of Public Health (CDPH) received on 1/5/26 indicated, received report that around 215pm a CNA requested assistance from alleged abuser to assist with care for the patient. During providing care, the patient grew agitated and scratched to the left side of the alleged CNA's face. Primary patient's CN A stated that (the) one other CN A was scratched, CN A then slapped the right side of the patient's Face. CN A was immediately removed from the care of the patient. The accompanying Report of Suspected Dependent Adult/Elder Abuse (SOC 341) indicated date/time of incident was 1/4/26 2:15 p.m. A review of eInteract SBAR Summary for Providers dated 1/4/26 15:40 indicated: . Outcomes of Physical Assessment: . Nursing observations, evaluation, and recommendations are: According to the assigned CN A of AM shift, CN A witnessed another CN A who was not assigned to the resident, slap the resident [name of Resident], to the right side of the face, stating a medium slap as the description. Neither soft nor hard. All of this incident occurred while the CN A who abused the resident, tried to help provide a brief change to the resident. Primary Care Provider Feedback: . Monitor for Psychosocial and emotional well being post abuse for 72 hrs. Monitor latent effect on the right face for 7 days During an interview with CNA B on 2/11/26 at 12:22 p.m., CNA B stated that on the day of the incident at around 2:00 p.m. (1/4/26), CNA A was helping her clean and change Resident 1. CNA B stated, CNA A insisted on holding Resident 1's wrist even after telling her not to because it was uncomfortable for Resident 1. CNA B stated Resident 1 was able to free her hands and hit CNA A's face. CNA B then stated she witnessed CNA A hit Resident 1 back in the face and left the room. CNA B also stated, Resident 1 sat up on the bed and was pointing at</p> <p>(continued on next page)</p>

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 2

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F 0600 Level of Harm - Actual harm Residents Affected - Few	her wrist to her. A review of CNA A's employee records indicated she was hired on 9/22/25. Her background screening was done on 9/17/25 and her last training on Abuse was during her date of hire on 9/22/25. A review of facility's policy and procedure (P&P) entitled Abuse Prevention and Management revised 5/30/24, the P&P indicated, 1. Definitions .d. 'Physical Abuse' is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment which is physical punishment used to correct and/or control behavior. 2. Screening employees, registry, contracted, or temporary agency staff, or students from affiliated academic institutions: a. The facility will screen potential employees for history of abuse, neglect, or mistreating residents, including attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.3. Training. a. The facility conducts mandatory staff training programs during orientation, annually and as needed on: . v. understanding resident behavioral symptoms that many increase the risk of abuse and neglect and how to respond. 4. Prevention. d. The Facility identifies corrects, and intervenes in situations in which abuse, neglect, exploitation, misappropriation of resident property and/or mistreatment is more likely to occur.		