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	02/23/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of three residents (Resident 1) when Resident 1's diclofenac sodium (Brand name is Voltaren, a drug used to treat mild to moderate pain, and helps to relieve symptoms of arthritis such as inflammation, swelling, stiffness, and joint pain) was not available for administration on 2/9/2026 at 5:00 p.m. and 2/10/2026 at 9:00 a.m. This failure had the potential for unrelieved pain, inflammation, and stiffness.Findings:A review of Resident 1's clinical record titled, admission Record, dated 2/5/2026, indicated Resident 1 was admitted to the facility with diagnoses including ankylosing spondylitis (an inflammatory form of arthritis [a general term for diseases that cause inflammation, pain, stiffness, and swelling in one or more joints] that primarily affects the spine [back bone] causing long-term pain and stiffness) of unspecified sites in spine, rheumatoid arthritis (a chronic disease that causes inflammation around the body and commonly presents with pain in the joints), osteoarthritis (the most common form of arthritis, often called wear and tear disease, where the protective cartilage cushioning the ends of bones wears down over time), other chronic pain, arthropathy (a medical term for any disease or abnormality affecting a joint), unspecified.A review of Resident 1's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1's brief interview for metal status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (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 clinical record, titled, Order Summary Report, indicated an order dated 4/13/2025 of diclofenac sodium 25 milligrams (mg-unit of measurement) to be taken three tablets by mouth two times a day for rheumatoid arthritis.A review of Resident 1's 1/2026 medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), it indicated a code 9, on 2/9/2026 at 5:00 p.m., and code 9, on 2/10/2026 at 9:00 a.m. Further review indicated, code 9 was for Other/See Progress Notes.A review of Resident 1's nursing progress notes dated 2/9/2026, indicated, During medication pass, resident's prescribed diclofenac was unavailable.A review of Resident 1's nursing progress notes dated 2/10/2026, indicated the diclofenac sodium was still unavailable in the morning.During an interview with Resident 1 on 2/18/2026 at 11:30 a.m., Resident 1 stated he missed two doses of his diclofenac sodium. Resident 1 further stated, I badly needed that medication for my rheumatoid arthritis. He also stated the nurses did not give me the medication and they blamed the pharmacy.During an interview with licensed vocational nurse A (LVN A) on 2/18/2026 at 2:05 p.m., LVN A confirmed he did not administer Resident 1's morning dose of diclofenac sodium on 2/10/2026 because it was not available. LVN A stated nurses should order the medication five days before the resident consumed all medications and the pharmacy should have delivered the medication within 24 to 48 hours (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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when ordered.During an interview with the director of nursing (DON) on 2/18/2026 at 3:00 p.m., DON stated nurses should order the medication three days prior to consuming all of it. DON confirmed Resident 1 missed two doses of the diclofenac sodium because the medication was not available.During a follow up interview with DON on 2/18/2026 at 3:57 p.m., DON stated nurses ordered the diclofenac sodium to their pharmacy on 1/26/2026 and 2/5/2026, and the medications were not delivered on time.During a review of the facility's policy and procedure titled, Medication - Administration, date revised 1/1/2012, indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines.