

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

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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 07/31/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services according to professional standards for five out of five residents (Residents 1, 2, 3, 4, and 5) when social services did not follow up with the psychologist (a mental health professional with a doctoral degree in psychology who focuses on behavior, emotions, and thought patterns)/psychiatrist (a medical doctor that focuses on physical and biological causes of mental health) consultation (psych consult - mental health consultation or initial intake meeting) and treatment as ordered by their physician. These failures had the potential to affect Residents 1, 2, 3, 4, and 5's psychosocial needs and behavioral well-being. Findings: 1a. Review of Resident 1's face sheet (summary page of a patient's important information) indicated Resident 1 was admitted to the facility with diagnoses including encounter for attention to ileostomy (a surgical operation that creates an opening [called a stoma] on the abdomen), hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (a type of stroke caused by a blockage in brain blood vessels, resulting in a lack of oxygen and brain cell death) affecting right dominant side (the side of the body that a person prefers, uses more frequently, and is stronger or more skillful with) and other psychoactive substance (any chemical that affects how the brain works and changes a person's mood, awareness, thoughts, feelings or behavior) dependence, in remission. Review of Resident 1's order summary report dated 7/6/2026, it indicated an order dated 2/11/2026 for Psychology/Psychiatrist consult, with follow-up treatment as indicated. Review of Resident 1's clinical record titled Health Status Note, dated 6/19/2026, indicated Resident 1 was an alleged abuser when he struck the resident [Resident 2] with a closed fist on the left face. and was engaged in a verbal altercation after. Review of Resident 1's Social Services (SS) notes, dated 6/19/2026, indicated a psych (psychology/psychiatrist) referral was sent after the incident. During an interview with Resident 1's assigned certified nursing assistant A (CNA A) on 7/3/2026 at 10:28 a.m., CNA A confirmed the altercation that happened between Resident 1 and Resident 2. CNA A stated Resident 1 tried to stop Resident 2 from yelling. During an interview with Resident 1 on 7/31/2026 at 12:28 p.m., Resident 1 stated Resident 2 was a bully, and he hit him. 1b. Review of Resident 2's face sheet indicated Resident 2 was admitted to the facility with diagnoses including type 2 diabetes mellitus (DM - a condition which affects the way the body processes blood sugar), unspecified psychosis (a mental state where a person loses touch with reality), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy, and activity levels) and dementia (decline in mental capacity affecting daily function), moderate with agitation (feeling very restless, nervous, or upset). Review of Resident 2's order summary report dated 7/6/2026, it indicated an order dated 6/18/2026 for Psychology/Psychiatrist consult, with follow-up treatment as indicated. Review (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident 2's clinical record titled, Health Status Note, dated 6/19/2026, indicated Resident 2 was seated on his wheelchair at the hallway, yelling at his CNA and called her some names when Resident 1 punched him on the left side of his face. During an interview with social services director (SSD) on 7/31/2026 at 2:04 p.m., when asked if the psych consult was completed for both Resident 1 and Resident 2 as ordered, SSD stated he could not find the psych consult notes in their system and would ask their medical records director (MRD). During a phone interview with social services B (SS B) on 8/5/2026 at 11:24 a.m., SS B confirmed a psych referral were made for Resident 1 on 6/19/2026 and Resident 2 on 6/18/2026. SS B stated she was not sure if both Residents 1 and 2 were seen for psych consultation. 2a. Review of Resident 3's face sheet indicated Resident 3 was admitted to the facility with diagnoses including metabolic encephalopathy (a change in brain function caused by chemical imbalance, illness, organ failure in the body), Marfan syndrome (an inherited genetic condition that affects the body's connective tissue, which is the material that supports, binds, and gives strength to bones, muscles, organs, and blood vessels), and major depressive disorder. Review of Resident 3's order summary report dated 7/6/2026, it indicated an order dated 5/29/2025 for Psychology/Psychiatrist consult, with follow-up treatment as indicated. Review of Resident 3's clinical record titled, Change in Condition, dated 5/18/2026, indicated Resident 3 was an alleged aggressor, when he punched Resident 4 (roommate) to his face. Review of Resident 3's clinical record titled, Multidisciplinary Care Conference, dated 5/27/2026, indicated under social services notes, .Patient can get physically aggressive with other patients. Further review indicated, Non-Pharmacological Interventions in place. Psych Referral. 2b. Review of Resident 4's face sheet indicated, Resident 4 was admitted to the facility with diagnoses including cerebral infarction, metabolic encephalopathy, Alzheimer's disease (a brain disorder that slowly destroys memory, thinking skills, and the ability to do simple daily tasks), and adult failure to thrive (a general term for a serious physical and mental decline in older adults). Review of Resident 4's order summary report dated 7/6/2026, it indicated an order dated 5/25/2026 for Psychology/Psychiatrist consult, with follow-up treatment as indicated. Review of Resident 4's clinical record titled, Change in Condition, dated 5/18/2026, indicated Resident 4 was a victim of an alleged abuse when Resident 3 grasped his shirt and punched his face. During an interview with licensed vocational nurse C (LVN C) on 7/3/2026 at 1:06 p.m., LVN C stated Residents 3 and 4 used to be roommates. LVN C further stated that they were separated when Resident 3 punched Resident 4 in the face and Resident 3 did not state the reason why he had to punch Resident 4. During a concurrent interview with SSD and record review of both Resident 3 and Resident 4's order summary report on 7/31/2026 at 2:04 p.m., the SSD confirmed both Residents 3 and 4 had orders for psych consult and treatment. The SSD stated that he was not sure if the psych consult was completed because it was not in their system. The SSD further stated he will check with their MRD. 3. Review of Resident 5's face sheet, indicated Resident 5 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD - a long-term lung disease that makes it hard to breathe), and unspecified dementia with psychotic disturbance (a mental health event where a person loses touch with everyday reality). Review of Resident 5's order summary report dated 7/6/2026, it indicated an order dated 6/18/2026 for Psychology/Psychiatrist consult, with follow-up treatment as indicated. Review of Resident 5's clinical record titled, Change in Condition Evaluation, dated 6/17/2026, indicated Resident 5 alleged someone hit her but she was unable to describe or identify who did it. During a concurrent observation and interview with Resident 5 on 7/3/2026 at 10:44 a.m., inside Resident 5's room, Resident 5 was on her bed, without signs and symptoms of distress and stated there was a young kid who always hit me. Resident 5 further stated that she did not know the name of the young kid, and she confirmed he (young kid) lived in the facility. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5 stated the young kid was about 23 to [AGE] years old, heavy set, and he was on a wheelchair. During an interview with the director of nursing (DON) on 7/3/2026 at 11:05 a.m., the DON confirmed she was aware of Resident 5's allegation of abuse, and they did not have a resident with the age of 23-[AGE] years of age. During a concurrent interview with SSD and record review of Resident 5's order summary report and SS note dated 6/18/2026 on 7/31/2026 at 2:10 p.m., SSD confirmed there was an order for psych consult and there was a psych referral sent by their SS. SSD stated, she would have to ask their MRD if the psych consult was completed. During a follow up with the facility's MRD related to the psychologist or psychiatrist notes for Residents 1, 2, 3, 4, and 5, the MRD sent an email to this writer dated 8/5/2026, indicated, .As we conducted a deeper review of this matter, we identified that the provider did not see the patients as scheduled. We acknowledge this lapse on our part and have accepted responsibility for the oversight. During a phone interview with SS B on 8/6/2026 at 10:15 a.m., SS B stated they only emailed the providers whenever they requested for their residents' psych consultation. SS B further stated they never called the providers to follow up with their request and to checked if the residents in their referral list were seen or not seen. SS B confirmed she sent out an urgent referral for psych consult for Resident 5, and she never followed up by phone with the providers. During a review of the facility's undated job description titled, Social Service Coordinator, indicated, Ensure the resident's psychosocial and concrete needs are identified and met in accordance with federal, state and company requirements. Communicate needs and plan of care to resident, families, responsible parties and appropriate staff. Participate in the facility's Behavior Management program.		