

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

Printed: 07/18/2026
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 12/22/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen when:1.A peeled/sliced peaches was beside the red and green bucket at the three-compartment sink tap;2. Two kitchen staff did not perform handwashing/ hand hygiene before and after gloving; and 3. An open box of Almond nondairy beverage was inside the residents' refrigerator with an open date of 12/18/25 and use by date of 12/21/25 and still there on 12/22/25. These failures had the potential to cause food contamination and spread food-borne illnesses to residents who received their food from the kitchen.Findings:1. During a concurrent initial kitchen observation and interview with the Dietary Manager (DM) on 12/16/25 at 10:55 a.m., it was observed in the three-compartment sink tap was a clear square food storage container with peeled /sliced and chopped peaches without cover and left open beside the green and red plastic bucket with chemical solution. Dietary [NAME] (DC) F verified the above observation and stated the peaches should not be placed at the countertop near the red and green bucket because of infection control. The DM confirmed and stated the peeled /sliced and chopped peaches should not be placed beside the red and green bucket because the area is not clean and can cause food contamination.The United States Food and Drug Administration's 2022 Food Code 3-305.14 Food Preparation , indicated Food preparation activities may expose food to an environment that may lead to the food's contamination. Just as food must be protected during storage, it must also be protected during preparation. Sources of environmental contamination may include splash from cleaning operation .2a. During Kitchen observation with the DM on 12/16/25 at 11:02 a.m., DC G picked the kitchen thermometer that fell on the floor then took a new kitchen thermometer without performing hand washing before donning (putting on) new gloves. During a concurrent observation and interview with DC G on 12/12/25 at 11:04 a.m., DC G confirmed he did not perform handwashing before donning a new glove. During an interview with the DM on 12/16/25 at 11:09 a.m., the DM acknowledged DC G did not perform handwashing. The DM stated it can cause infection control.2b. During a concurrent kitchen observation and interview with the DM on 12/19/25 at 8:39 a.m., with Dietary Aide (DA), DA did not perform hand washing before donning a new glove. On further observation DA was observed fixing her hairnet and clothes then proceeded to prepare food with her gloves on. The DA verified she was wearing gloves and did not perform handwashing before donning new gloves. The DM confirmed the DA did not perform handwashing before donning a new glove.The United States Food and Drug Administration's 2022 Food Code 2-301.14 indicated, Food employees shall clean their hands and exposed portions of their arms specified under S2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment . (H). Before donning gloves to initiate a task that involves working with food. (I) After engaging in other activities that contaminate the hands. During a review of the facility's policy and procedure (P&P) titles, Hand Hygiene, revised 9/1/2020, the P&P indicated, The Facility considers hand hygiene as the primary means to prevent the spread of infections. Hand hygiene means cleaning your hands by handwashing (washing hands with soap and water) .II Facility staff follow the hand hygiene procedure to prevent the spread of infections to other staff, Resident, volunteers and visitor. The following situation require appropriate (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene. iv. Before and after food preparation.3. During a concurrent observation and interview with the DM on 12/22/25 at 2:25 p.m., it was observed in NS BB Residents' refrigerator, a box of almond nondairy beverage 32 fluid ounce (fl oz, unit of volume) was labeled with open date 12/18/25 and used by date 12/21/25. The DM stated food that was expired should be thrown on expiration date and it should not be in the refrigerator. The DM further stated it can cause food borne illnessesDuring a review of the facility's policy and procedure (P&P) titles, Food Brought in by Visitors, revised 4/24/25, the P&P indicated, The facility staff will 4. When refrigerated, it will be labeled, dated and discarded after 48 hours if not consumed.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to ensure refuse materials (any disposable materials, which include recyclable and non-recyclable materials) were disposed properly when One of two garbage dumpsters were found to be overflowing, and garbage bags were found on the floor outside the containers. This failure had the potential for an unsafe environment for the residents and visitors due to possible pest infestation and spread of diseases in the facility. Findings: During the initial observation at the designated waste area on 12/19/25 at 8:12 a.m., one garbage dumpster was observed to be overflowing. During a concurrent observation and interview on 12/22/25 at 9:00 a.m., accompanied by the Dietary Manger (DM) and Maintenance Director (MD), at the designated waste area, two black plastic bags and cardboard were outside of the dumpster. Both MD and DM confirmed the observation and stated it should be put inside the bins. The MD stated the garbage should be placed inside the dumpster to prevent attracting pests and for infection control. The United States Food and Drug Administration's 2022 Food Code 5-501.110 indicated, Refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. The Food Code further indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. During a review of the facility's policy and procedure (P&P) titles, Waste Management, revised 4/2022, the P&P indicated, To reduce risk of contamination from regulated waste and maintain appropriate handling and disposable of all waste.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a valid copy of a resident's Physician Orders for Life-Sustaining Treatment (POLST, a written medical order that assists people in making decisions about medical treatment and life saving measures during end-of-life care or medical crisis) when one of 31 sampled residents (Resident 3) had a POLST with no signature and identity of the person who discussed it. This failure had the potential to result in a resident's end-of-life choices not being honored. Findings: A review of Resident 's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/25, indicated that Resident 3 was admitted on [DATE] with a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 00 (scores of 0-7 suggests severe cognitive impairment, 8 to 12 suggests moderate cognitive impairment, and 13 to 15 suggests that cognition is intact), which indicate severe cognitive impairment. A review of Resident 3's POLST, undated, indicated that To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant .and (2) the patient or decisionmaker. During a concurrent interview and record review with the Director of Nursing (DON), on 12/19/25 at 3:08 p.m., of Resident 3's POLST, the DON stated the POLST should be completed by the Resident representative and physician will be notified and informed to sign. The DON verified that the POLST was mostly blank without signatures of physician and Resident representative /decisionmaker. The DON further stated it should be completely signed by physician and Resident representative to be valid. The facility's policy titled Physician Orders for Life -sustaining Treatment (POLST), revised date June3, 2020, indicated Policy III. Must be signed by a physician, physician assistant or nurse practitioner, acting under the supervision of the physician and within the scope of practice authorized by law in order to be legally effective; Initiating a POLST, . D. The POLST form must be completed, signed and dated, include the practitioner's medical license number and signed by the resident, or resident's representative or the resident health care decision maker. E. v. POLST form are NOT valid unless signed by an attending physician, physician assistant or nurse practitioner.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to ensure one of three sampled residents (Residents 151) had the baseline care plan completed within 48 hours of admission. This failure had the potential for the facility staff not to meet the residents' immediate care needs and safety against adverse events that are most likely to occur right after admission. Findings: 1. Review of Resident 151's Face sheet (a summary document containing a Resident's personal and demographic information, including contact details and medical history) indicated Resident 151 was admitted on 9/5//25 with diagnoses including bradycardia (a slow heart rate), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), thrombocytopenia [deficiency of platelets (a small colorless cell fragments in our blood that form clots and stop or prevent bleeding)] and, hypertension (when your blood consistent pushes too forcefully against artery walls forcing your heart to work harder). Review of Resident 151's Baseline care plan dated 9/23/25, indicated the health condition, and medications was not completed. Review of Resident 151's Order Summary Report, dated 9/5/25, indicated an order of Apixaban Oral Tablet 5 milligram (mg. unit of mass), give 1 tablet by mouth two times a day for Atrial Fibrillation. During a record review and interview with Director of Nursing (DON) on 12/19/25 at 3:24 p.m., the DON confirmed the baseline care plan of Resident 151 was incomplete. The DON stated the Baseline care plan should be completed within 48 hours of the resident's admission to monitor what the resident is taking. During a review of the facility's policy (P) titles, Person -Centered Care Planning, revised 4/24/2025, the P indicated, 2. Baseline Care Plan a. The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and what assistance with activities of daily living is necessary.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop an individualized, resident-centered care plan for two of two residents (Residents 20 and 3) with a sitter (a caregiver who provides companionship and supervision to patients who need constant observation or assistance, often due to medical conditions or behavioral issues that could pose a risk). This failure had the potential not to meet care needs appropriately for Residents 20 and 3. Findings: 1. Review of Resident 20's clinical record titled, admission Record, dated 12/19/2025, indicated Resident 20 was admitted to the facility with diagnoses including dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning) with agitation (a state of anxiety, or restlessness, often making someone feel tense, irritable, and unable to relax), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and history of falling. Review of Resident 20's quarterly minimum data set (MDS &ndash; a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 20's 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 was 0 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with certified nursing assistant E (CNA E) on 12/16/2025 at 12:38 p.m., inside Resident 20's room, Resident 20 was asleep in bed and CNA E was at bedside. CNA E confirmed she was the sitter for Resident 20 because she was at risk of falling. CNA E stated Resident 20 was ambulatory but due to her confusion, she had history of falling. During an observation on 12/17/2025 at 8:45 a.m., inside Resident 20's room, Resident 20 was asleep in bed, and another certified nursing assistant (CNA) was at bedside. During another observation on 12/18/2025 at 1:51 p.m., at the facility's hallway, Resident 20 was observed walking at the hallway and was assisted by a CNA. During a concurrent interview with the MDS nurse (MDSN) and record review of Resident 20's care plans on 12/19/2025 at 3:54 p.m., MDSN confirmed there was no specific care plan for Resident 20's sitter. MDSN further confirmed Resident 20 had a sitter and was wandering when she was admitted to the facility. MDSN could not state the date they started Resident 20's sitter. The MDSN stated Resident 20's used of sitter should have been care planned when it was initiated. During an interview with the director of nursing (DON) on 12/22/2025 at 11:01 a.m., the DON could not state the date when they started Resident 20's sitter. DON confirmed there was no care plan developed, and it should have been care planned because it was a part of their interventions for Resident 20's risk of falling and elopement. 2. Review of Resident 3's clinical record indicated Resident -- was admitted on [DATE] and had diagnoses including Metabolic Encephalopathy(global brain dysfunction caused by chemical imbalance (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from an underlying illness) ; Senile degeneration of brain not elsewhere(severe cognitive decline in older adults); Dementia (decline in mental abilities like memory , thinking and reason)in other diseases classified; unspecified severity with agitation (state of anxiety); Cognitive communication deficit; Major depressive disorder recurrent severe with psychotic symptoms(severe form of ofc depression where intense mood symptoms[sadness, hopelessness] combine with psychosis{break from reality). A review of Resident 's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/25, indicated that Resident 3 was admitted on [DATE] with a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 00 (scores of 0-7 suggest severe cognitive impairment, 8 to 12 suggests moderate cognitive impairment, and 13 to 15 suggest that cognition is intact), which indicate severe cognitive impairment. During a concurrent observation and interview on 12/17/25 at 9:46 a.m., inside Resident 3's room, Resident 3 was asleep with CNA H beside sitting and watching the resident. CNA H stated he was the sitter for Resident 3 because Resident wanders. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) I on 12/18/25 at 12:58 p.m., inside Resident 3's room. CNA H was inside Resident 3's room sitting at bedside. LVN I confirmed Resident 3 has a sitter. Reviewed of Resident 3's Elopement Evaluation dated 8/25/25 with Resident at risk elopement with score of 4.0 on Admission. Reviewed Care Plan - Resident has a wander guard to the right wrist r/t wandering aimlessly. Reviewed goals and intervention: Check functioning of wander guard, check placement of wander guard (right wrist), monitor for episodes of wandering every shift, monitor skin integrity to right wrist. During a concurrent interview and record review with DON on 12/19/25 at 1:21p.m., the DON confirmed Resident 3 had a sitter. The DON stated the Resident has tendency to walk or wander around which might be a risk for elopement. The DON confirmed no care plan for the one on one sitter for the Resident. The DON further stated it should be care planned and it's individualized for each resident. During a review of the facility's policy and procedure titled, NP04 Comprehensive Person-Centered Care Planning, dated 9/7/2023, indicated, The comprehensive care plan must describe the following: i. The services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure enteral feeding (the delivery of nutrients through a feeding tube directly into the stomach) was provided with appropriate care and services when an enteral feeding was found to be running for more than 24 hours for one (Resident 13) out of 31 sampled residents. This failure had the potential to put Resident 13 at risk for enteral feeding complications such as tube clogging/displacement, fluid overload, abdominal distention and infections. During an observation on 12/16/25 at 9:22 a.m. at Resident 13's bedside, Resident 13 was on the bed with eyes closed and noted rise and fall of the chest. Resident 13 had an enteral feeding bottle with contents below 300 ml (milliliters, a unit of measurement) connected to a running feeding pump (a machine that uses a pump to control the flow, ensuring precise amounts are given over time, often using a bag of special liquid formula, tubing, and a small pump mechanism). The feeding bottle indicated it started on 12/15/25 at 1 a.m. A review of Resident 13's medical record indicated an admission date of 3/22/23. Resident 13's medical diagnoses included gastrostomy status (feeding tube placed through the belly wall directly into the stomach). A review of Resident 13's physician order indicated, Enteral feed: two times a day [brand name 1.5] 55 ml/hr [hour] via pump x [times] 20 hrs = 700 ml/24 hrs. OFF @ 1000 and ON at 1400. During an interview on 12/16/25 at 11:15 a.m. with Licensed Vocational Nurse (LVN) A, LVN A stated enteral feeding bottle, and tubing must be changed every 24 hours. During an interview on 12/18/25 at 1:53 p.m. with Licensed Vocational Nurse (LVN) D, LVN D stated enteral feeding bottle should not run for more than 24 hours. During an interview on 12/18/25 at 3:15 p.m. with Registered Nurse (RN) B, RN B stated enteral feeding bottle, and tubing should only be good for 24 hours. The feeding bottle's manufacturer's manual was requested but was not provided. A review of facility's policy and procedure (P&P) entitled, Enteral Tube Management: Gastrostomy Tube-Jejunostomy Tube revised 9/28/23, the P&P indicated, 1. Enteral tubes should be verified for placement and patency prior to intermittent feeding, at every shift, and prior to administering medications, hydration, and nutrition via enteral feeding tubes.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the daily staffing information was posted in a clear and readable format and in a prominent place readily accessible to residents, staff, and visitors. This failure had the potential to result in staffing misinformation for residents, families, and visitors. Findings: During multiple observations from 12/16/2025 to 12/19/2025, between 8:30 a.m. to 10:30 a.m., at the lobby, nurse station AA (NS AA) and nurse station BB (NS BB), there was no daily staffing information posted. There was no daily staffing information placed on top of the lobby desk or on top of nurse stations AA and BB. During an observation on 12/22/2025 at 9:35 a.m., in the facility's lobby, there was no daily staffing information posted that could easily be seen by visitors or residents. During an observation on 12/22/2025 at 9:39 a.m., in NS AA, there was no daily staffing information posted that could easily be seen by visitors or residents. During a concurrent observation and interview with registered nurse C (RN C) on 12/22/2025 at 9:42 a.m., in NS BB, RN C confirmed they did not have the daily staffing information posting. During a concurrent observation and interview with the director of staff development (DSD) on 12/22/2025 at 9:44 a.m., in NS BB and lobby, the DSD confirmed there was no daily staffing information posted in each nurse station. DSD showed the staffing information written in fine prints and posted behind the facility's check-in kiosk (a digital terminal that allows users to register their arrival and complete related tasks without assistance from staff). The DSD confirmed the daily staffing information could not be seen right away once a visitor entered their lobby and stated she would notify their administrator about it (ADM). During a concurrent observation and interview with the director of nursing (DON) on 12/22/2025 at 10:02 a.m., in the lobby, the DON confirmed the daily staffing information was printed in small prints and stated it was hard to print in larger prints. The DON stated the daily staffing information used to be located on top of the lobby desk. During a review of the facility's policy and procedure titled, Nursing Department - Staffing, Scheduling & Postings, date revised 7/2018, indicated, B. Posting requirements. The Facility will post the nurse staffing data specified above, on a daily basis at the beginning of each shift. ii. Data must be posted as follows: a. Clear and readable format. b. In a prominent place readily accessible to residents and visitors.		

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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. Based on observation, interview and record review, the facility failed to ensure accurate account of controlled drugs was maintained and periodically reconciled when Clonazepam (medication used to prevent and treat anxiety disorders, and seizures) was dispensed but was not recorded in the Narcotics Record book for one (Resident 65) out of 31 sampled residents. This failure had the potential for diversion of controlled medications. During a concurrent observation and record review of Station 2 medication cart on 12/16/25 at 11:29 a.m. with Registered Nurse (RN) B, RN B verified Narcotics Record book indicated Resident 65 had 16 remaining Clonazepam pills dated 12/15/25 at 5:20 p.m. RN B also verified Clonazepam blister pack for Resident 65 had 15 pills. A review of Resident 65's physician order indicated Clonazepam 1 MG [milligram, a unit of measurement] give 1 tablet orally two times a day for anxiety m/b [manifested by] continuous yelling, screaming, calling out. During an interview and record review of Resident 65's medication administration record on 12/18/25 at 2:07 p.m. with the Director of Nursing (DON), the DON verified Clonazepam was administered to Resident 65 on 12/16/25 at 9:00 a.m. The DON stated they should have recorded it in the Narcotics Record book if they took a Clonazepam pill. The DON also stated she was not informed of the incident. The DON stated nurses must report any discrepancies in the Narcotics Record book immediately. During an interview on 12/18/25 at 3:15 p.m. with RN B, RN B stated she went to Resident 65's nurse-in-charge and clarified the Narcotics discrepancy immediately. RN B also stated we must ensure we record every controlled drug taken and administered to residents in the Narcotics Record book. RN B stated it should have been reported to the DON. A review of facility's policy and procedure (P&P) entitled, Controlled Medication Storage effective 8/2014, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures.E. Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. A review of facility's policy and procedure (P&P) entitled, Using the Brigg's Narcotic Record Book dated 2/2021, the P&P indicated, .Signing out A Narcotic Medication: When a narcotic medication is to be administered, the Licensed Nurse will record the following details:-Date that the medication was signed for-Time-Dose to be used-Amount Remaining-Licensed Nurse Signature.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and record review, the facility failed to ensure irregularities were identified during drug regimen review for the medication Lurasidone (an antipsychotic medication, works by rebalancing important natural substances in the brain called dopamine and serotonin to improve thinking, mood, and behavior) for one (Resident 17) out of 31 sampled residents when adequate monitoring for the medication was not done. This failure had the potential to compromise the physical, social, and mental well-being of Resident 17. A review of Resident 17's medical records indicated an admission date of 4/28/25. Resident 17's diagnoses included but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, judgment, and behavior, often caused by nerve cells in the brain stopping working properly), and bipolar disorder (a mental health condition causing extreme mood swings, shifting between emotional highs [mania or hypomania] and lows [depression], affecting energy, sleep, behavior, and thinking, and disrupting daily life). A review of Resident 17's Minimum Data Set (MDS, an assessment tool), dated 10/30/25, indicated a brief interview for mental status score of 13 [BIMS, a tool used to assess cognition (knowing, learning, and understanding), a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. A review of Resident 17's Physician Order indicated, Lurasidone HCl [hydrochloride, a chemical substance] Oral tablet 40 MG [milligram, a unit of measurement] Give 1 tablet by mouth in the evening for Bipolar as m/b [manifested by] depressive mood as eb [evidenced by] withdrawn from prior activity. During a concurrent interview and record review of Resident 17's medical chart with the Director of Nursing (DON) on 12/22/25 at 10:48 a.m., the DON verified Resident 17's physician order for Lurasidone and the recent dose increase in November 2025. The DON also verified there was no AIMS (Abnormal Involuntary Movement Scale, a checklist to spot and measure jerky, uncontrollable movements [tardive dyskinesia] in people taking certain medicines, especially antipsychotics, by rating facial tics, tongue movements, limb motions, and how much it bothers the person, using a 0 [none] to 4 [severe] scale for different body parts.) done for Resident 17 since admission. The DON stated AIMS should have been done for Resident 17. During a concurrent interview and record review of Resident 17's medical chart with the Consultant Pharmacist (CP) on 12/22/25 at 1:18 p.m., the CP verified Lurasidone was started in the facility and not prior to admission. The CP verified Resident 17's dose for Lurasidone was increased from 20 MG to 40 MG in 11/2025. The CP verified there was no AIMS done for Resident 17 since admission. The CP stated there should have been a baseline AIMS for Resident 17. The CP also stated there was an increased risk for EPS (Extrapyramidal Symptoms, involuntary movement problems, like tremors, stiffness, restlessness, or spasms, caused by certain medications, especially antipsychotics, affecting the brain's motor control areas, leading to Parkinson's-like symptoms or other uncontrolled movements) with Resident 17's current dose of Lurasidone. The CP also stated AIMS should have been included in the recommendation in Resident 17's medication regimen review. During a concurrent observation and interview on 12/22/25 at 1:43 p.m. with Resident 17, Resident 17 was on a wheelchair and stated she had lunch. Tremors were noted on Resident 17's both hands. A review of Resident 17's list of diagnoses did not include Parkinson's disease or parkinsonism. A review of facility's policy and procedure (P&P) entitled, Behavior/Psychoactive Medication Management revised on 10/30/25, the P&P indicated, .4. Parameters for use of Anti-psychotic Medications.c. Monitoring and Reporting for Side Effectsi. The resident will be observed and/or monitored for side effects, and adverse consequences, including sedation. An Abnormal Involuntary Movement Scale Assessment (AIMS), should be completed upon admission, every six months, and with increase in dose on all residents that are prescribed Antipsychotic medications. All complications and side effects should be reported to the healthcare practitioner.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when:1. Opened eyedrop medications without open and discard date labels, an eyedrop medication past discard date, and an opened Phenytoin Oral Suspension (a medication used for seizures) without open date label were found.2. Insulin pen without opened date label and an expired inhalation solution (medication used to keep airways open and to control and prevent symptoms like wheezing, shortness of breath, coughing and chest tightness) were found.3. Insulin pen without open and discard date was found.These failures had the potential for residents to receive medications with reduced efficacy.1. During a concurrent observation and interview regarding Station 5 Medication Cart on [DATE] at 10:04 a.m. with Licensed Vocational Nurse (LVN) A, the following were identified and verified by LVN A:a. A Latanoprost Eye Drop Medication indicated an open date label of [DATE] and without a discard date label. The packaging indicated, Discard unused portion after 28 days.b. A Latanoprost Eye Drop Medication indicated an opened and discard date label of 11/15-[DATE]. LVN A stated it should have been discarded.c. An opened Bimatoprost Eye Drop Medication did not have an open and discard date labels.d. An opened bottle of Phenytoin Oral Suspension was found without an open date label. LVN A stated opened date should have been indicated on the bottle. 2. During a concurrent observation and interview regarding Station 2 Medication Cart on [DATE] at 11:29 a.m. with Registered Nurse (RN) B, the following were identified and verified by RN B:a. A prefilled insulin pen had no open and discard date. The packaging indicated, Discard unused portion after 28 days.b. An opened inhalation powder indicated an opened date of [DATE] and expiry date of 12/8. 3. During a concurrent observation and interview regarding Station 3 Medication Cart on [DATE] at 11:51 a.m. with Registered Nurse (RN) C, an opened prefilled insulin pen did not indicate an open and discard date. RN C, the open and discard date should be written on the insulin pen. RN C verified the packaging indicated, Discard unused portion after 28 days.A review of facility's policy and procedure (P&P) entitled Medication Storage In The Facility effective [DATE], the P&P indicated, Medications and biologicals are stored, safely, securely, and properly, following manufacturer's recommendations or those of the supplier.M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock.Policy and procedure for Medication Labeling was requested but was not provided.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and facility document review, the facility failed to provide food that was palatable. This failure places all residents who eats food from the facility's kitchen at risk for poor food intake which may compromise their nutritional status. Findings: 1) A review of Resident 8's medical record indicated he was initially admitted on [DATE]. Resident 8's Minimum Data Set (MDS, an assessment tool), dated 10/29/25, indicated he had a BIMS [Brief Interview for Mental Status] score of 15 - cognitively intact. Further review of the medical record indicated Resident 8 was on NAS (no added salt) regular diet. During an interview with Resident 8 on 12/16/2025 at 10:50 a.m., he stated that the facility does not know how to cook chicken. Resident 8 further described the texture of the chicken served at the facility as being [NAME] to rubber. During an observation and concurrent interview on 12/19/25 at 2:00 p.m., three surveyors, along with two Dietary Managers (DMs), conducted a taste test of the food the facility served the residents for lunch that day. The facility's menu indicated the lunch consisted of chicken, pasta marinara sauce, and spinach for regular diet. During the food tasting, all three surveyors agreed that the chicken was tough and dry. A review of the facility's policy and procedure (P&P) titled, DD05 Dining Program, revised 1/30/2025, the P&P indicated, Dining Program is a service organized, staffed and equipped to assure that food service to residents is safe, appetizing, and provides for their nutritional needs. 2) During the test tray observation and tasting with the Dietary Manager (DM) and Regional Dietary Manager (RDM), on 12/19/25 at 1:54 p.m., two test plates in the trays were brought and tasted. One of the test plates contained regular (no modification or restriction) Chicken parmesan, penne with garlic & herbs, and spinach with onions. The second test plate contained pureed chicken, penne pasta, and spinach. The survey team tasted the regular chicken and pureed foods after; the pureed chicken parmesan had a strong burned taste. The RDM verified the taste of pureed chicken has an after taste, the RDM further stated it would follow up on this concern and on improving the taste of these pureed foods. During an interview with the DM and the RDM on 12/22/25 at 1:55 p.m., the DM confirmed the puree chicken was not palatable. The RDM confirmed the texture of the puree chicken is not palatable. During a review of the facility's policy (P) titles, Dining Program , revised 1/30/25, the P & P indicated Dining Program is a service organized, staffed and equipped to assure that food service to resident is safe, appetizing and provides for their nutritional needs.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure infection control practices were implemented when:1.Housekeeper J (HK J) did not wear the proper personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when mopping inside a the room of cohorted (joined together) residents (Resident 62 and Resident 1) who were on contact precautions (extra steps, like wearing of gloves and gown, needed to stop the spread of germs by touch) and enhanced barrier precautions (EBP, an infection control measures in nursing homes to stop the spread of multidrug-resistant organisms [MDROs]), and did not perform hand hygiene upon exit of the room. Resident 62 was on contact precautions for C. Diff [Clostridium difficile, a common, often harmful bacterium that causes severe diarrhea and inflammation of the colon]) and Resident 1 was on enhanced barrier precaution (EBP). 2.Licensed vocational nurse I (LVN I) did not perform hand hygiene (cleaning of hands with soap and water or an alcohol-based sanitizer to remove germs and prevent infections) upon doffing (to take off or remove something) gloves and prior to donning (act of putting on something) a new pair of gloves; and3.Licensed vocational nurse K (LVN K) did not change gloves after touching contaminated gauze wrappers, and the box of gauze during Resident 7's wound treatment, exposed Resident 7's stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure injury/pressure ulcer (PI/PU - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) in the sacrum (a triangular bone just below the lumbar vertebrae) area while cleaning Resident 7's right lower leg wounds, did not clean the surrounding skin of sacrum's stage 4 PI and did not clean the other wounds at the back of Resident 7's right thigh as ordered by the physician.These failures had the potential to compromise resident's health and safety, and spread infections to residents, staff, and visitors.Findings:1.Review of Resident 62's admission Record dated 12/22/2025, indicated Resident 62 was admitted to the facility with diagnoses including paraplegia (paralysis or weakness in the lower body, legs, and sometimes trunk), dorsalgia (pain in the back) and enterocolitis (inflammation affecting both small intestine and large intestine) due to C. diff. [Clostridium difficile - a common, often harmful bacterium that causes severe diarrhea and inflammation of the colon], recurrent.Review of Resident 1's admission Record dated 12/22/2025, indicated Resident 1 was admitted to the facility with diagnoses including 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 (commonly referred to as stroke), affecting left non-dominant side (the part of the body [like hand, foot or eye] that is less preferred nor used for tasks compared to its paired counterpart, which is the dominant side), dysphagia (difficulty in swallowing) following cerebral infarction, and gastrostomy (or G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) status.Review of Resident 1's Order Summary Report dated 12/22/2025, indicated an order of enhanced barrier precaution (EBP, an infection control measures in nursing homes to stop the spread of multidrug-resistant organisms [MDROs]) due to having a feeding tube.During an observation on 12/16/2025 at 9:48 a.m., in front of Residents 62 and 1's room, the room entrance had a posting indicated that Resident 62 was on contact precaution while Resident 1 who was in B bed was on EBP. HK J was observed mopping inside the room, not wearing proper PPE. HK J was just wearing a facemask, no gown and no gloves on. HK J mopped the floor where Resident 62 was, she moved Resident 62's overbed table without gloves on, touched the privacy curtain, mopped Resident 1's floor, touched Resident 1's overbed table to moved it near the bed, continued mopping to the doorway, and touched the garbage container to move against the wall, still no gown and no gloves on. HK J stepped out of the room, took a long-handled broom, did not perform hand hygiene, and swept the doorway floor. HK J touched the cleaning cart and moved in front of Room CC without hand hygiene.During an interview with HK J on 12/16/2025 at 9:52 a.m., HK J confirmed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above observations and stated she did not know Resident 62 was on contact precaution. During an interview with the director of nursing (DON) on 12/22/2025 at 11:03 a.m., the DON confirmed Resident 62 was on contact precaution because Resident 62 was admitted with C-diff. The DON stated the housekeeper should have worn gown and gloves, if resident was on contact precaution, it's our protocol. During a review of CDC's Guideline for Isolation Precautions titled, Precautions to Prevent Transmission of Infectious Agents, dated 11/22/2023, indicated, . for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. C.difficile. During a review of the facility's policy and procedure titled, Hand Hygiene, date revised 9/1/2020, indicated, The following situations require appropriate hand hygiene: 1. Immediately upon entering and exiting a resident room. 2. During a wound treatment observation on 12/19/2025 at 9:27 a.m., inside Resident 7's room, LVN I was observed wearing a new pair of gloves and was about to assist LVN K with wound treatment, but a box of gloves fell on the floor. LVN I removed his gloves, picked up the box of gloves and dropped it on top of a covered garbage container, and donned a new pair of gloves without hand hygiene. During an interview with LVN I on 12/19/2025 at 10:15 a.m., LVN I confirmed above observation, and stated he should have performed hand hygiene prior to donning a new pair of gloves. 3. Review of Resident 7's admission Record dated 12/19/2025, indicated Resident 7 was admitted to the facility with diagnoses including pressure ulcer of sacral region, stage 4, chronic peripheral venous insufficiency (a condition where the veins, typically in the legs, have difficulty sending blood back up to the heart), non-pressure chronic ulcer (a long-lasting skin sore [ulcer] that doesn't heal properly and isn't caused by constant pressure) of right lower leg and acquired absence of left leg above knee. During wound treatment observation on 12/19/2025 at 9:38 a.m., inside Resident 7's room, LVN K removed the dressing on Resident 7's right lower leg's non-pressure ulcers, and with the same gloves, removed the old dressing in Resident 7's sacrum area. The wound in the sacrum area was a Stage 4 PI, the wound bed was pink, red in color and had a depth. LVN K started to work on the right lower leg's wounds while the sacrum wound was exposed. LVN K opened the wrappers of each gauze one at a time to moisten with normal saline (NS-sterile saltwater solution) and cleansed each wound with one moistened gauze at a time. LVN K left all the gauze wrappers on top of the overbed table. At 9:49 a.m., with a new pair of gloves, LVN K touched all contaminated gauze wrappers and threw them, opened a wrapper of calcium alginate (a natural, gel-forming substance from seaweed, used in wound dressings to absorb fluid and create a moist healing environment) and started to apply the calcium alginate to the right lower leg wounds, continued to apply dressings to cover the wound, without changing her gloves and no hand hygiene observed. At 9:55 a.m., LVN K went to the treatment cart and took out a box of gauze and placed it on top of the overbed table. LVN K donned a new pair of gloves and touched the box of gauze to take some gauze and started to clean inside the PI wound on Resident 7's sacrum area, without changing her gloves. The surrounding skin of the PI was not cleansed and LVN K packed the wound with calcium alginate and covered with foam dressing. At 10:00 a.m., LVN K proceeded to clean Resident 7's right posterior thigh (at or toward the back or rear of something) scattered open wounds. She cleansed only one open wound with NS then started to apply zinc oxide ointment (a topical medication that acts as a protective barrier for the skin) to all wounds without cleaning them. During an interview with LVN K on 12/19/2025 at 10:20 a.m., LVN K confirmed above observations and stated she should have changed gloves and performed hand hygiene every time she touched a contaminated material or environment. LVN K stated she should have cleansed the PI's surrounding skin prior to application of foam dressing. During an interview with the DON on 12/22/2025 at 10:55 a.m., she stated if needed to change the dressings of resident's multiple wounds, the nurse should take care of one wound at a time to prevent cross contamination. The DON further stated hand hygiene should be performed before donning a new pair of gloves, and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses should change gloves once they touch a dirty surface. She confirmed wounds should be cleansed as well as their surrounding skin prior to application of any treatment order. Review of Resident 7's order summary report, it indicated a physician's order dated 10/29/2025 to cleanse the right posterior thigh wounds with NS, pat dry, apply the zinc oxide and leave open to air. Review of the facility's policy and procedure titled, Hand Hygiene, date revised 9/1/2020, indicated, Facility staff follow the hand hygiene procedures to help prevent then spread of infections to other staff, Resident, volunteers and visitors. Wearing gloves does not replace the need for hand hygiene. Before donning and after doffing Personal Protective Equipment (PPE). Review of the facility's policy and procedure titled, Dressings - Application, date revised 1/1/2012, indicated, To ensure cleanliness and prevent infection by protecting the skin's surface and to promote resident comfort and wound healing. Wash hands before and after each procedure. Open all dressings to be used. Pour solutions into med (medication) cup as indicated. Reapply non-sterile gloves and proceed with cleansing of wound. Start with inside and move in circular motion away from wound. Gentle cleansing recommended. apply ointments.		