STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056026	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Empress Care Center, LLC	1299 S. Bascom Avenue San Jose, CA 95128

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46552 Based on interview and record review, the facility failed to ensure their policy and procedure (P&P) was followed for an advance directive (AD: a written instructions, such as a living will or durable power of attorney that authorizes to act on behalf of resident for healthcare when the individual is incapacitated) for six of eight sampled residents (Resident 6, 20, 23, 31, 42, and 249). This failure could lead to the delivery of unnecessary or inappropriate medical services against sampled resident's goals and wishes. Findings: Review of Resident 6's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 6 was admitted to facility on 4/18/2016. Review of Resident 6's form for physician orders for life-sustaining treatment (POLST: a document that specifies the medical treatments the resident wants to receive during serious illness) form prepared on 4/19/2016 indicated section D for AD documented No Advance Directive. Further review of Resident 6's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 6. Review of Resident 20's FS indicated Resident 20 was admitted to facility on 2/10/2022. Review of Resident 20's POLST form prepared on 2/11/2022 indicated section D for AD documented No Advance Directive. Further review of Resident 20's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 20. Review of Resident 23's FS indicated Resident 23 was admitted to facility on 3/14/2023. Review of Resident 23's POLST form prepared on 4/17/2023 indicated section D for AD documented No Advance Directive. Further review of Resident 23's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 23. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 31's FS indicated Resident 31 was admitted to facility on 4/19/2024. Review of Resident 31's POLST form prepared on 4/19/2024 indicated section D for AD documented No Advance Directive. Further review of Resident 31's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 31. Review of Resident 42's FS indicated Resident 42 was admitted to facility on 6/14/2024. Review of Resident 42's POLST form prepared on 6/14/2024 indicated section D for AD documented No Advance Directive. Further review of Resident 42's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 42. Review of Resident 249's FS indicated Resident 249 was admitted to facility on 4/10/2025. Review of Resident 249's POLST form prepared on 4/10/2025 indicated section D for AD documented No Advance Directive. Further review of Resident 249's clinical record indicated there was no documented evidence for facility discussed for AD or offered or assisted to execute AD for resident 249. During a concurrent record review and interview with facility's social service director (SSD) on 4/23/2025 at 10:37 a.m., SSD reviewed POLST form for above residents. SSD confirmed there was no AD for above residents. SSD stated did not offered or assisted to execute AD for these residents. SSD also stated should have offered and assisted to execute AD for these residents. During a concurrent record review and interview with facility's director of nursing (DON) on 4/23/2025 at 2:01 p.m., DON reviewed POLST form for above residents. DON confirmed there was no AD for above residents. DON stated SSD was responsible to verify, offer and provide assistance to execute AD for residents. DON also stated SSD should have offered and provided assistance to execute advance directives as needed for above residents. Review of facility P&P titled, Advance Directive, undated, the P&P indicated, When an advance directive or other Request regarding resuscitative measures document is NOT completed: Admission Coordinator, Social Service Director, Licensed Nurse schedule the Ombudsman (advocates for residents in facility, trained to resolve problems and concerns) or patient advocate to visit the resident promptly to assist the resident in completing an advance directive.

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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** 44185 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, resident-centered care plan for two out of eighteen sampled residents, (Residents 27 and 20), when: 1. for Resident 27, there was no care plan for his continuous oxygen inhalation use and 2. for Resident 20, there was no care plan as well for her significant weight loss for six months. These failures had the potential to result in the residents, not receiving the intervention and monitoring necessary to maintain their highest level of well-being. Findings: 1. During the observation of Resident 27 on 4/21/25 at 11:05 a.m., Resident 27 was comfortably sleeping in his bed. He was on oxygen (O2, colorless and odorless gas that is essential for life) inhalation at 2 liters (l, a metric unit of volume)/minute via nasal cannula (n/c, device that delivers extra oxygen through a tube and into the nose). Review of Resident 27's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 27 was admitted to the facility on [DATE] with the primary diagnosis of unspecified chronic kidney disease (longstanding disease of the kidneys leading to renal failure), stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of the blood). Review of Resident 27's order summary report dated 4/22/25 indicated, Resident 27 had an order of continuous oxygen inhalation at 2 l/minute via n/c to maintain oxygen above 95 percent (%, one part in a hundred), ordered on 4/1/25. During the interview with registered nurse D (RN D), on 4/25/25 at 10:45 a.m., RN D acknowledged that Resident 27 is on oxygen inhalation at 2 l/minute via n/c, continuous to maintain the oxygen above 95% (normal blood oxygen levels). Review of Resident 27's care plans indicated that Resident 27 did not have a comprehensive, resident-centered care plan for his continuous oxygen inhalation use. During the concurrent review of Resident 27's care plans and interview with infection preventionist (IP) on 4/25/25 at 3:26 p.m., IP reviewed the care plans of Resident 27 and she confirmed that Resident 27 did not have a comprehensive, resident-centered care plan for his continuous oxygen inhalation use. IP then stated that she would update the care plan of Resident 27. During the interview with the director of nursing (DON) on 4/28/25 at 10:24 a.m., DON acknowledged that the continuous oxygen inhalation use of Resident 27 should have a care plan and would check on it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Care Plan, indicated, Each individual resident has a comprehensive care plan which is objective, measurable and time-framed This individual comprehensive care plan identifies the professional services and the responsible person that evaluates the concerns and carried out the interventions to prevent or reduce re-occurrences of the same problems/concerns. It further prevents, if feasible, further declines and deterioration of resident's function or status. It illustrates how the approaches being provided 46552 2. Review of Resident 20's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 20 was admitted to facility on 2/10/2022. Resident 20's FS also indicated diagnoses including diabetes type 1 (a chronic condition which little or no insulin [a hormone that regulates blood sugar levels] production leads to high blood sugar levels), alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in day-to-day activities). Review of Resident 20's monthly weight monitoring indicated resident 20's weight was 158.2 pounds on 10/3/2024 and weight was 141.6 pounds on 4/1/2025. Resident 20's noted with significant weight loss of 16. 6 pounds/ 10.5% for 6 months. Review of Resident 20's dietary notes dated 4/3/2025 indicated significant weight variance -16.6 lbs (lbs-pounds, mass of weight) -10.5% for 6 months. Review of Resident 20's weight management review notes dated 4/4/2025 indicated significant weight loss, -16.6 lbs, -10.5% for 6 months. Review of Resident 20's care plans indicated there was no care plan for significant weight loss, that includes measurable objectives and timetables to meet the Resident 20's person centered nutritional needs to address Resident 20's significant weight loss. During a concurrent record review of Resident 20's monthly weights and care plans interview with license vocational nurse F (LVN F) on 4/23/2025 at 1:36 p.m., LVN F reviewed monthly weights for Resident 20, LVN F confirmed significant weight loss for 6 months for Resident 20. LVN also reviewed Resident 20's care plans and confirmed there was no care plan for significant weight loss for Resident 20. LVN F stated Resident 20 should have a care plan for significant weight loss x 6 months. During an interview with director of nursing (DON) on 4/23/2025 at 1:48 p.m., DON confirmed there was no care plan for significant weight loss for Resident 20. DON stated license staff should have initiated care plan for significant weight loss for Resident 20. Review of facility policy and procedure (P&P) titled, Policy and Procedure-Care Plan, undated, the P&P indicated, A care plan is the summation of the resident concerns, goals, approaches, and interventions in order to meet the goals and help minimize if not totally eradicate residents' problems. Short term care plan: this is the actual concern or problem of the resident noted as it occurs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the residents received the necessary care and services for one of six residents (99) when the licensed nurses administered hydrocodone-acetaminophen (used to relieve severe pain) 5-325 milligrams (mg, a metric unit of mass) for Resident 99's moderate pain. This failure had the potential for the residents to experience unnecessary adverse effects from the medication. Findings: Review of Resident 99's Admission Record indicated she was admitted to the facility on [DATE] with polyneuropathy (a condition where several nerves in different parts of the body are damaged, and it can impact sensation, movement, or both) diagnosis. Review of Resident 99's physician orders indicated the licensed nurses were to monitor Resident 99's pain level every shift, 0 = no pain, 1-3 = mild pain, 4-7 = moderate pain, and 8-10 = severe pain, started on 4/10/25; and hydrocodone-acetaminophen 5-325 mg every 12 hours as needed for severe pain 8-10, started on 4/14/25. Review of Resident 99's Medication Administration Record (MAR), dated 4/2025, indicated hydrocodone-acetaminophen 5-325 mg was administered to her on 4/17/25 for pain level 7 and on 4/22/25 for pain level 5. During an interview with the director of nursing (DON) on 4/18/25, at 11:40 a.m., she reviewed Resident 99's 4/2025 MAR and confirmed that the licensed nurses administered hydrocodone-acetaminophen 5-325 mg to Resident 99 on 4/17/25 for pain level 7 and on 4/22/25 for pain level 5. The DON stated the licensed nurses should notify the physician and get the order for Resident 99's moderated pain when Resident 99 complained of pain level less than 8. Review of the facility's undated policy, Pain Assessment and Management, indicated . 6. Implement the medication regimen as ordered .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure the residents received oxygen therapy as ordered by the physician for two of 13 residents (34 and 99). This failure had the potential for the residents to have complications related to improper oxygen treatment. Findings: 1. Review of Resident 34's Admission Record indicated he was admitted to the facility on [DATE] with chronic obstructive pulmonary disease (COPD, a lung disease causing restricted airflow and breathing problems) diagnosis. Review of Resident 34' physician order, dated 3/7/25, indicated he had an order for the licensed nurse to place him on oxygen at 2 liters (L, a metric unit of volume) per minute (LPM) every shift related to COPD. During an observation with licensed vocational nurse F (LVN F) on 4/21/25, at 9:44 a.m., Resident 34 was sitting in the lobby and was on 1.5 LPM of oxygen. During a concurrent interview with LVN F, she reviewed Resident 34's physician order and confirmed that Resident 34 should be on 2 LPM of oxygen as ordered by the physician. 2. Review of Resident 99's Admission Record indicated she was admitted to the facility on [DATE] with COPD diagnosis. Review of Resident 99' physician order, dated 4/11/25, indicated she had an order for the licensed nurse to place her on oxygen at 2 LPM every shift for shortness of breath, chest pain. During an observation with licensed vocational nurse F (LVN F) on 4/21/25, at 9:50 a.m., Resident 99 was lying in bed and was on 1.2 LPM of oxygen. During a concurrent interview with LVN F, she reviewed Resident 99's physician order and confirmed that Resident 99 should be on 2 LPM of oxygen as ordered by the physician. Review of the facility's undated policy, Oxygen Treatment, indicated It is the policy of this facility that oxygen therapy is administered as ordered by the physician . 5. Adjust oxygen flow, as ordered by the physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed 1. To complete the bed rail entrapment assessment for 48 of 48 residents (1, 28, 8, 3, 26, 14, 5, 25, 99, 37, 19, 24, 15, 44, 2, 13, 6, 10, 33, 32, 42, 249, 39, 31, 36, 250, 21, 4, 251, 252, 23, 20, 38, 199, 40, 46, 34, 30, 17, 11, 18, 29, 9, 7, 22, 12, 27, and 200); 2. To attempt alternatives measures for 6 of 48 residents (4, 33, 44, 99, 249, and 250) prior to implementing the bed rails; and 3. To complete the bed rail care plan for one of 48 residents (40). These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During observations on 4/21/25, from 9:25 a.m. to 10:52 a.m., Residents 13, 6, 10, 33, 32, 42, 249, 39, 31, 36, 250, 21, 4, 251, 252, 23, 20, and 38 had bilateral bed rails up. Review of Residents' 13, 6, 10, 33, 32, 42, 249, 39, 31, 36, 250, 21, 4, 251, 252, 23, 20, and 38 clinical records indicated they did have the entrapment assessments completed for the use of bed rails. During observations on 4/21/25, from 10:49 a.m. to 1:17 p.m., Resident 11 had left bed rail up; Resident 18 had right bed rail up; Residents 199, 40, 46, 34, 30, 17, 29, 9, 7, 22, 12, 27, and 200 had bilateral bed rails up. Review of Residents' 199, 40, 46, 34, 30, 17, 11, 18, 29, 9, 7, 22, 12, 27, and 200 clinical records indicated they did have the entrapment assessments completed for the use of bed rails. During observations on 4/22/25, from 3:36 p.m. to 3:45 p.m., Resident 1 had left side rail up; Resident 3 had right side rail up; Residents 28, 8, 26, 14, 5, 25, 99, 37, 19, 24, 15, 44, and 2 had bilateral bed rails up. Review of Residents' 1, 28, 8, 3, 26, 14, 5, 25, 99, 37, 19, 24, 15, 44, and 2 clinical records indicated they did have the entrapment assessments completed for the use of bed rails. During an interview with the maintenance director (MD) on 4/24/2025, at 1:29 p.m., the MD stated he was not aware of resident's height and weight when measured beds for gap between mattress, bed rails, and safety of residents for using bed rails. The MD also stated applying and removing bed rails upon request by nursing staff based on preferences and need of resident. The MD further stated routinely monitoring function of the beds in facility, unable to provide evidence of documentation monitoring. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the director of nursing (DON) on 4/24/2025, at 2:14 p.m., the DON confirmed there was no risk for entrapment assessment for use of bed rails for residents. The DON stated facility MD should have coordinated with nursing staff to assess risk for entrapment for residents when using side rails. The DON also stated facility should have assessed residents for risk for entrapment for use of bed rails. During the interview with the DON on 4/24/25, at 2:10 p.m., the DON acknowledged that the maintenance director and nurses should coordinate with each in checking the risks of entrapment and safety of the side rails and residents using them. During the interview with the MD on 4/24/25, at 2:25 p.m., the MD verified that the risks of entrapment and whether the bed rails to be installed were appropriate for the size and weight of the resident were not assessed prior to the installation of the side rails. During another interview with the DON on 4/24/25, at 2:35 p.m., the DON also verified that the risks of entrapment and whether the bed rails to be installed were appropriate for the size and weight of the resident were not assessed prior to the installation of the side rails. She further acknowledged that there should be proper coordination between the nurses and the maintenance director in assessing the side rails for the risks of entrapment and safety of the residents using the side rails and will remind them about that. During an interview with the MD on 4/24/25, at 2:30 p.m., he stated when nursing staff let him know, there would be new admission, he would have the bed and the bed rails ready before the new resident came. After the resident was admitted , if the resident needed only one rail or no rails then he removed them; if the resident needed padded rails, then he padded the rails, but he did not do any adjustment according to the resident's size. The MD stated he did the routine check on the beds and the bed rails, and he only checked on their functions. He did not check or assess the resident's risk for entrapment. 2. During an observation on 4/21/25, at 10:24 a.m., Resident 4's bed had partial bed rails up on both sides. Review of Resident 4's Physical Restraint Assessment, dated 2/18/25, indicated alternative measures were not attempted prior to use of bed rails. During an observation on 4/21/25, at 9:36 a.m., Resident 33's bed had partial bed rails up on both sides. Review of Resident 33's Physical Restraint Assessment, dated 3/5/25, indicated alternative measures were not attempted prior to use of bed rails. During an observation on 4/21/25, at 10:12 a.m., Resident 249's bed had partial bed rails up on both sides. Review of Resident 249's Physical Restraint Assessment, dated 4/11/25, indicated alternative measures were not attempted prior to use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/21/25, at 10:27 a.m., Resident 250's bed had partial bed rails up on both sides. Review of Resident 250's Physical Restraint Assessment, dated 4/11/25, indicated alternative measures were not attempted prior to use of bed rails. During an observation on 4/22/25, at 3:36 p.m., Resident 44 and Resident 99 had bed rails up on both sides. Review of Resident 44's Physical Restraint Assessment, dated 3/19/25, indicated alternative measures were not attempted prior to use of bed rails. Review of Resident 99's Physical Restraint Assessment, dated 4/11/25, indicated alternative measures were not attempted prior to use of bed rails. During an interview with the director of nursing (DON) on 4/28/25, at 11:14 a.m., the DON reviewed Resident 44's and Resident 99's Physical Restraint Assessments and confirmed alternative measures were not attempted prior to use of bed rails for Resident 44 and Resident 99. During an interview with the DON on 4/24/2025, at 2:14 p.m., the DON confirmed there were no alternative attempts prior to starting using bed rails for Residents 4, 33, 249, and 250. The DON also confirmed nursing staff did not complete physical restraint assessment for attempts of alternatives for these residents. The DON stated nursing staff should have attempted and completed assessments for alternatives for bed rails before starting using bed rails for these residents. 3. During the observation of Resident 40 on 4/21/25, at 10:52 a.m., Resident 40 was walking via his front wheel walker, alert, calm, comfortable and verbally responsive to questions. Resident 40's bilateral half side rails were up. Review of Resident 40's Admission Record indicated, Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's physician orders indicated, Resident 40 had an order of bilateral half side rails up when in bed for turning and repositioning as enabler, ordered on 3/4/25. Review of Resident 40's care plans indicated, there was no care plan for his bilateral half side rails use. Resident 40 had no separate and specific care plan for his side rails. During the concurrent review of Resident 40's care plans and interview with the director of nursing (DON) on 4/24/25, at 11:17 a.m., the DON verified that Resident 40 did not have a separate and specific care plan for his bilateral half side rails. The DON further verified that his side rails should have a separate and specific care plan and would update the care plan of Resident 40. 44185 46552

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on interview and record review, the facility failed to ensure the effective use of medications for one of 13 residents (28) when Resident 28 received ferrous sulfate (iron, used for prevention/treatment of iron deficiency) and Calcium (a medication used to prevent or treat low blood calcium levels) at the same time. This failure had the potential for the residents to not receive the amount of prescribed iron supplements. Findings: Review of Resident 28's Admission Record indicated she was admitted to the facility on [DATE] with anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells) diagnosis. Review of Resident 28's clinical record indicated, she had physician orders for ferrous sulfate 325 milligrams (mg, a metric unit of mass) every day for anemia at 9 a.m., started on 8/25/22, and for Calcium 500 mg every day at 9 a.m., started on 7/26/24. Thus, since 7/26/24, ferrous sulfate and Calcium were given at the same time at 9 a.m. every day. During an interview with the pharmacy consultant (PC) on 4/25/25, at 2:49 p.m., she stated ferrous sulfate and Calcium should be administered at least two hours apart due to drug-to-drug interaction that decreases the absorption of iron. According to Lexicomp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of calcium and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of DDI was that the calcium may decrease the absorption of oral preparations of iron salts. It indicated the iron absorption decreased an average of 60% when given as ferrous sulfate and co-administered with calcium. Lexicomp also indicated to separate the administrations of these medications so it may minimize the potential for significant interaction. Review of the facility's undated policy, Provider Pharmacy Requirements, indicated . 4. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: . i. Screening each new medication order for medication/drug interactions with other medications ordered for the resident .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on interview and record review, the facility failed to ensure the pharmacy consultant (PC: a licensed pharmacist provides expert clinical advice and guidance on medication use) identified and reported drug irregularities to the facility during the monthly medication regimen review (MRR: a thorough evaluation of resident's medications) for one of three sampled resident (Resident 31); and facility failed to follow up MRR recommendations for one of thirteen sampled resident (Resident 2). These failures resulted in Resident 31 received more than therapeutic (safety of medication with regard to risk of overdose) dose of medication for over ten months; and Resident 2 received medication for over one month. Findings: 1. Review of Resident 31's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 31 was admitted to facility on 4/19/2024. Review of Resident 31's FS indicated Resident 31's diagnoses including left femur neck fracture (broken left hip upper part of the bone) dated 4/19/2024. Review of Resident 31's physician order dated 6/2/2024 indicated cholecalciferol (vitamin D3, a supplement important for building and keeping strong bones) 2000 mcg (microgram, a unit of measurement for mass, equal to one millionth of a gram) one time a day for supplement related to left femur neck fracture. Review of Resident 31's electronic medication administration record (EMAR: a digital system used in healthcare setting to track and document the administration of medications to residents) for February 2025, March 2025 and April 2025 indicated Resident 21 received cholecalciferol 2000 mcg daily at 9:00 a.m. Review of manufacturer recommendations for cholecalciferol indicated 25 mcg/1000 IU (international units, a unit of measurement used for vitamins) daily for adults. Review of facility provided MRR reports for Resident 31 indicated there was no MRR for medication cholecalciferol since medication ordered on 6/2/2024 for Resident 31. During a concurrent record review of medication orders and interview with registered nurse D (RN D) on 4/22/2025 at 12:51 p.m., RN D reviewed order for cholecalciferol for Resident 31. RN D confirmed physician prescribed cholecalciferol 2000 mcg one time a day for Resident 31. RN D stated order should be 2000 IU not 2000 mcg, will reach out to MD (medical doctor) to clarify the order. During an interview with facility's director of nursing (DON) on 4/22/2025 at 1:02 p.m., DON confirmed the order for cholecalciferol 2000mcg. DON stated this order should be 2000 IU not 2000 mcg. (continued on next page)

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	056026	A. Building B. Wing	04/28/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of MRR for Resident 31 and interview with DON on 4/22/2025 at 2:05 p.m. , DON confirmed there was no MRR and recommendations related to cholecalciferol order. DON stated PC does medication regimen review for all residents on monthly basis. DON also stated PC identifies irregularities with medication orders and reports recommendations to facility as needed for corrections. DON further stated PC should have identified, reported, and provided recommendations to correct this high dose cholecalciferol order for Resident 31. During over the telephone interview with facility's PC on 4/23/2025 at 4:03 p.m., PC confirmed there was no MRR provided to facility for cholecalciferol order for Resident 31. PC stated order for cholecalciferol 2000 mcg equal to 80,000 IU, high dose. PC also stated this medication order should be 2000 IU not 2000 mcg. PC further stated PC should have identified during monthly MRR and reported to MD/facility to correct this medication order. Review of facility's policy and procedure titled, Medication Regimen Reviews, undated, the P&P indicated, The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: medication ordered in excessive doses or without clinical indication. The consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports. Follow-up reports relative to facility's corrective action related to problem areas; and other pertinent information. 37409 2. Review of Resident 2's Admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 2's physician order indicated she had order for omeprazole (used to treat conditions where there is too much acid in the stomach) 20 milligrams (mg, a metric unit of mass) every day, started on 8/10/23. Review of Resident 2's consultant pharmacist's Note to the Attending Physician/Prescriber, dated 3/28/25, indicated the consultant pharmacist asked the physician to evaluate continued need for omeprazole 20 mg as long term therapy has been associated with low magnesium (a mineral used by the body to help maintain muscles, nerves, and bones), osteoporosis (a disease that weakens the bones), and an increased incidence of C. diff infections (an infection that primarily causes diarrhea and inflammation of the colon). However, Resident 2's consultant pharmacist's Note to the Attending Physician/Prescriber was not presented to the physician; there were no physician's response and no physician's signature on it. During an interview with the Minimum Data Set Staff (MDSS) on 4/25/25, at 5:09 p.m., she reviewed Resident 2's consultant pharmacist's Note to the Attending Physician/Prescriber and confirmed that it was not presented to the physician. The MDSS stated Resident 2's consultant pharmacist's Note to the Attending Physician/Prescriber should be presented to the physician as soon as possible. Review of the facility's undated policy, Medication Regimen Review and Reporting, indicated . 6. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure palatability and nutritive value of cooked foods were maintained when: 1.Two of forty-nine facility residents (Residents 12 and 4), receiving food from the kitchen, complained that the food tasted bland (lacking taste or flavor); and 2. Regular (no modifications to food texture or consistency) oven barbecue roast beef and pureed foods (smooth, thick liquid or paste made by crushing or grinding solid foods and often made using a food processor and has a consistency that's thicker than juice) were held in the heated oven for an extended period. These failures resulted in decreased food palatability that could lead to decrease in food consumed by residents, and the food held in the heated oven for extended period could lose nutritive value, that could lead to decreased nutrient intake for the forty-nine facility residents receiving food from the kitchen. Findings: 1. During the concurrent observation and interview of Resident 12 during the resident council meeting (gathering where residents of a facility come together to discuss issues) on 4/22/25 at 10:45 a.m., Resident 12 was in his wheelchair in the activity room, alert, oriented, verbally responsive and participating in the resident council meeting. Resident 12 stated that his food tasted bland. Review of the admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) of Resident 12 indicated, Resident 12 was admitted to the facility on [DATE] with the primary diagnosis of hemiplegia (complete paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following other cerebrovascular disease (group of conditions that impact the brain's blood vessels and blood flow) affecting left non-dominant side. Review of the order summary report of Resident 12 dated 4/22/25 indicated, Resident 12 had an order of no added salt, controlled carbohydrate diet (CCHO, type of diet, in which the individual consumes a consistent daily amount of carbohydrates), regular diet texture, with thin liquids consistency (liquid that is easy to pour and no additives), cut up meat, ordered and started on 11/30/18. During the concurrent observation and interview of Resident 4 during the resident council meeting on 4/22/25 at 10:47 a.m., Resident 4 was in her wheelchair in the activity room, alert, oriented, calm, verbally responsive and participating in the resident council meeting. Resident 4 verbalized that the food did not taste good, did not have taste or tasted bland. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 4's admission record indicated, Resident 4 was readmitted to the facility on [DATE] with the primary diagnosis of infection (disease caused by microorganisms that invade tissue) and inflammatory reaction (body's response to illness) due to other cardiac and vascular devices (tools used to diagnose, treat or monitor conditions affecting the heart and blood vessels), implants (inserted into the heart and blood vessels to treat or support various cardiovascular conditions) and grafts (surgical procedures involving the transplantation of blood vessels or other tissues to repair or replace damaged parts of the heart or blood vessels), initial encounter. Review of Resident 4's order summary report dated 4/28/25 indicated, Resident 4 had an order of regular diet texture, thin liquids consistency, ordered and started on 3/8/25. During the test tray observation and tasting with cook I (COOK I) on 4/23/25 at 12:45 p.m., one test tray with two plates was brought and tasted. One of the test plates contained regular oven barbecue roast beef, regular vegetables and regular mashed sweet potatoes. The second test plate contained pureed oven barbecue roast beef, pureed vegetables and pureed mashed sweet potatoes. Tasted the regular oven barbecue roast beef, regular vegetables and regular mashed sweet potatoes and they all tasted bland. During the interview with COOK I after he tasted the test plate with regular foods, on 4/23/25 at 12:46 p.m., COOK I verified that the regular oven barbecue roast beef, regular vegetables and regular mashed sweet potatoes, tasted bland. During the tasting of the second test plate containing pureed oven barbecue roast beef, pureed vegetables and pureed mashed sweet potatoes on 4/23/25 at 12:48 p.m., tasted all the pureed foods and the pureed oven barbecue roast beef and pureed vegetables, tasted bland. During the interview with COOK I after he tasted the test plate with pureed foods, on 4/23/25 at 12:50 p.m., COOK I verified that the pureed oven barbecue roast beef and pureed vegetables, tasted bland. During the interview with the registered dietitian (RD), on 4/23/25 at 4:07 p.m., RD acknowledged that foods served by the facility kitchen should be palatable and not bland in taste. Review of the undated facility's policy, Food and Nutrition Services, indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . 2. During the cooking observation with COOK I on 4/23/25 at 9:17 a.m., COOK I was making regular mechanically mashed sweet potatoes for lunch and after making it, COOK I then kept it in the oven, heated at 350 degrees Fahrenheit (F, temperature scale) to above 400 degrees F. During the pureed making observation with COOK I on 4/23/25 at 9:25 a.m., COOK I was pureeing vegetables, zucchini and carrots. After pureeing the vegetables, COOK I then placed them in the oven, heated at 350 degrees F to above 400 degrees F. During another pureed making observation with COOK I on 4/23/25 at 9:38 a.m., COOK I was making pureed oven barbecue roast beef and after pureeing it, he set it aside in the oven, heated at 350 degrees F to above 400 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the concurrent observation and interview with COOK I on 4/23/25 at 10:00 a.m., COOK I showed me the regular oven barbecue roast beef that was placed in the heated oven already. COOK I verified that it was placed in the oven at 9:15 a.m. today and the oven was heated at 150 degrees F. During another concurrent observation and interview with COOK I on 4/23/25 at 10:02 a.m., COOK I showed me the pureed mashed sweet potatoes that were already placed in the heated oven. COOK I verified that the pureed mashed sweet potatoes were placed in the oven at 9:00 a.m., and the oven was heated at 350 degrees F to above 400 degrees F. During the trayline preparation observation with COOK I on 4/23/25 at 12:00 p.m., COOK I started preparing for the trayline by checking the temperature of the foods that he cooked and prepared earlier, before filling out each resident meal trays based on their respective menus. During the interview with COOK I on 4/23/25 at 12:50 p.m., COOK I acknowledged that foods should be cooked and pureed near the tray line preparation, to preserve the taste and food nutrients. During an interview with RD on 4/23/25 at 4:07 p.m., RD verified that foods should be prepared near the tray line preparation to keep the food palatability and food nutrients as well. Review of the facility's policy and procedure titled, Food Preparation, dated 2023 indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance . Hold foods prior to service for as short a time as practical. A maximum 1-hour holding time is recommended .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44185 Based on observation, interview, and record review, the facility failed to ensure food items were stored and prepared in accordance with professional standards for food safety when: 1. There were unsanitary cooking equipment in the kitchen; 2. A bucket of corrosive chemical was kept beside the food utensils; 3. Ice scoop for the ice machine was placed in the area near the ice machine that was accessible to everyone; and 4. Kitchen staff was not observing hand hygiene and sanitation during the tray line preparation. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the forty-nine residents who received foods from the facility kitchen. Findings: 1. During the initial kitchen tour observation with cook I (COOK I), on 4/21/25 at 8:46 a.m., observed 3 large pans with brownish to blackish discolorations and rusty spots in them. During the interview with COOK I on 4/21/25 at 8:47 a.m., COOK I acknowledged that the 3 large pans had brownish to blackish discolorations and rusty spots and would have them replaced. During the initial kitchen tour observation with COOK I on 4/21/25 at 8:50 a.m., there were also 9 cooking pans that had brownish to blackish discolorations and rusty spots. During the interview with COOK I on 4/21/25 at 8:51 a.m., COOK I verified that the 9 large cooking pans had brownish to blackish discolorations and rusty spots as well and would have them replaced also. Review of the facility's policy and procedure titled, Kitchen Equipment and Sanitation, dated 2023 indicated, All equipment shall be maintained as necessary and kept in working order All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, crackers and chipped areas. 2. During the initial kitchen tour observation with COOK I on 4/21/25 at 8:48 a.m., there was a bucket of corrosive chemical that was stored beside the paper plates, plastic knives, forks and cups. During the interview with COOK I on 4/21/25 at 8:49 a.m., he acknowledged that the bucket of corrosive chemical should not be kept there and removed it right away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy and procedures titled, Poisonous and Toxic Materials, indicated, Poisonous and toxic materials shall be stored in areas away from the food service area Poisonous and toxic materials will be stored in a place outside the food storage and preparation area 3. During the concurrent observation of the ice machine and interview with COOK I on 4/21/25 at 11:17 a.m., observed that the ice scoop for the ice machine was placed beside the ice machine and was accessible to everyone in the facility and anybody could touch and contaminate it. COOK I verified that the ice scoop for the ice machine should not be placed there for infection control. During the interview with the maintenance director (MD) on 4/22/25 at 9:30 a.m., MD verified that the ice scoop for the ice machine should not be placed there because anyone could touch it and for infection control and would remove it there. Review of the facility's undated policy and procedure titled Ice Machines and Ice Storage Chests, indicated, Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice Keep the ice scoop/bin in a covered container when not in use 4. During the tray line preparation observation on 4/23/25 at 12:15 p.m., dietary aide J (DA J) helped in filling out one of the tray carts with the resident meal trays. After one of the tray carts was done and ready for distribution, she pushed it outside of the kitchen, opening the kitchen door with her gloved hand. After, DA J went back inside the kitchen to continue helping with the tray line preparation without removing her gloves, washing hands and putting on new gloves. During the interview with DA J on 4/23/25 at 12:17 p.m., DA J verified that she should have removed her gloves, washed her hands and put on new gloves, before she continued helping with the tray line preparation, when she went out of the kitchen to put the meal tray cart that was ready for distribution and then came back to the kitchen right after. During the interview with the director of staff development (DSD) on 4/28/25 at 11:00 a.m., DSD verified that if the kitchen staff went out of the kitchen and then came back after, that kitchen staff should remove her gloves, do hand hygiene and put on new gloves before continuing with her kitchen task. Review of the undated facility's policy and procedure titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, indicated, Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness . Employees must wash their hands . whenever entering or re-entering the kitchen . During the interview with the registered dietitian (RD) on 4/23/25 at 4:07 p.m., RD verified, all the above findings. RD further verified that she would follow up on all those concerns and would talk to the kitchen staffs as well about these concerns.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure the license of the administrator (ADM) was current when the ADM was working as the facility's administrator without supervision after his license was expired more than 10 days. This failure violated the state licensure requirements for nursing home administrator (NHA). Findings: Review of the ADM's NHA license indicated his license expired on [DATE]. Review of the ADM's proof of renewal indicated he wrote the check for his renewal application on [DATE]. During an interview with the ADM on [DATE], at 5:25 p.m., he confirmed that his NHA license expired on [DATE]. During observations from [DATE] to [DATE], the ADM was working as the facility's administrator without supervision by a licensed NHA. Review of the facility's job description and performance standards, Administrator, dated [DATE], indicated one of the required qualifications was to possess a current unencumbered license as NHA with the State of California. Review of the Health and Safety Code section 1416.42 indicated (b) To renew an unexpired license the licensee shall, at least 30 days prior to the expiration of the license, submit an application for renewal on a form provided by the program, accompanied by the renewal fee . (d) . The reinstatement shall be effective on the date that the completed application, including required fees, is submitted and approved. Review of the Health and Safety Code section 1416.45 indicated A licensee may not engage in licensed activity while his or her license is suspended or revoked, or after it has expired. Review of the Health and Safety Code section 1416.6 indicated (a) It shall be a misdemeanor for any person to act or serve in the capacity of a nursing home administrator, unless he or she is the holder of an active nursing home administrator's license issued in accordance with this chapter . (b) . (3) No person shall act as an administrator for more than 10 days unless arrangements have been made for part-time supervision of his or her activities by a nursing home administrator who holds a license or provisional license under this chapter. Supervision shall include at least 8 hours per week of direct onsite supervision by the licensed administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Certified Nursing Assistant G (CNA G) did not sanitized her hands before feeding Resident 3; 2. Certified Nursing Assistant H (CNA H) grabbed the door knob of Resident 24's room, the curtain, Resident 24's glass with her contaminated gloved hands, walked out of Resident 24's room and in the hallway with the same contaminated gloves on her hands; 3. Resident 34's oxygen tubing was not dated; 4. The filter of Resident 99's oxygen concentrator was dusty; 5. Face mask below the nose for certified nursing assistant A (CNA A); 6. Resident's ADL (active daily living) care supplies for not labeled; 7. No receptacle in room with enhanced barrier precautions (EBP, an infection control strategy that expands the use of personal protective equipment [PPE, specifically gowns and gloves] for residents with high risk for infection and in high contact). These failures had the potential to spread infection to resident and staff. Findings: 1. During an observation on 4/21/25, at 12:59 p.m., certified nursing assistant G (CNA G) sanitized her hands and brought the lunch tray to Resident 3 in her room. CNA G pulled the chair from the side wall to Resident 3's bed side, picked up the bed remote control and raised Resident 3's head of bed up, opened Resident 3's drawer to get a straw, then sat down and fed Resident 3 her lunch without sanitizing her hands. During a concurrent interview with CNA G, she stated she should sanitize her hands before feeding Resident 3. During an interview with the infection preventionist (IP) on 4/28/25, at 11:04 a.m., she stated staff should sanitize their hands before feeding the residents. 2. During an observation on 4/21/25, at 9:58 a.m., certified nursing assistant H (CNA H) was helping Resident 24 in her room. CNA H carried Resident 24's soiled linen with her gloved hands and threw them in the big bin in front of Resident 24's room. With the same gloves on her hands, CNA H grabbed the door knob to close the door, but the door opened itself; CNA H walked back to Resident 24, pulled and pushed Resident 24's curtain, picked up Resident 24's glass to get water for her in the bathroom, walked out of Resident 24's room, and pushed the big bin in the hallway with the contaminated gloves on her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with CNA H and with the Spanish translator K (STL K), CNA H stated she should remove her contaminated gloves and cleanse her hands before touching clean objects and before walking out of Resident 24's room and in the hallway. During an interview with the IP on 4/28/25, at 11:10 a.m., she stated the staff should remove their contaminated gloves and cleanse their hands before touching clean objects and before walking out of the resident's room and in the hallway. Review of the facility's undated policy, Handwashing/Hand Hygiene, indicated . 1. Hand hygiene is indicated: . d. After touching a resident; e. After touching the resident's environment. Review of the facility's undated policy, Personal Protective Equipment - Gloves, indicated . 2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. 3. Review of Resident 34's Admission Record indicated he was admitted to the facility on [DATE] with chronic obstructive pulmonary disease (COPD, a lung disease causing restricted airflow and breathing problems) diagnosis. Review of Resident 34' physician order, dated 3/7/25, indicated he had an order for the licensed nurse to place him on oxygen at 2 liters (L, a metric unit of volume) per minute (LPM) every shift related to COPD. During an observation and interview with licensed vocational nurse F (LVN F) on 4/21/25, at 9:44 a.m., Resident 34 was sitting in the lobby and was on oxygen. His oxygen tubing was undated. LVN F stated Resident 34's oxygen tubing should be dated. During an interview with the IP on 4/28/25, at 11:07 a.m., she stated the resident's oxygen tubing should be dated and changed every week. Review of the facility's undated policy, Oxygen Treatment, indicated . 8. Label oxygen tubing with date. 4. Review of Resident 99's Admission Record indicated she was admitted to the facility on [DATE] with COPD diagnosis. Review of Resident 99' physician order, dated 4/11/25, indicated she had an order for the licensed nurse to place her on oxygen at 2 LPM every shift for shortness of breath, chest pain. During an observation and interview with licensed vocational nurse F (LVN F) on 4/21/25, at 9:50 a.m., Resident 99 was lying in bed and was on oxygen. The filter of Resident 99's oxygen concentrator was dusty. LVN F confirmed that the filter was dusty, and it should be cleansed every week. During an interview with the IP on 4/28/25, at 11:08 a.m., she stated the filter of the oxygen concentrator should be kept clean, and she would check on how often it should be cleansed. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated policy, Oxygen Concentrator, indicated It is the policy of this facility to inspect all mobile equipment at least once a week . 3. Check and clean filters or replace if required. 46552 5. During concurrent observation and interview with CNA A on 4/21/2025 at 9:22 a.m., noted CNA A's surgical face mask below nose while CNA A walking in hallway near residents' room [ROOM NUMBER]. CNA A confirmed face mask was not covered CNA A's nose. CNA A adjusted mask to cover the nose. CNA A stated facial mask should have covered mouth and nose for infection control. During an interview with facility's infection preventionist (IP) on 4/25/2025 at 9:11 a.m., IP stated staff's face mask should have covered nose for infection prevention and control. 6. During initial room rounds on 4/21/2025 at 9:45 a.m., noted one empty unlabeled plastic wash basin (a lightweight container used for personal care for residents) and one unlabeled emesis basin (a small shallow kidney [bean shape body organ] shape basin, used for residents) with toothpaste and a toothbrush inside. Both items were left on counter near sink in bathroom between residents' rooms [ROOM NUMBERS]. During an interview with CNA C on 4/21/2025 at 9:50 a.m., CNA C confirmed wash basin and emesis basin were not labeled with resident's name. CNA C also confirmed both items were in use by resident from room [ROOM NUMBER] or 112. CNA C stated bathroom been shared between 2 residents from room [ROOM NUMBER] and 112, without resident's name, risk for using these items for unassigned resident. CNA C stated nursing staff should have labeled these care items with resident's name before started using for resident for infection control. During an interview with IP on 4/25/2025 at 10:25 a.m., IP stated nursing staff should have labeled all resident's ADL care items to prevent use by unassigned residents and infection prevention and control. 7. During initial room rounds on 4/21/2025 at 9:55 a.m., noted EBP sign posted outside residents' room [ROOM NUMBER]. Review of this sign indicated everyone must wear gloves and gown (PPE). Further observation indicated there was no closed lid receptacle inside the room to discard used PPE before leaving the room. During a concurrent observation and interview with CNA B on 4/21/2025 at 10:04 a.m., CNA B confirmed sign for EBP, everyone must wear required PPE. CNA B also confirmed there was no receptacle inside the room to discard used PPE before coming out of this room. CNA B stated there should be a separate closed lid receptacle inside the room for to discard PPE in after use. During an interview with IP on 4/25/2025 at 9:15 a.m., IP confirmed residents'room [ROOM NUMBER] with EBP, everyone must wear required PPE before entering to room. IP stated resident's room with EBP should have a closed lid receptacle to discard PPE after use, before coming out of the room. IP also stated responsible to make sure appropriate receptacle in room with EBP for infection prevention and control. IP further stated she should have verified and placed a closed lid receptacle when started EBP for residents' room [ROOM NUMBER]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056026	A. Building B. Wing	04/28/2025

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Empress Care Center, LLC	1299 S. Bascom Avenue San Jose, CA 95128

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy and procedure (P&P) titled, Personal Protective Equipment- Using Face Masks, undated, the P&P indicated, Be sure that face mask covers the nose and mouth ., Place mask over the nose and mouth. Review of facility's policy and procedure (P&P) titled, Policy and Procedure on Cleaning and/or Disposal of ADL Supplies, undated, the P&P indicated, Bedpans, urinals, basins-disposable: The nurse shall label each item with the resident's initials or room number when dispensed. Review of facility's policy and procedure (P&P) titled, Personal Protective Equipment- Gloves, undated, the P&P indicated, Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. Review of facility's policy and procedure (P&P) titled, Personal Protective Equipment- Using Gowns, undated, the P&P indicated, After completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 46552 Based on observation, interview, and record review, the facility failed to ensure dryer's lint filter was free from lint. This failure had the potential to adversely affect safety of residents, laundry equipment and facility environment. Findings: During a concurrent observation of laundry room and interview with housekeeping/laundry staff E (HLS E) on 4/25/2025 at 8:27 a.m., noted 2 dryers were on drying clothes. Also noted both machines lint (composed of tiny fibers that detach from clothing during drying process) filters covered with thick white layer of lint. HLS E removed lint from both filters. HLS E confirmed both dryer lint filters covered with thick layer of white lint. HLS E stated forgot to check and clean the lint from both dryer's filters since morning. HLS E also stated should have checked and cleaned lint from both lint filters before started the dryers this morning. During an interview with facility's housekeeping/laundry supervisor (HLS) on 4/25/2025 at 8:42 a.m., HLS stated laundry staff should have checked and cleaned lint from lint filters for both dryers before started using dryers this morning. HLS also stated if lint filters not cleaned, dryers get too hot, risk for fire hazard. Review of facility's policy and procedure (P&P) titled, Laundry Policies & Procedure, undated, the P&P indicated, Clean lint filters after each use of washer or dryer or at least daily.