

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Pacific Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 370 Noble Court Morgan Hill, CA 95037	
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 - Many	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 store, prepare, and serve food in accordance with professional standards for food service safety when: 1. Staff incorrectly tested the Quaternary sanitizer solution; and, 2. Staff performed incorrect thermometer calibration. These failures had the potential to negatively impact the nutrition and health status of the facility's 95 residents. Findings: 1. During a concurrent observation and interview on 12/4/25, at 9:30 a.m., with Dietary Aide (DA) K, in the kitchen, DA K demonstrated testing of the strength of the quaternary (chemicals used in cleaners because of their antiviral and antibacterial properties) sanitizing solution in the red bucket by immersing a chemistry test strip into a red bucket filled with the sanitizing solution, for about 5 seconds. When DA K was asked how long the test strip should stay in the solution to test the strength, DA K stated, A few seconds. DA K compared the test strip to the color-coded graph on the chemistry test strip container (measures the concentration of sanitizer in solution), and stated, It's zero but should be 150. The color of the chem strip indicated zero PPM (parts per million) when compared to the graph on the container. During a concurrent observation and interview on 12/4/25, at 10:15 a.m., DA L filled another red bucket with sanitizing solution located in the kitchen. DA L proceeded to use a different chem strip to test the solution, and DA L stated, It's between 150-200. DA L stated DA K used the wrong test strips to test the sanitizing solution in the red bucket. During an interview on 12/4/25 at 10:18 a.m. with the Registered Dietitian (RD), The RD stated DA K received an in-service on sanitizer testing upon hiring one month ago and should know the proper technique and equipment to use when testing the sanitizer used in the kitchen. A review of the manufacturer's guidance indicated when using the quaternary test strips to check the concentration, typically 150-400 ppm for food safety, dipping times should be 10 seconds followed by immediate color matching to the chart. A review of the facility's Policy and Procedure (P&P) titled, Sanitization, revised November 2022, indicated, The food service area is maintained in a clean and sanitary manner. 9. Service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration. A review of the facility's P&P titled, Food Preparation and Service, revised November 2022, indicated, Food Preparation Area. 4. Appropriate measures are used to prevent cross-contamination. These include: . c. sanitizing towels and cloths used for wiping surfaces in containers filled with approved sanitizing solution (at concentrations specified by the manufacturer of the solution used). 2. During an observation 12/5/20 at 10:20 a.m., [NAME] (CK) M demonstrated thermometer calibration. CK M took a medium sized clear plastic cup and filled it with ice and water, then placed four thermometers inside the cup with the tips of the thermometers visibly touching the bottom of the cup and two thermometers resting along the side of the cup. CK M then proceeded to check the thermometer temperature readings. During an interview on 12/4/25 at 10:25 a.m. with the RD, the RD stated, She should know, she's the cook. And proceeded to conduct an on the spot in-service with CK M regarding thermometer calibration. Review of the USDA recommendation for thermometer calibration dated March 2025 indicated, Ice Water Method: Prepare: Fill a glass with crushed ice and cold water. 2. Immerse: Place the thermometer stem at least 2 inches deep, ensuring it doesn't touch the bottom or sides. Review of the facility's P&P titled, Food Preparation Service, (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 - Many	revised November 2022, indicated, .5. Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their policy and procedures (P&P) for advance directives (AD: a written instruction, such as a living will or durable power of attorney [a document that authorizes to act on behalf of resident] for healthcare when the individual is incapacitated) and physician orders for life-sustaining treatment (POLST: a document that specifies the medical treatments the resident wants to receive during serious illness) were followed for five of nine sample residents (Residents 1, 23, 123, 57, and 97) when there was lack of evidence advance directives were discussed and/or carried out with them. These failures could lead to the delivery of medical services against residents' goals and wishes. Findings: Review of Resident 1's admission Record (summary page of a patient's important information) indicated Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's clinical record indicated there was no advance directive. Review of the social services notes indicated there was no documentation that the facility verified, offered, assisted, or obtained an advance directive for Resident 1. Review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST, a legal document stating the kinds of medical treatment patients want toward the end of their lives) form dated 10/27/25 indicated, section D, No Advance Directive was selected. Review of Resident 23's admission Record indicated Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's clinical record indicated there was no advance directive. Review of the social services notes indicated there was no documentation that the facility verified, offered, assisted, or obtained an advance directive for Resident 23. Review of Resident 23's POLST form dated 9/18/25 indicated, section D, No Advance Directive was selected. Review of Resident 123's admission Record indicated Resident 123's initial admission to the facility was on 12/6/22 and re-admitted to the facility on [DATE]. Review of the social services notes indicated there was no documentation that the facility verified, offered, assisted, or obtained an advance directive for Resident 123. Review of Resident 123's POLST form dated 12/6/22 indicated, section D, No Advance Directive was selected. During a concurrent interview and record review of the POLST forms for Residents 1, 23, and 123 with the Social Service Director (SSD) on 12/4/25 at 12:36 p.m., the SSD confirmed there was no documentation of advance directives for the above three residents. The SSD stated she should have verified, offered, assisted, or obtained an advance directive for the residents. During an interview with the Director of Nursing (DON) on 12/5/25 at 10:11 a.m., the DON stated the SSD should have verified and assisted residents with obtaining an advance directive. The DON also stated the SSD should have documented the efforts to obtain an advance directive during resident assessments, upon admission, and as needed. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 57's clinical record were as follows: The face sheet (FS: a document that gives a resident's information at a quick [NAME]) indicated Resident 57 was admitted to facility on 4/2/2025. The POLST form, dated 4/12/2024, had a section D for advance directive that indicated, Advance Directive not available. There was no documented evidence the facility offered and assisted to execute an advance directive for this resident. Review of Resident 97's clinical record were as follows: The FS indicated Resident 97 was admitted to facility on 10/18/2017. The POLST form, dated 12/21/202, had a section D for advance directive that indicated, No Advance Directive. There was no documented evidence the facility offered and assisted to execute an advance directive for this resident. During an interview with facility's social service director (SSD) on 12/4/2025 at 12:36 pm., SSD confirmed there was no advance directives for Resident 57. SSD stated social service department did not offer and assist to execute advance directives for this resident, and should have. During an interview with facility's director of nursing (DON) on 12/5/2025 at 11:58 a.m., DON confirmed POLST form section D indicated there was no advance directives for Resident 97. DON further stated SSD should have offered and assisted to execute advance directives for Resident 57. Review of facility's policy and procedure (P&P) titled, Advance Directives, revised September 2022, indicated, If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Review of facility's P&P titled, Code Status, Advance Directives, and POLST, undated, indicated, Upon admission, the facility will ask whether an Advance Directive exists and provide information regarding the residents' right to make such decisions. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy review, the facility failed to ensure medications were stored and labeled appropriately when medications were found past their discard date in Station 3 and Station 4 medication carts. This failure resulted in expired medications being administered to the residents. Findings: 1. On 12/1/25, at 11:05 a.m., during an observation of Station 3 medication cart with licensed vocational nurse F (LVN F), one Artificial Tears (eye drops used to lubricate dry eyes) bottle for the resident in room [ROOM NUMBER]B was labeled as opened on 9/25/25 and one Refresh Tears (lubricant eye drops) bottle for the resident in room [ROOM NUMBER]A was labeled opened on 10/16/25 were found in active use areas within the medication cart. 2. On 12/1/25, at 11:20 a.m., during an observation of Station 4 medication cart with licensed vocational nurse E (LVN E), the following were found: a. One bottle of latanoprost 0.005% (used to lower high pressure inside the eye) for Resident 61 labeled discard on 11/9/25. b. One bottle of latanoprost 0.005% for Resident 97 labeled discard after 11/3/25. c. One bottle of olopatadine Hcl 0.2% (used to treat allergies in the eyes and nose) for Resident 83 labeled discard on 11/30/25. d. One Artificial Tears bottle for the resident in room [ROOM NUMBER]A labeled discard on 10/25/25. e. One Artificial Tears bottle for the resident in room [ROOM NUMBER]A had no open date. f. One Refresh Tears bottle for the resident in room [ROOM NUMBER]C labeled open on 9/15/25. g. One Refresh Tears bottle for the resident in room [ROOM NUMBER]A labeled open on 9/28/25. h. One Systane Zaditor (used to relieve itchy allergy eyes) bottle labeled open on 10/21/25 and had no resident name or room number on it. During a concurrent interview with LVN E, she stated eye drop medication should be labeled with resident name, room number, open date and should be discarded 30 days after it was opened. Review of the facility's policy, Medication Labeling and Storage, dated 2/2023, indicated . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain informed consent (IC: written permission before implementing a healthcare intervention) prior to administering an increased dose of anti-psychotropic medication (medication capable of affecting the mind, emotions, and behavior) for one of three sampled residents (Resident 57). This failure resulted in the sampled resident receiving psychotropic medication without being informed about the risks and benefits of an increased dose. Findings: Review of Resident 57's clinical record yielded the following: The face sheet (FS, a document that gives resident's information at a quick glance) indicated Resident 57 was admitted to facility on 4/2/2025 with diagnoses including psychosis (a mental disorder with disorganized thinking, speech, and behavior). The FS also indicated Resident 57 had an assigned responsible party (RP, a person designated to make health care and treatment decisions on behalf of the resident). Review of Resident 57's IC for quetiapine indicated 25 MG two times a day, dated 4/2/2025. The order summary for discontinued medication orders indicated quetiapine 25 MG twice a day dated 4/2/2025. The order summary report indicated Resident 57 had an order for quetiapine (anti-psychotropic medication, used to treat mental health conditions with behavior concerns) 25 MG (milligrams, a unit of mass equal to one thousandth of a gram) every day and 50 MG in the evening for psychosis, dated 5/21/2025. The electronic medication administration record (EMAR, digital system for documenting medication administration) for October/2025, November 2025, and December 2025 indicated Resident 57 received quetiapine 25 MG at 0900 and 50 MG at 1700 every day. During an interview with Resident 57's RP over the telephone on 12/2/2025 at 2:28 pm., RP stated she was not aware of the quetiapine dose increase for Resident 57. RP also stated facility did not inform increased medication dose, risks versus benefits with increased dose and did not give informed consent (IC) for increased medication dose for Resident 57. During an interview with facility's director of nursing (DON) on 12/5/2025 at 12:14 p.m., DON confirmed Resident 57 currently receiving quetiapine 25 MG once a day and 50 MG every evening. DON also confirmed IC for 25 MG two times a day. DON stated Resident 57's medication order for quetiapine had been increased 25 MG more for every evening on 5/21/2025. DON also stated when dose increased, nursing staff did not inform RP of it, nor the risks and benefits of this increased dose. DON further stated nursing staff should have informed the RP and received the IC before administering the medication. Review of facility's policy and procedures (P&P) titled, Psychotropic Medication Use, undated, it indicated, Prior to initiating or increasing a psychotropic medication, the resident, family and /or resident representative must be informed of the benefits, risks, and alternatives for the medication .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure Residents were free from unnecessary psychotropic medications (medications capable of affecting the minds, emotions, and behaviors) for one of three sampled residents (Resident 35) when there was no documented evidence of non-pharmacological (treatments and strategies that manage health conditions without using medications) approaches attempted before psychotropic medications (used to treat mental health condition) were administered for Resident 35. This failure had the potential for sampled resident 35 to receive unnecessary psychotropic medications. Findings: Review of Resident 35's face sheet (FS: a document that gives a resident's information at a glance) indicated Resident 35 was admitted to facility on 12/17/2024. Review of Resident 35's diagnoses included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest with daily living) and anxiety (a mental health condition of excessive, persistent and uncontrollable worry of day to day situations). Review of Resident 35's order summary report indicated an order for lorazepam (a psychotropic medication to treat anxiety) 81 MG (milligrams, a unit of mass or weight, equal to one thousandth of a gram) two times a day for anxiety, dated 11/11/2025 and sertraline (a psychotropic medication to treat depression) 100 MG one time a day for depression, dated 10/23/2025. Review of Resident 35's electronic medication administration record (EMAR, a digital system used in healthcare setting to track and document the administration of medications to residents) for November 2025 and December 2025 indicated no documented evidence of non-pharmacological approaches attempted before lorazepam and sertraline administered for Resident 35. During a concurrent record review and interview with director of nursing (DON) on 12/5/2025 at 12:14 p.m., DON reviewed physician orders for lorazepam, sertraline and EMAR for Resident 35. DON confirmed there was no documented evidence of attempted non-drug approaches before administered above both psychotropic medications to Resident 35. DON also confirmed there was no contraindication for above resident to attempt non-drug approaches. DON stated license staff should have attempted non-drug approaches before both psychotropic medications were administered to minimize the need and allow the lowest possible dose for these two medications to Resident 35. Review of facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated, indicated, Non-pharmacological approaches will be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to ensure to complete significant change in status assessment (SCSA: a comprehensive assessment after a major change in improvement or decline in resident's health condition using minimum data set tool [MDS: resident assessment tool]) within 14 days after discontinued hospice care (a specialized support system, focusing on resident's comfort, quality of life and dignity than cure for residents with serious illnesses with prognosis of six months or less) for one of three sample resident (Resident 57). This failure had the potential for putting into effect inappropriate plans of care for Resident 57. Findings: Review of Resident 57's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 57 was admitted to facility on 4/2/2025. Review of Resident 57's physician orders indicated hospice care was discontinued on 11/18/2025. Review of Resident 57's nurse practitioner's (NP: a registered nurse with advance education and training allowing to provide a wide range of healthcare services, including diagnosing and treating illnesses) notes dated 11/18/2025 indicated Resident 57 graduated from hospice. Review of Resident 57's MDS assessments indicated there was no documented evidence of SCSA assessment completed within 14 days after Resident 57 graduated from hospice care on 11/18/2025. During a concurrent record review of physician orders and MDS assessments for Resident 57 with facility's MDS coordinator (MDSC) on 12/4/2025 at 11:35 a.m., MDSC confirmed Resident 57 graduated from hospice, and that hospice care orders were to be discontinued on 11/18/2025. MDSC also confirmed there was no SCSA for improvement of health status completed within 14 days after discontinuation of hospice care for this resident. MDSC stated per guidelines, Resident 57 qualified for SCSA for significant improvement in health condition and was taken off from hospice care on 11/18/2025. MDSC also stated MDS staff should have completed SCSA assessment within 14 days after Resident 57 was off from hospice. Review of facility's policy and procedure (P&P) titled, Comprehensive Assessments, revised October 2023, the P&P indicated, Significant Change in Status Assessment (SCSA) - The SCSA is a comprehensive assessment for a resident that must be completed when the IDT (interdisciplinary team, group of healthcare professionals from different specialties work together for resident's plan of care) has determined that a resident meets the significant change guidelines for either major improvement or decline. Chapter 2 of the Resident Assessment Instrument (RAI [detailed guidelines for healthcare facilities on using MDS for residents to ensure quality of care]) User Manual provides detailed Guidelines for Determining a Significant Change in a Resident's Status.		

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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. Based on observation, interview, and record review, the facility failed to develop or implement comprehensive and person -centered care plans that included target symptoms, measurable objectives, and interventions for two of eight sampled residents (Resident 35 and 3) when:1.Intervention not followed for risk for fall care plan for Resident 35; and,2. No care plan developed related to use of medication quetiapine (anti-psychotropic medication, used to treat mental health conditions with behavior concerns) for Resident 3.These failures had the potential to result in not meeting sampled residents' needs and plan of care.Findings:1. During room rounds on 12/3/2025 at 2:00 p.m., observed Resident 35 was in bed, sleeping and Resident 35's bed was not placed in low position.Review of Resident 35's FS indicated resident 35 was admitted to facility on 12/17/2024.Review of Resident 35's diagnoses included alzheimer's disease (a progressive brain disorder that slowly destroy memory, thinking and carry out daily living tasks), syncope (passing out or loss of consciousness), and anxiety (a mental health condition of excessive, persistent and uncontrollable worry of day to day situations).Review of Resident 35's comprehensive care plan for at risk for falls and injuries, dated 12/18/2024 with interventions included Low Bed, dated 12/18/2024.During an interview with certified nursing assistant N (CNA N) on 12/3/2025 at 2:10 pm., CNA N confirmed bed was not in low position while Resident 35 was in bed. CNA N stated due to risk for fall and injury, Resident 35's bed should be in lowest position while in bed. CNA N also stated nursing staff should have positioned bed to lowest position for when Resident 35 in bed. CNA N adjusted Resident 35's bed to lowest position before left the room.During an interview with DON on 12/4/2025 at 10:37 a.m., DON stated nursing staff should have kept bed in low position when Resident 35 was in bed. DON also stated nursing staff should have followed the care plan intervention for low bed to prevent risk of injury from the fall for Resident 35.2. Review of Resident 3's face sheet (FS: a document that provides resident's information at a quick glance) indicated Resident 3 was admitted to facility on 10/7/2021. Review of Resident 3's diagnoses included psychosis (a mental disorder with disorganized thinking, speech, and behavior).Review of Resident 3's order summary report indicated, quetiapine 50 MG (milligrams, a unit of mass equal to one thousandth of a gram) at bed time for psychosis, dated 10/3/2025.Review of Resident 3's care plans indicated there was no documented evidence for comprehensive care plan for use of medication quetiapine.During a concurrent interview and record review with the facility's director of nursing (DON) on 12/5/2025 at 12:14 p.m., Resident 3's medication orders and care plans were reviewed with the DON, who confirmed the above findings. DON stated Resident 3 should have a care plan for use of medication quetiapine.Review of facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, revised April 2009, the P&P indicated, Care plan goals and objectives are defined as the desired outcome for a specific resident problem.Review of facility's P&P titled, Psychotropic Medication Use,, undated, the P&P indicated, In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update and revise comprehensive and individualized care plans for hospice care (a specialized support system, focusing on resident's comfort, quality of life and dignity than cure for residents with serious illnesses with prognosis of six months) after hospice care services was discontinued for one of three sample resident (Resident 57). This failure in care planning had the potential for not meeting Resident 57's needs. Findings: Review of Resident 57's face sheet (FS: a document that provides resident's information at quick glance) indicated Resident 57 was admitted to facility on 4/2/2025. Review of Resident 57's discontinued orders indicated Resident 57 was discontinued from hospice care services on 11/18/2025. Review of Resident 57's care plans indicated care plans for hospice services, self - care deficit, at risk for falls and injuries, mood problem, depression, potential for pressure ulcer development, impaired skin integrity, incontinent of bowel and bladder, actual/chronic pain related to hospice care, dated 4/17/2025, psychosocial well-being problem, on hospice, dated 6/21/2025, long term stay for custodial care/hospice, dated 5/21/2025, and altered nutrition and hydration, on hospice care, dated 4/9/2025. Review of above care plans indicated current goals and objectives related to hospice care for Resident 57. During a concurrent record review of hospice discontinuation order and care plans for Resident 57 with facility's director of nursing (DON) on 12/4/2025 at 10:42 a.m., DON confirmed above findings. DON stated nursing staff should review, update and discontinue care plans related to hospice care and services for Resident 57 when off from hospice services on 11/18/2025. DON also stated nursing staff should have reviewed, updated and discontinued care plans related to hospice care after discontinued hospice for Resident 57. Review of facility's undated policy and procedure for care planning indicated, Goals and objectives are reviewed and/ or revised . When there has been a significant change in the resident's condition.		

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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** Based on observation, interview, and record review, the facility failed to ensure the residents received the necessary care and services for two of four residents (87 and 132) when: 1. Resident 87's oxygen tubing was not changed weekly as ordered by the physician; and, 2. Licensed vocational nurse C (LVN C) and licensed vocational nurse D (LVN D) did not know Resident 132 had a pacemaker (a small, battery-operated electronic device implanted in the body to regulate heartbeats), and Resident 132's pacemaker information was not in his medical records. These failures had the potential for adverse effects on the patients' health and well-being. Findings: 1. Review of Resident 87's admission Record indicated he was admitted to the facility on [DATE] with chronic obstructive pulmonary disease (COPD, diseases that restrict the breathing) diagnosis. Review of Resident 87's physician orders, dated 11/18/25 and 10/23/25, indicated he had orders for oxygen at 2 liters (L, a metric unit of volume) per minute as needed and change his oxygen tubing every week and as needed. During an observation with licensed vocational nurse B (LVN B) on 12/1/25, at 10:49 a.m., Resident 87's oxygen tubing had a label dated 11/16/25. Review of the facility's undated policy, Verbal Orders, indicated . 6. Follow through with orders by making appropriate contact or notification . 2. Review of Resident 132's admission Record indicated he was admitted to the facility on [DATE] with presence of cardiac pacemaker diagnosis. Review of Resident 132's physician order, dated 11/29/25, indicated he had an order for the license nurse to monitor signs and symptoms of pacemaker malfunction such as change in level of consciousness, chest pain, shortness of breath, slow or fast heartrate, blood pressure changes, dizziness, prolonged hiccups, and notify the physician every shift. During an interview with LVN C on 12/4/25, at 1:33 p.m., he stated Resident 132 had a Continuous Glucose Monitor (CGM, a wearable device that tracks a person's sugar levels every few minutes) on his arm, and that's all. Resident 132 did not have any other device. During an interview with LVN D on 12/4/25, at 4:33 p.m., he stated Resident 132 had a CGM on his arm, and he did not recall that Resident 132 had any other device. Review of Resident 132's medical records indicated a lack of his pacemaker information, other than what is indicated in this write-up. During an interview with the director of nursing (DON) on 12/5/25, at 11:30 a.m., she reviewed Resident 132's clinical record and could not located his pacemaker information. The DON stated Resident 132's pacemaker information should be reported in his medical records. Review of the facility's policy, Care of a Resident with a Pacemaker, dated 12/2015, indicated . Documentation: 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and g. Paced rate.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify fall risk to prevent falls for one of five residents (87) when Resident 87's fall risk was not assessed after he fell. This failure had the potential for Resident 87's fall risk score and interventions to be inaccurate. Findings: Review of Resident 87's admission Record indicated he was admitted to the facility on [DATE] with muscle weakness diagnosis. Review of Resident 87's Fall Report of Incident and Change of Condition Fall indicated he fell on [DATE] and 11/25/25. However, there were no indications that Resident 87 was assessed for fall risk after he fell. During an interview with the director of nursing (DON) on 12/5/25 at 1 p.m., she reviewed Resident 87's clinical record and confirmed that Resident 87 was not assessed for fall risk after he fell on [DATE] and 11/25/25. The DON stated the residents should be assessed for fall risk after the fall. Review of the facility's policy, Fall Risk Assessment, dated 3/2018, indicated . the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 12% when 3 medication errors occurred out of 25 opportunities during medication administrations for two out of 10 residents (27 and 72). This failure resulted in medications to not be given in accordance with the prescriber's orders. Findings: 1. During a medication pass observation with licensed vocational nurse E (LVN E) on 12/1/25, at 12:54 p.m., LVN E stated per the physician order, Resident 27 was to receive 9 units of insulin aspart (used to control high blood sugar) before meals. LVN E drew 8 units of insulin aspart 100 units/ml, brought the syringe with 8 units of insulin aspart to Resident 27, and was about to administer this to the resident. During a concurrent observation on the syringe with insulin aspart and interview with LVN E, she confirmed that she drew 8 units of insulin aspart to give to Resident 27 and not 9 units. Review of Resident 27's physician order, dated 4/6/25, indicated Resident 27 was to receive 9 units of insulin aspart 100 units/ml before meals three times a day. 2. During a medication pass observation with licensed vocational nurse C (LVN C) on 12/3/25, at 9:58 a.m., LVN C crushed one tablet of Zinc Sulfate (used to increase the amount of zinc in the body) 220 milligrams (mg, a metric unit of mass), mixed with water, and administered to Resident 72 via his gastrostomy tube (G-tube, a tube that is inserted through the abdominal wall and into the stomach). During a medication pass observation with LVN C on 12/3/25, at 10:56 a.m., LVN C administered Artificial Tears Solution (eye drops used to lubricate dry eyes) to Resident 72, one drop in each eye. Review of Resident 72's physician orders, dated 10/14/25 and 10/16/25, indicated Resident 72 was to receive Zinc Sulfate 50 mg one time a day for supplement and two drops of Artificial Tears Solution in both eyes three times a day for dry eye. During an interview with LVN C on 12/4/25, at 11:30 a.m., he reviewed Resident 72's physician orders and confirmed that the physician ordered Zinc Sulfate 50 mg via G-tube and two drops of Artificial Tears Solution in each eye for Resident 72, but he administered Zinc Sulfate 220 mg via G-tube and one drop of Artificial Tears Solution in each eye to Resident 72. Review of the facility's policy, Administering Medications, dated 4/2019, indicated . 10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate food preferences for one of 4 sample resident (Resident 85). This failure had the potential for decreased meal intake, thus negatively affecting the health and well-being for the sampled resident. Findings: During an initial dining room observation for lunch meal on 12/1/2025 at 12:26 p.m., noted Resident 85 was received lunch meal with no cranberry juice. Review of Resident 85's face sheet (FS, document that gives resident's information at a quick [NAME]) indicated Resident 85 was admitted to facility on 12/31/2025. Review of Resident 85's lunch tray card dated 12/1/2025 indicated that, Cranberry JC (juice) mildly TH (thick, flows easily but slower than water) 1/2 C (cup). During an interview with certified nursing assistant J (CNA J) on 12/1/2025 at 12:36 p.m., CNA J confirmed Resident 85's lunch tray card indicated cranberry juice 1/2 cup; and that, Resident 85 did not receive this juice with the lunch meal. CNA J stated Resident 85 should receive cranberry juice along with lunch meal items. CNA J also stated kitchen staff should have sent this juice for Resident 85. CNA J requested dietary staff to send cranberry juice for Resident 85. During an interview with facility's registered Dietitian (RD) on 12/5/2025 at 8:50 a.m., RD stated kitchen staff should read meal tray cards with each meal and accommodate resident's food preferences. RD also stated kitchen staff should have sent cranberry juice to Resident 85 with lunch meal on 12/1/2025. RD further stated kitchen staff were educated for reading meal tray cards and accommodating food preferences as documented in the meal tray card for each resident. Review of facility's policy and procedure (P&P) titled, Food and Nutrition Services, revised October 2017, the P&P indicated, Reasonable efforts will be made to accommodate resident choices and preferences. Food preferences are implemented and included on the residents tray card for the dietary staff guidance in the resident's meal preparation.		

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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. Based on observation, interview, and record review, the facility failed to ensure food was prepared palatable (quality of taste) for one of eight sample resident (Resident 97) when food was overcooked and lacked flavor. This failure had the potential to affect meal intake and the nutritional value of the food served to Resident 97. Findings: During an interview with Resident 97 on 12/2/2025 at 11:40 a.m., Resident 97 stated vegetables always served mushy, overcooked, no flavor, and do not feel like eating vegetables with meals. Review of Resident 97's face sheet (FS: a document that gives resident's information at a quick glance) indicated, Resident 97 was admitted to facility on 10/18/2017. Review of Resident 97's order summary report indicated an order for heart healthy diet, regular texture, NAS (no added salt) dated 12/21/2022. Review of facility's lunch menu for 12/4/225 indicated, seasoned zucchini for vegetable item. During a lunch test tray and interview with facility's cook and registered dietician (RD) on 12/4/2025 at 1:12 pm., the regular texture zucchini tasted bland, and was soft and mushy. The cook tasted the regular texture zucchini from meal tray and confirmed it was oversoft, over cooked, and bland. The RD stated the zucchini was on the softer side and tasted bland. The RD also stated the cook should have cooked this vegetable with less time to prevent the softness. Review of facility's policy and procedure (P&P) titled, Food Palatability & Nutritive Value Policy, revised 2025, indicated, Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Providing meals that are varied in color and texture.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure communication with the hospice facility for one of seven residents (Resident 7) who were admitted to hospice, when a plan of care from hospice was not located. This failure had the potential to negatively affect the proper care and coordination of care of residents admitted to Hospice. Findings: During a record review of Resident 7's hospice binder located at nurse station 2, it lacked a plan of care. During an interview with the DON on 12/04/2025 at 2:44 p.m., the DON stated she was not sure about the hospice care plans for Resident 7 and stated she will check about care plans being in Resident 7's record or hospice binder. During a review of the facility's agreement with the hospice facility titled, First Amendment to Agreement for Nursing Facility, Inpatient and Inpatient Respite Services, effective 9/20/2019, indicated, . 2.1.7 Plan of Care. Per Section 2.1 of Appendix C and Section 2.2 of Appendix D of the Agreement, [the Hospice company] shall establish, modify as appropriate, and provide Facility with a copy of, a Hospice Plan of Care for each Hospice Patient admitted to Facility . Appendix C.II. [Hospice company] OBLIGATIONS. 2.1 Hospice Plan of Care. For each Residential Hospice Patient, [Hospice company] will (i) develop a Hospice Plan of Care, and (ii) furnish Facility a copy of such Residential Hospice Patient's Hospice Plan of Care at the time he/she is admitted to the Hospice or, in the case of a Hospice Patient who becomes a resident of Facility after admission to the Hospice, at the time the Hospice Patient is admitted to Facility. [Hospice company] will update each Hospice Plan of Care as required under the Conditions, and as otherwise required hereunder . Appendix D.2.2 Plan of Care: Interdisciplinary Team. For each Hospice Patient provided Inpatient and Inpatient Respite Services hereunder, [Hospice company] shall (i) establish, revise (as necessary), and provide Facility with a copy of a Plan of Care, and (ii) designate an Interdisciplinary Team.		

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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 policy review, the facility failed to implement infection control practices when:1. Certified nursing assistant I (CNA I) did not remove gloves before walking out of Resident 45's room;2. Registered nurse G (RN G) picked up the water pitcher on her medication cart with her contaminated gloved hand;3. Licensed vocational nurse H (LVN H) did not cleanse her hands and change gloves before administering eye drop to Resident 93; and,4. LVN H administered oral medications to Resident 76 with a contaminated spoon.These failures had the potential to spread infection in the facility.Findings:1. During an observation on 12/1/25, at 10:55 a.m., CNA I was helping Resident 45 in his room. Then CNA I carried a bag with soiled diaper inside with her gloved hands, walked out of Resident 45's room and in the hallway to throw the bag in the hamper.During a concurrent interview with CNA I, she stated she was changing Resident 45's brief. CNA I stated she should remove her gloves in Resident 45's room before walking out in the hallway.Review of the facility's policy, Personal Protective Equipment - Using Gloves, dated 9/2010, indicated . 2. Discard used gloves into the waste receptacle inside the examination or treatment room. 2. During a medication pass observation with RN G on 12/1/25, at 12:20 p.m., RN G sanitized her hands, put on gloves, brought Resident 117's medications to her room to administer them to her. RN G picked up Resident 117's bed remote control and raised Resident 117's head of bed up. RN G found out Resident 117 had no water. She went back to her medication cart, and with the same gloves on her hands, RN G picked up the water pitcher on her medication cart, poured water to the cup, and brought the cup of water to Resident 117.During an interview with RN G on 12/1/25, at 12:45 p.m., she acknowledged that she should remove gloves and cleanse hands before picking up the water pitcher on her medication cart. 3. During a medication pass observation with LVN H on 12/2/25, at 4:01 p.m., LVN H administered oral medications to Resident 93, then without cleansing her hands, LVN H put on gloves and administered two drops of Refresh Plus (used to relieve dry, irritated eyes) in both of Resident 93's eyes.During an interview with LVN H on 12/2/25, at 4:26 p.m., she acknowledged that she should cleanse her hands before giving eye drops to Resident 93.Review of the facility's policy, Instillation of Eye Drops, dated 1/2014, indicated . Steps in the Procedure: . 2. Wash and dry your hands thoroughly. 3. Put on gloves. 4. During a medication pass observation with LVN H on 12/2/25, at 4:39 p.m., LVN H brought Resident 76's medications and a spoon to Resident 76's room. LVN H placed the spoon on Resident 76's overbed table, then used the spoon to pick up the medications in the medication cup and put them in Resident 76's mouth.During an interview with LVN H on 12/2/25, at 4:50 p.m., she acknowledged that Resident 76's overbed table might not be clean and could contaminate the spoon.Review of the facility's policy, Administering Medications, dated 4/2019, indicated Medications are administered in a safe and timely manner, and as prescribed.		