STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056058	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almaden Health and Rehabilitation Center	2065 Los Gatos-Almaden Road San Jose, CA 95124

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37409 Based on observation, interview, and policy review, the facility failed to treat one of three sampled residents (Resident 1) with respect and dignity when certified nursing assistant A (CNA A) did not provide privacy to Resident 1 during transporting Resident 1 from her room to the shower room. This failure had the potential to cause embarrassment for the resident. Findings: During an observation on 8/14/24 at 4 p.m., CNA A transported Resident 1 in the hallway from her room to the shower room. Resident 1 was sitting on a shower chair. The front of Resident 1 was covered with a linen sheet, but her back and her buttocks were not covered and were exposed. During a concurrent interview with CNA A, she confirmed Resident 1's back and buttocks were not covered and were exposed. CNA A stated she missed the back of Resident 1's body, and she should cover Resident 1's body before transporting her in the hallway. During an interview with the director of nursing (DON), on 8/15/24 at 1:45 p.m., she stated staff should cover the resident's body before transporting the resident in the hallway. Review of the facility's undated policy, Tub Bath and Shower, indicated . General Guidelines: . 4. When transporting the resident to and from the bath area, make sure that the resident is covered and his or her privacy is maintained.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056058	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almaden Health and Rehabilitation Center	2065 Los Gatos-Almaden Road San Jose, CA 95124

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	Provide and implement an infection prevention and control program. 37409 Based on observation, interview, and policy review, the facility failed to implement infection control practices when: 1. Licensed vocational nurse B (LVN B) walked in the hallway with gloves on; 2. Housekeeper C (HKP C) wore the same gloves to wipe resident Room AA and Room BB; and 3. Certified nursing assistant D (CNA D) brought the lunch tray to Resident 2's room which was an isolation room for Coronavirus disease (COVID-19, an infectious disease caused by the SARS-CoV-2 virus which can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe) and fed her in the room wearing a surgical mask. These failures had the potential to spread infection in the facility. Findings: 1. During an observation and interview on 8/14/24 at 11:55 a.m., LVN B was walking in the hallway wearing gloves on her hands. LVN B stated she came to help a resident in her room. LVN B acknowledged that she should not wear gloves in the hallway. During an interview with the director of nursing (DON,) on 8/14/24 at 12:15 p.m., she stated staff should not wear gloves in the hallway. 2. During an observation on 8//14/24 at 12:10 p.m., HKP C finished wiping resident Room AA, threw the trash of Room AA into the trash bin on her cleansing cart, pushed the cleansing cart in the hallway to Room BB, and wiped Room BB with the same gloves on her hands. During a concurrent interview with HKP C and Spanish interpreter E (ITP E), HKP C acknowledged that she should change gloves after cleansing Room AA and before cleansing Room BB. During an interview with the DON on 8/14/24 at 12:15 p.m., she stated housekeeper should change gloves after cleansing one room and before cleansing another room. Review of the facility's undated policy, Standard Precautions, indicated . 4. Gloves: . Remove gloves promptly after use, and wash hands immediately before touching non-contaminated items and environmental surfaces, and before going to another resident. 3. During an observation on 8/14/24 at 12:35 p.m., CNA D brought a lunch tray to Resident 2's room, a COVID-19 isolation room, wearing a gown, gloves, and a surgical mask. During an interview with CNA D, on 8/14/24 at 12:50 p.m., he stated he was feeding Resident 2 in her room. CNA D acknowledged that he should wear an N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) when entering Resident 2's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056058	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almaden Health and Rehabilitation Center	2065 Los Gatos-Almaden Road San Jose, CA 95124

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	During an interview with the DON, on 8/14/24 at 1:30 p.m., she stated staff should wear N95 mask when entering COVID-19 isolation room. Review of the facility's undated policy, COVID-19 Using Personal Protective Equipment (PPE), indicated . 3. When caring for a resident with suspected or confirmed SARS-CoV-2 infection, the following infection prevention and control practices are followed: . b. Respirator: 1. An N95 respirator (or equivalent or higher-level respirator) is donned before entry into the resident room or care area .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056058	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almaden Health and Rehabilitation Center	2065 Los Gatos-Almaden Road San Jose, CA 95124

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 37409 Based on observation, interview, and facility document review, the facility failed to maintain an effective pest control to keep the facility free of cockroaches when live cockroaches were observed in Resident 4's room even though the room was inspected and treated for roaches. This failure had the potential to result in pest transferred disease to residents. Findings: During an interview with Resident 3, on 8/14/24 at 2:40 p.m., she stated about two weeks ago she saw a cockroach on her lunch tray. Review of the facility's Crossfire Pest Rodents and Termites Report indicated Resident 4's room was inspected and treated for cockroach and rodent on 5/31/24. However, on 6/10/24, the facility's Maintenance Work Request indicated pest control spray was requested for Resident 4's room because cockroaches were seen crawling on Resident 4's bed side rails and closet. It also indicated the request was completed on 6/12/24. Review of the facility's Ecolab Customer Services Report indicated Resident 4's room was treated for cockroaches again on 7/2/24. During an observation and interview with Resident 4 in his room, on 8/14/24 at 4:05 p.m., he stated there were many cockroaches in his room; they crawled under his bed and on his bed side rails. Resident 4 stated he told everyone about that; they sprayed, but there were still cockroaches. So, he bought the cockroach trap and placed it in his room. A cockroach trap was observed on the floor, beneath the curtain, and against the wall. Resident 4 stated he placed the trap there two weeks ago. The trap had five dead cockroaches on it. When Resident 4 pulled the basket on the floor toward him, there were five live cockroaches crawling out from underneath the bottom of the basket. During an observation and interview with the maintenance director (MD) in Resident 4's room, on 8/15/24 at 12 p.m., he confirmed there were five dead cockroaches on the trap and acknowledged that five live cockroaches were seen in Resident 4's room yesterday. Review of the facility's Maintenance Work Request, dated 8/13/24, indicated registered nurse F (RN F) reported cockroaches in Resident 5's room. During an interview with RN F, on 8/15/24 at 12:05 p.m., she stated on 8/13/24, a CNA in day shift reported to her that she and Resident 5 saw cockroaches in his room, so she submitted the Maintenance Work Request. During an interview with the MD, on 8/15/24 at 12:15 p.m., he reviewed the Maintenance Work Requests for Resident 4's and Resident 5's rooms, and he confirmed that the facility's pest control was not working and not effective.