

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2026
NAME OF PROVIDER OR SUPPLIER  Almaden Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one of three sample residents (Resident 1) received medication as ordered, when two medications were not available at scheduled time, and one medication was not administered after it was delivered to the facility. Those failures had the potential to compromise Resident 1's health and well-being. A review of Resident 1's medical record indicated he was admitted to the facility on [DATE] at 11:45 p.m. with diagnoses including unspecified intracranial injury (damage to the brain resulting from external physical force, such as falls, accidents, or assaults), nontraumatic subarachnoid hemorrhage, epilepsy (seizures), and cerebral edema (dangerous, often life-threatening brain swelling caused by fluid buildup from injury, tumors, infection, or stroke). Review of Resident 1's Order Summary Report indicated he had a physician order, dated 11/29/2025, for levetiracetam (medication used to manage epilepsy by treating various types of seizures, including partial-onset, myoclonic, and generalized tonic-clonic seizures) 1000mg (does measurement) one tablet by mouth twice a day (09:00 a.m. and 08:00 p.m.) for seizure. For phenytoin (medication used to control and prevent seizure disorders, particularly tonic-clonic seizures and status epilepticus), 50mg chewable tablet, 2 tablets by mouth three times a day. For trazodone (medication used to treat insomnia and, less frequently, anxiety or depression) 75mg, 0.5 tablet, by mouth at bedtime (9:00 p.m.) for insomnia related to depression. A review of Resident 1's Medication Administration Record (MAR), dated 11/29/2025, indicated that the resident did not receive levetiracetam 1000 mg at 8:00 p.m., phenytoin 50 mg at 8:00 p.m., and trazodone 75 mg at 9:00 p.m. There was no documentation indicating the reason these medications were not administered. A review of the pharmacy's electronic medication shipping manifest indicated that levetiracetam 1000 mg and trazodone 75 mg were delivered to the facility on [DATE] at 1:04 a.m., and the phenytoin 50 mg chewable tablets were delivered on 11/29/2025 at 5:48 p.m. The phenytoin was received by LVN A.1. During a concurrent interview and record review with the Director of Nursing (DON) on 3/20/2026 at 1:59 p.m., the DON confirmed that LVN A did not administer the above three night medications at their scheduled times on 11/29/2025, and there was no documentation indicating the reason they were not administered. During a phone interview with Licensed Vocational Nurse (LVN) A on 3/23/2026 at 4:40 p.m., LVN A stated that Resident 1 was admitted on [DATE] and had not received her medications by bedtime. As a result, three medications: phenytoin, trazodone, and levetiracetam were not administered. LVN A further stated that due to an update in the facility's medication administration system, she did not know how to enter notes in the system, and she acknowledged that she should have documented the information. During a phone interview with the Pharmacy Manager (PM) on 3/25/2026 at 2:09 p.m., the PM stated that there are three standard medication delivery times: 5:00 a.m., 1:00 p.m., and 9:00 p.m. Resident 1's medication orders were received on 11/29/2025 at 12:48 p.m., which was too late to meet the 1:00 p.m. delivery. Therefore, the medications were scheduled for the 9:00 p.m., and delivered to the facility on [DATE] at 1:04 a.m. The STAT (immediate) order for phenytoin was delivered to the facility on [DATE] at 5:48 p.m. The PM further stated that the facility could request all medications as STAT orders; however, only one (continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medication was ordered as STAT. During a phone interview with the Nursing Supervisor (NS) on 3/26/2026 at 12:47 p.m., the NS confirmed that he admitted Resident 1 on 11/29/2025 and sent the resident's medication orders to the pharmacy. He stated that he was aware of the pharmacy's 1:00 p.m. delivery time and assumed the medications would be delivered by bedtime; therefore, he ordered only phenytoin as a STAT order.2. During a phone interview with the Director of Nursing (DON) on 3/26/2026 at 3:14 p.m., the DON reviewed the pharmacy's electronic medication shipping manifest and confirmed that LVN A received the phenytoin on 11/29/2025 at 5:48 p.m. The DON further stated that LVN A should have administered the medication at the scheduled time 8:00 p.m. after receiving it.A review of the facility's undated policy titled Oral Medication Administration indicated, .administer oral medication in an accurate, safe, timely, and sanitary manner.</p>