STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555068	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Blossom Care Center	1990 Fruitdale Avenue San Jose, CA 95128

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590 Based on interview and record review, the facility failed to ensure one of three residents (Resident 2) were free from unnecessary psychotropic medications (medication capable of affecting the mind, emotions, and behavior) when Resident 2 received quetiapine fumarate (Seroquel, an antipsychotic medication used to treat certain mental/mood conditions) without adequate indication and monitoring a specific target behavior for its use. This failure could result in lack of adequate monitoring and had the potential for residents to receive unnecessary medications. Findings: Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (loss of thinking, remembering, and reasoning skills) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; type 2 diabetes mellitus (high levels of sugar in the blood) ; essential hypertension (high blood pressure that does not have a known cause). During a review of Resident 2's Minimum Data Set (MDS, a resident clinical assessment tool) dated 6/12/24, the MDS indicated, Resident 2 had a BIMS score of 99 (Brief Interview for Mental Status, a mandatory tool used to screen and identify the cognitive condition of residents. A score of 99 indicates that a patient was unable to complete the BIMS). During a review of Resident 2's nursing telehealth evaluation dated 6/7/24 9:49 p.m., indicated Resident 2's family member (FM) was requesting Seroquel because ER (emergency room) forgot to add that medication with discharge orders. During a review of Resident 2's physician order dated 6/7/24, it was indicated a new order for Seroquel 25 mg (milligram, unit of measurement) daily at bedtime for 3 days. The order did not have an indication for use and monitoring of side effects. During an interview on 7/26/24 at 4:12 p.m., with Licensed Vocational Nurse (LVN) B, she stated she went through the medication list with the FM and Seroquel was not in the list. LVN B stated the FM wanted Seroquel to ordered. LVN B stated she contacted the doctor and got an order for Seroquel. (continued on next page)

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
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/21/24 at 9:25 a.m., with the Pharmacy Consultant (PC), the PC stated a new admission review intermittent medication regimen review (IMRR) was done on 6/10/24. The PC stated the IMRR recommendation was to put an order to monitor target behavior and side effects. During a review of Resident 2's medication administration record (MAR) indicated Resident 2 received Seroquel on 6/8/24 and 6/9/24. There was no monitoring of target behavior and side effects on the MAR. During an interview on 9/11/24 at 4:29 p.m., with the PC, the PC stated the recommendation was to taper (gradual) antipsychotic medication. The PC stated some patients may see some rebound behaviors when stopping the antipsychotic. Review of the facility's policy, titled Antipsychotic Medication Use, undated, indicated Residents will only receive antipsychotic medications when necessary . The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, and specific symptoms. Residents who are admitted from the community or transferred from a hospital .will be evaluated for the appropriateness and indications for use. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications .

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590 Based on observation, interview, and record review, the facility failed to ensure infection prevention practices were followed for one of four residents (Resident 1) when the door of the Covid-19 isolation room was open. This failure had the potential to result in transmission and spread of Covid-19 infection. Findings: During an observation, on 8/21/24 at 3:20 p.m., the door of a Covid-19 isolation room AA was open. Review of Resident 1's clinical record indicated she was admitted on [DATE] with a diagnosis including acute pulmonary edema (fluid builds up in the lungs making it difficult to breathe), acute and chronic respiratory failure with hypoxia (a condition where not enough oxygen in the body) A condition in which the lungs have a hard time loading the blood with oxygen or removing carbon dioxide. Lungs cannot release enough oxygen into the blood). Resident 1 was covid positive on 8/21/24. During an interview on 8/21/24 at 3:27 p.m., with Licensed Vocational Nurse (LVN) A, she confirmed Resident 1 was Covid-19 positive and acknowledged that the door of the room was open. LVN A stated the door should be closed at all times. During an interview on 8/21/24 at 3:55 p.m., with the Infection Preventionist (IP), she stated the door of a covid positive room should be closed at all times to contain the infection. According to CDC's Infection Control Guidance:SARS-CoV-2/COVID-19, indicated Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed.