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	10/11/2024

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 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** 38573 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Eight plastic containers of [brand name] bleach (provide effective infection control for hard surfaces to help stop pathogen transmission) lids were not closed and were exposed in the hallways; 2. Two certified nursing assistants A and B (CNA A and CNA B) were wearing gloves in the hallway walking room to room and did not perform hand hygiene in between task; 3. One box of clean gloves and one bottle of hand sanitizer were on top of a clean movable cart and were approximately 1/2 inch from a treatment cart with attached trash bin with an open lid. 4. Three laundry hampers with three linens on top were stored outside by the facility patio; 5. A bin was over flowing with housekeeping towels outside the laundry area hallway; 6. Two empty drinking water bottles, clean rolled plastic bags, one opened gloves and hand sanitizer were all stored together in a housekeeping cart that was parked in the hallway; 7. Resident 1's nasal cannula (tubing inserted into the nostrils and attached to an oxygen tank or concentrator) was hanging and touching the wheelchair; 8. Red pushcart with used meal trays and utensils were parked underneath the water and juice dispenser in the nursing station. These failures had the potential to spread infection in the facility. Findings: 1.During an initial tour observation on 10/10/2024 at 10:57, 11, 11:02, 11:04 and 11:06 a.m., the following were observed: - Two plastic containers of [brand name] bleach were observed on top of garbage hampers. The two containers of [brand name] bleach had open lids and the contents were exposed. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two plastic containers of [brand name] bleach were observed on top of an isolation bin that were outside resident's room. The two containers of [brand name] bleach had open lids and the contents were exposed. -Four vital sign machines parked in the facility hallway contained plastic containers of [brand name] bleach. The four plastic containers of [brand name] bleach had open lids and the contents were exposed. During a concurrent observation and interview on 10/10/24 at 11:06 a.m., with the director of staff development (DSD), he confirmed the above observations and stated that the lids of the [brand name] bleach should have been closed and should not be exposed. 2. During an observation on 10/10/24 at 11:01 a.m., CNA A was wearing gloves in the hallway walking room to room with the same gloves on and did not perform hand hygiene in between task. During a concurrent observation and interview on 10/10/24 at 11:02 a.m., with CNA A, she confirmed the above observations and stated she should have not used the same gloves in the hallway going room to room. She further stated that she should have performed hand hygiene in between task to prevent the spread of infection. During a concurrent observation and interview on 10/10/24 at 11:20 a.m., with CNA B, she confirmed that she used the same gloves in the hallway coming from the room of resident's that was assigned for her and did not perform hand hygiene after discarding used gloves in the garbage can outside the resident's room. She further stated that hand hygiene was important to prevent the spread of infection. 3. During a concurrent observation and interview with licensed vocational nurse C (LVN C) on 10/10/24 at 11:05 a.m., one box of clean gloves and one bottle of hand sanitizer were on top of a clean movable cart and were approximately 1/2 inch from a treatment cart with attached trash bin with an open lid. LVN C confirmed the observation and stated the clean gloves and the bottle of hand sanitizer should not be exposed to an open trash bin containing used pair of blue gloves, papers, two empty tubes. 4. During a concurrent observation and interview with the DSD on 10/10/24 at 11:07 a.m., three laundry hampers with three linens on top were stored outside by the facility's patio. The DSD confirmed the observation and stated that hampers should have been stored in the laundry area and there should be no linens on top of the hampers to prevent the spread of infection. 5. During a concurrent observation and interview with the environmental director (ED) on 10/10/24 at 11:08 a.m., a bin was overflowing with housekeeping towels outside the laundry area hallway. The ED confirmed the observation and stated the housekeeping towels should be stored in the bin with the lid closed. 6. During a concurrent observation and interview with the DSD on 10/10/24 at 11:14 a.m., two empty drinking water bottles, clean rolled plastic bags, one opened gloves and hand sanitizer were all stored together in a housekeeping cart that was parked in the hallway. The DSD confirmed the observation and stated the empty drinking water bottles should not be stored together with the clean housekeeping items to prevent contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During a concurrent observation and interview with the DSD on 10/10/24 at 11:15 a.m., Resident 1's nasal cannula (tubing inserted into the nostrils and attached to an oxygen tank or concentrator) was hanging and touching the wheelchair. The DSD confirmed the above observation and stated the nasal cannula should not be exposed and should not be touching the wheelchair. The DSD further stated Resident 1's nasal cannula should be stored in a black mesh bag. 8. During a concurrent observation and interview with the DSD on 10/10/24 at 11:17 a.m., red push cart with used meal trays and utensils were parked underneath the water and juice dispenser in the nursing station. The DSD confirmed the observation and stated the red pushcart are used for dirty trays and resident's [NAME] after they ate and should not be parked underneath the water and juice dispenser due to infection control issue. A review of the facility's undated policy and procedure (P&P), titled Handwashing/Hand Hygiene, the P&P indicated all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand- rub (ABHR) dispensers are placed in areas of high visibility and in patient care areas. Review of the facility's undated policy and procedure, titled Personal Protective Equipment- using Gloves, indicated when gloves are indicated, use disposable single -use gloves . perform hand hygiene after removing gloves. (note: Gloves do not replace hand hygiene) . Discard used gloves into the waste receptacle inside the examination or treatment room. Review of the facility's undated policy and procedure, titled Standard Precaution, indicated keep the oxygen cannula and tubing used in a pouch when not in use.