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	03/13/2026

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

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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 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 ensure proper sanitation during storing and preparing food in accordance with professional standards for food service safety when:Three of three ice machines (one in kitchen, and two located in nursing station areas) were not clean.The strength of sanitizer used to sanitize a kitchen food preparation table was not an appropriate strength.A kitchen industrial can opener and its base were not clean.These failures had the potential to increase the risk of food contamination to the residents in the facility for 147 residents who ate food by mouth out of a facility census of 153.1. During a concurrent observation and interview on 3/10/26 at 10:03 a.m. with the Maintenance Supervisor (MS) in the kitchen, the ice machine was observed. MS stated maintenance staff cleaned the inside of the ice machine quarterly, and this ice machine in the kitchen was cleaned about three weeks ago. MS opened the ice machine so the inside components could be observed. There was black residue along the surface and corners of the cover for the water distribution tube (a component mounted on top of the evaporator plate to ensure water flows evenly over the freezing surface of the evaporator plate) located above the evaporator plate (a metal grid where water runs over and freezes to form ice cubes). On the evaporator plate frame, there was yellow residue on the surface, and it was rough to touch. By using white paper towel to wipe along the surface on the top plastic frame of evaporator plate, black residue was wiped off. MS confirmed the black residue, and he stated the ice machine was not considered clean. MS stated the yellow residue was the hard water build-up, and he had not done anything with the ice machine to address hard water build-up issue. As the observation and interview continued for the ice machine on 3/10/26 at 10:10 a.m., under the ice machine, there were three drainpipes. One of the drainpipes, which MS stated was a drain from the ice machine, had thick, dark brown residue build-up at the end of the drainpipe. Maintenance Assistant (MA) J removed the residue from the drainpipe. The residue was hard. MS stated it was likely the mineral build-up. MS stated the drainpipes were not checked the last time the ice machine was cleaned.During an interview on 3/11/26 at 2:15 p.m. with MS, MS stated he needed to pay more attention to the drainpipes under the ice machine, and clean as needed.During a concurrent observation and interview on 3/10/26 at 2:10 p.m. with MS in the pantry room at the mid-term nursing station, ice machine was observed. Ice machine dispenser had crusty, white, yellow, and pinkish residue around the chute. Using paper towel to wipe the chute, the surface was rough to touch. MS stated there used to be some sort of insulation around the chute surface. MS stated he dared not to try to remove or clean the rough surface because he was afraid it might affect the function of the ice machine. MS stated he guessed the rough residue was from the moisture of the ice machine.During a concurrent observation and interview on 3/10/26 at 2:29 p.m. with MS in the pantry room at the short-term nursing station, ice machine was observed. Ice machine dispenser also had crusty, white, yellow, and pinkish residue around the chute. Using paper towel to wipe the chute, the surface was rough to touch. Again, MS stated there used to be some sort of insulation around the chute surface. He stated it might be the mineral build-up.According to the 2022 Federal Food Code, food-contact surfaces are to be smooth, free of open seams, cracks, chips, inclusions, pits, and similar imperfections. Food-contact surfaces are to be clean to sight and (continued on next page)

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	touch. In addition, nonfood-contact surfaces are to be kept free of an accumulation if debris and are to be free of unnecessary projections, crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.2. During a concurrent observation and interview in the kitchen on 3/10/26 at 9:25 a.m. with Dietary Aide (DA) B and Dietary Manager (DM), DA B was observed to using a cloth soaked with a sanitizer from a red bucket to wipe down a food preparation table. DA B was asked to test the strength of the sanitizer in the red bucket that she was using. She used a test strip from a QAC (Quaternary Ammonium Compound; a type of sanitizer) test Strip. DM was asked to test the sanitizer. He dipped a test strip in and out of the sanitizer, then compared it to the color comparison chart on the test strip container. After the manufacturer's 5 second wait time for comparing the test strip to the color chart on the test strip bottle, DM stated the test strip showed 50 parts per million (ppm). DM stated the sanitizer was not strong enough, it should be between 200-400 ppm according to the sanitizer manufacturer's poster posted on the wall above the three-compartment sink, which showed sanitizer strength 200-400 ppm.According to the facility's Policy and Procedure (P&P) titled Sanitization dated 2001, all equipment are cleaned and sanitized using heat or chemical sanitizing solutions. Service area wiping cloths are placed in a chemical sanitizing solution of appropriate concentration. 3. During a concurrent observation and interview on 3/9/26 at 9:38 a.m. with the DM in the kitchen, an industrial can opener was stored in a base attached to end of the trayline table. There was orange residue on the blade of the can opener. DM stated the residue looked like jelly. He stated the kitchen staff cleaned the can opener once a day, not after each use. However, DM stated it was not okay to use the can opener if the blade was soiled. DM stated he guessed the can opener should have been cleaned after each use. In a consecutive observation and interview on 3/9/26 at 9:39 a.m., the base of the can opener attached to the preparation table was observed to have black, brown, orange residue build-up on the surface and embedded in the seam where the base attached to the table. DM stated it did not appear it was getting cleaned every day. It should have been cleaned every day.Review of the facility's P&P titled Sanitization, dated 2001, showed all equipment and counters are kept clean. According to the 2022 Federal Food Code, food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of food residue and other debris.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and document review, the facility failed to follow their policy and procedure regarding foods brought to residents by family and visitors when the facility did not educate family and visitors to prepare and transport food using safe handling practices outlined in the policy and procedure. This failure increased the risk of family members bringing contaminated food to residents leading to food born illness for 147 who ate food by mouth out of a census of 153.Review of the undated policy and procedure titled Foods Brought by Family/Visitors, showed family/visitors are asked to prepare and transport food using safe food handling practices, including: safe cooling and reheating processes, holding temperatures, preventing cross-contamination with raw or undercooked foods, and hand hygiene. During an observation and interview on 3/10/26 at 1:28 Licensed Vocational Nurse (LVN) L stated food brought in for residents by family and visitors could be stored for residents in the refrigerator located in a pantry room at a nursing station for up to three days. Family members bringing food for residents was confirmed when a person who identified herself as a family member placed food in the refrigerator, labeled with a resident's name. The bag of food contained food including soup and pureed food, all in reusable plastic containers. In an interview with the Director of Staff Development (DSD) and the Registered Dietitian (RD) on 3/11/26 at 10:26 a.m., DSD and RD were asked if family members/visitors who brought in food for residents were educated by the facility regarding safe food handling practices. DSD stated nursing checks for appropriate texture of food according to resident diet orders. When asked specifically about education regarding safe cooling of food, reheating processes, holding food temperatures, and preventing cross-contamination with raw or undercooked foods, RD stated we don't have control over what the family does at home. In an interview with the Director of Nursing (DON) and the Administrator (ADM) on 3/11/26 at 11:15 a.m., when asked if facility provides family members/visitors information regarding safe food handling practices for family members who bring in food for residents, the DON stated nursing was responsible what was in their scope of practice which was ensuring the texture is appropriate for the diet order. DON stated for anything (related to resident food) outside of the scope of practice for nursing, it would be referred to the RD, who would provide information to families during family care conferences. In an interview on 3/13/26 at 10:40 a.m., ADM stated a document about food brought in for residents from outside was provided in the resident admission packet. ADM stated the purpose of the document was to instruct family members regarding facility expectations on safe food practices. In an interview with ADM and facility document review on 3/13/26 at 5:07 p.m., the document titled Outside Food for a Resident dated 2026, was reviewed. ADM confirmed the document was not as detailed as the facility policy and procedure titled Foods Brought by Family/Visitors, but had some information on safe food handling, such as food made with raw eggs should not be brought in. ADM confirmed the Outside Food for a Resident document did not include safe cooling, reheating processes, holding temperatures, and preventing cross-contamination with raw undercooked foods.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for residents and staff when:Cloth straps used to hold ice chests were not clean.The floor around a metal cabinet in the kitchen was not clean, and the floor in the kitchen walk-in freezer was not clean.A kitchen's air conditioner surface was not clean.A large portion of paint was detached from the wall surface in the kitchen.The baseboard around the kitchen trayline table in the kitchen was broken and cracked.The vent in the kitchen's chemical room was not clean.There was no air gap for the kitchen food preparation sink drain.These failures had the potential to provide harborage for pests and/or contaminate equipment leading to contamination of food for 147 residents out of a census of 153.Findings:Review of the facility's policy and procedure titled, Sanitization, dated 2001, indicated, Policy Statement The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 2. All . equipment are kept clean, maintained in good repair. Review of the facility's policy and procedure titled, Maintenance Service, dated 2001, indicated, Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards.According to the 2022 Federal Food Code, physical facilities are to be maintained in good repair and cleaned as often as necessary to keep them clean. 1. During a concurrent observation and interview on 3/9/26 at 9:08 a.m. with the Dietary Manager (DM) in the kitchen, two ice chests were observed. Each ice chest was held by two cloth straps in a cart. DM stated the ice chests were used to store ice from the kitchen for use on the units during weekend when the kitchen was closed because the ice machines in the units were not working. The cloth straps holding wrapped around the ice chests had a significant amount of yellow and black residue on the surfaces. DM stated it looked stained.During an interview on 3/12/26 at 11:24 a.m. with Infection Preventionist (IP), a photo of cloth straps used to hold the ice chests was presented, IP stated the straps did not look clean and should have been replaced or cleaned. She stated even if the straps were outside of the ice chest, contamination could occur because people would handle the outside of the ice chest. During an interview on 3/13/26 at 7:12 p.m. with the DM, DM stated the ice was used for purposes such as keeping food/beverages cold on the medication carts. 2. During a concurrent observation and interview on 3/9/26 at 9:10 a.m. with the DM in the kitchen, there was a tall metal filing cabinet in proximity to the trayline steam table. In the space between the wall and the cabinet, there was a significant amount of debris on the floor, including black bits and a dead bug which DM stated was a dead cockroach. DM pulled the cabinet out from the wall and more black and brown debris was visible around the space where the cabinet was stored. DM stated the floor around this cabinet was not getting cleaned daily because the cabinet was heavy to move. During a concurrent observation and interview on 3/9/26 at 9:22 a.m. with the DM in the walk-in freezer in the kitchen, on the floor by the back wall under the food racks, there was debris, which appeared to be pieces of food, bits of paper, and brown residue. DM stated the staff did not remove the racks when they cleaned the room, so the residue was trapped under and behind the racks.3. During a concurrent observation and interview on 3/9/26 at 9:15 a.m. with the DM in the kitchen, the air conditioner on the wall in proximity to the trayline table was observed to have gray fuzzy residue on the top surface. DM stated it was dusty and it was supposed to be clean. He did not schedule staff to clean the area. DM stated the surface of the air conditioner should have been cleaned by kitchen staff once a week whether or not it was in use. 4. During a concurrent observation and interview on 3/9/26 at 9:13 a.m. with the DM in the kitchen, the wall on the left side of a cabinet (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in proximity to the trayline table, was observed to have over 1 foot by 1/2 foot paint surface pulled away from the wall. DM thought the wall may have been damp at one time to cause the paint to detach from the wall. DM stated he did not report this condition to the maintenance.During a concurrent observation and interview on 3/9/26 at 11:47 a.m. with the Maintenance Supervisor (MS) in the kitchen, the wall near the metal cabinet was observed. MS confirmed it was the paint that was coming off the wall. MS stated he was not aware of this condition. MS stated the maintenance staff did the rounds in the kitchen once a week, but the staff did not notice the wall because the cabinet was in the way. MS also stated kitchen staff were able to report maintenance needs which were usually done via text message.According to the 2022 Federal Food Code, wall materials are to be attached so they are easily cleanable. Indoor wall construction is to be finished and sealed to provide a smooth, nonabsorbent, easily cleanable surface. 5. During a concurrent observation and interview on 3/9/26 at 9:44 a.m. with the DM in the kitchen, baseboard around the trayline was broken and cracked. Some chunks were missing, and the edges of baseboard were jagged. DM stated dirt and dust could get stuck in the crevices when the baseboard was cracked and not smooth.According to the 2022 Federal Food Code, materials for indoor floor surfaces shall be smooth, durable, and easily cleanable for areas where food establishment operations are conducted.6. During a concurrent observation and interview on 3/9/26 at 9:47 a.m. with the DM in the chemical room in the kitchen, the vent on the wall was observed to have gray residue on the surface. DM stated it was dusty and maintenance staff were responsible for cleaning the vents.During a concurrent observation and interview on 3/9/26 at 11:47 a.m. in the chemical room in the kitchen, MS stated he was not aware of the vent in the chemical room in the kitchen. Normally, the main vents in the kitchen were cleaned by maintenance staff, but they missed this one. Review of the facility's policy and procedure titled, Departmental (Maintenance) - Plumbing, HVAC, and Related Systems, dated 2001, indicated, . General Guidelines - HVAC. 6. Clean air vents and air handling units at least annually. 7. During a concurrent observation and interview on 3/10/26 at 10:18 a.m. with the MS in the kitchen, a drainpipe from the food preparation sink was plumbed directly into the wall without an air gap (a gap that prevents contaminated water from flowing back into the food equipment). MS stated the drainpipe connected directly to the grease trap.According to the 2022 Federal Food Code, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide dialysis services consistently with professional standards and to ensure staff had coordinated residents' care with the dialysis center for three of five sampled residents (Residents 73, Resident 42, and Resident 99) receiving hemodialysis (medical procedure to remove fluid and waste products from the blood and to correct electrolyte, i.e., salts and mineral imbalances by using a machine and an artificial kidney) when:Inaccurate access site assessment information and communication with the facility to dialysis center prior (Pre) - Hemodialysis Communication/assessment Records (HCAR's) to dialysis treatment and after (Post) dialysis treatment; and, communication with the dialysis center was not properly coordinated when dialysis center hemodialysis communication observation/ assessment records (DCR) were not completed.These failures may affect the quality of dialysis care being provided to the residents and have the potential to cause resident health complications.Findings: 1. Review of Resident 73's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a condition in which the kidney no longer functions normally to filter waste and excess water from the blood as urine) and dependence on renal dialysis (a process of removing waste and excess water from the blood in those kidneys that have lost normal function). Review of Resident 73's Minimum Data Set (MDS, an assessment tool), dated 2/6/26, indicated he was cognitively intact with a brief interview for mental status (BIMS) score of 15. During a concurrent observation and interview on 3/9/26 at 9:04 a.m., with Resident 73, he stated that he was scheduled for dialysis every Tuesday, Thursday and Saturday. Resident 73 further stated that his dialysis access site was on his right upper chest. During a concurrent interview and record review on 3/12/26 at 10:30 a.m., with Licensed Vocation Nurse M (LVN M), LVN M reviewed resident 73's clinical records and stated Resident 73's dialysis access site location is on the right upper chest (RUC) (Perma Catheter, placement of a special (Intravenous) IV line or long, flexible tube inserted into a vein most commonly in the neck and into the heart to allow dialysis to occur) and Resident 73 was scheduled for dialysis every Tuesday, Thursday and Saturday. During a concurrent interview and record review on 3/12/26 at 10:44 a.m., with LVN M, He reviewed Resident 73's Pre- HCAR's dated 3/10/26,3/7/26, 3/5/26, 3/3 /26, 2/28/26, 2/26 /26, 2/24/26, 2/21/26, 2/19/26, 2/17/26, 2/14/26, 2/12/26, 2/11/26, 2/10/26, and 2/7/ 26. LVN M stated Resident 73's dialysis access site was central catheter (permacath) and the location was on the right upper chest (RUC) and the above-mentioned dates were inaccurate access site assessment because dialysis access site (permacath) does not need checking of bruit and thrill as indicated on this HCAR's. Review of Resident 73's hemodialysis care plan on 3/11/26 at 3:56 p.m., dated 1/28/26, indicated Resident 73 Requires Hemodialysis End Stage Renal Failure and has an RUC central Catheter located and is at risk for bleeding at access site. During a concurrent interview and record review on 3/12/26 at 10:55 a.m., with Nursing Supervisor (NS), reviewed Resident 73's Post- HCAR's dated 3/10/26,3/7/26, 3/5/26, 3/3/26, 2/28/26, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/26/26, 2/24/26, 2/21/26, 2/19/26, 2/17/26, 2/14/26, 2/12/26, 2/11/26, 2/10/26, and 2/7 /26. NS stated that Resident 73's dialysis access site was permacath on his RUC and for permacath, bruit and thrill does not need to be checked as indicated on the above dates of the HCAR's. During a concurrent interview and record review on 3/12/26 at 11:00 a.m., with NS, She reviewed Resident 73's DCR's dated 3/3/26, 2/28/26,2/21/26, 2/17/26,2/7/26, 2/5/26,2/3/26, 1/29/26 and 1/31/26 indicated access site and access location were blank and were not completed. NS stated that facility licensed nurses should have followed up with dialysis center and completed the DCR's for Resident 73's continuity of dialysis care and NS further stated that there were no documentations in the nurse's notes indicating that the licensed nurse called the dialysis clinic to complete the DCR's. 2. During a review of Resident 42's face sheet (summary page of a patient's important information), Resident 42 was admitted to the facility on [DATE] with diagnoses including muscle weakness (generalized) and dependence on renal dialysis (treatment that helps body to remove extra fluid and waste products from blood). During a review of Resident 42's physician's order indicated an order for check dialysis catheter site dressing Qshift (every shift) ., dated 2/13/26. During a concurrent interview and record review on 3/12/26 at 10:05 a.m., with RN N, RN N reviewed Resident 42's clinical records and she stated Resident 42 has right upper chest (RUC), two lumen catheter access for dialysis, RN N stated Resident 42 has no AV graft or shunt (types of vascular access for hemodialysis), she further stated they don't monitor for thrill and bruit for permcath. During a concurrent interview and record review on 3/12/26 at 1:27 p.m., with Assistant Director C (ADON C), ADON C reviewed Resident 42's pre-HCAR's dated 2/21/26, 2/24/26, 2/26/26, 3/2/26, and 3/7/26. ADON C reviewed Resident 42's post- HCAR's dated 3/3/26 and 3/10/26, ADON C confirmed the nurses were checking yes for positive bruit and thrills for above pre-HCAR's and post -HCAR's assessment dates, ADON C stated she expected the nurses to know how to check the permacath and she stated they [nurses] should not be checking for bruit and thrills for permacath. During a concurrent interview and record review on 3/12/26 at 1:23 p.m., with Assistant Director C (ADON C), ADON C reviewed Resident 42's DCR's dated, 2/17/26 and 2/21/26, ADON C confirmed the 42's DCR indicated access site and access location were blank and were incomplete. ADON C further stated she expected the nurses to call the dialysis center if the DCR is incomplete. 3. During a review of Resident 99's face sheet (summary page of a patient's important information), it indicated Resident 99 was admitted to the facility on [DATE] with diagnoses including Resistance to multiple antibiotics and dependence on renal dialysis. During a review of Resident 99's physician order indicated an order for check dialysis catheter site dressing Qshift. dated 1/18/26. During a concurrent interview and record review on 3/12/26 at 10:15 a.m., with Registered Nurse P (RN P), she reviewed Resident 99 and stated Resident 99's access site to right upper chest (RUC) permacath, she further stated for permacath they don't check for bruit and thrills. During a concurrent interview and record review on 3/12/26 at 1:17 p.m., with Assistant Director C (ADON C), ADON C stated Resident 99's has a permacath to right upper chest (RUC), ADON C (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed Resident 99's pre-HCAR's dates 3/2/26,3/4/26,3/6/26, and 3/11/26, then ADON C reviewed Resident 99's post-HCAR's dated 3/4/26,3/6/26, and 3/9/26. ADON C confirmed the nurses were checking yes for positive bruit and thrills for above pre-HCAR's and post -HCAR's assessment dates, ADON C stated they [nurses] should not answer yes for positive bruit and thrills for permacath. During a concurrent interview and record review on 3/12/26 at 1:13 p.m., with ADON C, ADON C reviewed and confirmed Resident 99's DCR, dated 2/25/26, 3/2/26, 3/4/26, and 3/6/26, indicated, access site and access location were blank and were incomplete. ADON C stated she expected the nurses to call the dialysis center if the DCR is incomplete. Review of the facility's policy titled, Dialysis Service, dated December 2024, indicated each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified facility, ongoing communication and collaboration with the physician and dialysis facility regarding dialysis care and services, ongoing assessment and oversight of the resident before and after dialysis treatments including monitoring the resident during treatments, monitoring for complications, implementing appropriate interventions and using appropriate infection control practices . The policy further indicated assessments will be done, completed and documented in the resident's clinical record and care plan.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and document review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis, especially on the weekend based on Staffing Data Report submitted to Centers for Medicare & Medicaid Services (CMS).This failure had the potential to affect resident's care, health, and psychosocial wellbeing. Findings:During a concurrent interview and record review with the staffing coordinator (SC) on 3/13/2026 at 11:52 a.m., SC reviewed the documents titled, Census and Direct Care Service Hours Per Patient Day, from July through December 2025, indicated the following dates with actual CNA DHPPD were below 2.4: 7/12-2.31;7/13- 2.37;7/19- 2.30;7/20-2.29;7/21-2.35;7/27-2.22;8/10-2.23;8/17-2.32;8/25-2.35;9/20-2.39;10/11-2.27;11/8-2.39;11/23-2.35;11/29-2.27 and for the following dates with actual DHPPD were below 3.5: 7/13-3.47;11/23-3.47;11/29-3.46;11/30-3.47;12/6-3.49;12/14-3.47;12/20-3.47;12/24-3.49;12/27-3.46.SC stated that the low staffing back on July - December 2025, were mostly on the weekend and the Direct Care Service Hours Per Patient Day (DHPPD) should have been 3.5 and Certified Nursing Assistant (CNA) Hours Per Patient Day (DHPPD) should have been 2.4. SC further stated that the facility has no staffing waiver.During a review of the All Facilities Letter (AFL) 21-11 dated March 17, 2021, indicated, The 3.5 DHPPD staffing requirement, of which 2.4 hours per patient day must be performed by CNAs, is a minimum requirement for SNFs (Skilled Nursing Facility). SNFs shall employ and schedule additional staff and anticipate individual patient needs for the activities of each shift, to ensure patients receive nursing care based on their needs. The staffing requirement does not ensure that any given patient receives 3.5 or 2.4 DHPPD; it is the total number of actual direct care service hours performed by direct caregivers per patient day divided by the average patient census.

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	555068	A. Building B. Wing	03/13/2026

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen staff had appropriate competencies when:Two of two kitchen staff (The Dietary Manager, Dietary Aide B) did not follow manufacturer's instructions for sanitizer test strips when testing the strength of the sanitizer used to clean the food contact surfaces in the kitchen.Three of three staff (The Registered Dietitian, the Dietary Manager, and [NAME] A) did not know and/or follow instructions for fortifying diets. The failure to ensure staff competency for testing sanitizer strength had the potential to increase the risk of food contamination to residents, and the failure to ensure staff competency for fortifying diets had the potential to result in decreased calorie intake for residents receiving a fortified diet.Findings:Review of the job description titled Registered Dietitian dated 2/2024, showed the Registered Dietitian (RD) was responsible for monitoring food service operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as federal regulations, and inspecting diet trays for conformance to physician's diet orders prior to delivery.Review of the job description titled Dietary Manager dated 2/2024, essential duties included supervising staff in the day-to-day facility operations of assigned areas. Direct and participate in food preparation and service of food that is safe, appetizing, and is of the quality and quantity to meet each resident's needs in accordance with the physician's orders. Ensure work equipment is clean, safe and orderly. 1. During a concurrent observation and interview on 3/10/26 at 9:25 a.m. with Dietary Aide (DA) B and the Dietary Manager (DM) in the kitchen, DA B was asked to test the strength of the sanitizer in the red bucket that she used to wipe down a preparation table. DA B used a test strip from [test strip brand] QAC [Quaternary Ammonium Compound; a type of sanitizer] test strip container. She dipped the test strip in the sanitizer in the red bucket, immediately removed it, and stated the sanitizer was okay to use. DA B did not compare the color of the test strip to the color comparison chart on the test strip bottle. The color of the test strip was observed to be light yellow color.DM was asked to test the sanitizer. He dipped a test strip in and out of the sanitizer, then compared it to the color comparison chart. The color of the test strip was observed to be light yellow. DM stated according to the test strip color chart, light yellow showed the sanitizer strength was 50 parts per million (ppm). DM stated 50 ppm was not strong enough. DM stated the test strip should be a darker green color to show the sanitizer strength was over 200 ppm. During a concurrent interview and record review on 3/10/26 at 9:57 a.m. DM stated there was not a time frame on the test strip instructions to wait after dipping and comparing to the chart. The manufacturer's instructions on the test strip bottle were reviewed, the instructions indicated, 1. Dip strip & remove. 2. Shake off excess water. 3. Wait 5 seconds. 4. Compare. DM confirmed there was a 5-second wait time. He was not aware of these instructions because the test strips were from a new company. DM stated the test strips from the new company were used for about a week. DM stated he thought they had the same instructions as the previous company which required no waiting time frame.During an interview on 3/10/26 at 1:18 p.m. DM stated for any new products such as test strips, the staff should be trained immediately before use. DM stated he was unaware the directions were different with the new test strips, so he did not provide an inservice before using.2. An observation in the kitchen of trayline food service (an assembly-line food service system commonly used in skilled nursing facilities placing resident food onto plates) on 3/9/26 at 12:05 p.m., showed 32 tray tickets (a piece of paper displaying information such as the resident's diet order, allergies, and food preferences) displayed Fortified as part of the diet order. When [NAME] A was asked how the diets were fortified, [NAME] A stated butter was added to the food. When asked which food had butter added, [NAME] A stated a butter packet was placed on the tray instead butter added to the food being served. DM confirmed a butter packet was placed on the tray for fortified diets.During a consecutive interview and record review on 3/9/26 at 1:30 p.m., when RD and DM were asked if there was a fortified menu for the cooks to follow, RD stated she did not (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know. DM stated he thought there were guidelines for a fortified diet in the diet manual. The section in the 2025 Diet Manual signed by RD and DM on 1/6/26, showed the fortified diet was designed for residents who could not consume adequate amounts of calories and/or protein to maintain their weight or nutritional status. The goal was to increase calorie density of foods commonly consumed by the residents. The amount of calorie increase should be approximately 300-400 per day. Examples of adding calories included adding extra margarine or butter to food items such as vegetables, potatoes, hot cereal, etc., extra gravy and sauces added to meats, pasta, etc. RD and DM confirmed butter was placed on the tray, but the food served was not fortified upon serving.During an observation, interview, and record review on 3/12/26 at 10:27 a.m., RD stated she just wrote out a schedule for fortified diets and posted it in the kitchen. The schedule showed high calorie cereal for breakfast, extra butter or one ounce of gravy for lunch, and one ounce of melted margarine and one ounce of gravy for dinner. When [NAME] A was asked what foods gravy was added to for the dinner meal for fortified diets, [NAME] A stated he put the gravy in a little cup on the plate, not on the food. Then [NAME] A asked RD if placing the gravy on the side of the food on a cup was correct. RD stated no, the gravy was to go on top of the food for the fortified diet. During an interview and document review on 3/13/26 at 11:05 a.m., DM stated he was not aware of an inservice on fortified diets prior to the start of the survey on 3/9/26.During an interview on 3/13/26 at 19:09 p.m., RD confirmed she was not aware of inservices on fortified diets provided to kitchen staff prior to 3/13/26.

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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** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:1.The Licensed Nurse did not establish a sterile field on the overbed table prior to performing the PICC line (a long, flexible tube inserted through a peripheral arm vein and advanced into a large vein near the heart) dressing change for Resident 7.2. Resident 73's unlabeled nebulizer mask (plastic mask and tubing used as a connection from compressor to deliver mist to client)that was attached to the machine was exposed and touching the bedside table and nasal cannula (NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration) was hanging at the side of his wheelchair and the two prongs were touching the floor;3. Registered Nurse E failed to perform hand hygiene between tasks that required hand washing;4.Resident 168's was on contact precaution and the signage outside her room was Enhance Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, are bacteria and microorganisms resistant to one or more classes of antimicrobial agents, making infections difficult to treat] in nursing homes.) and5.Resident 40 was not placed on Enhance Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, are bacteria and microorganisms resistant to one or more classes of antimicrobial agents, making infections difficult to treat] in nursing homes.) These failures had the potential to spread infections to residents, staff, and visitors.Findings: 1.A review of Resident 7's clinical record indicated that Resident 7 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to an internal right hip prosthesis (a device designed to replace a missing part of the body or to make a part of the body work better). A review of Resident 7's physician order dated 1/10/2026 indicated: IV (a method of administering fluids, medications, or nutrients directly into a vein) PICC line (a long, flexible tube inserted through a peripheral arm vein and advanced into a large vein near the heart) dressing change to the RUA (right upper arm). Cleanse using a PICC dressing kit, followed by application of a Bio patch and waterproof transparent dressing weekly, beginning 1/15/2026. During an observation on 3/12/2026 at 2:15 p.m. in Resident 7's room, RN N was observed changing the resident's PICC dressing. RN N did not establish a sterile field on the overbed table; instead, she placed a pair of sterile gloves on the resident's blanket over the resident's body, opened them there, and donned them. The PICC dressing kit was also placed and opened on the resident's blanket over the resident's body. During a phone interview with RN N on 3/12/2026 at 4:40 p.m., RN N confirmed that she had not set up a sterile field on the overbed table. She stated that she should have cleaned the overbed table, placed a barrier drape, and placed equipment on the table to prevent infection. A review of facility policies and procedures titled .Central Venous Catheter Care and Dressing Changes dated 2001 indicates that.clean the over the bed table with soap and water, or alcohol, place equipment on table. 2. During an initial observation tour of the facility and interview on 3/9/26 at 9:04 a.m., Resident 73's NC that was attached to the portable oxygen at the back of his wheelchair was hanging and the nasal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prongs were touching the floor. Resident 73 acknowledged the observation and stated he has portable oxygen at the back of his wheelchair and NC was attached to it. Resident 73 further stated that NC has been touching the floor since last night and he was using the wheelchair when he is going out for dialysis. During a concurrent observation and interview on 3/9/26 at 9:05 a.m., with Registered nurse E (RN E), She confirmed the above observation and stated NC attached to the portable oxygen at the back of Resident 73's wheelchair should not have been hanging and touching the floor. Review of Resident 73's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including respiratory disorders , end stage renal disease (a condition in which the kidney no longer functions normally to filter waste and excess water from the blood as urine) and dependence on renal dialysis (a process of removing waste and excess water from the blood in those kidneys that have lost normal function). Review of Resident 73's Minimum Data Set (MDS, an assessment tool), dated 2/6/26, indicated he was cognitively intact with a brief interview for mental status (BIMS) score of 15. Review of the Physician (MD) Order dated 1/28/26, indicated Oxygen - 2 Liters/Min Via Nasal Cannula (Continuous) (Medical DX:SOB).Goal To Maintain 02 Sats Greater Than 90% and Change Nasal Cannula (NC) every Sunday at night shift. Review of the undated facility's policy, titled Department (Respiratory Therapy)- Prevention of infection indicated, the purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment, including ventilators, among residents and staff. Change the oxygen cannula and tubing seven days, or as needed. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. During a concurrent observation and interview on 3/9/26 at 9:08 a.m., with RN E, She confirmed that Resident 73's unlabeled nebulizer mask that was attached to the machine was exposed and touching the bedside table. RN E stated that nebulizer tubing should have been dated when the staff changed the tubing for Resident #73 and should have been stored inside the plastic bag. Review of the undated facility's policy, titled Administering Medications through a Small Volume (Handheld) Nebulizer indicated, when equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days. 3. During an observation on 03/09/2026 at 9:09 a.m., RN E was wearing pair of gloves and using the white ointment she was rubbing the back of Resident #73 . RN E went to the medication cart, removed the pair of used gloves and disposed inside the garbage container attached to the medication cart , open the medication cart with the key from her pocket without performing hand hygiene. During a concurrent observation and interview on 03/09/2026 at 9:10 a.m., RN E confirmed the above observations and stated she forgot to perform hand hygiene after removing the used pair of gloves and should have performed hand hygiene before starting a new task . Review of the undated facility's policy, titled Handwashing/Hand Hygiene indicated Hand hygiene is the primary means for preventing healthcare- associated infections (HAIs) and the transmission of multidrug- resistant organisms (MDROs). This facility requires strict adherence to evidence -based (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene practices (as described in this policy) for all personnel, including licensed, unlicensed, contracted, therapy, dining, housekeeping, volunteers, and students as Policy Statement. Hand hygiene is indicated before and after touching a resident, after touching the resident's environment or belongings (e.g., bedrails, wheelchair, etc.) and after glove removal. 4. During an initial tour of the facility on 3/9/26 at 9:40 a.m., on 3/10/26 at 9:59 a.m., and on 3/10/26 at 10:05 a.m., Resident 168 has signage outside the door indicated (Enhanced Barrier Precautions or EBP and above the wall of her bed (EBP). No Isolation cart or bin outside the door except inside Resident 168's drawer has gown; hand sanitizer was attached to the resident's room wall and gloves are available inside the room. Facility staff were going in and out in Resident 168's room. During a concurrent observation and interview on 3/10/26 at 10:05 a.m., with the Assistant Director of Nursing D (ADON D) stated that Resident 168 was on EBP and has signage outside the door and above the wall of her bed. ADON D confirmed there was no isolation bin outside Resident 168's room. During a concurrent interview and record review on 3/10/26 at 10:37 a.m., with Infection Preventionist (IP), IP stated she track Residents that is on active precaution, nurses will report to her and she will give them guidance. IP reviewed Resident 168's clinical record and indicated Resident 168 was admitted to the facility on [DATE] and physician (MD) order dated 2/19/26 indicated contact isolation precaution due to ESBL (ESBL, are enzymes produced by certain Gram-negative bacteria that make them resistant to many common antibiotics). IP confirmed that MD order was active and Resident 168 should have a signage of contact precaution with the white bin outside the door, staff should wear gowns, and gloves whenever they enter Resident 168's room. Review of the undated facility's policy, titled Isolation- Categories of Transmission- Based Precaution, indicated Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident- care items in the resident's environment Staff and visitors wear disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed .Gloves are removed and hand hygiene performed before leaving the room. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors wear gloves (clean, non -sterile) when entering the room. 5. During a review of Resident 40's clinical record indicated Resident 40 was admitted to the facility on [DATE] with diagnosis including extended spectrum beta lactamase (ESBL, are enzymes produced by certain Gram-negative bacteria that make them resistant to many common antibiotics), resistance and sepsis (is the body's extreme response to an infection. It is a life-threatening medical emergency.), unspecified. During a review of Resident 10 Physician's order indicated Resident 40 were not placed on EBP. During a concurrent observation and interview outside Resident 40's room on 3/13/26 at 10:25 a.m., with Registered Nurse N (RN N), she stated resident 40 is not on EBP, she further stated there was no EBP signage posted outside Resident 40's room. During a concurrent interview and record review on 3/13/26 at 11:37 a.m., with the IP, the IP stated residents were placed on EBP when they have chronic wounds or MDRO, she further stated they review resident's labs (laboratory) and history to check if resident needs EBP. The IP reviewed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 40's clinical record, confirmed the diagnosis of ESBL resistance, the IP reviewed Resident 40's document from the hospital titled, Healthcare facility Transfer Report it indicated Patient Infection Status, patient has MDRO or other lab result requiring precautions and/or has been exposed to MDRO, infection ESBL, Onset 1/25/26, Urine culture. The IP stated Resident 40 should be on EBP and she missed this one. During a review of the facility's policy and procedures titled, Enhanced Standard/Barrier Precautions, undated, indicated, 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities.2. Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain respect and dignity for four of five sampled residents (Residents 17, 167, 28, and 7) when:1.Registered nurse F (RN F) was standing while feeding Resident 17 in bed, near the room's opened door;2.Resident 167's care instructions were posted above Resident 167's head of bed's wall uncovered; and,3. Resident 28 did not have a covering bag to conceal his drainage bag; and,4. The Licensed Nurse wrote her initials and the date on the tape while it was on Resident 7's arm during dressing change.These failures had the potential to negatively affect resident's emotional and psychosocial well-being. Findings: 1.Review of Resident 17's clinical record titled, admission Record, indicated Resident 17 was admitted to the facility with diagnoses including heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs), dementia (decline in mental capacity affecting daily function), and dysphagia (difficulty in swallowing). Review of Resident 17's quarterly minimum data set (MDS – a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 17's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 03 (a score of 0 to 07 indicates severe cognitive impairment, 08-12 moderate impairment, 13-15 patient is cognitively intact). During an observation on 3/9/2026 at 12:58 p.m., in front of Resident 17's opened room door, Resident 17 was repositioned by RN F in bed, and started feeding her while standing at the left side of Resident 17's bed. Resident 17 was positioned lower than RN F. During a concurrent observation and interview with certified nursing assistant G (CNA G) on 3/9/2026 at 1:05 p.m., inside Resident 17's room, CNA G entered the room and assisted Resident 17 to sit at the edge of the bed and positioned her overbed table with her lunch in front of her. Resident 17 was observed to eat independently. CNA G confirmed observation with RN F and stated the staff should reposition the residents first during mealtime and assist them as needed. CNA G stated the staff should sit beside the residents during meal assistance. During an interview with RN F on 3/9/2026 at 1:07 p.m., RN F confirmed above observation and stated she should have sat beside Resident 17 while feeding her for Resident 17's comfort. During an interview with the director of staff development (DSD) on 3/11/2026 at 9:25 a.m., the DSD stated, it's okay to feed resident while standing as long as the resident is not showing any parts of her body. During a review of the facility's policy and procedure titled, Assistance with Meals, date revised 3/2022, indicated, Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over resident while assisting them with meals. 2.Review of Resident 167's clinical record titled, admission Record, indicated Resident 167 was admitted to the facility with diagnoses including cerebral ischemia (also known as cerebrovascular or (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brain ischemia, occurs when there is a shortage of oxygen or blood flow to the brain caused by a blockage or bleeding in the arteries that supply blood to the brain), wedge compression fracture (a type of spinal break where the front part of a vertebra collapses, while the back remains intact) of first lumbar vertebra (the topmost bone of the five vertebra in the lower back [lumbar spine], located just below the chest [thoracic] spine), and benign neoplasm of meninges (a noncancerous tumor that grows from the protective membranes surrounding the brain and spinal cord). Review of Resident 167's quarterly MDS assessment dated [DATE] indicated Resident 167's BIMS score was 03. During an observation on 3/9/2026 at 10:59 a.m., in Resident 167's entrance door room, Resident 167 was in bed, asleep, and observed she had two care instructions posted above the head of bed's wall. The care instructions were displayed and could be read through Resident's 167's entrance door. The first care instruction posted indicated, Please DO Not remove splint from finger (if so, please put it back on). The second care instruction posted indicated, Please use rash oilment [ointment] when changing my diaper. Thank you! During a concurrent observation and interview with licensed vocational nurse H (LVN H) on 3/10/2026 at 9:331 a.m., inside Resident 167's room, the two care instructions were still posted above Resident 167's head of bed wall. LVN H confirmed above observation and stated the care instructions were posted there for a while now. LVN H further stated the care instructions should be removed or covered for Resident 167's confidentiality. During an interview with the DSD on 3/11/2026 at 9:23 a.m., DSD stated there were times families would post care instructions and nurses should speak with the family about it. DSD further stated, nurses should cover the care instruction if the family requested to have it posted During a review of the facility's policy and procedure titled, Dignity, date revised 2/2021, indicated, Residents are treated with dignity and respect at all times.Staff protect confidential clinical information. Examples include the following:.Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room.Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door). 3.A review of Resident 28's clinical record indicated that Resident 28 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including acute cholecystitis (the inflammation of the gallbladder, usually caused by gallstones blocking the bile duct) and an encounter for surgical aftercare following surgery on the digestive system on 12/18/2025. A review of Resident 28's physician order dated 2/22/2026 indicates measuring the RUQ (right upper quadrant) cholecystostomy (a medical procedure used to drain the gallbladder through either a percutaneous or endoscopic approach) drain every shift. During a concurrent observation and interview with Resident 28 on 3/10/2026 at 11:10 a.m. in the hallway, Resident 28 was sitting in a wheelchair with a drainage bag resting on his legs. No covering bag or privacy device was in place to conceal the drainage bag. Resident 28 stated that no covering bag was available to conceal the drainage bag. During a follow-up interview on 3/11/2026 at 10:29 a.m., Resident 28 stated that the lack of a proper covering bag caused the drainage bag to pull at the insertion site, resulting in pain. Resident 28 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated feeling embarrassed when the drainage bag was exposed. During an interview with Licensed Vocational Nurse (LVN) Q on 3/11/2026 at 10:39 a.m., the LVN Q confirmed that Resident 28 had a cholecystostomy drainage bag and stated that a covering bag should be provided for privacy and dignity. 4. A review of Resident 7's clinical record indicated that Resident 7 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to an internal right hip prosthesis (a device designed to replace a missing part of the body or to make a part of the body work better). A review of Resident 7's physician order dated 1/10/2026 indicated: IV (a method of administering fluids, medications, or nutrients directly into a vein) PICC line (a long, flexible tube inserted through a peripheral arm vein and advanced into a large vein near the heart) – Change (PICC) Dressing Site: RUA (right upper arm). Cleanse with PICC dressing kit followed by application of a Bio patch and waterproof transparent dressing weekly, beginning 1/15/2026. During an observation and interview with RN N on 3/12/2026 at 2:15 p.m. in Resident 7's room, after completing the PICC line dressing change, RN N placed a piece of tape directly on the resident's right arm and wrote her initials and the date on the tape while it was on the resident's right arm. During a phone interview on 3/12/2026 at 4:40 p.m., the RN N confirmed that she wrote her initials and the date on the tape while it was on the resident's arm. She acknowledged that, to maintain dignity, the initials, date, and time should be written on the tape prior to placing it on the resident. A review of the facility's polices and procedures titled Dignity indicates that .each resident shall be cared for in a manner that promotes and enhances the his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.Residents are treated with dignity and respect at all times.staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for one of two sampled residents (Resident 158), the facility failed to inform the Responsible Party (RP- person legally responsible to make decisions for a resident) regarding plan of care and/or treatment changes when Resident 158's RP was not informed of physician ordered laboratory tests involving a procedure to obtain a urinary sample. This failure resulted in Resident 158's Responsible Party to unaware of Resident 158's test and procedure for obtaining the urine sample.A review of Resident 158's admission Record indicated she was admitted to the facility on [DATE] with diagnoses including Aphasia (a disorder that makes it difficult to speak), dementia (decline in mental capacity affecting thinking and social abilities interfering with daily functioning), type 2 Diabetes Mellitus (high blood sugar), hemiplegia (paralysis that affects just one side) and hemiparesis (weakness on half of the body) following cerebral infarction (necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) affecting right dominant side.During observation on 3/10/26 at 11:30 a.m., 3/11/26 at 1:30 p.m., and 3/12/26 at 12:30 p.m., Resident 158 was inside her room and could not response verbally but had eye contact .Review of Resident 158's Minimum Data Set (MDS, an assessment tool) dated 1/19/26, indicated her cognition was impaired and rarely/never understood.During a concurrent interview and record review on 3/13/26 at 10:10 a.m., with Minimum Data Sheet Coordinator(MDSC) , she reviewed resident 158's clinical records and stated that on 2/7/26, NP / Physician Order dated 2/7/26 at 15:22 (3:22 p.m.) indicated new order from NP for Urine Analysis (UA) Culture & Sensitivity (C&S) order noted and carried out by licensed nurse (LN) . MDSC could not provide any documentation that LN notified Responsible Party (RP) about the above order and urine specimen collection was obtained for UA C&S.During a concurrent interview and record review on 3/13/26 at 10:43 a.m., with the Assistant Director of Nursing C (ADON C), reviewed Resident 158's clinical records and stated Nurse practitioner (NP) progress notes dated 2/7/26 indicated Resident 158 was seen by the NP in her room with plan to do urine analysis (UA), culture and sensitivity (C&S), which the assessment and plan was discussed with Physician (MD). on 2/7/26, NP / Physician Order dated 2/7/26 at 15:22 (3:22 p.m.) indicated new order from NP for UA C&S order noted and carried out by licensed nurse (LN). ADON further stated that on 2/11/26 due to Resident 158's incontinent of urine straight catheterization was used when urine sample was obtained for UA C&S.During a concurrent interview and record review on 3/13/26 at 10:45 a.m., with ADON C, She reviewed Resident 158's clinical records and could not show documentation the Resident 158's RP was notified of the urine sample collection procedure as ordered by MD on 2/7/26 for UA C&S. ADON stated that the LN was supposed to call the RP and document the notification.During a concurrent interview and record review on 3/13/26 at 10:57 a.m., with ADON C, She reviewed Resident 158's clinical records and stated that Nurse's Notes dated 2/11/26 at 8:35 a.m., indicated urinalysis results reviewed , results relayed to MD. Pending any new order by the LN and a change in condition evaluation record dated 2/11/26 indicated LN notified Resident 158's RP on 2/11/26 at 10:00 a.m., about UA result but not the laboratory tests or diagnostic procedure that was done on 2/7/26. ADON further stated that Resident 158's Care Plan (CP) dated 2/11/26 indicated Resident 158 has abnormal UA results.During telephone interview with Resident 158's RP on 3/13/26 at 2:37 p.m., Resident 158's RP stated that the facility staff did not inform her of the NP plan and physician's order for UA C&S and urine sample was obtained from her mother on 2/7/26. RP further stated that She was expecting the facility staff to notify her for any changes in her mother's changed of condition and plan of care .Review of the undated facility's policy, titled Change in a Resident's Condition or Status, the policy statement indicated facility promptly notifies the resident, his or her attending physician , and the resident representative of changes in the resident's medical/mental condition and/ or status. Regardless of the resident's current mental or physical condition, a nurse or health provider will inform the resident (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and /or representative of any changes in his/her medical or nursing treatments.The nurse will record in the resident's medical record information related to changes in the resident's medical/mental condition or status.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to safely administer medication for one of thirty sampled residents (Resident 108) when licensed vocational nurse I (LVN I) left three routine medications on Resident 108's overbed table unattended, for self-administration. These failures had the potential for unsafe and improper administration of medications.Findings:During a concurrent observation and interview with Resident 108 on 3/9/2026 at 9:31 a.m., inside Resident 108's room, Resident 108 was positioned flat on bed, awake and had three white tablets in a medication cup on top of his overbed table, unattended. The overbed table was positioned in front of Resident 108. Resident 108 stated he needed to sit up to take his medications.During a concurrent observation and interviews with both LVN I and Resident 108 on 3/9/2026 at 9:33 a.m., inside Resident 108's room, LVN I confirmed the observation and stated that he left the medication because Resident 108 was not ready to take his medications yet. Resident 108 stated he needed one big pill to be cut in half and he requested more water. LVN I stated he should not have left the medication at bedside. LVN I further stated, the three white medications were simethicone (it is a generic name for a widely used over-the counter [OTC] anti-gas medication), gabapentin (a prescription medication used primarily to treat nerve pain) 800 milligram (mg - unit of measurement) and aspirin (a common OTC medication used to reduce pain, fever, and inflammation).During an interview with the director of staff development (DSD) on 3/11/2026 at 9:20 a.m., when asked about medication left at bedside, the DSD stated nurses should not leave medication at resident's bedside. The DSD further stated nurses should stay with residents until they take their medications.During a review of the facility's undated policy and procedure titled, Administering Oral Medications, indicated, The purpose of this procedure is to provide guidelines for the safe administration of oral medications.Explain the procedure to the resident. Place medications on the bedside table or tray.Assist the resident to a sitting or side lying position. Offer water to assist the resident in swallowing medications.Remain with the resident until all medications have been taken.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive, individualized, resident-centered care plans for two of 30 sampled residents (Residents 105, and 13) when:1.Resident 105's care plan for diagnosis of alcohol dependence with alcohol induced persisting dementia (a form of permanent brain damage caused by long-term, heavy alcohol consumption) since 1/15/2026, with brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 08 (a score of 00 to 07 indicates severe cognitive impairment, 08-12 moderate impairment, 13-15 patient is cognitively intact) was not developed; and2.Resident 13's care plan for restorative nursing assistant (RNA - a healthcare professional who helps patients regain and maintain their independence and mobility) program for knee splinting (a temporary immobilization of the knee joint using a rigid device [like a brace, splint, or plaster] to keep the leg straight or in a set position) was not developed.These failures had the potential unmet care needs for Residents 105 and 13.Findings:1.Review of Resident 105's clinical record titled, admission Record, indicated Resident 105 was originally admitted to the facility on [DATE] with diagnosis of alcohol dependence with alcohol induced persisting dementia.Review of Resident 105's admission minimum data set (MDS - a federally mandated resident assessment tool) dated 1/16/2026, and 5-day MDS assessment dated [DATE], indicated Resident 105's BIMS score was 08 and had a diagnosis of non-Alzheimer's dementia.During a concurrent interview with social services director (SSD) and record review of Resident 105's 5-day MDS assessment dated [DATE], and list of care plans on 3/12/2026 at 1:26 p.m., SSD confirmed Resident 105 had diagnosis of dementia and her BIMS score was 08. SSD stated there was no care plan developed for Resident 105's diagnosis of dementia.During a concurrent interview with MDS coordinator (MDSC) and record review of Resident 105's 5-day MDS assessment dated [DATE], and list of care plans on 3/13/2026 at 1:26 p.m., MDSC confirmed she couldn't find a dementia care plan in Resident 105's care plan list. MDSC stated there should have been a care plan for dementia. MDSC further stated all nurses are responsible for the development of care plan.During a review of the facility's undated policy and procedure titled, Dementia - Clinical Protocol, indicated, For the individual with confirmed dementia, the IDT [interdisciplinary team - a group of health care professionals from diverse fields who work toward a common goal for residents] will identify a resident-centered care plan to maximize remaining function and quality of life.During a review of the facility's undated policy and procedure titled, Care Plans, Comprehensive Person-Centered, indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.2.Review of Resident 13's clinical record titled, admission Record, indicated Resident 13 was admitted to the facility with diagnoses including secondary malignant neoplasm of brain (brain metastases - are cancerous tumors that spread from primary cancers elsewhere, such as lungs, breast, or colon) and hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following unspecified cerebrovascular disease (CVA/stroke, a condition resulting from a lack of oxygen in the brain potentially causing a loss of sensory and motor function) affecting right dominant hand (the hand naturally prefer and use more often for precise tasks like writing, eating, or throwing).Review of Resident 13's quarterly MDS assessment dated [DATE], indicated a BIMS score of 06 and Resident 13 had five days of RNA program for splint or brace assistance.Review of Resident 13's clinical record titled, Order Summary Report, dated 3/13/2026, indicated an order dated 2/10/2026, RNA for knee Splinting or Bracing Program to (Rt [right] knee) 5x [times] week for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	90 days or as tolerated.During an interview with RNA O on 3/13/2026 at 8:49 a.m., RNA O confirmed Resident 13 was on RNA program for his right knee splinting. RNA O stated they applied Resident 13's right knee splint at 9:00 a.m. and removed at 3:00 p.m.During a concurrent interview with the director of rehabilitation (DOR) and record review of Resident 13's list of care plans on 3/13/2026 at 9:55 a.m., the DOR confirmed there was no care plan developed for Resident 13's RNA program.During a concurrent interview with the MDSC and record review of Resident 13's list of care plans on 3/13/2026 at 1:41 p.m., the MDSC confirmed there was no care plan developed for Resident 13's RNA program. MDSC stated there should have been a care plan developed for Resident 13's RNA program for knee splinting.During a review of the facility's undated policy and procedure titled, Care Plans, Comprehensive Person-Centered, indicated, The comprehensive, person-centered care plan:.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.The interdisciplinary team reviews and updates the care plan:.at least quarterly, in conjunction with the required quarterly MDS assessment.

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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. Based on interview, and record review, the facility failed to provide services according to professional standards for one of 30 sampled residents (Resident 15) when the speech language pathology (SLP) evaluation and treatment order was not carried out.This failure had the potential to affect Resident 15's care, health, and well-being.Findings:Review of Resident 15's clinical record titled, admission Record, indicated Resident 15 was admitted to the facility with diagnoses including Parkinsonism (a clinical syndrome characterized by a group of movement disorders, primarily featuring tremors, bradykinesia [slowness], muscle rigidity, and postural instability [balance issues]), and chronic pulmonary edema (a long-term condition where fluid slowly and consistently builds up in the lungs' air sac, which causes shortness of breath, fatigue, waking up breathless, and swollen legs).Review of Resident 15's clinical record titled, Order Summary Report, dated 6/30/2025, it indicated the following orders: Mechanical Soft Chopped texture, Thickened Liquid Nectar consistency, Resident on Hospice for Dysphagia [difficulty in swallowing], order dated 6/10/2025. admitted to .Hospice - Admitting Dx [diagnosis] Parkinsonism, unspecified., order dated 6/9/2025. SLP Evaluation and Treatment, order dated 6/11/2025.Review of Resident 15's clinical record titled, IDT [interdisciplinary team - a group of health care professionals from diverse fields who work toward a common goal for residents) Conference Notes, dated 6/17/2025, indicated in therapy services, No Therapy.Resident on hospice.During a concurrent interview with the assistant director of nursing C (ADON C), and record review of Resident 15's 6/17/2025 IDT Conference notes on 3/12/2026 at 9:37 a.m., ADON stated the IDT should review the physician's orders, medications, treatments, if with wounds, and physician orders for life-sustaining treatment (POLST, a legal document stating the kinds of medical treatment patients want toward the end of their lives). The ADON C stated she was not sure why the SLP evaluation was not completed.During an interview with the director of rehabilitation (DOR) on 3/12/2026 at 10:13 a.m., the DOR stated she ran a report this month (March 2026) and found out the SLP evaluation order in June 2026 was missed.Review of Resident 15's DOR note dated 3/8/2026, indicated, SLP eval [evaluation] and treat order was Missed for 6/11/2025.During a concurrent interview with registered dietitian (RD) and record review of Resident 15's 6/10/2025 RD Weights Note on 3/12/2026 at 12:30 p.m., RD confirmed she recommended the SLP evaluation because of the downgrade in Resident 15's diet. RD stated she did not follow up if her recommendation was completed.During a review of the facility's policy and procedure titled, Speech Therapy, date revised May 2013, indicated, The purpose of this procedure is to identify, assess and treat speech and language problems including swallowing disorders.Speech and Language Evaluation The speech therapist completes an evaluation of the following speech and language skills:.Ability to swallow.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 30 sampled residents (Residents 40) were free from unnecessary medication when Resident 40 received Lasix (used to treat edema [fluid retention; excess fluid held in body tissues]) for edema not indicating the specific site of edema and there were no monitoring for the nursing staff to monitor the edema. This deficient practice resulted in unmonitored medical condition.Finding:During a review of Resident 40's clinical record indicated Resident 40 was admitted to the facility on [DATE] with diagnosis including extended spectrum beta lactamase (ESBL, are enzymes produced by certain Gram-negative bacteria that make them resistant to many common antibiotics, including penicillins and cephalosporins) resistance and sepsis (is the body's extreme response to an infection. It is a life-threatening medical emergency.), unspecified. A review of Resident 40's physician's orders indicated an order for Lasix 40 milligram (mg, unit of measure), 1 tablet by mouth one time a day for edema HOLD if (systolic blood pressure) SBP < (is less than) 100, dated 2/6/26. A review of Resident 40's medication administration record (MAR) indicated the nursing staff did not monitor the edema. During a concurrent interview and record review on 3/12/26 at 2:45 p.m., with the Director of Nursing (DON), the DON was asked how they monitor the edema, the DON stated depending on the site of edema, the DON reviewed Resident 40's physician's order for Lasix 40mg for edema and for monitoring of edema, the DON confirmed Resident 40's Lasix the indication for edema, and there were no specific site of edema, the DON confirmed there was no monitoring for edema, the DON further stated Resident 40's Lasix it could be a maintenance medication. During a review of the facility's policy and procedures titled, Medication Therapy, undated, it indicated, Policy Statement 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. 2.Medication use shall be consistent with an individual's condition .and responses to such treatment.3. All medication orders will be supported by appropriate care and practices . Policy Interpretation and Implementation.2. All decisions related to medications shall include appropriate elements of the care process, such as: a. adequately detailed assessment.5. The physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: a. when medications is being given in excessive doses, fore excessive period of time, without adequate monitoring, or in the absence of a valid clinical rationale.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, the facility failed to ensure proper medication storage and maintenance of one out of two medication refrigerators, when1. A thermometer was not present inside the medication refrigerator, and the internal light did not function when the refrigerator door was opened; and,2. Resident 90's medication was not removed from active stock in the medication refrigerator for nine days after the resident expired.These deficient practices had the potential to result in residents receiving medications with reduced potency, as well as medication errors due to failure to remove discontinued medications from active stock. Findings:1.A review of the medication refrigerator temperature log for [DATE] indicated that, on [DATE], the recorded temperature was 39 F (Fahrenheit).During a concurrent observation and interview with the Assistant Director of Nursing (ADON) C in the medication room on [DATE] at 9:18 a.m., it was observed that there was no thermometer inside the medication refrigerator, and the internal light did not turn on when the refrigerator door was opened. The ADON C confirmed these observations. She stated that the light should function when the refrigerator is opened and that a thermometer should be kept inside the refrigerator to monitor temperature.During an interview with Nurse Supervisor (NS) R on [DATE] at 11:17 a.m., NS R stated that she had checked the thermometer inside the medication refrigerator and recorded a temperature of 39 F on the temperature log. She further stated that she did not know why the thermometer was no longer inside the refrigerator after she checked it. NS R confirmed that the thermometer should be kept inside the refrigerator and that the internal light should be functioning.A review of facility's Refrigerator Temperature log of [DATE] indicates that . record temperature twice daily during AM shift (0700-1530) and PM shift(1500-2330).if the temperature is too warm or too cold (above 41 deg F or below 36 deg F) write the temperature in the space provide and take action.A review of the facility's policies and procedures titled Refrigerators and Freezers dated 2001 indicates that . this facility will ensure safe refrigerator and freezer maintenance, temperature, and sanitation.Refrigerator and /or Freezers are maintained in good working condition.2. A review of Resident 90's clinical record indicated that the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a diffuse disease of the brain that alters brain function or structure). Further review of a nursing note dated [DATE] at 3:09 a.m. indicated that Resident 90 expired at 0300 on [DATE].A review of Resident 90's physician order dated [DATE] indicated Metoclopramide (a prescription medication used to treat gastroesophageal reflux disease [GERD] and gastroparesis, or delayed stomach emptying) oral solution 5 mg/5 mL, with instructions to administer 5 mL via G-tube every 8 hours for GERD, starting on [DATE].During a medication refrigerator inspection with the Assistant Director of Nursing (ADON) C on [DATE] at 9:41 a.m., a bottle of Metoclopramide oral solution 5 mg/5 mL labeled for Resident 90 was found inside the medication refrigerator. The ADON C confirmed the observation and stated that Resident 90 had already expired and that the medication should have been removed from the refrigerator.A review of the facility's policies and procedures titled Medication Labeling and Storage, dated 2001, indicates that .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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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and document review, the facility failed to offer provide a substitute of similar nutritional value for a menu item (milk), when Resident 133 preferred not to have milk at lunch meals. The failure to provide a substitute item of similar nutritional value had the potential to result in Resident 133 not receiving the nutrients meant to be provided by the planned menu leading to an inadequate nutrient intake.The menu spreadsheet titled Spring Cycle Menus dated 3/11/26, showed 8 ounces of milk on the menu for the Regular diet.During an observation in the resident dining room on 3/11/26 at 12:51 p.m., Resident 133 sat at a table eating her facility provided lunch. For her beverage, Resident 133 had one cup of juice in front of her. Resident 133's tray ticket (a piece of paper displaying information such as the resident's diet order, allergies, and food preferences) which was also on the table in front of her, showed Resident 133 was on a Regular diet, and Beverages: Coffee, 4 oz (ounce) Apple. During an interview with the Registered Dietitian (RD) and the Dietary Manager (DM) on 3/11/26 at 2:27 p.m., RD confirmed the menu was analyzed and should meet the DRIs (Dietary Reference Intake; a comprehensive set of scientifically developed evidence-based nutrient reference values for healthy populations in the U.S. They define the recommended daily intake for vitamins, minerals, and macronutrients, aimed at preventing deficiencies, reducing chronic disease risk, and preventing toxicities). DM confirmed milk was on the menu each day for each meal. DM stated Resident 133 did not dislike milk. DM stated he asked residents their preferences for beverages with their meals but a substitute for milk was not offered if residents preferred not to have milk for their meal/s. RD and DM agreed coffee and apple juice, which were Resident 133's beverage preference for lunch, did not provide the same nutrients as milk.During an interview on 3/13/26 at 10:18 a.m., DM stated he asked residents their beverage choices for meals but also offered snacks to residents which could be provided in between meals or on the meal tray. DM stated snacks could include milk products, but choices included food items that did not necessarily provide the same nutrients as milk, such as Jello and fruit. DM explained all residents were asked snack preferences and were not planned as a substitute for milk.