

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Vista Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Jose Figueres Avenue San Jose, CA 95116	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38243</p> <p>Based on observation, interview, and record review the facility failed to store food and maintain the kitchen under sanitary conditions when:</p> <ol style="list-style-type: none"> 1. Several food items were undated for use by dates in the refrigerators, freezers, and dry goods area, 2. Ice buildup was noted on the Dessert Freezer #2, 3. A black electric fan had dust accumulated on its surface, 4. Black residue was on the caulking of the dishwasher round sink and 3-compartment sink. <p>Failure to follow facility procedures and standards of practice for food safety has the potential of exposing residents, who are served food from the kitchen, to foodborne illnesses.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a kitchen observation and interview on 10/7/24 at 8:11 a.m., with the Registered Dietician (RD), several food items were observed with no use by dates (NUBD) in the following areas/locations and were acknowledged by the RD: <ol style="list-style-type: none"> 1a. Freezer #1 contained: A pack of diced carrots, with open date 9/29/24 lacked a use by date (NUBD). 1b. Freezer #3: (Meat Freezer) contained: A box of diced grilled chicken breast with open date 10/5/24 lacked a NUBD. A box of cheese pizza box, with open date 9/28/24 lacked a NUBD. A blue cup containing ice was found inside this Freezer #3 lacked a NUBD. 8 cups of butter pecan ice cream were found in this Freezer #3 (Meat Freezer) with no open dates or use by dates. 3 cups of sherbet were found with no open dates or use by dates. The RD agreed the staff should not store ice cream cups in the meat freezer. 1 box of Bean and Cheese Burritos w lacked a NUBD. 1 pack of Tortillas with open date 9/12/24 lacked a NUBD. 1 box of Pork Sausage with open date 9/12/24 lacked a NUBD. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1c. Two-Door Refrigerator contained: Marinara sauce, dated 9/24/24, lacked a NUBD. Ketchup, dated 9/24/24, lacked a NUBD. Black Bean sauce, dated 9/1/24, lacked a NUBD. Oyster sauce, dated 9/7/24, lacked a NUBD. Hoisien Sauce, dated 10/01/24, lacked a NUBD.</p> <p>1d. Freezer #4 (2-Door) contained: a box of Apple Turnover with open date 9/18/24 lacked a NUBD. A box of Waffles with open date 10/01/24 lacked a NUBD.</p> <p>1e. Dry Goods Area contained: A container of Dry [NAME] Peas had received date of 6/18/24 and lacked a NUBD. A container of Dry Lentil had a received date of 10/01/24 and lacked a NUBD. A container of [NAME] Rice had a received date of 7/2/24 lacked a NUBD.</p> <p>2. During observation and interview with the RD on 10/7/24 that started at 8:11 a.m., Dessert Freezer #2 was observed with ice buildup on the sides. The RD stated, I just noticed it this weekend .</p> <p>3. During an observation with the RD on 10/7/24 that started at 8:11 a.m., a black electric fan hanging by the dishwashing area was observed with dust and debris (visible particles that can accumulate on surfaces). The RD confirmed this observation and stated, Yes, definitely needs cleaning.</p> <p>4. During observation and interview with the RD and [NAME] E on 10/7/24 that started at 8:11 a.m., black residue was on the caulking of the round sink in the dish washing area. A 3-Compartment sink had black residue on the caulking. [NAME] E stated, I think it is molds. The RD acknowledged the observation.</p> <p>Review of facility policy and procedure titled Food Storage, dated 2023, indicated, Sufficient storage facilities will be provided to keep foods safe, wholesome, an appetizing. Food will be stored in an area that is clean, dry, and free from contaminants . Food should be dated as it is placed on the shelves if required by state regulation . Date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat TCS (Time and Temperature Control) food should be consumed, sold, or discarded . All containers or storage bags must be legible and accurately labeled and dated . Refrigerated food storage . All foods should be covered, labeled, and dated and routinely monitored to assure that foods will be consumed by their use by dates, or frozen (where applicable) or discarded . Frozen Foods . All foods will be checked to assure that foods will be consumed by their use by dates or discarded .</p> <p>Review of facility's undated policy and procedure titled Dietary Services - Sanitation, indicated, The food service area shall be maintained in a clean and sanitary manner . All kitchen, kitchen areas, and dining areas shall be kept clean . All utensils, counters, shelves, and equipment shall be kept clean and maintained in good repair. Seals, hinges, and fasteners will be kept in good repair . Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and as needed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection prevention practices were followed for two of five residents (Resident 19 and 64) under enhanced barrier precautions (EBP, used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) when:</p> <ol style="list-style-type: none"> 1. For Resident 19, proper PPE (Personal Protective Equipment) was not worn during a medication administration, 2. For Resident 64, the family member (FM) did not wear proper PPE while assisting staff to render care. <p>These failures had the potential to place the residents at risk of transmissible infections.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 19's medical record indicated she was admitted on [DATE] and had diagnoses including diabetes mellitus (too much sugar in the blood) with foot ulcer (breakdown of the skin and tissues creating an open wound), cutaneous abscess (localized collection of pus in the skin) of the right foot, and long-term antibiotics use. <p>Review of Resident 19's MAR (Medication Administration Record) indicated she had an order to administer Cefazolin Sodium (antibiotic used to treat bacterial infections) 1 GM (GM -a unit of measure) intravenously (into or within a vein) every 8 hours for right ankle cellulitis (a bacterial infection that affects the skin and underlying tissues) for six weeks.</p> <p>Review of Resident 19's Order Summary Report, dated 8/28/24, indicated an order for Enhanced Barrier Precautions (EBP) for high resident care activities related to PICC line (Peripherally Inserted Central Catheter, a thin, soft, long catheter [tube] that is inserted into a vein of the arm or leg and the tip of the catheter is positioned in a large vein that carries blood into the heart).</p> <p>During an observation on 10/7/24, at 2:00 p.m., Resident 19 had a room signage indicating EBP were in place, which required the use of PPE for high-contact resident care activities. The signage indicated that, providers and staff must also wear gloves and a gown for the following High-Contact Activities . Device care or use of . central line .</p> <p>During an observation and concurrent interview with registered nurse A (RN A) on 10/7/24 at 2:20 p.m., RN A administered Resident 19's intravenous antibiotic medication. RN A wore gloves during the medication administration, but she did not wear any additional PPE. When RN A exited Resident 19's room after the medication administration, she was alerted to the signage for the EBP outside Resident 19's room. RN A was asked why she did not don (To put on an article of clothing) a gown during the medication administration. RNA stated, I never wear a gown when I give Resident 19 her intravenous medication.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and concurrent interview with the infection preventionist (IP, professional who ensures healthcare workers and residents are practicing infection prevention measures) on 10/7/24 at 2:35 p.m., she confirmed the signage outside of Resident 19's room door that indicated EBP were in place for Resident 19. The IP stated that administering an intravenous medication, via a PICC line would require the licensed nurse to wear gloves and a gown. The IP confirmed that RN A should have worn a gown during the administration of Resident 19's intravenous medication.</p> <p>A review of the facility's policy titled Enhanced Barrier Precautions, dated May 2024, indicated, Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. EBPs employ targeted gown and glove use during high contact resident care activities . Examples of high -contact activities requiring the use of gown and gloves for EBPs include . g. device care or use (central line, urinary catheters, feeding tubes).</p> <p>38243</p> <p>2. Review of Resident 64's clinical record indicated he was admitted on [DATE] with diagnoses including Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and Hemiparesis (muscle weakness of partial paralysis on one side of the body that can affect arms, legs, and facial muscles) following cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting left non-dominant side, Dysphagia (difficulty in swallowing) following cerebral infarction and Encounter for attention for Gastrostomy (surgical procedure used to insert a tube, often referred as G-Tube, through the abdomen and into the stomach).</p> <p>Review of Resident 64's Order Summary Report, printed 10/8/24, indicated he had enteral feeding orders that started 4/17/24, and orders for Enhanced Standard Precautions (ESP) for high contact resident care activities r/t (related to) RISK FACTORS Indwelling Medical Device: G-Tube Perform hand hygiene & apply personal protective equipment (PPE), gloves, gown and/or goggle/face shield worn if risk of splash/spray during high contact resident care activities, every shift for Prevents Transmission of unknown MDROs (Multidrug resistant organism) . with the start date of 5/8/2024.</p> <p>Review of Resident 64's care plan Enhanced Barrier Precautions/Enhanced Standard Precautions (EBP/ESP) ., with an initiated date of 5/10/24, included, Approaches/Tasks: Educate resident's family members and visitors on helping resident understand the importance of personal hygiene and enhanced barrier/standard precautions. Date initiated: 5/13/24.</p> <p>During observations on 10/6/24 at 2:21 p.m. and 10/7/24 at 10:15 a.m., Resident 64' room had a sign hanging outside the room door and on the wall above the head of his bed that indicated, STOP, ENHANCED BARRIER PRECAUTIONS, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing; Bathing and Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting; Device care or use of central line, urinary catheter, feeding tube . Wound care: any skin opening requiring a dressing; Cleaning and disinfecting the environment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/7/24 at 10:20 a.m., Resident 64 was observed being transferred to a shower chair by certified nursing assistant (CNA) G from his bed. CNA G wore a PPE and gloves, but the family member (FM) who was assisted CNA G only wore gloves, and no other PPE. Licensed Vocational Nurse (LVN) D was called, and LVN D also called LVN C, to come and translate in Resident 64's primary language. LVN C pointed to CNA G to indicate that the resident's wife only wore gloves. LVN C and CNA G reminded the FM to wear the PPE (gown and gloves) in her primary language. After Resident 64 left on the shower chair with CNA G, the wife was also observed cleaning his bed while wearing only the same pair of gloves. LVN C reminded the wife in her primary language to wear PPE every time. LVN C stated the FM said she understood.</p> <p>During an observation on 10/9/24 at 3:30 p.m. with LVN D, who was about to perform a bolus tube feeding to Resident 64, the FM was present and sitting on a chair, was observed wearing PPE of gown and gloves. After LVN D was done with the Tube Feeding, the FM received a towel/big bib from another staff distributing them. The FM placed the folded towel/big bib just below Resident 64's G-Tube site that was covered with a dry clean dressing.</p> <p>During a concurrent observation and interviews with LVN C and with the FM on 10/10/24 at 2:53 p.m., LVN C translated for the FM and Resident 64 in their preferred language. FM was in the room wearing a mask and was sitting on a chair. Resident 64 was sitting up in his wheelchair and facing the window. FM was asked if she was informed before 10/7/24 to wear a gown (PPE) when helping to care for Resident 64 and was asked when she was informed to wear the PPE when she helped to take care of Resident 64. LVN C talked to FM in her language and stated, They told her before but sometimes she forgot, she is supposed to wear the gown, she only remembers the gloves, sometimes the weather is very hot, and it's hard to wear the gown, she only wears the gloves, LVN C pointed to the PPE RACK hanging on the door to the bathroom and reminded the FM she must wear the gown (PPE) when she helps to care for Resident 64 (touch him) to protect herself from say secretions/splashes, since Resident 64 had an indwelling G-Tube, and also to do hand hygiene before and after PPE to protect herself, her family and the community from spreading infection. LVN C also reminded the FM to make sure to take off the PPE after use, to place it in the trash can inside the room, and to do hand hygiene. The FM agreed. Resident 64 listened and also stated in his language that the FM knew and that she was informed before about wearing the PPE. LVN C was informed that, on 10/7/24, CNA G could have reminded FM to wear a gown while FM was helping to transfer Resident 64 to a shower chair.</p> <p>Review of Facility policy titled Enhanced Barrier Precautions, dated May 2024 indicated, . 2. EBPs employ targeted gown and glove use during high contact resident care activities and when cleaning/disinfecting the environment when contact precautions do not otherwise apply . a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens . i. environmental cleaning and disinfection . 4. EBP are indicated for residents with any of the following . 2) Wounds and wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage . or similar dressing and/or indwelling medical devices, device care or use . feeding tube . even if the resident is not known to be infected or colonized with a MDRO.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38243</p> <p>During observation, interview and record review, the facility failed to maintain equipment for one of 19 sampled residents (Resident 10) when Resident 10's bedside rolling table edge trimmings were peeled off and the footboard of her bed was wobbly (shaky).</p> <p>These failures posed as hazardous risks for injury to Resident 10.</p> <p>Findings:</p> <p>Review of Resident 10's face sheet (summary page of a patient's important information) indicated she was admitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness of partial paralysis on one side of the body that can affect arms, legs, and facial muscles) following cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), aphasia (a disorder that makes it difficult to speak) following cerebral infarction, Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Review of Resident 10's Brief Interview for Mental Status (BIMS, an assessment to test a person's cognition level), dated 7/18/2024, indicated a score of 99, which meant Resident 10 was unable to complete the interview.</p> <p>During an observation and interview on 10/9/24 at 9:41 am in Resident 10's room, certified nursing assistant (CNA) B wheeled Resident 10 from the bathroom to her bedside. The rolling table positioned over Resident 10's wheelchair/lap had a black strip of trimming that was peeling off. After CNA B left the room, Resident 10 was asked by surveyor if she was okay. Resident 10 stated, No, and pointed at the footboard of her bed.</p> <p>During a concurrent interview and observation in Resident 10's room with licensed vocational nurse (LVN) C on 10/9/24 at 9:47 am, Resident 10 sat on her wheelchair while LVN C stated, She (Resident 10) understands but will only answer 'okay'- she agrees or disagrees only . Sometimes [when] she yells okay, she will not use the call light, but that means she needs help. Resident 10 showed the peeling strip on the edges of her rolling table. LVN C was asked if it could hurt Resident 10, LVN C stated, Yes, I will ask maintenance to change her table now. LVN C asked the maintenance assistant (MA) to call the maintenance director (MD). LVN C was asked again if it is a hazard, and she stated, Yes, we will wait for maintenance to get a new table. The MA got another rolling table, cleaned it, and changed the one with the peeling edges. At 9:55 am the MD arrived. This surveyor pointed to the footboard of the bed that had two metal bars on it, one of which was loose and made it the footboard wobbly. The MD stated he would get his screwdriver, left the room, came back, and fixed the foot board of the bed. When it was done, Resident 10 smiled in agreement.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview with licensed vocational nurse (LVN) C on 10/10/24 at 8:48 am, she stated Resident 10 went to therapy. Surveyor checked both the footboard of the bed and the rolling table in Resident 10's room. The footboard of the bed was no longer wobbly, and the rolling table had no peeling strips. LVN C stated, We are supposed to tell maintenance, but I did not know . Resident (10) didn't tell me, but maintenance came yesterday and fixed it.</p> <p>Review of facility's policy Maintenance Schedules/Equipment, dated December 2004, indicated, Preventive maintenance schedules shall be developed and implemented to assure that the building and equipment are maintained in a safe and operable manner. Policy Interpretation and Implementation: 1. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p> <p>Review of facility policy Bed Safety and Bed Rails, dated August 2022, indicated, Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications.</p>		