

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Immediate jeopardy to resident health or safety 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 measures were implemented during the facility's COVID-19 (name of disease caused from SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2, a type of coronavirus]) outbreak (when a disease spreads to more people than usual, and caused by an infectious agent, such as bacteria, viruses, or parasites) when: 1. There was no Transmission-Based Precaution (a second tier of basic infection control used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission) related to COVID-19 posted at the double doors, and no isolation cart (a cart used in hospitals and other healthcare facilities to store all the personal protective equipment [PPE, are items like gloves, masks, gowns, and eye protection worn by healthcare workers to create a barrier and prevent the spread of infections] and supplies needed to care for a patient in isolation) found prior to the entry into Station AA (COVID-19 designated area and Dementia [a group of symptoms affecting thinking and social abilities interfering with daily functioning] locked unit) with 30 residents who tested positive for COVID-19 infections (residents with the virus and had an infection) and with 10 residents who tested negative for COVID-19 infections (residents who were not infected and had a negative test result). 2. There was inconsistent use of personal protective equipment among staff assigned to Station AA, and the room doors of residents with COVID-19 infections were left open; 3. Two activity aides provided group activities in the hallway to three residents, who were without face masks in place, seated close to each other in Station AA; and, 4. The facility failed to report timely the COVID-19 outbreak to the California Department of Public Health (CDPH, a state government agency). These infection control failures required immediate correction to prevent further transmission of the outbreak's virus among people at the facility. On 8/11/2025 at 7:09 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator (ADM) related to the above failures. On 8/15/2025 at 4:34 p.m., the IJ was removed after the ADM submitted an acceptable IJ Removal Plan (IJRP, a plan with interventions to immediately correct the deficient practices), and after the survey team verified and confirmed the corrective actions while onsite. The failures resulted in an increased number of COVID-19 infections among 36 residents (Residents 23, 97, 11, 22, 8, 34, 115, 70, 136, 80, 45, 37, 100, 86, 88, 39, 89, 7, 77, 131, 60, 67, 73, 33, 78, 35, 122, 18, 92, 148, 101, 125, 42, 44, 121, and 75) and staff. Resident 22 was transferred to an acute care (medical care provided to patients with sudden, severe, or time-sensitive health conditions that require immediate attention and treatment) hospital on 8/5/2025 due to medical complications related to COVID-19 infection. The failures had the potential for the remaining facility residents and staff that tested negative, and visitors to acquire the virus for a COVID-19 infection. Findings: 1. During an observation on 8/11/2025 at 9:15 a.m., in front of the facility's double doors to Station AA, there was no Transmission-Based Precaution related to COVID-19 infection posted. There was no isolation cart on sight prior to the entry into Station AA. During an interview with the infection preventionist (IP) on 8/11/2025 at 1:28 p.m., the IP confirmed (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555487	Facility ID: 555487 If continuation sheet Page 1 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	there was no signage posted in the Station AA's double doors which indicated the use of PPE prior to entry. The IP further confirmed visitors were just wearing face masks when they entered Station AA and should only don (put on) the rest of the PPE (gown, face shield and gloves) prior to resident's room entry. The IP confirmed visitors were exposed to residents with COVID-19 infection that frequently walked at the hallway. During a phone interview with the county's communicable disease investigator (CCDI) on 8/11/2025 at 12:26 p.m., the CCDI confirmed due to the increasing number of positive COVID-19 residents, she recommended transferring them to Station AA to contain all positive COVID-19 residents. During a review of the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines provided by Santa [NAME]'s Public Health office to the facility titled, Infection Control Guidance: SARS-CoV-2 [the virus that causes a respiratory disease called coronavirus disease 19], dated 6/24/2024, indicated, Post visual alerts (e.g. signs, posters) at the entrance and in strategic places (e.g. waiting areas, elevators.). These alerts should include instructions about current IPC [infection prevention and control] recommendations (e.g. when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. 2. During a concurrent observation and interview with activity aide H (AA H) on 8/11/2025 at 9:20 a.m., inside Station AA's hallway in front of Rooms BB and CC, the AA H was wearing an N95 mask (a respiratory protective device that filters out at least 95% of airborne particles when worn and fitted correctly), face shield and gown at the hallway. The AA H stated they were instructed to wear the full PPE when they entered Station AA. There were three residents seated outside Rooms BB and CC and were observed not wearing any mask. Further observation revealed there were residents walking in the hallway not wearing any masks. During a concurrent observation and interview with activity aide I (AA I) on 8/11/2025 at 9:22 a.m., in Station AA's hallway, the AA I was observed wearing an N95, face shield and gown at the hallway and stated they were instructed to wear the full PPE because they have to assist residents who were positive of COVID-19 infection at the hallway. During a concurrent observation and interview with restorative nursing aide J (RNA J) on 8/11/2025 at 9:23 a.m., in Station AA's hallway, the RNA J was observed wearing a mask, face shield and putting on the gown while walking at the hallway. The RNA J stated she needed to follow residents at the hallway, especially the wanderers [residents, often with dementia, who moves around in a confused, aimless, or repetitive manner, sometimes without awareness of their location or surroundings, and can become lost or disoriented]. During additional observation on 8/11/2025 at 9:24 a.m., at Station AA's hallway, two facility staff were observed just wearing N95 masks, not wearing gowns, and face shields, walking from the nurse station to the hallway, passed by wandering residents in Station AA. Some residents were not wearing face masks. During an interview with the IP on 8/11/2025 at 9:26 a.m., the IP confirmed that it was last week when she instructed staff in Station AA to wear gowns and face shields at the hallway because of the wanderers who tested positive of COVID-19 infections in Station AA. The IP stated staff inside Station AA should protect themselves by wearing PPE at the hallway. During an interview with the activity supervisor (AS) on 8/11/2025 at 10:02 a.m., AS confirmed AA H and AA I were assigned in Station AA. The AS stated, they were not instructed to wear a gown, and face shield at the Station AA hallway. During an observation in front of Station AA's double door entry on 8/12/2025 at 3:10 p.m., two visitors went inside Station AA with only face masks. During an observation inside Station AA on 8/12/2025 at 3:16 p.m., in front of Resident 73 and 33's room, the door was left open, with transmission-based precaution posted and Resident 73 was observed in bed with productive cough (a cough that brings up mucus or phlegm [sputum] from the airways and lungs). Resident 33 was asleep in bed. During an observation inside Station AA on 8/12/2025 at 3:19 a.m., in front of Resident 60 and 67's room, the door was left open, with transmission-based precaution posted and both residents were not in their room. During an observation inside Station AA on 8/12/2025 at 3:23 p.m., in front of Resident 148 and 18's room, the door was left open, with transmission-based precaution posted and both Residents 148 and 18 were asleep. During an observation inside Station AA's hallway on 8/12/2025 at 3:25 p.m., there were (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	residents observed seated outside their rooms and there were residents who wandered at the hallway without face masks.During an observation inside Station AA on 8/12/2025 at 3:27 p.m., in front of Resident 34 and 131's room, the door was left open, with transmission-based precaution posted and Resident 34 was asleep in bed. Resident 131 was not in the room.During an observation inside Station AA on 8/12/2025 at 3:29 p.m., in front of Resident 37, 136, and 45's room, the door was left open, with transmission-based precaution posted, Resident 37 was not in the room, Resident 136 was seated at the edge of the bed watching a show via a tablet, and Resident 45 was asleep in bed.During an observation inside Station AA on 8/12/2025 at 3:30 p.m., in front of Resident 100's room, the door was left open, with transmission-based precautions posted, and Resident 100 was observed in bed.During an observation inside Station AA on 8/12/2025 at 3:32 p.m., in front of Resident 22, and 11's room, the door was left open, with transmission-base precaution posted, both Residents 22 and 11 were asleep in bed.During an observation inside Station AA on 8/12/2025 at 3:33 p.m., in front of Resident 70, 89, and 7's room, the door was left open, with transmission-based precaution posted, and Residents 70 and 89 were not in the room. Resident 7 was observed asleep in bed.During an observation inside Station AA on 8/12/2025 at 3:37 p.m., in front of Resident 35 and 39's room, the door was left open, with transmission-based precaution posted, Resident 35 walked out of the room without face mask, while Resident 39 was asleep in bed.During an interview with registered nurse M (RN M) on 8/12/2025 at 3:43 p.m., RN M confirmed there were three rooms with residents still negative of COVID-19 infection. RN M confirmed negative residents mingled with positive residents.During a concurrent observation inside Station AA and interview with certified nursing assistant L (CNA L) on 8/12/2025 at 3:45 p.m., in front of Resident 78 and 122's room, the door was left open, with transmission-based precaution posted, CNA L was wearing N95, face shield and gown while standing in front of Resident 78 and 122's room, while Resident 78 was seated outside the room. Resident 122 was observed asleep in bed. CNA L confirmed both Residents 78 and 122 were at risk of falling and she was their sitter (a caregiver who provides companionship and supervision to patients who need constant observation or assistance, often due to medical conditions or behavioral issues that could pose a risk). CNA L further confirmed both residents were positive for COVID-19 infection. CNA L stated staff should encourage residents to wear face masks whenever they are out of their rooms. During an observation inside Station AA on 8/12/2025 at 3:48 p.m., in front of Resident 92 and 86's room, the door was left open, with transmission-based precaution posted, and both Residents 92 and 86 were in bed.During an observation inside Station AA 8/12/2025 at 3:50 p.m., in front of Resident 101 and 125's room, the door was left open, with transmission-based precaution posted, and both Residents 101 and 125 were in bed.During an observation inside Station AA on 8/12/2025 at 3:52 p.m., in front of Resident 115, 77 and 8's room, the door was left open, with transmission-based precaution posted. Resident 115 and Resident 8 were in bed. Resident 77 walked out of the room to greet the nurse surveyor without a face mask.During an observation inside Station AA on 8/12/2025 at 3:55 p.m., in front of Resident 88's room, with transmission-based precaution posted and the door was closed.During an interview with RN M on 8/12/2025 at 4:00 p.m., RN M confirmed residents with COVID-19 infections should be encouraged to wear face masks when they were out of their rooms. RN M further confirmed their residents' (with COVID-19 infection) doors should remain closed.During a concurrent interview with the infection preventionist (IP) and record review of the 8/11/2025 infection control line listing (a spreadsheet-like table that provides a quick summary of essential information about each case during a disease outbreak) on 8/19/2025 at 2:36 p.m., the IP confirmed the following:a. There were 26 residents (Residents 22, 8, 34, 115, 70, 136, 80, 45, 37, 100, 86, 88, 39, 89, 7, 77, 131, 60, 67, 73, 33, 78, 35, 122, 18, and 148) from Station AA who tested positive for COVID-19 infections from 8/4 - 8/8/2025 and Resident 22 was transferred out to the hospital on 8/5/2025 due to fever, episodes of vomiting and low oxygen saturation (a lower than normal level of oxygen in the blood typically defined as below 90%);b. There were 6 residents (Residents 23, 97, 11, 92, 101, 125) from Station DD (designated COVID-19 area until 8/6/2025) who (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	tested positive for COVID-19 infections from 7/28 - 8/9/2025;c. Certified nursing assistant N (CNA N) had a cough and was tested positive for COVID-19 on 7/19/2025. CNA N was assigned in Station DD residents on the fourth day of infection;d. Certified nursing assistant O (CNA O) had a cough and sore throat and was tested positive for COVID-19 infection on 7/23/2025. CNA O was exposed to CNA N when they shared their food with each other. CNA O worked with some residents in Station DD prior to being tested positive for COVID-19;e. [NAME] C had a runny nose, sneezes, and was tested positive for COVID-19 infection on 7/31/2025;f. Physical therapy assistant P (PTA P) had a fever and was tested positive for COVID-19 infection on 8/1/2025;g. Certified nursing assistant Q (CNA Q) had a headache and was tested positive for COVID-19 infection on 8/1/2025. CNA Q worked the day shift and was assigned to some residents in Station DD prior to being tested positive for COVID-19;h. Certified nursing assistant R (CNA R) had fever and headache and was tested positive for COVID-19 infection on 8/2/2025. CNA R worked the night shift and had the same assigned residents with CNA Q prior to being tested positive for COVID-19 infection;i. AA H had a cough, sore throat on 8/3/2025, and was tested positive for COVID-19 infection on 8/4/2025. The AA H assignment was in Station AA prior to being tested positive for COVID-19 infection;j. Certified nursing assistant S (CNA S) had fever, chills and weakness on 8/3/2025, and tested positive for COVID-19 infection on 8/4/2025. CNA S's assignment was in Station AA prior to testing positive; k. IP stated staff in Station AA were only wearing N95 and not the full PPE at the hallway until she instructed them on 8/9/2025 to wear the full PPE;l. Registered nurse T (RN T) did not have symptoms but tested positive for COVID-19 infection on 8/6/2025. RN T was assigned in Station DD prior to testing positive;m. Licensed vocational nurse U (LVN U) did not have symptoms but tested positive for COVID-19 infection on 8/7/2025. LVN U was assigned to Station AA prior to testing positive; n. Certified nursing assistant V (CNA V) had a cough and was tested positive for COVID-19 infection on 8/7/2025. CNA V was assigned to Station AA prior to testing positive;o. Certified nursing assistant W (CNA W) had body malaise (a general feeling of discomfort, weakness, or simply not feeling well) and tested positive for COVID-19 infection on 8/8/2025. CNA W was assigned to Station AA prior to testing positive; and, p. Licensed vocational nurse X (LVN X) did not have any symptoms but tested positive for COVID-19 infection on 8/9/2025. He worked in Station EE on 8/6/2025. During a concurrent interview with the infection preventionist (IP) and record review of the 8/19/2025 infection control line listing on 8/19/2025 at 3:30 p.m., the IP confirmed the following:a. Certified nursing assistant Y (CNA Y) had a cough, felt dizzy, with runny nose and tested positive for COVID-19 infection on 8/13/2025. CNA Y's previous assignment was in Station EE prior to testing positive;b. Resident 42 had an occasional cough with body malaise and tested positive for COVID-19 infection on 8/13/2025. Resident 42 was from Station DD and Resident 125 was her roommate;c. Resident 44 tested positive for COVID-19 infection on 8/14/2025. Resident 44 was from Station DD;d. Resident 121 tested positive for COVID-19 infection on 8/17/2025 and was transferred out to acute care on 8/17/2025 due to gastrointestinal bleeding (GI); and,e. Resident 75 tested positive for COVID-19 infection on 8/18/2025 and was from Station EE (Station residents tested negative of COVID-19 infections).During a review of the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines provided by the Santa [NAME] County Public Health Department's office to the facility titled, Infection Control Guidance: SARS-CoV-2, dated 6/24/2024, indicated, Patient Placement Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed. Limit transport and movement of the patient outside of the room. Visitation Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric [strict used of PPE based on the spread of infection] use of Transmission Based Precautions for residents and work restriction of HCP [healthcare professional] with higher-risk exposures. Further review indicated, Implement Source Control Measures Source Control refers to use of respirators or (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control is recommended for individuals in healthcare settings who: *Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g. those with runny nose, cough, sneeze); or *Had a close contact (patients and visitors) or higher-risk exposure (HCP) with someone with SAR-CoV-2 infection, for 10 days after their exposure.3. During an interview with the AS on 8/11/2025 at 10:02 a.m., AS stated activities should be provided inside the room of residents with COVID-19 infection. AS further stated, group activities should be cancelled since they had an outbreak.During an interview with the IP on 8/11/2025 at 1:28 p.m., IP stated there should be no activities outside resident rooms during the outbreak.During a review of the Centers for Disease Control and Prevention (CDC) COVID-19 guidelines provided by Santa [NAME]'s Public Health office to the facility titled, Infection Control Guidance: SARS-CoV-2, dated 6/24/2024, indicated, Take measures to limit crowding in communal spaces [an area or facility shared and used by a group of people for activities].4. During an interview with infection preventionist (IP) on 8/11/2025 at 8:54 a.m., the IP confirmed they have a total of 32 patients and 12 staff who tested positive for COVID-19 infection from 7/23 - 8/9/2025. The IP confirmed she did not report this COVID-19 outbreak to CDPH.During an interview with the IP on 8/19/2025 at 2:31 p.m., the IP confirmed they had a total of five patients and three staff who tested (+) for COVID-19 infections in June 2025. The IP confirmed she did not report this outbreak to the Department as well.During a review of the facility's policy and procedure titled, REPORTABLE DISEASES, date revised 3/2023, indicated, The purpose of this procedure is to provide guidelines for facility staff to report infectious, contagious, or communicable diseases to the appropriate city, county and/or state health department officials. Should any resident(s) or staff be suspected or diagnosed as having a reportable communicable/infectious disease according to State-specific criteria, such information shall be promptly reported to appropriate local and/or state health department officials.During a review of the facility's Job Description job titled, Infection Preventionist, date signed 10/2/2023, indicated, Other Clinical Responsibilities.Confirm, investigate, and report outbreaks in compliance with local, state, and federal guidance. This includes any reporting required during instances of pandemics or outbreaks.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietitian. Based on interview and document review, the facility failed to have qualified, full-time oversight of Food and Nutrition Services in accordance with State requirements when the Registered Dietitian did not fulfill the role in the Dietitian job description, and the staff put in charge of supervising the kitchen were not qualified. This deficient practice could result in compromising the safety and nutritional status of residents through potential transmission of foodborne illness and decreased quality of food for 144 residents, who received food from the kitchen out of a census of 151. Findings: Review of California Code Regulations Title 22 S 70271 - Dietetic Service Definition, shows Dietetic Services refers to operations in relation to food, specifically providing safe, satisfying and nutritionally adequate food for patients with appropriate staff, space, equipment and supplies. Review of California Code Regulations Title 22 S 70271 - Dietetic Service Staff shall include a full-time qualified person to manage and oversee the day-to-day supervision and management, specifically of dietetic services. There are multiple pathways to achieve the qualification including a full-time registered dietitian who is responsible for supervising and managing all aspects of dietetic services. Title 22 S 70271 also notes if the duties of the registered dietitian do not include the responsibilities of managing and supervising the day to day operations of dietetic services the facility shall employ a qualified dietary services supervisor. Examples of day-to-day operation include providing food of the quality and quantity to meet patient's needs in accordance with physicians' orders; maintaining current profile cards for residents/patients indicating diet, likes, dislikes and other pertinent information concerning the patient's dietary needs; ensuring food is prepared by methods which conserve nutritive value, flavor and appearance; ensuring food is served attractively and in a form to meet individual needs; ensuring food storage areas are clean at all times; ensuring readily perishable foods or beverages capable of supporting rapid and progressive growth of microorganisms which can cause food infections or food intoxication are maintained at appropriate temperatures; ensuring all kitchen areas are kept clean and protected from pests; ensuring all utensils, counters, shelves, and equipment are clean, maintained and maintained in good repair; ensuring all utensils used for eating, drinking and in the preparation and serving of food and drink are cleaned appropriately; ensuring all dietetic service personnel are trained and their working hours are scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service areas; ensuring weekly staff schedules are posted, ensuring proper staff hygiene, ensuring equipment of the type and in the amount necessary for the proper preparation, serving and storing of food and for proper dishwashing is provided and maintained in good repair; procuring food to meet menu requirements, and ensure food is of good quality. During an observation and interview on 8/11/25 at 9:17 a.m., the Environmental Director (ED) and the Assistant Dietary Supervisor (ADS) were in the supervisor office located in the kitchen. When asked who the kitchen supervisor was, ED stated I guess that's me. ED stated she was the Environmental Director, and also in charge of Central Supply, Housekeeping, and Maintenance. ADS stated she helped ED supervise the kitchen. During an interview on 8/12/25 at 8:40 a.m., the Administrator (ADM) stated the RD did not oversee the day-to-day operation of the kitchen. The ADM stated ADS oversaw the day-to-day operation of the kitchen, but she was not qualified. During an interview on 8/13/25, the Registered Dietitian (RD) stated she handled clinical nutrition only, but did complete a monthly sanitation checklist in the kitchen. During an interview on 8/14/25 at 12:10 p.m., when ED was asked what her role was in the kitchen, she stated she had a supervisor role. ED stated she did staff scheduling, contacted vendors, ordered equipment, and oversaw anything that was needed. ED stated she and ADS evaluated kitchen staff quality of work. During an interview on 8/15/25 at 3:54 p.m., the ADM stated the RD was in charge of all of Food and Nutrition Services. ADM stated the RD supervised the day-to-day operation of the kitchen up to a month to a month and a half ago and now ADS is the Assistant Supervisor with support of ED. The ADM stated ADS was more qualified than ED to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	supervise the kitchen because ADS had foodservice experience. During an interview on 8/18/25 at 10:57 a.m., ADM stated ADS and ED did not meet any of the qualification pathways listed in HSC S 1265.4, subdivision (b).Review of the California Code, Health and Safety Code - HSC S 1265.4, showed the requirements of subdivision (b) included:(1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility.(2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration.(3) A graduate of a dietetic assistant training program approved by the American Dietetic Association.(4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.(5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.(6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision.(7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).Review of the document titled Dietitian dated 2003, showed the primary purpose of the position was to plan, organize, develop and direct the overall operation of the Food Services Department, and to assure that quality nutritional services are provided on a daily basis and the Food Services Department is maintained in a clean, safe, and sanitary manner. Specific requirements for the position included a current active license to practice as a dietitian in the state. Review of the facility's Organization Chart dated 2021, showed the Dietary Services Supervisor reported to the Registered Dietitian and the Administrator, and the Dietary Staff reported to the Dietary Services Supervisor. ADS and ED names were handwritten in for the Dietary Supervisor position, and RD's name was handwritten in for the Registered Dietitian position. Because the organization chart showed kitchen staff reported directly to the Dietary Services Supervisor, this showed the Dietary Services Supervisor was responsible for supervising kitchen staff and demonstrated the need for the Dietary Services Supervisor to be qualified by one of the qualification pathways listed in HSC S 1265.4, subdivision (b).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based observation, interview, and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. ADS was unable to accurately demonstrate the procedure for testing the concentration, according to manufacturer specifications, of the sanitizing solution used on food contact surfaces. Cook C was unable to accurately identify the acceptable calibration temperature for two thermometers in an ice water solution. These failures had the potential to result in ineffective sanitation practices and the use of inaccurate temperature-measuring devices for verifying safe food temperatures, thereby increasing the risk of foodborne illness among a high-risk population of 144 residents who consumed food prepared in the facility's kitchen. At the time, the facility's census was 151. Findings: 1. ADS was unable to accurately demonstrate the procedure for testing the concentration, according to manufacturer specifications, of the sanitizing solution used on food contact surfaces. During a concurrent observation and interview on 08/12/2025 at 10:40 AM at the three-compartment sink in the kitchen with Assistant Dietary Supervisor (ADS), ADS tested the sanitizing solution for wiping kitchen surfaces by first pouring sanitizer from a tube dispenser, located above the three-compartment sink, into a container. The sanitizing solution container was labeled as a quaternary ammonia sanitizer. ADS then removed a test strip from the test strip container and dipped the test strip into sanitizing solution and moved the test strip in circles, while in the sanitizing solution, for more than 5 seconds. ADS then removed the test strip from the sanitizing solution and held it up to the color chart located on the test strip container. The test strip appeared dark. ADS noted that the color of the test strip dipped in the sanitizing solution matched the color for 200 parts per million (ppm). ADS was asked to verbalize the amount of time the test strip should be dipped in the sanitizing solution. ADS stated the test strip should be dipped in sanitizing solution for 5 to 10 seconds. ADS was asked to read the instructions on the test strip container and ADS verbalized that the test strip should be dipped in sanitizing solution for 1 second, according to the instructions. ADS was asked to repeat the process for testing the sanitizing solution by following the instructions on the test strip container. At the end of the process, ADS held the test strip up to the color chart located on the test strip container and ADS confirmed the color did not match 200 ppm and was closer to the color for 100 ppm. ADS stated the vendor would need to be notified. During a review of the Directions for Use (undated) for the sanitizer, the Directions for Use indicate that the automatic dispensing equipment is adjusted by serviceman to provide 1/2 oz (ounce) of sanitizer per gallon of water (200 ppm) or according to requirements of Public Health Authorities. 2. [NAME] C was unable to accurately identify the acceptable calibration temperature for two thermometers in an ice water solution. During a concurrent observation and interview on 08/13/2025 at 9:50 AM with [NAME] C in the kitchen, [NAME] C demonstrated thermometer calibration for 4 thermometers by placing each of the 4 thermometers in ice water. The 4 thermometers showed the following temperatures in degrees Fahrenheit: 32, 33.1, 32.4 and 28.5. [NAME] C was asked what temperature was expected from the 4 thermometers and [NAME] C stated that a temperature of 32 degrees Fahrenheit (degrees F) or lower was considered acceptable. [NAME] C stated that all the temperatures of the thermometers were acceptable, except for the thermometer that read 33.1 degrees F, which would require notifying (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ADS. [NAME] C was asked if a temperature of 28.5 degrees F was an acceptable temperature. [NAME] C confirmed a temperature of 28.5 degrees F was acceptable. During a concurrent observation and interview on 08/13/2025 at 10:12 AM with ADS in the kitchen, after [NAME] C had completed demonstration of thermometer calibration for 4 thermometers in ice water, ADS was asked to look at the temperatures of the 4 thermometers in ice water. ADS was asked if a temperature of 28 degrees F was acceptable for one of the thermometers. ADS stated that 28 degrees F was considered too low and that a supervisor would need to be notified. ADS also stated that the thermometer with a temperature reading of 33.1 degrees F was not acceptable. ADS stated that a temperature of 32 degrees F is an acceptable temperature. ADS confirmed not knowing how to calibrate the thermometers. During an interview on 08/12/2025 at 3:10 PM in the kitchen with ADS, ADS stated that stated thermometers are calibrated by the cooks every Monday or Tuesday at around 5:30 AM. During a review of the facility's Food and Nutritional Services Policy and Procedures titled Calibrating the Thermometer, last revised on January 2025, the following guidance was noted: thermometer shall register +/- 1 degree F (Fahrenheit) from 0-230 F. It also indicated that there are two ways to calibrate a thermometer: a. the ice point method; and b. the boiling point method. It also indicated that thermometers should be calibrated at least monthly. It also indicated under ICE POINT CALIBRATION the following instructions: 1. To calibrate the thermometer using the ice point method, begin with a container large enough to easily accommodate your thermometer. 2. Fill the container with ice, add tap water to fill and stir. 3. Allow ice water mixture to cool for several minutes. 4. Place thermometer probe into the ice water mixture and hold the probe so that it does not touch the sides of the container. 5. It is important to wait about 30 seconds. 6. Be sure the temperature indicators is no longer moving. 7. Calibrate the thermometer via individual thermometer methods, i.e. screwdriver or wrench until the reading on the face of the dial reads 32 degrees Fahrenheit (0 degrees Celsius). 8. If the thermometer does not permit calibration and the temperature reading exceeds or does not reach temperature accuracy, the thermometer shall be removed from service.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 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: Discard unused pork leftovers following dinner service on 08/10/2025. Discard 2 expired raw thawing turkey loaves with a use by date of 08/09/2025. Maintain food at or below 41 F in the one-door refrigerator, as required for proper refrigeration. Maintain cleanliness of 4 out of 12 knives. These deficiencies had the potential to compromise food safety and increase the risk of foodborne illness for 144 of the 151 residents who consumed meals prepared in the facility's kitchen. Findings: 1. Failure to discard unused pork leftovers following dinner service on 08/10/2025. Potentially hazardous foods (PHF) are those capable of supporting bacterial growth associated with foodborne illness. Protein-based products such as meat are considered to be potentially hazardous and require time/temperature control for food safety. PHF's that are cooked and held must be monitored for time/temperature control to ensure food safety. PHF's must be cooled from 135 degrees F (Fahrenheit) to 70 degrees F within 2 hours and from 70 F to 41 F or below in an additional 4 hours, a timeframe not to exceed 6 hours (USDA Food Code, 2022). During an observation on 08/11/2025 at 9:36 AM in the walk-in refrigerator, 2 metal pans, each of which were covered with a foil cover and pork inside the pan. One of the metal pans covered with foil had writing on the foil with black marker indicating pork use by 8-11-25, and the other had writing on the foil with black marker indicating puree pork use by 8-11-25. It was also noted the 2 metal pans sat on top of 2 raw thawing turkey loaves (turkey in a cylindrical plastic packaging) that were inside a large metal pan with a label indicating a use by date of 08/09/2025. During a concurrent observation and interview on 08/11/2025 at 2:51 PM with the Assistant Dietary Supervisor (ADS) in the kitchen, the ADS stated the 2 metal pans with pork inside the walk-in refrigerator was leftover pork from 08/10/2025 dinner meal and the ADS was not sure why it had been in the walk-in refrigerator. The ADS confirmed that the pork from the 08/10/2025 dinner meal should not have been stored as leftovers. ADS was asked about the 2 metal pans with pork inside, which had been sitting on top of 2 raw thawing turkey loaves. ADS stated that the 2 metal pans with pork inside should not have been stored on top of the 2 loaves of raw thawing turkey. ADS confirmed the facility uses a cool down logbook, but that only egg salad and tuna salad are logged. ADS stated there is no cool down process for any other foods. During an interview on 08/12/2025 at 11:08 AM with [NAME] L, [NAME] L was asked about the 2 metal pans with pork inside and [NAME] L stated the pork was leftovers from 08/10/2025 dinner meal. [NAME] L stated the pork was going to be thrown away on 08/10/2025, but because [NAME] L was in a hurry after the shift on 08/10/2025, and did not have time to throw the pork out, [NAME] L added a use by date to the 2 metal pans with pork inside and placed them in the refrigerator. [NAME] L stated the facility does not use leftovers. [NAME] L confirmed it was incorrect to store leftover pork in the refrigerator. During an interview on 08/13/2025 at 2:20 PM with Registered Dietician (RD), the RD stated that the facility does not implement a cooling process. When asked about awareness of pork leftovers from the 08/10/2025 dinner meal, the RD confirmed not being aware that any leftovers existed and added that the facility does not utilize leftovers. During a review of the facility's policy and procedure titled, Hazardous Foods Cooling Monito, dated 01/31/2018, outlines procedures for cooling potentially hazardous foods, identifying meats among several food types classified as hazardous. The procedures advise to record the temperature of food every hour and to record action taken to achieve proper temperature cooling on a DS-23-Form A-Cooling Monitor Log. The DS-23-Form A-Cooling Monitor Log is included at the end of the policy and procedure document. During a review of the facility's policy and procedure titled, Food Receiving and Storage dated 01/2025, indicated the refrigerated storage guideline: Separating raw foods (e.g. beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods. During a review of the facility's policy and procedure titled, Food Receiving and Storage dated (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	01/2025, indicated the refrigerated storage guideline: Separating raw foods (e.g. beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods.2. Failure to discard 2 expired raw thawing turkey loaves with a use by date of 08/09/2025.During an observation on 08/11/2025 at 9:38 AM, 2 raw thawing turkey loaves sitting in a metal pan covered with a foil had a use by date of 08/09/2025 and a prep date of 08/07/2025.During an interview on 08/11/2025 at 2:51 PM with ADS, ADS confirmed the 2 raw thawing turkey loaves should have been discarded on 08/09/2025. The ADS also confirmed expired items should not have been in the refrigerator and that staff had not been checking for expired items on a daily basis.During a review the job descriptions for both cooks and diet aides (undated), indicated that, under 'Duties and Responsibilities' related to safety and sanitation, staff are instructed to dispose of food and waste in accordance with established policies.During a review of the facility's policy and procedure titled, Food Receiving and Storage, dated 01/2025, indicated that practices to maintain safe refrigerated storage include.labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded.3. Failure to maintain food at or below 41 F in the one-door refrigerator, as required for proper refrigeration.During an observation on 08/11/2025 at 9:46 AM at the one-door refrigerator in the kitchen, the internal temperature of the one-door refrigerator was 45 F.During a concurrent observation and interview on 08/11/2025 at 9:47 AM with Diet Aide K (DA K) at the one-door refrigerator in the kitchen, DA K was asked how long the small individual-sized milk cartons inside the one-door refrigerator had been there, since they were not cold to touch. DA K stated, the small individual-sized milk cartons had recently been in the breakfast tray line, and were previously on ice while in the breakfast tray line. DA K stated the breakfast tray line was completed at 8:30 AM.During an observation on 08/11/2025 at 9:50 AM at the one-door refrigerator in the kitchen, the refrigerator did not feel very cold. The internal thermometer temperature had a reading of 45 F. There were 5 gallons of milk, along with a number of other items including approximately 32 cups of juices for tray line, approximately 3 small individual-sized yogurt containers, approximately 5 containers with tofu, 4 breakfast meals covered with plastic wrap, several covered cups of milk used for tray line, and approximately 3 small individual-sized milk cartons.During an observation on 08/11/2025 at 9:50 AM at the one-door refrigerator in the kitchen, 4 out of the 5 containers with tofu had a use by date of 8/8 and one container with tofu had a use by date of 8/14. One out of the 5 containers with tofu contained pureed tofu that measured at 43.6 F. One out of the 5 containers with tofu contained minced tofu that measured at 43.9 F.During an interview on 08/11/2025 at 9:52 AM with [NAME] Assistant N (CA N), CA N stated the containers with tofu were prepared 3 days ago and then placed in the one-door refrigerator. CA N confirmed that 4 out of the 5 containers with tofu were beyond the use by date of 08/08/2025 and should have been discarded on 08/08/2025. CA N stated that the 5 containers with tofu had been taken out of the tray line and placed inside the one-door refrigerator today (08/11/2025). CA N confirms that the use by date means it's past already in reference to when the food can no longer be consumed. The tofu inside the 4 containers were thrown out after the interview.During an observation on 08/11/2025 at 9:57 AM at the one-door refrigerator in the kitchen, the 5 gallons of milk do not feel very cold.During a concurrent observation and interview on 08/11/2025 at 12:52 PM with the ADS at the one-door refrigerator in the kitchen, the ADS stated that DA E had moved the 5 gallons of milk from the walk-in refrigerator to the one-door refrigerator today at around 6:00 AM. The internal thermometer temperature had a reading of 40 F at the time of the interview. ADS stated the one-door refrigerator was used to store tray line items such as beverages. Temperatures were measured for all 5 gallons of milk, and 4 out of 5 gallons of milk were outside the desired temperature of 41 F and below, with readings of 50.0 F, 49.8 F, 49.8 F, and 49.5 F. The temperatures were confirmed with the ADS thermometer. ADS stated the temperatures of the milk should be below 41 F.During an interview on 08/11/2025 at 2:51 PM with ADS, the ADS stated the 4 containers with tofu with use by dates of 08/08/2025 should not have been inside the one-door (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refrigerator and should have been discarded on 08/08/2025. During a review of the facility's policy and procedure titled, Food Receiving and Storage dated 01/2025, indicated practices to maintain safe refrigerated storage includes monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation. 4. Failure to maintain cleanliness of 4 out of 12 knives. During an observation on 08/11/2025 at 10:00 AM at the knife station, 4 out of 12 knives appeared dirty with grime. During a concurrent observation and interview on 08/11/2025 at 10:15 AM with [NAME] B, [NAME] B agreed that 4 out of 12 knives in the knife rack appeared dirty with grime (residue that is stuck to a surface and is often hard to clean) on the blade, and should be returned back to the washer. [NAME] B confirmed the knife rack should only contain clean knives. [NAME] B stated knives are washed in the dish machine. During a concurrent observation and interview on 08/11/2025 at 10:16 AM with ADS, ADS agreed that 4 out of 12 knives appeared dirty with grime and should be returned back to the washer. ADS confirmed that clean and dirty knives should not be stored together in the knife rack. During a review the job descriptions for the cooks (undated), indicated that, under 'Duties and Responsibilities', cooks are instructed to, ensure that food and supplies for the next meal are readily available, and ensure that the department is maintained in a clean and safe manner by assuring that necessary equipment and supplies are maintained. During a review of the facility's policy and procedure (P&P) titled, Dietetic Cleaning and Disinfection of Utensils, dated 01/2025, indicated policy statement, All utensils used for eating, drinking and in the preparation and serving of food and drink shall be cleaned and disinfected or discarded after each usage. The P&P also indicated, Gross food particles shall be removed by careful scraping and prerinse in running water.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 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 record review, the facility failed to allow residents to store perishable food brought in by visitors and family. This failure had the potential to result in decreased food intake leading to weight loss and/or food related medical complications for 144 residents who ate food by mouth out of a census of 151. Findings: During an interview on 8/11/25 at 3:39 p.m., Licensed Vocational Nurse (LVN) A, stated perishable food brought in for residents, such as by family or visitors, was not stored for residents. LVN A stated residents and families were provided education that food brought in had to be consumed or discarded within one hour. When LVN A was asked if family brought in perishable food in the morning, but the resident wanted to eat it later in the day, LVN A stated the family needed to take the food home and bring it back later when the resident wanted to eat it. During an interview on 8/13/25 at 2:20 p.m., the Registered Dietitian (RD) stated she was aware food brought by visitors for residents was not stored and it had to be discarded within two hours. RD stated the facility did not have enough refrigerators to store resident's personal perishable food. An observation on 8/15/25 at 10:31 a.m., showed the kiosk at the located at the facility's front desk, used for checking in visitors, displayed a message for a visitor to sign, stating I understand that any food I bring in must be reviewed by nursing for appropriateness prior to giving to patient/resident. Additionally, food left with patient/resident that is not consumed during my visit will need to be disposed of if not consumed timely. During an interview on 8/15/25 at 5 p.m., the Administrator confirmed the facility did not store residents' personal perishable food. Review of the facility document titled Bringing in Food for a Resident dated 2018, showed it was a document for visitors to sign and date and stated . all prepared food must be consumed during visit with resident . NO MICROWAVE IS AVAILABLE FOR REHEATING FOOD FROM OUTSIDE.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain the outside waste collection area in good condition. This failure had the potential to create unsafe and unsanitary conditions by attracting pests, such as rodents and insects, which could carry and spread disease, posing a risk of foodborne illness to all 151 residents of the facility. Findings: During an observation on 08/11/2025 at 3:46 PM at the waste collection area outside, a large green metal container labeled compost/organics with 2 top covers, had the left top cover closed and the right top cover open. Dark yellow-brown liquid streaks were observed running down the green metal container, actively spilling onto the concrete surface. The spill extended approximately 20 feet from the bin and was accompanied by a strong foul odor. A sign posted on the green metal container displayed the instruction: 'Clean up spills.' A large white metal container labeled recyclable items only with 2 top covers had both top covers closed. Runoff coming from the green metal container was seen in front of the white metal container. During an interview on 08/12/2025 at 3:54 PM at with the Environmental Director (ED), the ED acknowledged the outdoor waste collection area was unclean, required power washing, and that maintaining the area is the facility's responsibility. ED stated that the outside waste collection area was power washed whenever it was necessary. During a review of the facility's policy and procedure titled, Dispose of Garbage and Refuse, dated 01/2025, it indicated, Garbage and refuse containers are maintained in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids covered. Garbage storage shall be maintained in a sanitary condition to prevent the harborage and feeding of pests.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and implement individualized, resident-centered care plans for 11 of 29 sampled residents (Residents 15, 22, 64, 55, 92, 78, 70, 89, 136, 60, and 67) when care plans for: 1. Resident 15's diagnosis of schizophrenia (a chronic mental health condition that affects a person's thoughts, feelings, and behavior) was not developed; 2. Residents 22 and 64's use of bed rails (an adjustable metal or rigid plastic bars that attach to the bed, like side rails, bed side rails, safety rails, grab bars and assist bars) were not developed; 3. Residents 55, 92, 78, 70, 89, 60, and 67's interventions for use of positioning device (e.g. bed rails) were not implemented; and 4. Resident 136's care plan for use of bed rails was resolved, and a new care plan for continued use of bed rails was not developed. These failures had the potential for unmet care needs for Residents 15, 22, 64, 55, 92, 78, 70, 89, 136, 60, and 67. Findings: 1. During a review of Resident 15's facesheet (one-page summary of a patient's key information within their medical record), dated 8/14/25, it indicated, a diagnosis of Schizophrenia since 2/9/23. During a concurrent interview and record review on 8/15/25, at 3:46 p.m., with the Director of Nursing (DON). Resident 15's Care Plans were reviewed. A care plan for the diagnosis of Schizophrenia was lacking. The DON stated, I do not see a care plan for Schizophrenia for Resident 15 . she should have one. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Plans-Timing, dated 2025 the P&P indicated, Each resident has a person-centered, comprehensive care plan developed, reviewed, and revised by the facility interdisciplinary team including the resident representative, if applicable. 2a. Review of Resident 22's clinical record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD- a condition involving constriction of the airways and difficulty or discomfort in breathing) with exacerbation, osteoarthritis (form of arthritis mainly affects joints in your hands, knees, hips and spine), essential hypertension (a condition in which the force of the blood against the artery walls is too high). During an observation on 8/12/25 at 3:28 p.m., Resident 22 has two bilateral bedrails attached to the bed. During a concurrent interview and record review with RN G on 8/18/25 at 1:10 p.m., RN G confirmed there was no person-centered care plan developed and implemented for Resident 22's bedrail use as a positioning device, and there should be. 2b. Review of Resident 64's clinical record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses of encounter for palliative care (specialized medical care that focuses on providing relief from pain or other symptoms of serious illness), degenerative (a group of progressive conditions that causes irreversible deteriorations of organs, tissues, and cells over time) disease of nervous system , dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily living). During an observation in Resident 64's room on 8/12/2025 at 3:20 p.m., Resident 64 had bilateral (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(both sides) bedrails attached to the bed that were both up. During a concurrent interview and record review with RN G on 8/18/25 at 2:30 p.m., RN G confirmed there was no person-centered care plan that was developed and implemented for Resident 64's bedrail use, and there should be. 3a. During an observation on 8/11/2025 at 9:10 a.m., inside Resident 55's room, Resident 55 was in a wheelchair and was able to wheel herself out of her room. Resident 55's bed had grab bar on the left side (another form of bed rail) in upright position. During a concurrent interview with minimum data set nurse K (MDSN K) and record review of Resident 55's Bedrail Use and Entrapment Risk Evaluation dated 6/18/2021 and Positioning Device care plan (CP) on 8/18/2025 at 11:19 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 6/18/2021. MDSN K confirmed that one of the interventions in the positioning device care plan indicated, Re-evaluate resident safety and use of bed rails quarterly. that was not implemented. MDSN K stated bed rail re-assessments should have been completed, and were not done. 3b. During an observation on 8/12/2025 at 3:19 p.m., in front of Resident 60's room, Resident 60's bed had both left and right grab bars in an upright position. During a concurrent interview with MDSN K and record review of Resident 60's Bedrail Use and Entrapment Risk Evaluation dated 12/5/2024 and Positioning Device CP on 8/18/2025 at 11:41 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 12/5/2024, and there was no documentation that alternatives were offered or attempted prior to bed rail use. MDSN K confirmed an intervention in the positioning device care plan that indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 3c. During an observation on 8/12/2025 at 3:20 p.m., in front of Resident 67's room, Resident 67's bed had a left bed rail in upright position. During a concurrent interview with MDSN K and record review of Resident 67's Bedrail Use and Entrapment Risk Evaluation dated 11/11/2024 and Positioning Device CP on 8/18/2025 at 11:45 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 11/11/2024 and there was no documentation that alternatives were offered or attempted prior to bed rail use. MDSN K confirmed an intervention in the positioning device care plan that indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 3d. During an observation on 8/12/2025 at 3:33 p.m. in front of Resident 70's room, Resident 70 was not in the room and her bed had two grab bars in an upright position. During a concurrent interview with MDSN K and record review of Resident 70's Bedrail Use and Entrapment Risk Evaluation dated 1/29/2025 and Positioning Device CP on 8/18/2025 at 11:26 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 1/29/2025. MDSN K confirmed that one of the interventions in the positioning device care plan which indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 3e. During an observation on 8/12/2025 at 3:34 p.m., in front of Resident 89's room, Resident 89 was not in the room and her bed had two upper bed rails in upright position. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with MDSN K and record review of Resident 89's Bedrail Use and Entrapment Risk Evaluation dated 12/9/2024 and Positioning Device CP on 8/18/2025 at 11:50 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 12/9/2024 and there was no documentation that alternatives were offered or attempted prior to bed rail use. MDSN K confirmed that an intervention in the positioning device care plan which indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 3f. During an observation on 8/12/2025 at 3:45 p.m., in front of Resident 78's room, Resident 78 was not in the room and her bed had two grab bars in upright position. During a concurrent interview with MDSN K and record review of Resident 78's Bedrail Use and Entrapment Risk Evaluation, dated 4/10/2024, and Positioning Device CP on 8/18/2025 at 11:21 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 4/10/2024. MDSN K confirmed that one of the interventions in the positioning device care plan which indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 3g. During an observation on 8/12/2025 at 3:48 p.m., in front of Resident 92's room, Resident 92's bed had two upper bed rails in upright position. During a concurrent interview with MDSN K and record review of Resident 92's Bedrail Use and Entrapment Risk Evaluation dated 9/27/2024 and Positioning Device CP on 8/18/2025 at 11:19 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 9/27/2024. MDSN K confirmed that one of the interventions in the positioning device care plan which indicated, Re-evaluate resident safety and use of bed rails quarterly. was not implemented, and should have been. 4. During an observation on 8/12/2025 at 3:29 p.m., in front of Resident 136's room, Resident 136 was seated at the edge of bed, and her bed had two upper bedrails in upright position. During a concurrent interview with MDSN K and record review of Resident 136's Bedrail Use and Entrapment Risk Evaluation dated 7/10/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:34 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 7/10/2024, and it was indicated to increase Resident 136's independence with functional mobility. MDSN K confirmed the positioning device care plan for Resident 136 was initiated on 7/16/2024 and was resolved on 4/15/2025. MDSN K stated there should have been a care plan developed related to Resident 136's continued use of bed rails.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' care plan for siderails were reviewed and updated quarterly for safety and effectiveness for 19 of 29 sampled residents (Resident 31, 38, 4, 59, 96, 54, 97, 109, 110, 11, 138, 142, 145, 151, 150, 26, 81, 62 and 151) when:1. Residents 31, 38, 4, 59, 96, 54, 97, 109, 110, 11,138, 142, 145, and 151 were without revised quarterly care plan; and2. Residents 150, 26, 81, 62 and 151, were without revised bed rails care plan. These failures had the potential to result in the residents not receiving the interventions necessary to maintain their highest level of well-beingFindings: 1a. Review of Resident 31's admission Record, indicated Resident 31 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), absence of right leg below knee, age-related osteoporosis (weak and brittle bones due to lack of calcium [abundant mineral in the body],and vitamin D). During an observation on 8/12/25 at 9:47 a.m., inside Resident 31's room, Resident 31 had two bed rails attached to the bed. Review of the Order Summary, dated 4/16/25, indicated Resident 31 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:05 p.m., RN G confirmed Resident 31's care plan for bed rails, was initiated on 4/16/25 and was not revised. 1b. Review of Resident 38's admission Record, indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including unspecified protein-calorie malnutrition (lack of sufficient nutrient in the body), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), and adult failure to thrive. During an observation on 8/12/25 at 10:07 a.m., inside Resident 38's room, Resident 38 had two bed rails attached to the bed. Review of the Order Summary, dated 2/17/25, indicated Resident 38 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:22 p.m., RN G confirmed Resident 38's care plan for bed rails, was initiated on 2/17/25 and was not revised. 1c. Review of Resident 4's admission Record, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including unspecified diastolic (the phase in the cardiac cycle when the heart relaxes between beats, allowing it to fill with blood) heart failure, asthma (a condition in which a person's airway become inflamed, narrow and swell), type 2 diabetes mellitus with unspecified complications. During an observation on 8/12/25 at 9:33 a.m., inside Resident 4's room, Resident 4 had two bed rails attached to the bed. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Order Listing Report, dated 1/7/25, indicated Resident 4 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:47 p.m., RN G confirmed Resident 4's care plan for bed rails, was initiated on 1/7/25 and was not revised since then. 1d. Review of Resident 59's admission Record, indicated Resident 59 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily living) unspecified severity, with psychotic disturbance (a mental disorder characterized by a disconnection from reality), essential hypertension (a condition in which the force of the blood against the artery walls is too high), insomnia (persistent problems falling and staying asleep). During an observation on 8/12/25 at 9:13 a.m., inside Resident 59's room, Resident 59 had two bed rails attached to the bed. Review of the Order Listing Report, dated 3/12/25, indicated Resident 59 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:47 p.m., RN G confirmed Resident 59's care plan for bed rails, was initiated on 3/12/25 and was not revised. 1e. Review of Resident 96's admission Record, indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly caused poor blood flow), essential hypertension, type 2 diabetes mellitus without complications. During an observation on 8/12/25 at 9:29 a.m., inside Resident 96's room, Resident 96 had two bed rails attached to the bed. Review of the Order Summary, dated 4/23/24, indicated Resident 96 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:54 p.m., RN G confirmed Resident 96's care plan for bed rails, was initiated on 4/24/24 and was not revised for five quarters. 1f. Review of Resident 54's admission Record, indicated Resident 54 was admitted to the facility on [DATE] with diagnoses including hypertensive chronic kidney disease (longstanding disease of the kidneys leading to renal failure) with stage 1 through stage 4 chronic kidney disease, chronic kidney disease, stage 2, type 2 diabetes mellitus without complications, primary osteoarthritis(form of arthritis mainly affects joints in your hands, knees, hips and spine), right shoulder. During an observation on 8/12/25 at 8:55 a.m., inside Resident 54's room, Resident 54 had two bed rails attached to the bed. Review of the Order Listing Report, dated 11/23/23, indicated Resident 54 may have bilateral positioning device in bed to enhance independence in bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:54 p.m., RN G confirmed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 54's care plan for bed rails, was revised on 6/18/24. RN G further stated no revision since then. 1g. Review of Resident 97's admission Record, indicated Resident 97 was admitted to the facility on [DATE] with diagnoses including displaced fracture of greater trochanter (a rough bony prominence at the upper part of the femur[thigh bone] that serves as a muscle attachment site) of right femur, subsequent encounter for closed fracture with routine healing, other displaced fracture of seventh cervical vertebra, subsequent encounter for fracture with routine healing, age related osteoporosis with current pathological fracture, right femur, subsequent encounter During an observation on 8/12/25 at 9:37 a.m., inside Resident 97's room, Resident 97 had two bed rails attached to the bed. Review of the Order Listing Report, dated 2/14/25, indicated Resident 97 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/19/25 at 9:41 a.m., RN G confirmed Resident 97's care plan for bed rails, was initiated on 2/24/25. RN G further stated no quarterly care plan was done. 1h. Review of Resident 109's admission Record, indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including other secondary parkinsonism(a disorder of the central nervous system that affects movement , often including tremors), type 2 diabetes mellitus with diabetic polyneuropathy(a form of diabetic neuropathy caused by high blood sugar that damages multiple nerves through the body), hypertensive heart disease with heart failure. During an observation on 8/12/25 at 9:21 a.m., inside Resident 109's room, Resident 109 had two bed rails attached to the bed. Review of the Order Listing Report, dated 1/27/25, indicated Resident 109 may have bilateral positioning bars in bed to promote independence with mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:50 p.m., RN G confirmed Resident 109's care plan for bed rails, was initiated on 1/27/25. RN G further stated no current care plan was done for two quarters. 1i. Review of Resident 110's admission Record, indicated Resident 110 was admitted to the facility on [DATE] with diagnoses including, type 2 diabetes mellitus without chronic kidney disease, anemias, acute and chronic respiratory failure with hypercapnia (occurs when there's too much carbon dioxide (CO2) in the bloodstream). During an observation on 8/12/25 at 9:00 a.m., inside Resident 110's room, Resident 110 had two bed rails attached to the bed. Review of the Order Listing Report, dated 2/22/25, indicated Resident 110 may have bilateral positioning device in bed to enhance independence in bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:36 p.m., RN G confirmed Resident 110's care plan for bed rails, was revised on 7/30/24. RN G further stated care plan should (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be done quarterly. 1j. Review of Resident 11's admission Record, indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, type 2 diabetes mellitus without complications. During an observation on 8/12/25 at 3:34 p.m., inside Resident 11's room, Resident 11 had two bed rails attached to the bed. Review of the Order Listing Report, dated 5/7/25, indicated Resident 11 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:59 p.m., RN G confirmed Resident 11's care plan for bed rails, was initiated on 5/7/25. RN G further stated no quarterly care plan was made. 1k. Review of Resident 138's admission Record, indicated Resident 138 was admitted to the facility on [DATE] with diagnoses including other fracture of second lumbar vertebra, multiple fracture of ribs, left side, type 2 diabetes mellitus without complications. During an observation on 8/12/25 at 9:33 p.m., inside Resident 138's room, Resident 138 had two bed rails attached to the bed. Review of the Order Summary, dated 3/17/25, indicated Resident 138 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 1:59 p.m., RN G confirmed Resident 138's care plan for bed rails, was not updated and it was initiated on 3/17/25. 1l. Review of Resident 142's admission Record, indicated Resident 142 was admitted to the facility on [DATE] with diagnoses including hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, type 2 diabetes mellitus with unspecified complications, peripheral vascular disease unspecified. During an observation on 8/12/25 at 3:22 p.m., inside Resident 142's room, Resident 142 had two bed rails attached to the bed. Review of the Order Listing Report, dated 8/15/25, indicated Resident 142 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:32 p.m., RN G confirmed Resident 142's care plan for bed rails, was initiated on 1/10/24 and was revised on 8/18/25. RN G further stated no quarterly care plan was made. 1m. Review of Resident 145's admission Record, indicated Resident 145 was admitted to the facility on [DATE] with diagnoses including parkinsonism, unspecified, osteoarthritis, atherosclerotic heart disease (damage or disease in the heart's major blood vessels) of native coronary artery without angina pectoris (a type of chest pain caused by reduced blood flow to the heart). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/12/25 at 9:58 p.m., inside Resident 145's room, Resident 145 had one bed rails attached to the left side of the bed. Review of the Order Summary, dated 11/23/23, indicated Resident 145 may have left side positioning device in bed to enhance independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:14 p.m., RN G confirmed Resident 145's care plan for bed rails, was initiated on 11/23/23 and revised on 12/12/23. RN G further stated no quarterly care plan was made since 12/12/23. 1n. Review of Resident 151's admission Record, indicated Resident 151 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles) following cerebral infarction affecting left dominant side, unspecified diastolic heart failure, asthma. During an observation on 8/12/25 at 9:54 a.m., inside Resident 151's room, Resident 151 had two bed rails attached to the bed. Review of the Order Summary, dated 2/14/25, indicated Resident 151 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with RN G, on 8/18/25 at 2:50p.m., RN G confirmed Resident 151's care plan for bed rails, was initiated on 2/14/25 and no quarterly care plan was made since. 2a. Review of Resident 150's admission Record, indicated Resident 150 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (uncontrolled, abnormal growth of cells within the prostate gland), essential hypertension (high blood pressure that does not have a known cause). During an observation on 8/12/25 at 10:13 a.m., inside Resident 150's room, Resident 150 had two bed rails (BR, adjustable rigid bars attached to the side of the bed) attached to the bed. Review of the Order Listing Report, dated 12/12/23, indicated Resident 150 may have bilateral positioning bars in bed to promote independence with bed mobility and functional transfer. During a concurrent interview and record review with the Unit Manager (UM) E, on 8/15/25 at 1:21 p.m., the UM E confirmed Resident 150's care plan for bed rails, was initiated on 12/12/23 and was not revised. The UM E stated the care plan should have been reviewed and updated quarterly, and was not. 2b. Review of Resident 26's admission Record, indicated Resident 26 was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus with hyperglycemia (high levels of sugar in the blood), orthostatic hypotension (blood pressure drops too quickly for the body to adjust), essential hypertension (high blood pressure that does not have a known cause). During an observation on 8/12/25 at 10:30 a.m., inside Resident 26's room, Resident 26 had two BR attached to the bed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Order Listing Report, dated 12/12/23, indicated Resident 26 may have bilateral positioning bars in bed to promote independence with bed mobility and functional transfer. During a concurrent interview and record review with the UM E on 8/18/25 at 1:48 p.m., the UM E confirmed Resident 26's care plan was initiated on 5/16/24 and was not revised. UM E stated the care plan should have been reviewed and updated quarterly, and was not. 2c. Review of Resident 81's admission Record, indicated Resident 81 was admitted to the facility on [DATE] with diagnoses including anemia (body does not have enough red blood cells to carry oxygen), essential hypertension (high blood pressure that does not have a known cause). During an observation on 8/12/25 at 10:31 a.m., inside Resident 81's room, Resident 81 had two BR attached to the bed. Review of the Order Listing Report, dated 12/3/24, indicated Resident 81 may have bilateral positioning bars in bed to promote independence with bed mobility and functional transfer. During a concurrent interview and record review with the UM E on 8/18/25 at 1:55 p.m., the UM E confirmed Resident 81's care plan was initiated on 12/3/24 and was not revised. UM E stated the care plan should have been reviewed and updated quarterly, and was not. 2e. Review of Resident 62's admission Record, indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including hypotension (blood pressure abnormally low), anemia in other chronic diseases classified elsewhere (body does not have enough red blood cells to carry oxygen), age-related osteoporosis (condition where bones become weak and brittle, making them more likely to break). During an observation on 8/12/25 at 10:32 a.m., inside Resident 62's room, Resident 62 had two BR attached to the bed. Review of the Order Listing Report, dated 6/18/24, indicated Resident 62 may have bilateral positioning bars in bed to promote independence with bed mobility and functional transfer. During a concurrent interview and record review with Registered Nurse (RN) G on 8/19/25 at 8:37 a.m., RN G confirmed Resident 62's care plan was initiated on 6/18/24 and was not reviewed and updated quarterly. 2f. Review of Resident 141's admission Record, indicated Resident 141 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness (a brain bleed caused by head trauma where blood leaks into space around the brain), contusion of other part of head (injury to the soft tissue by a non-sharp object hitting or striking the body). During an observation on 8/12/25 at 10:46 a.m., inside Resident 141's room, Resident 141 had one BR attached to the bed. Review of the Order Listing Report, dated 11/7/24, indicated Resident 141 may have bilateral positioning bars in bed to promote independence with bed mobility and transfer. During a concurrent interview and record review with UM E on 8/18/25 at 10:46 a.m., UM E confirmed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 141's care plan was initiated on 11/7/24 and was not reviewed and updated quarterly. During an interview with Registered Nurse (RN) G on 8/21/25 at 10:20 am, RN G stated care plan should be revised quarterly, and if there was a change in condition. Review of the facility's policy and procedure, titled Comprehensive Care Plan-Timing, revised 1/25, indicated, Each resident has a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and the resident representative, if applicable.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice for four (Resident 116, 130, 22 and 64) of 59 sampled residents when: For Resident 116, the Blood Glucose (BG) testing was performed one hour prior to insulin given and two hours prior to breakfast being served and there was no monitoring for episodes of hyperglycemia or hypoglycemia, and For Resident 130, 22 and 64, there was no physician order for the use of side rails or positional bars. This failure had the potential to result in Resident 116's blood glucose not being treated appropriately and jeopardize their health and well-being. Findings: 1. A review of Resident 116's admission record indicated Resident 116 was admitted with multiple diagnoses including choledocholithiasis (Choledocholithiasis (also called bile duct stones or gallstones in the bile duct) is the presence of a gallstone in the common bile duct), pneumonia (an inflammation of the lungs caused by an infection) and diabetes (a disease in which too little or no insulin is produced or insulin is produced but cannot be used normally resulting in high levels of sugar in the blood). A review of Resident 116's Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 8/4/2024, indicated the resident had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decisions making. During an interview on 8/12/2025 at 11:40 a.m. with Resident 116 in the room, Resident 116 stated, staff come into her room, woke her up to do her finger stick for her insulin at 5:00 a.m., that is too early breakfast is at 7:30 a.m. During an interview on 8/14/2025 at 9:23 a.m. with Licensed Vocational Nurse F, LVN F stated blood sugar for [insulin sliding scales] are done 15 minutes before the tray comes, for lunch it is done 11:30 a.m. - 11:45 a.m. lunch comes just before noon. Breakfast comes around 8:00 a.m., the BG is done at 6:30 a.m. and insulin if needed is given at 6:30 a.m., not 15 minutes prior to breakfast. During a review of Resident 116's medical record, dated August 14, 2025, the physician orders indicated Resident 116 takes four medications for diabetes. Medications included Alogliptin Benzoate (Alogliptin works by regulating the levels of insulin your body produces after eating), Lantus (Insulin Glargine- a long-acting, insulin used to manage blood glucose levels), Metformin (helps to control the amount of glucose (sugar) in the blood) and Insulin- Regular per sliding scale (a short-acting type of insulin used to manage blood sugar levels, sliding scale - amount of insulin at mealtime is based on blood sugar measurements.) During an interview on 8/18/2025 at 4:38 p.m. with Registered Nurse (RN) G, RN G stated, for diabetics, the Charge Nurses (CN) test blood sugar based on the order for regular insulin, the order says to check sugar before meals and at bedtime - 6:30 a.m.- 11:30 a.m. - 4:30 p.m. and 9:30 p.m. During a concurrent interview and record review on 8/18/25 at 4:42 p.m. with RN G, Resident 116's medical record was reviewed. The blood glucose results tab reviewed indicated on 8/13/25 Resident 116's blood glucose was done at 5:30 a.m. RN G stated BG should not be done that early, 5:30 is too early to give insulin if needed. BG checks done and insulin given should be prior to a meal. Review of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 116's BG results documentation for insulin sliding scale administration indicated BG done prior to 6:30 on the following dates: 7/13/25 at 5:37 a.m., 7/14/25 at 5:55 a.m., 7/16/25 at 5:54 a.m., 7/20/25 at 5:33 a.m., 7/22/25 at 5:46 a.m., 7/23/25 at 5:41 a.m., 7/25/25 at 5:45 a.m., 7/26/25 at 5:58 a.m., 8/1/25 at 5:42 a.m., 8/6/25 at 5:33 a.m., 8/7/25 at 5:35 a.m., and 8/12/25 at 5:51 a.m. During the continued concurrent interview and record review on 8/18/25 at 4:50 p.m. with RN G, Resident 116's chart was reviewed, there was no indication that there was monitoring for hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar), RN G stated they should be monitoring, no monitoring was found. During a review of Resident 116's Care plan (CP) , dated 7/15/25, the CP for Diabetes indicated, Assess/document/report to MD prn for s/s (signs/symptoms) of hyperglycemia: increased thirst and hunger, frequent urination, weight loss, fatigue, dry skin. Assess/document/report to MD prn for s/s hypoglycemia: sweating, tremor, increased heart rate. Review of Resident 116's CP for Antidiabetic medications dated 7/15/25 indicated Monitor for hyperglycemia Monitor for hypoglycemia. Review of an online professional organization website the American Diabetes Association (https://diabetes.org/health-wellness/medication/insulin-routines#:~:text=When%20to%20Take%20Insulin%20indicated) When to Take Insulin for Diabetes: Insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat. 2a. Review of Resident 130's admission Record, indicated Resident 130 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a decline in mental abilities, severe enough to interfere with daily life), wedge compression fracture of thoracic vertebra (bone in the middle back has collapsed). During an observation on 8/12/25 at 10:43 a.m., inside Resident 130's room, Resident 130 had one bed rail (BR, adjustable rigid bars attached to the side of the bed) attached to the bed. During a concurrent interview and record review with the Unit Manager (UM) E, on 8/15/25 at 2:09 p.m., UM E confirmed that there was no physician order for the use of BR for Resident 130. 2b. During an observation in Resident 22's room on 8/12/2025 at 3:28 p.m., Resident 22 had a bilateral bedrail attached to the bed. Review of Resident 22's order of summary report indicated Resident 22's order for may have bilateral positioning bars in bed to promote and enhance independence in bed mobility was discontinued on 11/17/23. During a concurrent interview and record review with RN G on 8/18 /25 at 1:10 p.m., RN G confirmed no physician order on file for the use of bedrails for Residents 22. 2c. During an observation in Resident 64's room on 8/12/2025 at 3:20 p.m., Resident 64 had bilateral (both sides) bedrail attached to the bed and were both up. During a concurrent interview and record review with RN G on 8/18 /25 at 2:30 p.m., RN G confirmed no physician order on file for the use of bedrails for Residents 64. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled Physician Orders, date revised 5/1/2019, indicated This will ensure that all physician orders are complete and accurate. The Medical Records Department will verify that physician orders are complete, accurate and clarified.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure the proper use of bed rails (BR, adjustable rigid bars attached to the side of the bed) for 38 out of 114 residents when:1. There was no Bedrail Use and Entrapment Risk Evaluation completed prior to the use of BR for two of 114 residents (Resident 130, and 64);2. There was no documentation that indicated alternatives were offered and/or attempted prior to the use of side rails for 20 out of 114 residents (Residents 159, 140, 83, 46, 141, 129, 160, 136, 60, 67, 101, 125, 31, 38, 98, 53, 138, 142, 151 and 96) who used them;3. There was no quarterly re-evaluation of the safety and use of bed rails as indicated in the care plan for 35 out of 114 residents (Residents 72, 161, 150, 47, 105, 81, 62, 87, 119, 83, 141, 129, 55, 92, 78, 70, 89, 136, 60, 67, 22, 38, 4, 59, 96, 54, 97, 10, 109, 110, 11, 138, 142, 145, and 151); and4. There was no consent for the use of bed rails for two out of 38 residents (Residents 130 and 64).These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1a. During an observation on 8/12/25 at 10:43 a.m., inside Resident 130's room, Resident 130 had one bed rail (BR, adjustable rigid bars attached to the side of the bed) attached to the bed. During a concurrent interview and record review with the Unit Manager (UM) E on 8/18/25 at 2:09 p.m., the UM E reviewed Resident 130's medical record and confirmed there was no Bedrail Use and Entrapment Risk Evaluation completed. 1b. During an observation on 8/12/25 at 3:20 p.m., inside Resident 64's room, Resident 64 had two bed rails attached to the bed. During a concurrent interview and record review with Registered Nurse (RN) G on 8/18/25 p.m., the RN G reviewed Resident 64's medical record and confirmed there was no Bedrail Use and Entrapment Risk Evaluation completed. 2a. During a concurrent interview and record review with RN G, on 8 /18 /25 at 2:05 p.m., RN G reviewed Resident 31's Bedrail Use and Entrapment Risk Evaluation was done on 1/21/25. RN confirmed Resident 31's, had no documented use of alternatives prior to using bedrails. 2b. During a concurrent interview and record review with RN G, on 8 /18 /25 at 2:22 p.m., RN G reviewed Resident 38's Bedrail Use and Entrapment Risk Evaluation was done on 2/14/25. RN confirmed Resident 38's, had no documented use of alternatives prior to using bedrails. 2c. During a concurrent interview and record review with RN G, on 8 /18 /25 at 1:31 p.m., RN G reviewed Resident 98's Bedrail Use and Entrapment Risk Evaluation was done on 8/4/25. RN confirmed Resident 98's, had no documented use of alternatives prior to using bedrails. 2d. During a concurrent interview and record review with RN G, on 8 /18 /25 at 2:27 p.m., RN G reviewed Resident 53's Bedrail Use and Entrapment Risk Evaluation was done on 6/30/25. RN confirmed Resident 53's, had no documented use of alternatives prior to using bedrails. 2e. During a concurrent interview and record review with RN G, on 8 /18 /25 at 1:59 p.m., RN G reviewed Resident 138's Bedrail Use and Entrapment Risk Evaluation was done on 3/14/25. RN confirmed Resident 138's, had no documented use of alternatives prior to using bedrails. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2f. During a concurrent interview and record review with RN G, on 8 /18 /25 at 2:32 p.m., RN G reviewed Resident 142's Bedrail Use and Entrapment Risk Evaluation was done on 4/12/24. RN confirmed Resident 142's, had no documented use of alternatives prior to using bedrails. 2g. During a concurrent interview and record review with RN G, on 8 /18 /25 at 2:50 p.m., RN G reviewed Resident 151's Bedrail Use and Entrapment Risk Evaluation was done on 2/12/25. RN confirmed Resident 151's, had no documented use of alternatives prior to using bedrails. 2h. During a concurrent interview and record review with RN G, on 8 /18 /25 at 1:54 p.m., RN G reviewed Resident 96's Bedrail Use and Entrapment Risk Evaluation was done on 4/22/24. RN confirmed Resident 96's, had no documented use of alternatives prior to using bedrails. 2i. For Resident 60: During an observation on 8/12/2025 at 3:19 p.m., in front of Resident 60's room, Resident 60's bed had both left and right grab bar in an upright position. During a concurrent interview with minimum data set nurse K (MDSN K) and record review of Resident 60's Bedrail Use and Entrapment Risk Evaluation dated 12/5/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:41 a.m., MDSN K confirmed there was no documentation that alternatives were offered or attempted prior to bed rail use. 2j. For Resident 67: During an observation on 8/12/2025 at 3:20 p.m., in front of Resident 67's room, Resident 67's bed had a left bed rail in upright position. During a concurrent interview with MDSN K and record review of Resident 67's Bedrail Use and Entrapment Risk Evaluation dated 11/11/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:45 a.m., MDSN K confirmed there was no documentation that alternatives were offered or attempted prior to bed rail use. 2k. For Resident 136: During an observation on 8/12/2025 at 3:29 p.m., in front of Resident 136's room, Resident 136 was seated at the edge of bed, and her bed had two upper bedrails in an upright position. During a concurrent interview with MDSN K and record review of Resident 136's Bedrail Use and Entrapment Risk Evaluation dated 7/10/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:34 a.m., MDSN K confirmed the previously attempted alternatives in the evaluation were not checked. MDSN K further confirmed there was no documentation that alternatives were offered or attempted prior to bed rail use. 2l. For Resident 101: During an observation on 8/12/2025 at 3:50 p.m., in front of Resident 101's room, Resident 101's bed had two upper bed rails in an upright position. During a concurrent interview with MDSN K and record review of Resident 101's Bedrail Use and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Entrapment Risk Evaluation dated 7/17/2025 and Positioning Device care plan (CP) on 8/19/2025 at 2:25 p.m., MDSN K confirmed there was no documentation that alternatives were offered or attempted prior to bed rail use. 2m. For Resident 125: During an observation on 8/12/2025 at 3:51 p.m., in front of Resident 125's room, Resident 125's bed had two upper bed rails in an upright position. During a concurrent interview with MDSN K and record review of Resident 125's Bedrail Use and Entrapment Risk Evaluation dated 7/29/2025 and Positioning Device care plan (CP) on 8/19/2025 at 2:20 p.m., MDSN K confirmed there was no documentation that alternatives were offered or attempted prior to bed rail use. 2n. During an observation on 8/12/25 at 9:52 a.m., inside Resident 159's room, Resident 159 had two bed rails attached to the bed. During a concurrent interview and record review with the UM E on 8/14/25 at 12:24 p.m., the UM E reviewed Resident 159's Bedrail Use and Entrapment Risk Evaluation completed on 7/30/25. UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2o. During an observation on 8/12/25 at 9:56 a.m., inside Resident 160's room, Resident 160 had two BR attached to the bed. During a concurrent interview and record review with the UM E on 8/18/25 at 11:54 a.m., the UM E reviewed Resident 160's Bedrail Use and Entrapment Risk Evaluation completed on 8/5/25. The UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2p. During an observation on 8/12/25 at 10:36 a.m., inside Resident 140's room, Resident 140 had two BR attached to the bed. During a concurrent interview and record review with the UM E on 8/19/25 at 9:24 a.m., Registered Nurse (RN) G reviewed Resident 140's Bedrail Use and Entrapment Risk Evaluation completed on 12/3/24. RN G confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2q. During an observation on 8/12/25 at 10:42 a.m., inside Resident 83's room, Resident 83 had two BR attached to the bed. During a concurrent interview and record review with the UM E on 8/18/25 at 2:03 p.m., the UM E reviewed Resident 83's Bedrail Use and Entrapment Risk Evaluation completed on 11/14/24. The UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2r. During an observation on 8/12/25 at 10:44 a.m., inside Resident 46's room, Resident 46 had two BR attached to the bed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the UM E on 8/18/25 at 2:20 p.m., the UM E reviewed Resident 46's Bedrail Use and Entrapment Risk Evaluation completed on 6/16/25. The UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2s. During an observation on 8/12/25 at 10:46 a.m., inside Resident 141's room, Resident 141 had one BR attached to the bed. During a concurrent interview and record review with the UM E on 8/18/25 at 2:25 p.m., the UM E reviewed Resident 141's Bedrail Use and Entrapment Risk Evaluation completed on 11/6/24. The UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. 2t. During an observation on 8/12/25 at 10:52 a.m., inside Resident 129's room, Resident 129 had one BR attached to the bed. During a concurrent interview and record review with the UM E on 8/18/25 at 2:39 p.m., the UM E reviewed Resident 129's Bedrail Use and Entrapment Risk Evaluation completed on 11/19/24. The UM E confirmed the documentation did not indicate that they offered or attempted any alternatives prior to the use of BRs. During a review of the facility's policy and procedure titled, BEDRAILS, date revised 1/2025, indicated, The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. To ensure that prior to the installation or use of bed rails, the facility attempts to use alternatives. The resident evaluation includes alternatives to the use of a bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. 3a. Review of Resident 22's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 22's bed rail evaluation was not done regularly or quarterly. Resident 22's last bed rail evaluation was done on 11/16/23 and there were no more updated after that. During a concurrent interview and record review with RN G on 8/18/25 at 1:10 p.m., RN G confirmed that the last update was on 11/16/23 and there were no more updates after that. 3b. Review of Resident 38's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 38's bed rail evaluation was not done regularly or quarterly. Resident 38 's last bed rail evaluation was done on 2/14/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:22 p.m., RN G confirmed that the last update was on 2/14/25 and there were no more updates after that. 3c. Review of Resident 4's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 4's bed rail evaluation was not done regularly or quarterly. Resident 4's last bed rail evaluation was done on 1/1/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:47 p.m., RN G confirmed that the last update was on 1/1/25 and there were no more updates after that. 3d. Review of Resident 59's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 59's bed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rail evaluation was not done regularly or quarterly. Resident 59's last bed rail evaluation was done on 3/11/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:47 p.m., RN G confirmed that the last update was on 3/11/25 and there were no more updates after that. 3e. Review of Resident 96's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 96's bed rail evaluation was not done regularly or quarterly. Resident 96's last bed rail evaluation was done on 4/22/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:54 p.m., confirmed that the last update was on 4/22/25 and there were no more updates after that. 3f. Review of Resident 54's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 54's bed rail evaluation was not done regularly or quarterly. Resident 54's last bed rail evaluation was done on 6/5/24 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:31 p.m., RN G confirmed that the last update was on 6/5/24 and there were no more updates after that. 3g. Review of Resident 97's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 97's bed rail evaluation was not done regularly or quarterly. Resident 97's last bed rail evaluation was done on 2/6/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/19 /25 at 9:41 a.m., RN G confirmed that the last update was on 2/6/25 and there were no more updates after that. 3h. Review of Resident 10's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 10's bed rail evaluation was not done regularly or quarterly. Resident 10's last bed rail evaluation was done on 5/20/25 and there were no more updated after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:54 p.m., RN G confirmed that the last update was on 5/20/25 and there were no more updates after that. 3i. Review of Resident 109's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 109's bed rail evaluation was not done regularly or quarterly. Resident 109's last bed rail evaluation was done on 1/24/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:50 p.m., RN G confirmed that the last update was on 1/24/25 and there were no more updates after that. 3j. Review of Resident 110's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 110's bed rail evaluation was not done regularly or quarterly. Resident 110's last bed rail evaluation was done on 6/27/24 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:36 p.m., RN G confirmed that the last update was on 6/27/24 and there were no more updates after that. 3k. Review of Resident 11's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 11's bed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rail evaluation was not done regularly or quarterly. Resident 11's last bed rail evaluation was done on 5/6/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:59 p.m., RN G confirmed that the last update was on 5/6/25 and there were no more updates after that. 3l. Review of Resident 138's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 138's bed rail evaluation was not done regularly or quarterly. Resident 138's last bed rail evaluation was done on 3/14/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 1:59 p.m., RN G confirmed that the last update was on 3/14/25 and there were no more updates after that. 3m. Review of Resident 142's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 142's bed rail evaluation was not done regularly or quarterly. Resident 142's last bed rail evaluation was done on 4/5/24 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:32 p.m., RN G confirmed that the last update was on 4/5/24 and there were no more updates after that. 3n. Review of Resident 145's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 145's bed rail evaluation was not done regularly or quarterly. Resident 145's last bed rail evaluation was done on 6/18/21 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:14 p.m., RN G confirmed that the last update was on 6/18/21 and there were no more updates after that. 3o. Review of Resident 151's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 151's bed rail evaluation was not done regularly or quarterly. Resident 151's last bed rail evaluation was done on 2/12/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/18 /25 at 2:50 p.m., RN G confirmed that the last update was on 2/12/25 and there were no more updates after that. 3p. For Resident 55: During an observation on 8/11/2025 at 9:10 a.m., inside Resident 55's room, Resident 55 was in a wheelchair and was able to wheel self out of her room. Resident 55's bed had left grab bar (another form of bed rail) in upright position. During a concurrent interview with minimum data set nurse K (MDSN K) and record review of Resident 55's Bedrail Use and Entrapment Risk Evaluation dated 6/18/2021 and Positioning Device care plan (CP) on 8/18/2025 at 11:19 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 6/18/2021. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3q. For Resident 60: During an observation on 8/12/2025 at 3:19 p.m., in front of Resident 60's room, Resident 60's bed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had both left and right grab bar in an upright position. During a concurrent interview with MDSN K and record review of Resident 60's Bedrail Use and Entrapment Risk Evaluation dated 12/5/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:41 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 12/5/2024. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3r. For Resident 67: During an observation on 8/12/2025 at 3:20 p.m., in front of Resident 67's room, Resident 67's bed had a left bed rail in upright position. During a concurrent interview with MDSN K and record review of Resident 67's Bedrail Use and Entrapment Risk Evaluation dated 11/11/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:45 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 11/11/2024. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3s. For Resident 136: During an observation on 8/12/2025 at 3:29 p.m., in front of Resident 136's room, Resident 136 was seated at the edge of bed, and her bed had two upper bedrails in an upright position. During a concurrent interview with MDSN K and record review of Resident 136's Bedrail Use and Entrapment Risk Evaluation dated 7/10/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:34 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 7/10/2024. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3t. For Resident 70: During an observation on 8/12/2025 at 3:33 p.m. in front of Resident 70's room, Resident 70 was not in the room and her bed had two grab bars in an upright position. During a concurrent interview with MDSN K and record review of Resident 70's Bedrail Use and Entrapment Risk Evaluation dated 1/29/2025 and Positioning Device care plan (CP) on 8/18/2025 at 11:26 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 1/29/2025. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3u. For Resident 89: During an observation on 8/12/2025at 3:34 p.m., in front of Resident 89's room, Resident 89 was not in the room and her bed had two upper bed rails in an upright position. During a concurrent interview with MDSN K and record review of Resident 89's Bedrail Use and Entrapment Risk Evaluation dated 12/9/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:50 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 12/9/2024. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3v. For Resident 78: During an observation on 8/12/2025 at 3:45 p.m., in front of Resident 78's room, Resident 78 was not in the room and her bed had two grab bars in an upright position. During a concurrent interview with MDSN K and record review of Resident 78's Bedrail Use and Entrapment Risk Evaluation dated 4/10/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:21 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 4/10/2024. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3w. For Resident 92: During an observation on 8/12/2025 at 3:48 p.m., in front of Resident 92's room, Resident 92's bed had two upper bed rails in an upright position. During a concurrent interview with MDSN K and record review of Resident 92's Bedrail Use and Entrapment Risk Evaluation dated 9/27/2024 and Positioning Device care plan (CP) on 8/18/2025 at 11:19 a.m., MDSN K confirmed the latest bed rail use assessment or evaluation was dated 9/27/2024. MDSN K stated the bed rail assessment or evaluation should have been completed quarterly or when there was a significant change in resident's condition. 3x. Review of Resident 72's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 72's bed rail evaluation was not done regularly or quarterly. Resident 72's last bed rail evaluation was done on 11/16/22 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 11:38 a.m., the UM E confirmed that the last update was on 11/16/22 and there were no more updates after that. 3y. Review of Resident 161's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 161's bed rail evaluation was not done regularly or quarterly. Resident 161's last bed rail evaluation was done on 7/23/24 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 11:55 a.m., the UM E confirmed that the last update was on 7/23/24 and there were no more updates after that. 3z. Review of Resident 150's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 150's bed rail evaluation was not done regularly or quarterly. Resident 150's last bed rail evaluation was done on 8/30/24 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 1:21 p.m., the UM E confirmed that the last update was on 8/30/24 and there were no more updates after that. 3aa. Review of Resident 47's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 47's bed rail evaluation was not done regularly or quarterly. Resident 47's last bed rail evaluation was done on 6/5/24 and there were no more updates after that. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the UM E on 8/18/25 at 1:29 p.m., the UM E confirmed that the last update was on 6/5/24 and there were no more updates after that. 3bb. Review of Resident 105's Bedrail Use and Entrapment Risk Evaluation indicated, Resident 105's bed rail evaluation was not done regularly or quarterly. Resident 105's last bed rail evaluation was done on 5/5/23 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 1:37 p.m., the UM E confirmed that the last update was on 5/5/23 and there were no more updates after that. 3cc. Review of Resident 81's Bedrail Use and Entrapment Risk Evaluation indicated Resident 81's bed rail evaluation was not done regularly or quarterly. Resident 81's last bed rail evaluation was done on 11/22/24 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 1:55 p.m., the UM E confirmed that the last update was on 11/22/24 and there were no more updates after that. 3dd. Review of Resident 62's Bedrail Use and Entrapment Risk Evaluation indicated Resident 62's bed rail evaluation was not done regularly or quarterly. Resident 62's last bed rail evaluation was done on 6/13/24 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/19/25 at 8:37 a.m., RN G confirmed that the last update was on 6/13/24 and there were no more updates after that. 3ee. Review of Resident 87's Bedrail Use and Entrapment Risk Evaluation indicated Resident 87's bed rail evaluation was not done regularly or quarterly. Resident 87's last bed rail evaluation was done on 2/20/25 and there were no more updates after that. During a concurrent interview and record review with RN G on 8/19/25 at 9:12 a.m., RN G confirmed that the last update was on 2/20/25 and there were no more updates after that. 3ff. Review of Resident 119's Bedrail Use and Entrapment Risk Evaluation indicated Resident 119's bed rail evaluation was not done regularly or quarterly. Resident 119's last bed rail evaluation was done on 12/26/23 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/19/25 at 9:12 a.m., the UM E confirmed that the last update was on 12/26/23 and there were no more updates after that. 3gg. Review of Resident 83's Bedrail Use and Entrapment Risk Evaluation indicated Resident 83's bed rail evaluation was not done regularly or quarterly. Resident 83's last bed rail evaluation was done on 11/14/24 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 2:03 p.m., the UM E confirmed that the last update was on 11/14/24 and there were no more updates after that. 3hh. Review of Resident 141's Bedrail Use and Entrapment Risk Evaluation indicated Resident 141's bed rail evaluation was not done regularly or quarterly. Resident 141's last bed rail evaluation was done on 11/6/24 and 6/12/25. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the UM E on 8/18/25 at 2:25 p.m., the UM E confirmed that the last update was on 11/6/24 and 6/12/25. 3ii. Review of Resident 129's Bedrail Use and Entrapment Risk Evaluation indicated Resident 129's bed rail evaluation was not done regularly or quarterly. Resident 129's last bed rail evaluation was done on 11/19/24 and there were no more updates after that. During a concurrent interview and record review with the UM E on 8/18/25 at 2:39 p.m., the UM E confirmed that the last update was on 11/19/24 and there were no more updates after that. During a review of the facility's policy and procedure titled, BEDRAIL TRAINING, date revised 3/2021, indicated, Ongoing evaluation of risks quarterly and as needed with significant change. 4a. During an observation on 8/12/25 at 10:43 a.m., inside Resident 130's room, Resident 130 had one bed rail attached to the bed. During a concurrent interview and record review with the UM E on 8/18/25 at 2:09 p.m., the UM E reviewed Resident 130's medical record and confirmed there was no consent obtained prior to the use of BRs. During a concurrent observation and interview with the UM E on 8/18/25 at 2:45 p.m., inside Resident 130's room, the UM E confirmed there were two BRs attached to the bed. 4b. During an observation in Resident 64's room on 8/12/2025 at 3:20 p.m., Resident 64 had bilateral (both sides) bedrail attached to the bed and were both up. During a concurrent interview and record review with RN G on 8/18 /25 at 2:30 p.m., RN G confirmed no consent on file for the use of bedrails for Residents 64. During a review of the facility's policy and procedure titled, BEDRAIL, date revised 1/2023, indicated, The facility must attempt to use appropriate alternatives prior to installing a side or bedrails. 3.Informed consent is obtained from the resident or if applicable, the resident representative.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a pre-admission screening and resident review (PASARR, a federal requirement to help ensure that individuals who have mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was accurately completed for one of three residents (Resident 8). This failure had the potential for inaccurate care and services provided to residents with mental disorder (MD), intellectual disability (ID), or related conditions. Findings: Review of Resident 8's clinical record titled, admission Record, dated 8/18/2025, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), adult failure to thrive (a syndrome of progressive functional and nutritional decline, characterized by weight loss, poor appetite, inactivity, and other symptoms like fatigue, dehydration, and depression), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making) and anxiety disorder (a mental illness that causes constant fear). Review of Resident 8's clinical record titled, Order Summary Report, dated 8/21/2025, indicated an order of Depakote Sprinkles (are capsules containing tiny, coated pellets of the medication divalproex sodium [an anti-epileptic drug also used as a mood stabilizer]) 125 milligrams (mg - unit of measurement) to give 2 capsules by mouth, one time a day for bipolar disorder manifested by physical aggression like hitting staff and other residents. Further review indicated Depakote Sprinkles was ordered on 1/3/2025. Review of Resident 8's 8/2025 medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), indicated Resident 8 had behaviors like: swinging her feet when someone would passed by in front of her, crying episodes, verbal aggression as evidenced by yelling, physically aggressive as evidenced by hitting, scratching staff, refusal to be changed, and throwing objects when she was upset. Review of Resident 8's PASARR Level I Screening dated 6/15/2020, indicated Resident 8 was negative for serious mental illness and no need for a PASARR Level II evaluation. Further review indicated the following questions were skipped: 18.a. Has the attending physician certified before/upon admission to the NF [nursing facility] that the resident is likely to require less than 30 days of NF services? 18.b. Enter Physicians Name. 18.c. I acknowledge that the information entered in 18a and 18b (if applicable) is true. 18.d. Date new Level I Due (Day 31 after admission). During a concurrent interview with registered nurse G (RN G) and record review of Resident 8's admission record and PASARR Level I Screening document dated 6/15/2020 on 8/18/2025 at 9:45 a.m., RN G confirmed Resident 8's original date of admission was 8/4/2019 and she was re-admitted to the facility on [DATE]. RN G confirmed sections 18a to 18d of Resident 8's PASARR Level I screening were skipped because Resident 8 stayed at the facility for more than 30 days since admission. RN G stated Resident 8 was still in the facility. RN G confirmed there was no other PASARR Level 1 screening evaluation completed for Resident 8 except for the one dated 6/15/2020. RN G further confirmed they should have completed another PASARR Level 1 screening for Resident 8 on day 31 after her admission. During an interview with the director of nursing (DON) on 8/19/2025 at 10:41 a.m., DON confirmed Resident 8 had bipolar disorder and she had some behaviors. DON further confirmed they should have completed another PASARR Level I Screening for Resident 8 since she stayed with them for more than 30 days upon admission. During a review of the facility's policy and procedure titled, Preadmission SCREENING AND RESIDENT REVIEW (PASRR), date revised 1/2025, indicated, If the State program permits the use of the exceptions and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. If an individual who (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enters a NF [nursing facility] as an exception (an exempted hospital discharge) is later found to require more than 30 days of NF care, the State mental health or intellectual disability authority must conduct a Level II resident review within 40 calendar days of admission.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review the facility failed to follow its Policy & Procedure (P&P) titled, Dignity and Respect Psychoactive Medications, dated 2025, for one of 30 sampled residents (Resident 15), when the facility failed to monitor Resident 15 for behaviors related to her diagnosed mental illness. This failure had the potential for Resident 15's behavior related to a diagnosed mental illness to go unnoticed by staff, contributing to a potential in psychosocial harm to Resident 15. Findings: During a review of Resident 15's facesheet (one-page summary of a patient's key information within their medical record), dated 8/14/25, the facesheet indicated a diagnosis of Schizophrenia (a chronic mental health condition that affects how a person thinks, feels, and behaves), dated 2/9/23. During a concurrent interview and record review with the Director of Nursing (DON) on 8/15/25 at 3:56 p.m., Resident 15's physician orders indicated no order for behavioral monitoring. DON stated, Resident 15 should have an order for behavioral monitoring, since she has a diagnosed mental illness. During a review of the facility's P&P titled, Dignity and Respect Psychoactive Medications, dated 2025, the it indicated, Behavioral interventions: individualized, nonpharmacological [non-drug] approaches to care that are provided as part of a supportive psychosocial environment, direct toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical, or psychosocial well-being. 20. The facility ensures that resident's behaviors. circumstances that warrant evaluation of a resident's underlying medical condition and medications include. b a new or worsening change in condition.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a system for physician prescribed fortified diets (a diet with added nutrients, such as calories and protein, to increase the nutritional value of the diet, especially for individuals with or at risk for weight loss and/or malnutrition). This failure had the potential to result in weight loss and or further complicate medical conditions for 1 sampled resident (Resident 3) who was on a physician prescribed fortified diet. Findings: Review of Resident 3's electronic medical record showed Resident 3 was initially admitted on [DATE] and had diagnoses including but not limited to a stage 4 pressure ulcer (most severe stage of a pressure ulcer, characterized by full-thickness skin tissue loss, with exposed bone, tendon, or muscle). Review of Resident 3's electronic medical record showed in the Order Summary Report, Fortified diet Minced & Moist, ordered on 6/15/25. During an observation of trayline lunch service (a food assembly system, where meal trays are prepared in a linear, conveyor-belt style fashion. Workers assemble the trays with specific items according to the tray ticket, as the trays move along the line) on 8/11/25 at 12:14 p.m., kitchen staff placed food on a tray for Resident 3 according to what was listed on the tray ticket. The tray ticket for Resident 3 showed she was on a Minced & Moist (MM5) [a texture modified diet consisting of food that are minced or mashed into small, uniform pieces, requiring minimal chewing and no biting] Fortified, Regular Portion diet. Beverages listed on the tray ticket were coffee, juice, and 2% milk (milk with a fat percent of 2%). During a consecutive observation and interview on 8/11/25 at 12:14 p.m., when [NAME] B was asked how the lunch diets were fortified, [NAME] B stated the fortified diets should receive a pat of butter on the tray. There was no butter Resident 3's tray before it was placed on the food delivery cart. [NAME] B spoke to Diet Aide (DA) D who was the first person on the trayline and placed condiments on the trays. [NAME] B said to DA D that fortified diets were supposed to get butter on the tray. During an interview on 8/11/25 at 12:47 p.m., the Assistant Dietary Supervisor (ADS) stated residents on a fortified diet were supposed to receive fortified milk and whipped topping on the dessert, and extra butter. ADS stated when fortified diets were ordered, she added the words fortified milk and whipped topping to the tray ticket. ADS confirmed fortified milk and whipped topping were not added to Resident 3's tray ticket. ADS stated fortified milk was whole milk with powdered milk added to it. ADS stated there was a binder that explained fortified diets and it included recipes. ADS stated she was confused about what residents on fortified diets were really supposed to receive to fortify their diet. During an interview on 8/11/25 at 3:42 p.m., the Registered Dietitian (RD) stated she placed recommendations for physicians to order fortified diets for residents. When RD was asked how diets were fortified, RD stated the cook fortified food on the menu. RD stated there was a fortified menu for the cooks to follow. When RD was asked to show the fortified menu, RD stated she was not familiar with the menu, and it was necessary to ask either the cook or ADS about it. When RD was asked how many extra calories the fortified diet provided, RD stated she did not know although she worked at the facility for over six months. During an observation and interview on 8/13/25 at 10:06 a.m., [NAME] C stated for fortified diets at breakfast this morning (8/13/25) she added one ounce of butter to the pancakes. [NAME] C removed a one ounce ladle from a drawer to show what she used to place the liquid butter on the pancakes. [NAME] C stated for fortified pureed diets, she added butter when she pureed the pancakes. During an interview with ADS and RD on 8/13/25 at 10:22 a.m., ADS stated the Special Nutrition Program (SNP) was followed fortified diets always received Super Cereal and fortified milk for breakfast every morning, and for lunch and dinner fortified diets received fortified milk. ADS stated recipes for items such as Super Cereal were in the SNP recipe book. ADS stated fortified diets did not receive extra butter at meals. ADS stated cooks were focused on adding extra butter, and if a cook said fortified diets received extra butter, it was because that is how they were trained by the previous supervisor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADS stated residents on fortified diets did not receive extra butter this morning for breakfast. ADS and RD if they knew how many extra calories Residents on a fortified diet received. ADS did not answer but RD stated she estimated the fortified diet provided 200 calories per day. When asked how she estimated 200 calories, RD sated for fortified diet they follow the recipe. In a concurrent interview and record review on 8/13/25 at 10:22 a.m., ADS provided the SNP [Special Nutrition Program] Recipe Book nutritional requirements of residents who are underweight, have pressure ulcers, experiencing significant weight loss, have poor intake and/or have a low albumin (a protein primarily produced by the liver). The supplement order should read Mini Special Nutrition Program, Special Nutrition Program or Special Nutrition Program with 2 oz [ounce] 2 cal [calorie]/ml [milliliter] med pass [a protein/calorie supplement] qid [four times a day]. The Mini Special Nutrition Program included six ounces of super cereal and eight ounces of milk for breakfast, 8 ounces of whole milk for lunch, eight ounces of whole milk for dinner, and provided approximately 665 calories and 17 grams of protein per day. The Special Nutrition Program included the same as the Mini Nutrition Program for breakfast and lunch, for dinner included 8 ounces of whole milk, and four ounces of high calorie pudding or a high calorie brownie. There was also a list of optional items that could be added such as melted butter. The Special Nutrition Program provided 880 to 1000 calories and 23 to 24 grams of protein per day. The Special Nutrition Program with Med Pass was the same as the Special Nutrition Program with 2 oz of Med Pass four times a day, and provided 1360 to 1480 calories, and 43 to 54 grams of protein per day. The recipe for Super Cereal showed it contained oatmeal, whole milk, non-fat dry milk, margarine, granulated, and brown sugar and it provided 425 calories per serving. In addition, ADS spoke with [NAME] C and [NAME] C confirmed she placed an extra ounce of liquid butter on the pancakes for breakfast. During an interview on 8/13/25 at 1:28 p.m., ADS stated residents on a fortified diet should only receive what was listed on the tray ticket. ADS explained, if the tray ticket showed fortified milk, the resident only received fortified milk to fortify the diet, and if the tray ticket showed super cereal, the resident only received super cereal to fortify the diet. During an interview and record review on 8/15/25 at 10:50 a.m., RD stated fortified diets were recommended by the RD; then, the recommendation went to a nurse and the nurse contacted the physician for permission to order the diet. The records of residents with fortified diet orders were reviewed. RD stated fortified diets were recommended for residents who were underweight and/or experienced weight loss. When Resident 3's electronic medical record was reviewed, RD stated Resident 3 was admitted in February 2025 and her average intake was 54 percent. She had a deep tissue injury on her upper back and coccyx. Then Resident 3 went out to the hospital in March 2025 and upon readmission she was not eating very well at all, and her average intake was only 32 percent, and she still had the wound. RD stated she tried different interventions to increase calories due to Resident 3's poor intake and for wound healing. RD stated she recommended a fortified diet for Resident 3 because her food intake was not improving, and Resident 3 needed more calories. RD confirmed Resident 3's fortified diet was ordered on 6/15/25.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure lunch menus were followed on 08/11/2025 as evidenced by: Resident 163 received a mixed fruit cup instead of 1 fresh apple as indicated on the menu. Resident 143 received tarter sauce when it was not indicated on the menu. These deficiencies had the potential to compromise the medical and nutritional status of Residents 163 out of 143. Findings: 1. Resident 163 received a mixed fruit cup instead of 1 fresh apple as indicated on the menu. During a concurrent observation, interview, and record review on 08/11/2025 at 12:01 PM with Diet Aide K (DA K) in the kitchen during lunchtime tray line, lunch tray for Resident 163 showed a mixed fruit cup that included cubes of melons and peaches. DA K was asked if the mixed fruit cup was appropriate for Resident 163's lunch tray and DA K stated the mixed fruit cup was appropriate. DA K was asked to verify that the mixed fruit cup was appropriate using diet menu spreadsheet for Monday 08/11/2025, and after reviewing the spreadsheet, DA K removed a pink colored juice from Resident 163's tray and exchanged it for a cup of apple juice. During a concurrent observation & interview on 08/11/2025 at 12:01 PM with ADS, ADS was asked what Resident 163 should have for lunch dessert. The ADS stated that Resident 163 should receive 1 fresh apple, and not mixed fruit cup. The ADS exchanged the mixed fruit cup for the apple. During an interview on 08/11/2025 at 2:51 PM with ADS, the ADS was asked what fruit was in the mixed fruit cup. ADS stated the mixed fruit cup had honeydew, papaya, cantaloupe, and canned peaches. During a review of Lunch Tray Ticket for Resident 163, dated Monday 08/11/2025, the Lunch Tray Ticket indicated a Vegetarian Renal and Regular Portion meal. During a review of daily menu spreadsheet for Monday 08/11/2025, the daily menu spreadsheet only indicated one type of renal diet titled Liberal House Renal. The daily menu spreadsheet for Lunch Liberal House Renal meal indicated dessert should be 1 fresh apple, as an alternative to the Regular Diet menu item of Fresh Fruit in Season. During a review of daily menu spreadsheet, last revised on 10/19/2022, the daily menu spreadsheet indicated that the Liberal House Renal diet is for individuals on dialysis who do not have strict dietary restrictions and fluids are restricted according to physician orders. 2. Resident 143 received tarter sauce when it was not indicated on the menu. During an observation on 08/11/2025 at 12:13 PM, lunch tray for Resident 143 showed a plate with a tarter sauce container and a packet of mayonnaise. During a concurrent observation and interview on 08/11/2025 at 12:14 PM with [NAME] B in the kitchen during lunchtime tray line, [NAME] B was asked if the tray items for Resident 143 were correct. [NAME] B identified Resident 143 had tarter sauce on the tray and mayonnaise. [NAME] B confirmed that Resident 143 should not have tarter sauce and should only have mayonnaise on the tray. During a review of Lunch Tray Ticket for Resident 143, dated Monday 08/11/2025, the Lunch Tray Ticket indicated an Easy to Chew (EC7) Small Portion meal. During a review of daily menu spreadsheet for Monday 08/11/2025, the daily menu spreadsheet for Lunch Easy to Chew (EC7) meal indicated Mayonnaise 1 Tbsp is substituted for Tartar Sauce. During a review of the facility's policy and procedure titled, Food and Nutritional Services Policy & Procedures titled Menus, last revised on January 2025, indicated, The facility assures menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure a dryer's lint filter compartment and lint trap cleaning log were routinely maintained. The facility's documentation indicated laundry staff did not clean the dryer lint for several hours on multiple days. This failure had the potential to for an excess accumulation of lint that could catch on fire. Findings:During a concurrent observation and interview with the environmental director (ED) in linen room on 8/19/25 at 8:25 a.m., one of the clothes dryer's lint compartment (an area of the clothes dryer designed to catch lint and debris from clothing and linen as they are tumble dried) contained laundry lint fibers from the tumble drying of clothing and linen. The ED stated lint traps were supposed to be cleaned every two hours. During an interview and concurrent record review with the ED on 8/19/25, at 9:03 a.m., the ED reviewed the facility's laundry lint trap cleaning log. The laundry lint trap cleaning log was missing signatures on 8/1/25 at 10:00 p.m., 8/7/25 at 3:00 p.m., 8/9/25 at 1:00 p.m., 7:00 p.m., 10:00 p.m., 8/10/25 at 7:00 p.m., 8/11/25 at 5:00 a.m., 8/13/25 at 3:00 pm and 5:00 pm, and on 8/15/25 at 1:00 p.m The ED confirmed the lint trap cleaning log was left blank and unsigned on these dates and times, and should have been filled out. During an interview with the infection preventionist (IP) on 8/20/25, at 11:27 a.m., the IP confirmed that there were missing signatures on the lint trap cleaning log that should have been completed by the laundry staff.During a review of the facility's undated policy and procedure (P&P), Laundry Fire Safety, revised March 2023, it indicated, It is the policy of this facility to maintain laundry equipment in a safe and sanitary condition, in compliance with the National Fire Protections Association (NFPA) codes, the California Health & Safety Code (HSC S1275 , S1319), and Title 22, California Code of Regulations. Accumulation of lint in clothes dryer and exhaust ducts presents a fire hazard and must be prevented through routine cleaning and documentation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure the kitchen was free from flies. This failure had the potential to compromise food safety and increase the risk of foodborne illness for 144 of the 151 residents who consumed meals prepared in the facility's kitchen. Findings: During an observation on 08/11/2025 at 10:02 AM in the kitchen, multiple flies were observed throughout the kitchen area. During an interview on 08/12/2025 at 9:49 AM with [NAME] B, [NAME] B confirmed the presence of flies and added that the flies have been seen around the kitchen for 1 week. During an observation on 08/12/2025 at 10:15 AM in the kitchen, a fly was observed landing on a can of spray used for coating pans. Another fly was seen landing on the foil covering a pan containing a pureed entree. Additionally, a third fly was observed flying around a pan of cake. During an interview on 08/12/2025 at 11:16 AM with Assistant Dietary Supervisor (ADS), the ADS reported the presence of flies in the kitchen to the Environmental Director (ED) on 08/06/2025, and the ED subsequently called the pest control company. ADS stated that flies have been present in the kitchen for approximately one week. During an interview on 08/12/2025 at 11:31 AM with the ED, the ED confirmed being informed of the presence of flies in the kitchen on 08/06/2025. The ED stated that the pest control company is scheduled to address the issue on 08/14/2025 and noted that pest control services are routinely provided every two weeks, and 08/14/2025 was a routine service date. When asked whether pest control could have been contacted sooner, the ED explained that the facility chose to conduct an internal investigation prior to reaching out. Additionally, when asked to describe the policy and procedure for addressing fly-related concerns, the ED stated that upon identifying the presence of flies, the issue is reported immediately, followed by contacting the pest control company for guidance on the most appropriate treatment approach. During an interview on 08/12/2025 at 4:25 PM with the Infection Preventionist (IP), the IP had was not aware of the flies in the kitchen. IP expects to be notified if any issues with flies are identified in the kitchen. During an interview on 08/13/2025 at 10:10 AM with the ED, the ED confirmed that treatments for flies are currently not part of the normal pest control contract for the facility. During an interview on 08/13/2025 at 1:20 PM with the Infection Preventionist (IP), the IP stated that if a fly issue arises, pest control should be contacted to respond to the facility immediately. During an observation on 08/14/2025 at 9:36 AM in the kitchen, a fly count was performed, and approximately 152 flies were observed. During an interview on 08/15/2025 at 5:00 PM with the Administrator (ADM), the ADM was asked when pest control should be contacted upon identification of flies, and the ADM responded that they do not have control over when pest control arrives at the facility. The ADM confirmed that designated facility staff can contact pest control services between routine visits, as needed. The ADM was unsure whether pest control was contacted last week to address the fly issue at the facility. During a review of pest control company invoice dated 08/14/2025, for service from 7:35 PM to 8:26 PM, the invoice indicated routine pest control service and no specific treatment for flies, despite surveyor observations of approximately 152 flies earlier in the day. During an interview on 08/15/2025 at 1:06 PM with a customer service representative from the pest control company, a request was made to interview the pest control technician who had performed services for the facility on 08/14/2025. The customer service representative stated the pest control technician was unavailable for an interview. The surveyor requested a return call and provided a contact phone number. During a review of pest control company invoice dated 08/16/2025, the invoice indicated the service included treatment on drains for flies and fruit flies. During an interview on 08/18/2025 at 10:14 AM with a customer service representative from the pest control company, a second request was made to interview the pest control technician who had performed services for the facility on 08/14/2025. The customer service representative stated the pest control technician was unavailable for an interview. The surveyor requested a return call and provided a contact phone number. During an interview on 08/18/2025 at 4:25 PM with customer service representative (CSR) from the pest control company, a third request (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Mission DE LA Casa		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Alvin Avenue San Jose, CA 95121	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was made to interview the pest control technician who had performed services for the facility on 08/14/2025. The CSR stated the pest control technician was unavailable for an interview. The surveyor requested a return call and provided a contact phone number. The CSR was asked to specify the services requested for the facility on 08/14/2025. The representative indicated that the service provided on 08/14/2025 was a routine service, and there was no record of a separate service order specifically for addressing flies. The customer service representative confirmed fly treatments are not included in the regular service and any fly treatments are considered a separate service. During a review of pest control company invoice dated 08/19/2025, it indicated the service included treatment to 5 of the big drains in the kitchen, and the technician suggested installation of 2 or 3 fly lights to address the flies. During a review of the facility's policy and procedure (P&P) titled, Pest Control Program, dated 01/2025, it indicated the purpose of the P&P was, To maintain a safe, sanitary environment that is free of insects, rodents, and other pests through an effective, integrated pest management program. The pest prevention management program shall apply to all service areas (e.g., kitchen, laundry, resident rooms, outdoor spaces, and grounds under the facility's control). the facility has a licensed pest management professional, retained under contract to provide routine inspections/treatments and emergency response. Staff should be trained to report any sightings of pests or vermin immediately. The environmental services lead should review pest control logs and vendor reports with significant trends quarterly.		