

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: 555799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were trained and competent in the use of Wander Management Transmitters (wander guard, a device placed on a resident's wrist, ankle, or wheelchair that alarms to notify the staff if a resident tries to leave the facility) used for two of two residents (Residents 7 and 35). This failure had the potential to result in transmitter equipment failure or system failure and resident elopement (to leave a health facility without notification or permission). Findings: Review of Resident 7's face sheet indicated she was admitted to the facility with diagnoses including dementia (decline in mental capacity affecting daily function) and type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar). Review of Resident 7's elopement care plan, dated 12/26/25 indicated the resident exhibited wandering behavior and was at risk for elopement. Review of Resident 7's Order Listing Report, dated 1/9/26 indicated she had a physician order to apply wander guard to right ankle and check placement and functioning every shift as a monitoring device due to episodes of going out of the facility unassisted. Review of Resident 35's face sheet indicated she was admitted to the facility with diagnoses including congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and schizophrenia (a mental illness that is characterized by disturbances in thought). Review of Resident 35's elopement care plan, dated 5/21/25 indicated the resident is at risk for elopement and had episodes of going out of the facility unassisted. Review of Resident 35's Order Listing Report, dated 1/9/26 indicated he had a physician order to apply wander guard to right ankle and check placement and functioning every shift as a monitoring device due to episodes of going out of the facility unassisted. During an observation and interview on 1/8/26 at 10:50 a.m., licensed vocational nurse C (LVN C) stated the door will alarm when the resident gets close to the door. LVN C stated the nurses should check that wander guard is intact. LVN C went Resident 7's room to check whether Resident 7 had her wander guard in place. Resident 7 was asleep in bed with a blanket covering her body. LVN C was not able to check whether the wander guard was in place and stated she would try again later. During an observation and interview on 1/8/26 at 11:02 a.m., licensed vocational nurse D (LVN D) stated he is pretty sure there is a way to check whether the wander guard is functioning. LVN D checked whether Resident 35's wander guard had a light and confirmed there was no light on his wander guard. LVN D stated he will ask the director of nursing (DON). During an interview on 1/8/26 at 11:05 a.m. the DON stated there is a device that lights up that is used as a tester to test whether the wander guard is functioning. The DON stated the nurses should know. She stated she will check where the tester was. During an interview on 1/8/26 at 11:05 a.m., the director of staff development (DSD) stated will look for documentation of a training or inservice related to the use of the wander guard During an interview on 1/9/26 at 4 p.m., the DON stated maintenance has the testing device that tests the functionality of the wander guard. The manufacturer's user manual for the wander guard was requested. During an interview on 1/12/26 at 9:51 a.m., the DSD stated she was not able to find an inservice on the wander guard. The DSD stated they started training nurses regarding the use of the wander guard on 1/9/26. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and concurrent interview on 1/12/26 at 2:30 p.m., the administrator (ADM) stated the testing device tested the function of the door alarm. The ADM stated there was nothing to test the wander guard's functioning. The testing device had no label or instructions for use. The ADM was not able to provide the manufacturer's user manual for the wander guard transmitter. Review of the facility's policy, Wandering and Elopements, dated 3/2019 indicated, If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of the Secure Care Products, LLC's Transmitter User Guide, dated 12/11/17 indicated the following: This Product must be installed, set-up, tested, supported, operated, maintained, repaired and used only in accordance with all manuals and instructions (including the user, installation, technical and other manuals) issued by Secure Care (the Product Manuals). It is also your responsibility to assure that any person who might be operating or using this Product knows the contents of and has access to the Product Manuals and has successfully completed Secure Care in-service training. Testing the Transmitter Using the 707 Tester. 1. Turn the switch to TRANSMITTER TEST. 2. Press and release the RESET button. 3. Bring the Transmitter in front of the Tester. The yellow RECEIVED SIGNAL (LED) should [NAME] and the green TRANSMITTER OK light should come on. The 707 Tester is receiving transmitter signal.		

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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 a comprehensive, person-centered care plan for four out of fifteen sampled residents (Residents 12, 5, 8 and 31): 1. For Resident 12, there was no comprehensive, person-centered care plan for his side rail or bed rail (bars attached to the side of the bed for safety and mobility aids); 2. For Resident 5, she had no bed rail care plan; 3. For Resident 8, staff did not implement a care plan intervention of monitoring oxygen saturation (measurement of how much oxygen is in the blood) every shift. 4. For Resident 31, she had no activity care plan. These failures had the potential to result in the residents, not receiving the intervention and monitoring necessary to maintain their highest level of well-being. Findings: 1. During the initial observation of Resident 12 on 1/6/26 at 12:40 p.m., Resident 12 was laying in his bed. Resident 12 was calm, comfortable, confused and could not answer questions. He had 1/3 left side rail or bed rail up. Review of Resident 12's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) dated 1/8/26 indicated, Resident 12 was readmitted to the facility on [DATE] with the primary diagnosis of catatonic schizophrenia (subtype of schizophrenia characterized by significant disruptions in motor behavior and extreme psychological disturbances). Review of Resident 12's order listing report dated 1/9/26 indicated, Resident 12 had an order to put 1/3 left bed rail up when in bed, to assist resident in bed mobility and/or transfers, last ordered on 1/4/26. Review of Resident 12's care plans indicated, Resident 12 did not have a comprehensive, person-centered care plan for his bed rail. During the concurrent review of Resident 12's care plans and interview with assistant director of nursing/infection preventionist (ADON/IP) on 1/9/26 at 10:20 a.m., ADON/IP acknowledged that Resident 12 had 1/3 left bed rail up when in bed but did not have a comprehensive, person-centered care plan for his 1/3 left bed rail and would have it updated. During the interview with director of nursing (DON) on 1/9/26 at 2:13 p.m., DON verified that the care plan for the bed rail should be comprehensive and person-centered and would follow up on it. 2. Review of Resident 5's admission record dated 1/8/26 indicated, Resident 5 was admitted to the facility on [DATE] with the primary diagnosis of hemiplegia (paralysis affecting one side of the body, resulting from brain or spinal cord damage), unspecified affecting left dominant side (preference to use this side of the body over the other). Review of Resident 5's order listing report dated 1/9/26 indicated, Resident 5 had an order to put 1/5 bilateral bed rails up when in bed, to assist resident in bed mobility and/or transfers every shift. Resident 5 was discharged to home, 12/23/25 with medications, discharge instructions and home health was set-up. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's care plans indicated, Resident 5 did not have a comprehensive, person-centered care plan for her bed rails. During the concurrent review of Resident 5's care plans and interview with ADON/IP on 1/9/26 at 11:40 a.m., ADON/IP acknowledged that Resident 5 had 1/5 bilateral bed rails but did not have a comprehensive, person-centered care plan for her bed rails. During the interview with director of nursing (DON) on 1/9/26 at 2:13 p.m., DON verified that the care plan for the bed rails should be comprehensive and person-centered and would follow up on it. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. During an observation on 1/6/26 at 10:28 a.m. Resident 8 was in bed and was on oxygen at 2 liters per minute (L/min, unit of flow rate). Review of Resident 8's clinical record indicated she was under hospice care and depended on supplemental oxygen. Review of Resident 8's physician orders indicated the resident had an order for oxygen at 2 L/min via nasal cannula for shortness of breath and comfort. Review of Resident 8's care plan for oxygen therapy, dated 6/3/25 indicated an intervention, Monitor and record O2 saturation QS [every shift]. There was no documentation that indicated Resident 8's oxygen saturation was monitored and recorded every shift. During an interview on 1/09/26 at 10:11 a.m., the Director of Nursing (DON) confirmed Resident 8 was on oxygen and her oxygen saturation should be taken every shift. The DON stated there was no order for Resident 8's oxygen saturation to be taken every shift. Review of the facility's policy, Oxygen Administration, revised 10/2010 indicated while the resident is receiving oxygen therapy, assess for vital signs, lunch sounds, and oxygen saturation. 4. Review of Resident 31's clinical record indicated she was admitted to the facility on [DATE]. Review of Resident 31's activity care plan indicated a created date of 1/6/26. There was no documentation Resident 31 had an activity care plan after her 11/18/25 admission. During an interview on 1/12/26 at 1:42 p.m. the DON stated Resident 31 only had one activity care plan and confirmed it was created on 1/6/26. Review of the facility's policy, Activity Evaluation, dated 2/2023 indicated, An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident . Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record reviews, the facility failed to ensure that the nurse staffing information was kept and maintained for at least eighteen months when their direct care service hours per patient day (DHPPD, a critical staffing metric for skilled nursing facilities requiring a minimum of 3.5 total hours of which 2.4 hours per patient day must be performed by certified nursing assistants or CNA) for 7/1/25 to 9/30/25, were not available and provided when requested. This failure had the potential to affect the quality of care that were provided to the forty-six residents residing in the facility that could also affect the residents' quality of life and well-being. Findings: Review of the Centers for Medicare and Medicaid Services (CMS, United States federal agency managing Medicare, Medicaid, Children's Health Insurance Program or CHIP and the health insurance marketplace), Certification and Survey Provider Enhanced Reporting's (CASPER's, tools used by skilled nursing facilities and CMS to monitor, review, and report the daily staffing hours and resident census data) Payroll-Based Journal (PBJ, quarterly submission by nursing homes to the CMS detailing direct care staff hours and resident census) Staffing Data Report from 7/1/25 to 9/30/25 indicated, excessively low weekend staffing and one star staffing rating (much below average staffing levels compared to other facilities). During the concurrent interviews with the director of nursing (DON) and the administrator (ADM) on 1/12/26 at 2:01 p.m., they both acknowledged that they currently did not have the DHPPD staffing data reports from 7/1/25 to 9/30/25 that would dispute the excessively low weekend staffing and one star rating for these dates. They further acknowledged the above CASPER's PBJ staffing data report from 7/1/25 to 9/30/25. Review of the facility's DHPPD staffing data reports from 7/1/25 to 9/20/25 that were emailed late on 1/14/26 at 12:15 p.m., by the DON indicated, they have low actual staffing and certified nursing assistants' DHPPD for the following dates: 1. 7/6/25 - 3.3086 actual staffing DHPPD and 2.3475 actual CNA DHPPD; 2. 7/12/25 - 3.4060 actual staffing DHPPD and 2.3503 actual CNA DHPPD; 3. 8/30/25 - 3.4322 actual staffing DHPPD and 2.3765 actual CNA DHPPD. No DHPPD staffing data reports were provided for 9/21/25 to 9/30/25. Review of the Centers for Medicare and Medicaid Services, State Operations Manual (SOM, provides federal rules, guidelines and procedures from CMS), Appendix PP, Guidance to Surveyors for Long Term Care Facilities, issued 7/3/25 indicated, .The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: except when waived.licensed nurses; and other nursing personnel, including but not limited to nurse aides.The facility must, upon oral or written request, make sure staffing data available to the public for review at a cost not to exceed the community standard.The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely notify a representative of the Office of the State Long-Term Care Ombudsman (an entity that serves as an impartial advocate for individuals or groups who have concerns or complaints about a particular organization) regarding transfers for two of three sampled residents (Residents 3 and 7). This failure resulted in missed opportunities for an ombudsman to advocate if residents had concerns about their discharge. Findings: Review of Resident 3's clinical record indicated she was transferred to the hospital on [DATE] due to hypotension (low blood pressure) and desaturation (low oxygen levels in the blood. There was no documentation that indicated a notice was sent to the Ombudsman regarding Resident 3's transfer. Review of Resident 7's clinical record indicated she was transferred to the hospital on [DATE] due to hyperglycemia (increased blood sugar) and altered level of consciousness. There was no documentation that indicated a notice was sent to the Ombudsman regarding Resident 3's transfer. During an interview on 1/8/26 at 3:48 p.m., the social services director stated the notices regarding Residents 3 and 7's transfers were not sent to the Ombudsman. Review of the facility's policy, Transfer or Discharge, Facility-Initiated, dated 10/2022 indicated Notice of Transfer is provided to the long-term (LTC) ombudsman when practicable.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure the residents assessments were reviewed and updated for effectiveness and accuracy for two of fifteen sampled residents, (Residents 12 and 40), when their activity assessments were not reviewed and revised quarterly. These failures had the potential to result in the residents not receiving the appropriate plan of care and interventions necessary to maintain their highest level of well-being. Findings: 1. During the initial observation of Resident 12 on 1/6/26 at 12:40 p.m., Resident 12 was laying in his bed. Resident 12 was calm, comfortable, confused and could not answer questions. Review of Resident 12's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) dated 1/8/26 indicated, Resident 12 was readmitted to the facility on [DATE] with the primary diagnosis of catatonic schizophrenia (subtype of schizophrenia characterized by significant disruptions in motor behavior and extreme psychological disturbances). Review of Resident 12's assessments indicated, Resident 12's activity assessment was not reviewed and updated quarterly for effectiveness and accuracy. It was last updated on 4/26/22. During the concurrent review of Resident 12's activity assessment and interview with assistant director of nursing/infection preventionist (ADON/IP) on 1/9/26 at 10:20 a.m., ADON/IP verified that the last activity assessment of Resident 12 was done on 4/26/22 and would follow up on it. During the concurrent review of Resident 12's activity assessment and interview with the activity director (AD) on 1/9/26 at 2:05 p.m., AD confirmed that she was not able to update the activity assessment of Resident 12 quarterly and his last activity assessment was done on 4/26/22. AD then stated that she would do the activity assessment updates every three months or quarterly. During the interview with the director of nursing (DON) on 1/9/26 at 2:13 p.m., DON verified that assessments including activity assessments are updated quarterly and would follow up on this concern. 2. During the observation of Resident 40 on 1/6/26 at 12:45 p.m., Resident 40 was laying in her bed. Resident 40 was comfortable, alert, oriented and able to answer questions. Review of Resident 40's admission record dated 1/8/26 indicated, Resident 40 was admitted to the facility on [DATE] with the primary diagnosis of encounter for palliative care (specialized medical care that focuses on improving quality of life, providing relief from pain and other symptoms of a serious illness). Review of Resident 40's assessments indicated, Resident 40's activity assessment was not reviewed and updated quarterly for effectiveness and accuracy. Last update was on 5/27/25. During the concurrent review of Resident 40's activity assessment and interview with AD on 1/9/26 at 2:08 p.m., AD confirmed that she was not able to update the activity assessment of Resident 40 quarterly and her last activity assessment was done on 5/27/25. AD then stated that she would do the activity assessment updates every three months or quarterly. During the interview with the DON on 1/9/26 at 2:13 p.m., DON verified that assessments including activity assessments are updated quarterly and would follow up on this concern. Review of the facility's policy and procedure titled, Activity Evaluation, revised February 2023 indicated, In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. The completed activity evaluation is part of the resident's medical record and is updated as necessary but at least quarterly.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to follow the recommendations of the Preadmission Screening and Resident Review (PASARR, a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Individualized Determination Report for one of three residents (Resident 39). This failure had the potential to result in the resident not receiving appropriate care and services for a mental health condition. Findings: Review of Resident 39's clinical record indicated he was admitted to the facility with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 39's physician orders indicated staff was monitoring the resident for picking skin on his fingers, fidgeting, verbalization of sadness related to his health condition, difficulty sleeping, inappropriate sexual behavior, and rapid speech leading to exhaustion. Review of Resident 39's PASARR Individualized Determination Report, dated 5/19/25 indicated the resident required Specialized Add-on Services to address mental health needs. The report indicated one of the recommended Specialized Add-on Services was Psychiatry consultation (psych consult) and/or follow-up care. During an interview on 1/8/26 at 8:20 a.m. the social services director stated the Psychiatric Mental Health Nurse Practitioner (psych NP) was coming in the afternoon today to speak to Resident 39 in response to two abuse allegations involving Resident 39. Review of Resident 39's Social Services Notes, dated 1/8/26 indicated the resident was seen by the psych NP on 1/8/26. The notes indicated Resident 39 stated he had a plan to harm another resident. The notes also indicated Resident 39 was transferred to a psychiatric facility on a 5150 hold (an emergency intervention which allows a person experiencing a mental health crisis to be held involuntary for up to 72 hours) for emergency psychiatric evaluation and treatment. There was no documentation that indicated Resident 39 had a psych consult after his PASRR Individualized Determination Report on 5/19/25 and before the psych NP visit on 1/8/26. During an interview on 1/12/26 at 1:16 p.m., the Director of Nursing (DON) stated there were no psych consults for Resident 39 after May 2025 and stated, Just the latest one (referring to the psych NP visit on 1/8/26). Review of the facility's policy, admission Criteria, dated 3/2019 indicated, Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure, the resident's medication was administered as per physician's orders by one of two nurses observed when the furosemide (a powerful loop diuretic, given to help treat fluid retention and swelling) 40 milligrams (mg, unit of mass or weight) tablet of Resident 53 was still given, without following the medication's parameter order (specific components of a prescription order that define how a medication should be safely administered). This failure had the potential to compromise the resident's health, safety and well-being. Findings: During the medication pass observation of Resident 53 with licensed vocational nurse A (LVN A) on 1/7/26 at 9:48 a.m., LVN A gave furosemide 40 mg tablet, one tablet by mouth. Review of Resident 53's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) dated 1/12/26 indicated, Resident 53 was admitted to the facility on [DATE] with the primary diagnosis of chronic embolism (occurs when blood clots in the lungs don't fully dissolve, leading to organized scar tissue that blocks arteries causing high blood pressure in the lungs, shortness of breath, fatigue and potential right heart failure) and thrombosis (formation of blood clot inside a blood vessel) of left femoral vein (large left thigh blood vessel that carries deoxygenated blood from the left lower leg back to the heart). Review of Resident 53's order listing report dated 1/12/26 indicated, Resident 53 had an active physician's order of furosemide tablet 40 mg, give 1 tablet by mouth two times a day for congestive heart failure (CHF, long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply), hold for systolic blood pressure (SBP, the top number in the blood pressure reading, measuring the pressure in the arteries when the heart beats and pushes blood out) below 100 millimeters of mercury (mmHg, unit used to measure the force of blood against artery walls, recorded as two numbers, the top is the systolic blood pressure over the bottom which is the diastolic blood pressure or when the heart rests). Review of Resident 53's medication administration record (MAR, vital legal document in healthcare that tracks all medications given to a resident) for 1/6/26 indicated, Resident 53 was still given one tablet of Furosemide 40 mg at 9:00 a.m., even if his systolic blood pressure was 94 mmHg. During the interview with LVN A on 1/8/26 at 11:55 a.m., LVN A acknowledged that the furosemide 40 mg tablet of Resident 53 should not be given on 1/6/26 at 9:00 a.m., because his SBP was only 94 mmHg and would not do it next time. During the interview with the director of nursing (DON) on 1/8/26 at 4:50 p.m., DON verified that the medication parameter orders should be followed and the furosemide tablet of Resident 53 should not be administered on 1/6/26 at 9:00 a.m. and would follow up on this concern. Review of the facility's policy and procedure titled, Medication and Treatment Orders, revised July 2016 indicated, Orders for medications and treatments shall be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of the undated facility's, Job Description: Licensed Vocational Nurse indicated, .Duties and Responsibilities; Administrative Functions: Administers medications as prescribed by the healthcare provider.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER The Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1355 Clayton Road San Jose, CA 95127	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented by one of two licensed vocational nurses observed during medication pass observation, when the licensed vocational nurse B (LVN B) did not remove dirty gloves, perform hand hygiene (the act of cleaning hands with soap and water or an alcohol-based hand sanitizer to remove germs and prevent the spread of infections) and don (put on) a new pair of gloves prior to medication administration of Resident 38 after she threw garbage and touched the garbage container attached to the side of the medication cart with the gloved hand. These failures had the potential for the spread of infection and cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could affect the forty-six residents residing in the facility, staff, and visitors. Findings: During the medication pass observation of LVN B on 1/8/26 at 5:06 p.m., LVN B was preparing medications for Resident 38 with her sanitized hands. When she was done preparing the medications of Resident 38, LVN B sanitized her hands again and put on a new pair of gloves. But then, LVN B threw garbage in the garbage container attached to the side of the medication cart, touching the garbage container to fix it with her gloved hand, then she proceeded to give the medications of Resident 38 without removing the dirty gloves, performing hand hygiene after and then putting on a new pair of gloves before the medication administration of Resident 38. During the interview of LVN B on 1/8/26 at 5:35 p.m., LVN B acknowledged the above concern. LVN B further acknowledged that she should have removed her dirty gloves because she contaminated it, sanitized hands and put on a new pair of gloves before she gave the medications of Resident 38 and would not do it next time. During the interview with the director of nursing (DON) on 1/8/26 at 5:50 p.m., DON verified that LVN B should have observed proper infection control and should have removed her dirty gloves, sanitized her hands and put on new pair of gloves before giving the medications of Resident 38 and would follow up on it. Review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, revised August 2019 indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before preparing or handling medications. after contact with objects. in the immediate vicinity of the resident.		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to ensure multiple resident rooms with two beds (Rooms 101, 102, 103, 104, 105, 106, 107, 109, 110, 114, 115, 116, 117, 118, 120, and 121) measured at least 80 square feet per resident. Less than 80 square feet per resident in resident rooms could adversely affect resident health and safety. Findings: Room measurements indicated multiple resident rooms with two beds were less than 80 square feet per resident. Rooms 101, 102, 103, 104, 105, 106, 107, 109, 110, 114, 115, 116, 117, 118, 120, and 121 with two beds all measured 69.51 square feet per resident. None of the rooms were observed to inhibit the staff from providing care or the residents from receiving adequate care. The staff and the residents moved freely in the rooms. Wheelchairs and walkers were easily accommodated. The residents and the staff stated the square footage of the rooms was not a concern. Recommendation is for a continuance of the room waiver.		