

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: 555916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER O'Connor Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 Forest Avenue San Jose, CA 95128	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure needed care and services were provided in accordance with professional standards of practice for four residents (Resident 3, 5, 12, 16) when:1.Resident 3 had a rectal tube (a flexible tube inserted into the rectum to manage bowel issues, such as channeling loose stool or gas into a collection bag) without a Physician Order,2. For Resident 5 and Resident 12, licensed staff did not administer a water flush prior to medication administration,3. For Resident 16, licensed staff did not use two resident identifiers to verify the resident's identity (ID) before medication administration.These failures resulted in insertion of a rectal tube into a Resident without physician orders, and the potential for errors in administering medications to the wrong Resident.Findings: 1.During an observation in Resident 3's room on 8/25/25 at 10:44 a.m., a covered collection bag connected to a tubing was noted hanging on the side of Resident 3's bed. A review of Resident 3's face sheet indicated an admission date of 4/15/25. During a concurrent interview with Registered Nurse (RN) A and record review on 8/26/25 at 3:02 p.m., RN A stated Resident 3 had a rectal tube for loose stool. RN A verified there was no Physician Order for rectal tube for Resident 3. RN A verified Resident 3's Care Plan for Bowel Elimination indicated Resident 3 had a rectal tube in place on admission, and rectal tube was changed on 8/5/25. RN A stated there must be a physician order for a rectal tube. During a concurrent observation and record review on 8/27/25 at 10:16 a.m. with Licensed Vocational Nurse (LVN) B by Resident 3's opened door, LVN B verified Resident 3 still had a rectal tube in place. LVN B also verified there was no Physician Order for a rectal tube. LVN B stated there should be a physician order for a rectal tube. A review of facility's policy and procedure (P&P) entitled Stool management System (SMS) revised 6/2024, the P&P indicated, I. Policy A. The Stool Management Systems will be inserted and maintained in accordance with evidence-based guidelines, manufacturer's recommendations, and by provider order. G. A provider's order is required. V. Process A. Obtain provider order for rectal tube placement. 2a. Review of Resident 5's clinical record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including motor vehicle accident (MVA) with severe injury, right hemicraniectomy (surgical procedure where a portion of the skull is removed from one side of the head), cranioplasty (surgical procedure involving repair or reconstructing defects in the skull, chronic respiratory failure and gastrostomy status (GT or G-tube- a tube, a surgical opening into the stomach for administration of nutrition and medications). (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER O'Connor Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 Forest Avenue San Jose, CA 95128	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on 8/26/25 at 8:23 a.m., Licensed Vocational Nurse (LVN) C was observed preparing 3 medications for Resident 5. LVN C crushed each solid medication individually and diluted each with about 30 ml (milliliter, a unit of measurement) of water. After finishing, LVN C brought the medications, along with an 8-ounce cup of water, to the resident's bedside. At 8:30 a.m., LVN C was observed attaching a syringe to Resident 5's gastrostomy tube. LVN C then checked the GT placement, checked for the GT residual, and then poured the medications into the syringe without flushing the GT with water. Review of Resident 5's Nursing Orders dated 6/4/24, indicated, Flush tube- see comments- until discontinued. Comments: Flush 50 ml of water before giving medications. During an interview with LVN C on 8/26/23 at 8:40 a.m., LVN C stated, I usually give a little water before the medication but this time I didn't, and she confirmed she should have. 2b. Review of Resident 12's clinical record indicated Resident 12 was admitted to the facility on [DATE] with the diagnoses including chronic respiratory failure (a condition that affects the lungs and airways making it difficult for air exchange in the lungs) and comatose state (inability to respond to surroundings) following brain injury. During the medication administration observation for Resident 12 on 8/26/25 at 1:32 p.m., LVN B turned the feeding pump off, disconnected the G-tube connection tubing, and then checked for the G-tube placement and residual. Then LVN B started the medication administration without flushing the G-tube with any water. During an interview with LVN B on 8/26/25 at 1:40 p.m., the LVN B stated, I usually flush before giving the medication with 30 ml of water, but I didn't do it now. During an interview with the Registered Nurse (RN) A on 8/29/22 at 11:53 a.m., RN A stated, The GT tube is always flushed with 50 ml of water before and after medication administration unless the resident is on fluid restriction. Review of the facility's policy and procedure, Medication Administration Enteral Tube, dated 5/23, indicated, . 11. Enteral tubes are flushed with at least 15 ml of water before administering any medications and after all medications have been administered. 3. Review of Resident 16's medical record indicated Resident 16 was admitted on [DATE] with diagnoses including traumatic brain injury, dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), hypertension (a condition in which the force of the blood vessels is too high), and dysphagia (difficulty swallowing foods or liquids). During a concurrent observation and interview on 8/26/22 at 1:07 p.m., with LVN C, LVN C was observed administering one medication crushed and mixed with pudding to Resident 16. LVN C fed the crushed medication and pudding mixture to Resident 16 without checking the identification of Resident 16 before administering the medication. LVN C stated, I should have checked the ID before giving the medication but I know him so well. During an interview with RN A on 8/26/25 at 2:13 p.m., RN A stated, two resident identifiers such as comparing the resident's face against the picture on the electronic medication administration record and checking the resident's armband are done before administering medications. (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: 555916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER O'Connor Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 Forest Avenue San Jose, CA 95128	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure, Medication Administration General Guidelines, dated 3/23, indicated, . 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include: a. Check identification band. B. Check photograph attached to medical record. C. Verify resident identification with other nursing care center personnel.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER O'Connor Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 Forest Avenue San Jose, CA 95128	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 8.1% when three medication errors occurred out of 37 opportunities during the medication administration observation for three out of nine residents (Residents 5, 12, and 16) when:1. Nursing staff did not flush Resident 5 and 12's gastrostomy tube (G-tube; a tube surgically inserted through the abdomen into the stomach to administer nutrition and medications) prior to medication administration, 2. Nursing staff did not use two resident identifiers before administering medication to Resident 16.These failures had the potential for complications, such as clogging of the G-tube, for the residents, and potential errors in administering medications to the wrong Resident. Findings:1a. During a medication administration observation on 8/26/25 at 8:23 a.m., Licensed Vocational Nurse (LVN) C was observed preparing 3 medications for Resident 5. LVN C crushed each solid medication individually and diluted each with about 30 ml (milliliter, a unit of measurement) of water. After finishing, LVN C brought the medications, along with an 8-ounce cup of water, to the resident's bedside.On 8/26/25 at 8:30 a.m., LVN C was observed attaching a syringe to Resident 5's gastrostomy tube. LVN C then checked the GT placement, checked for the GT residual then poured the medications into the syringe without flushing the GT with water.Review of Resident 5's Nursing Orders dated 6/4/24, indicated, Flush tube- see comments- until discontinued. Comments: Flush 50 ml of water before giving medications. During an interview with LVN C on 8/26/23 at 8:40 a.m., LVN C stated, I usually give a little water before the medication but this time I didn't, and confirmed she should have.1b. During the medication administration observation for Resident 12 on 8/26/25 at 1:32 p.m., LVN B turned the feeding pump off, disconnected the G-tube connection tubing then checked for the G-tube placement and residual. Then LVN B started the medication administration without flushing the G-tube with water.During an interview with LVN B on 8/26/25 at 1:40 p.m., the LVN B stated, I usually flush before giving the medication with 30 ml of water, but I didn't do it now. During an interview with the Registered Nurse (RN) A on 8/29/22 at 11:53 a.m., RN A stated, The GT tube is always flushed with 50 ml of water before and after medication administration unless the resident is on fluid restriction.A review of the American Society for Parenteral and Enteral Nutrition (ASPEN) Consensus Recommendation titled Safe Practices for Enteral Nutrition Therapy, dated 1/2017, indicated that when administering medication via enteral tube, Provide appropriate tube irrigation around the timing of drug administration by flushing the tube with at least 15 milliliters (mL, unit of measurement) water prior to, in between, and after medication administration.Review of the facility's policy titled, Medication Administration Enteral Tube, dated 5/23, indicated, .11. Enteral tubes are flushed with at least 15 ml of water before administering any medications and after all medications have been administered.2. During a concurrent observation and interview on 8/26/22 at 1:07 p.m., with LVN C, LVN C was observed administering one medication crushed and mixed with pudding to Resident 16. LVN C fed the crushed medication and pudding mixture to Resident 16 without checking the identification of Resident 16 before administering the medication. LVN C stated, I should have checked the ID before giving the medication but I know him so well.During an interview with RN A on 8/26/25 at 2:13 p.m., RN A stated, two resident identifiers such as comparing the resident's face against the picture on the electronic medication administration record and checking the resident's armband are done before administering medications.Review of the facility's policy and procedure, Medication Administration General Guidelines, dated 3/23, indicated, . 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include: a. Check identification band. B. Check photograph attached to medical record. C. Verify resident identification with other nursing care center personnel.		