STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CUPERTINO HEALTHCARE & WELLNESS CENTER	22590 VOSS AVENUE CUPERTINO, CA 95014

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

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure neurologic assessment was consistently filled out for one of two sampled residents (Resident 1), after a fall with sustaining right [MEDICAL CONDITION]. This failure had the potential to put the resident at risk of sustaining injuries. Findings: During a review of Resident 1's clinical records, indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1's falls change of condition assessment, dated 6/5/2020, indicated Resident 1 reported to the facility staff on 6/5/2020 at 7:00 a.m., that she fell and lost her balance. The Minimum Data Set (MDS, an assessment tool) dated 5/6/2020, indicated her cognition (ability to remember, judge and use reason) was severely impaired. During a concurrent interview and record review on 6/11/2020 at 3:05 p.m., with the director of nursing (DON), he reviewed and acknowledged the neurological flow sheet dated 6/5/2020 was not consistently filled out by nursing staff after Resident 1's fall. A licensed nurse initiated it on 6/5/2020 at 7:00 a.m. The DON stated a neurological flow sheet should have been completely filled out and the licensed nurse would complete the neurological checks for 72 hours following the fall incident on any resident who sustained a fall, witnessed or unwitnessed per facility's fall management policy. The DON further stated that neurological checks assessment (assessment to determine nervous system function or [MEDICAL CONDITION]) was a required nursing assessment to be performed for 72 hours after a resident sustained [REDACTED]. Interdisciplinary team (IDT, facility staff members from different departments who coordinate care provided to residents) conference review dated 6/5/2020, indicated Resident 1 fell when she tried to transfer herself and on 6/5/2020 at around 3:30 p.m., a licensed nurse observed Resident 1's right lower extremity had shortening and Resident 1 was sent to the hospital for further evaluation. Review of the facility's undated policy, Fall Management Program, indicated post fall response for unwitnessed fall or a witnessed fall with suspected or known head injury, the licensed nurse will complete neurological checks for 72 hours following the fall incident. Perform neurological checks at the ordered frequency or as listed. Equaling 72 hours: every 15 minutes X 1hr., then every 30 minutes X1hr., then every hour X 4 hr., then every 4 hrs., X 66 hours or until the physician states it is no longer necessary or after 72 hours if the Resident's condition is stable and not showing signs and symptoms of neurological injury.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Resident 1 with adequate pain management for two of three Residents (Resident 1). This has the potential for physical harm with the resident due to pain and discomfort. During a review of Resident 1's clinical records, indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1's change of condition assessment, dated 6/5/2020, indicated Resident 1 reported to the facility staff on 6/5/2020 at 7:00 a.m., she fell and lost her balance. The pain scale was 8/10 and [MEDICATION NAME] 650 milligrams (mg. a unit of measurement) PRN (as needed) for mild pain 4/10, was given. The Minimum Data Set (MDS, an assessment tool) dated 5/6/2020, indicated her cognition (ability to remember, judge and use reason) was severely impaired. Review of Resident 1's physician orders, dated 2/6/2020, indicated [MEDICATION NAME] 650 mg. (2 tablets of 325 mg.) by mouth (PO) every 4 hours PRN for mild pain. Review of Resident 1's Medication Administration Record [REDACTED]= no pain, 1-4=mild pain, 5-7=moderate pain, 8-9=severe pain, 10= horrible pain, initiated on 2/6/2020 and on 6/5/2020 indicted 0 pain for 7-3 shift. Review of Resident 1's pain assessment flow sheet dated 6/5/2020, indicated at 8:00 a.m., Resident 1 had hip pain 5-10 and [MEDICATION NAME] 650 mg was given and was not relieved 2-10, at 2 p.m. The physician was not notified the pain was not relieved after 1 hour that medication was given to the Resident 1. On 6/5/2020, at 2:00 p.m., Resident 1 had pain of 4-1. [MEDICATION NAME] 650mg. as PRN order given with relief after one hour. During a concurrent interview and record review with the director of nursing (DON) on 6/11/2020 at 2:50 p.m., he reviewed the above Resident 1's clinical records and confirmed. He further stated the licensed nurse should have notified the physician and requested pain MEDICATION ORDERS FOR [REDACTED]. Review of the facility's undated policy, Pain Management, indicated Pain assessment a licensed nurse will assess each resident for pain upon admission, quarterly, new onset of pain, exacerbation of pain, or when there is a significant change in stat. The licensed nurse will assess the resident for pain and document on the MAR indicated [REDACTED]. The shift pain score will indicate the highest pain level that occurred on that shift. If there is a new onset of pain, if the pain has changed in nature, or the pain has not been relieved with current medication, the Licensed Nurse will notify the Attending Physician. Nursing staff will implement timely interventions to reduce an increase in severity of pain. Nurses will complete the pain assessment flow sheet for residents receiving PRN medication to evaluate the effectiveness of the medication regimen. Review of the facility's revised policy, Physician Orders, dated 01/2012, indicated medication orders will include the following; Name of the medication; dosage; frequency; and duration of order. The route and the condition/[DIAGNOSES REDACTED]. Orders will include a description complete enough to ensure clarity of the physician's plan of care. Medication/treatment orders will be transcribe onto the appropriate resident administration record.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility social service department (SSD) failed to follow-up on emotional and psychological need after a physical altercation for four of four sampled residents (Residents 2, 3, 4 and 5). This failure could potentially cause psychosocial and emotional distress for residents. Findings: 1. Review of Resident 4's clinical record indicated he was admitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, an assessment tool) dated 4/24/2020, indicated Resident 4's cognitive was intact. Review of Resident 4's change of condition assessment, dated 6/2/2020, indicated Resident 4 reported that Resident 5 hit him on his chin and noted to have discoloration on his chin by nursing staff. During an interview on 6/11/2020 at 3:40 p.m., with Resident 4, he stated the social service coordinator (SSC) did not talk and follow-up with him after the incident on 6/2/2020. Review of Resident 5's clinical records indicated he was admitted with [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated his cognition (ability to remember, judge and use reason) was severely impaired. During an interview on 6/11/2020 at 3:15 p.m., with the SSC, she stated she did not follow-up with both Residents 4 and 5 for 72 hours after the alleged abuse incident. The SSC further stated she should had followed-up for Residents 4 and 5 for 72 hours after the alleged abuse incident for emotional distress monitoring and for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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CUPERTINO HEALTHCARE & WELLNESS CENTER	**22590 VOSS AVENUE CUPERTINO, CA 95014**

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) any changes in psychosocial wellbeing post incident. During a concurrent interview and record review on 6/17/2020 at 2:05 p.m., with the director of nursing (DON), he reviewed Resident 4 and 5's clinical records and confirmed the SSC did not follow-up with both residents for 72 hours after the alleged abuse incident. He further stated the SSC should have monitored Residents 4 and 5 for emotional distress or any changes in psychosocial wellbeing post incident for 72 hours. During a concurrent interview and record review on 6/17/2020 at 2:00 p.m., with the DON, he reviewed Resident 4 and 5's clinical records and confirmed that nursing staff were not consistent with emotional and psychological monitoring every shift. He further stated nursing staff should have monitored both residents for emotional distress every shift for 72 hours for any changes in psychosocial wellbeing post incident. A review of Resident 4's interdisciplinary team conference review, dated 6/3/2020, indicated Resident 4 reported that his roommate hit his chin and interdisciplinary team (IDT, facility staff members from different departments who coordinate care provided to residents) recommended Resident 4 will be monitored for emotional distress every shift for 72 hours for any changes in psychosocial wellbeing post incident. A review of Resident 4's care plan, dated 6/2/2020, indicated the approach intervention was for staff to assess for any signs and symptoms of distress. 2. Review of Resident 2's clinical record indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of MDS dated [DATE], indicated Resident 2's cognitive was intact. Review of Resident 2's change of condition assessment, dated 5/31/2020, indicated Resident 2 reported that Resident 3 hit her left upper arm with a shoe after she told Resident 2 to stop touching her toothbrush. During an interview on 6/11/2020 at 3:10 p.m., with Resident 2, she stated the SSC did not follow-up with her after the incident on 5/31/2020. Review of Resident 3's clinical records indicated she was admitted to the facility with the [DIAGNOSES REDACTED]. MDS dated [DATE] indicated Resident 3's cognition was moderately impaired. During an interview on 6/11/2020 at 3:20 p.m., with the SSC, she stated she did not follow-up with both residents after the alleged abuse incident. The SSC further stated she should have followed-up for both residents for 72 hours after the alleged abuse incident for emotional distress monitoring and for any changes in psychosocial well-being post incident. During a concurrent interview and record review on 6/11/2020 at 4:00 p.m., with the DON, he reviewed Resident 2 and 3's clinical record and both confirmed the social service coordinator did not follow-up with both residents for 72 hours after the alleged abuse incident, which she should have done. He further stated that the SSC should have monitored Residents 2 and 3 for emotional distress or any changes in psychosocial wellbeing post incident for 72 hours. A review of the undated job description for the job title Social Service Coordinator, indicated the social worker's principal duties and responsibilities, included the following: Ensure the residents' psychosocial and concrete needs are identify and met in accordance with federal, state and company requirements.