SECTION 1424 NOTICE

CITATION NUMBER: 07-2818-0012939-F

Date: 02/03/2017 Time: 1:35PM

Type of Visit : Recertification

Incident/Complaint No.(s) : No complaints found

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Licensee Name:	Cupertino Healthcare & Wellness Center, LLC
Address:	22590 Voss Avenue Cupertino, CA 95014-2627
License Number:	220000407 Type of Ownership: Limited Liability Company

Facility Name:	Cupertino Healthcare & Wellness Center
Address:	22590 Voss Ave Cupertino, CA 95014
Telephone:	
Facility Type:	Skilled Nursing Facility Capacity: 170
Facility ID:	220001009

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 2/13/17 8:00 a.m.

F314

CLASS B CITATION -- PATIENT CARE

F314 - 483.25(b)(1)TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
(b) Skin Integrity -
(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

The facility failed to ensure Resident 9 received appropriate care to prevent a pressure ulcer (skin injury caused by unrelieved pressure that results in damage to the underlying tissues). The facility failed to update Resident 9's Braden scale (a tool to predict pressure ulcer risk) and failed to implement a different kind of intervention to prevent a pressure ulcer. This failure resulted in Resident 9's left inner heel with a stage II pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough).

A review of Resident 9's clinical record indicated he was admitted on 9/11/16 with diagnoses including dementia (memory problem), muscle weakness and cognitive

Name of Evaluator:

Evaluator Signature :

Without admitting guilt, I hereby acknowledge receipt of

Signature :

Name :

Title : Administrator

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	communication deficit. Resident 9's Minimum Data Set (MDS, an assessment tool) dated 10/9/16, indicated the resident had impaired cognition, required assistance with bed mobility, transfer, hygiene and bathing. The MDS also noted he was at risk for the development of a pressure ulcer. Resident 9's MDS for 12/2016 was not completed. During an interview with the MDS Coordinator (MDSC) on 1/17/17 at 1:40 p.m., she stated Resident 9's quarterly assessment was scheduled on 12/15/16 and it was not completed. A review of Resident 9's admission assessment dated 9/11/16 indicated under skin integrity he had skin discoloration on the left hand and left forearm, multiple skin rashes on the right and left forearms, and skin redness on the resident's buttocks. Resident 9 had no pressure ulcer on the left inner heel upon admission. A review of Resident 9's Braden scale dated 9/11/16 indicated he was at mild risk for developing a pressure ulcer. Resident 9's Braden Scale for 12/2016 was not updated. A review of Resident 9's skin care plan dated 9/11/16 indicated the resident was at risk for a pressure ulcer related to impaired mobility, cognitive impairment, and fragile skin. The interventions to prevent pressure ulcer included repositioning with care rounds and referral to the registered dietitian (RD) if needed. A review of Resident 9's weekly pressure ulcer progress report dated 1/9/17, indicated he had developed a blister (it was raised on the skin which contains clear liquid and that was caused by injury or rubbing against something) on his left inner heel, which measured approximately three centimeters (cm, unit in measurement) length and three cm in length. The interventions for preventing pressure ulcer were floating heel (the heels were off the bed) and heel protector. During an observations on 1/17/17 at 3 p.m., 1/18/17 at 3:35 p.m., and 1/19/17 at 8:00 a.m., Resident 9 was lying on his back and his left inner heel rested on his bed with no heel protector. During an interview with licensed vocational nurse A (LVN A) on 1/18/17, at 3:30 p.m., she stated she was the assigned charge nurse when Resident 9 developed a blister on his left heel with a stage II pressure ulcer on 1/9/17. LVN A stated Resident 9 was always in bed and got his blister from his bed.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

During an observation and interview with LVN B on 1/18/17, at 3:35 p.m., she confirmed Resident 9 was lying on his back. The left inner heel pressure ulcer rested on the bed with yellowish color around the dressing, and Resident 9's bed linen had yellow circle color drainage from his left inner heel pressure ulcer. She stated Resident 9 should have been repositioned and the left inner heel stage II pressure ulcer should have been floating when he was in bed.

During an interview and record review with the assistant director of nursing (ADON) on 1/18/17, at 3:45 p.m., she stated she was not aware of Resident 9's left inner heel pressure ulcer. She stated Resident 9 developed his left inner heel stage II pressure ulcer from his bed and nursing staff should have repositioned Resident 9 when he was in bed. The ADON confirmed Resident 9 was a high risk for developing a pressure ulcer, he was immobile, and it was an avoidable pressure ulcer. She also stated there was no interdisciplinary (IDT, team members from different departments involved in a resident's care) notes, the Braden scale was not updated, and no RD referral.

During wound care observation and interview with treatment nurse I (TN I) on 1/18/17, at 8:50 a.m., Resident 9's left inner heel pressure ulcer was observed with slough and dry black blood in the wound bed area. TN I stated Resident 9's left inner heel pressure ulcer had increased in size, and measured approximately 5.5 cm in length and 4.8 cm in width. TN I confirmed Resident 9 had no heel protector and he should have it.

A Review of the facility's policy titled, "Pressure Injury Prevention" dated 8/12/16, indicated to provide interventions for residents identified as high risk for developing a pressure ulcer. A risk assessment (Braden Scale) for a developing pressure ulcer will be completed in a timely manner. The nursing staff will implement interventions identified in the care plan based on individual risk factors. Nursing staff will observe for any signs of potential or active pressure injury daily while providing nursing care.

This failure had a direct relationship to the health, safety, or security of residents.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/20/2017
NAME OF PROVIDER OR SUPPLIER: Cupertino Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Recertification visit: CLASS B CITATION -- PATIENT CARE 07-2818-0012938-F Complaint(s): No complaints found Representing the Department of Public Health: Surveyor ID # 34383 The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F323-483.25(d)(1)(2)(n)(1)-(3) Free of Accident Hazards/Supervision/Devices (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.		**Preparation, submission, and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provisions of federal and state law.** **F323** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 19 will be re-assessed by the IDT	2/~~20~~ 13/17

Event ID:MEE911 [redacted] 2/3/2017 8:55:05AM

LABOR[redacted]E'S SIGNATURE TITLE Administrator (X6) DATE 2/3/17

By signi[redacted]ket, *Page(s). 1 thru 7*

Any defic[redacted]h the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

State-2567

POC accepted by: [redacted] HFEN 2/3/17 @ 2:35PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/20/2017
NAME OF PROVIDER OR SUPPLIER: Cupertino Healthcare & Wellness Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The facility failed to ensure adequate assistance to prevent accidents and injuries for Resident 19. The facility failed to assist the resident to the bedside commode, and failed to implement a different kind of intervention in response to Resident 19's frequent falls. These failures resulted in Resident 19 sustaining a bump on the left side of her eye and a left clavicle fracture. Review of Resident 19's clinical record indicated the resident was admitted on 9/23/11 with diagnoses including hepatic failure (liver failure), convulsions (seizure) and dementia (memory problem). Her minimum data set (MDS, an assessment tool) dated 7/6/16, indicated the resident had impaired cognition (mental process), required assistance for bed mobility, transfer, and toileting. There were no MDS's in 10/2016 and 1/2017. Review of Resident 19's Fall Risk Assessment dated 9/19/16, indicated she had a score of 14. A score of 10 or above represents a high risk for falls. Review of Resident 19's Fall Risk Prevention and Management care plan dated 5/19/16, indicated Resident 19 had a risk for fall related to her history of falls and unsteady gait (abnormal walking). The interventions to prevent falls included placing the call light within reach, remind the resident to use the call light, provide an environment which minimized hazards over which the facility has control, and encourage the use of a front wheel walker.		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An in-service will be given to the LN/IDT by the DSD/designee regarding fall prevention; the issues in this 2567 will be used as examples The DON/Designee will log all falls in the incident log The IDT will review all reported falls and develop plans of care to assist in reducing future falls	2/20/17 13

Event ID:MEE911 2/3/2017 8:55:05AM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Review of Resident 19's cognitive loss care plan dated 5/19/16 indicated Resident 19 had a period of forgetfulness, short term memory loss and poor judgment. Review of Resident 19's situation background assessment recommendation (SBAR, a technique used to facilitate prompt and appropriate communication) dated 9/19/16, indicated the resident had an unwitnessed fall when she was found on the floor next to her bed. This resulted in a skin tear on the back of the head and a skin tear on her right hand. Review of Resident 19's post fall short term care plan dated 9/19/16, indicated the incident occurred when Resident 19 wanted to use the bedside commode. The intervention to prevent falls was to place the resident on bladder assistance (assist to the bathroom) every two to three hours. There was no evidence Resident 19 was placed on bladder assistance every two to three hours. Review of Resident 19's bowel and bladder assessment and interventions dated 7/6/16, indicated the resident would proceed with a retraining program. There was no bowel and bladder assessment in 10/2016. Review of Resident 19's post fall interdisciplinary (team members from different department involved in a resident's care) assessment dated 9/19/16, indicated the resident lost her balance during transfer. The intervention to prevent falls was to remind the resident to use the call light for needs,		**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The incident log will be reviewed by the DON and/or ADM monthly to track and identify any trends Any trends identified will be used by the facility to provide training and education **How the facility plans to monitor its performance to make sure that solutions are sustained:** The trending and tracking will be used to develop a QAPI. The QAPI will be part of the facility quarterly QA process.	2/20/17 2/13

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/20/2017

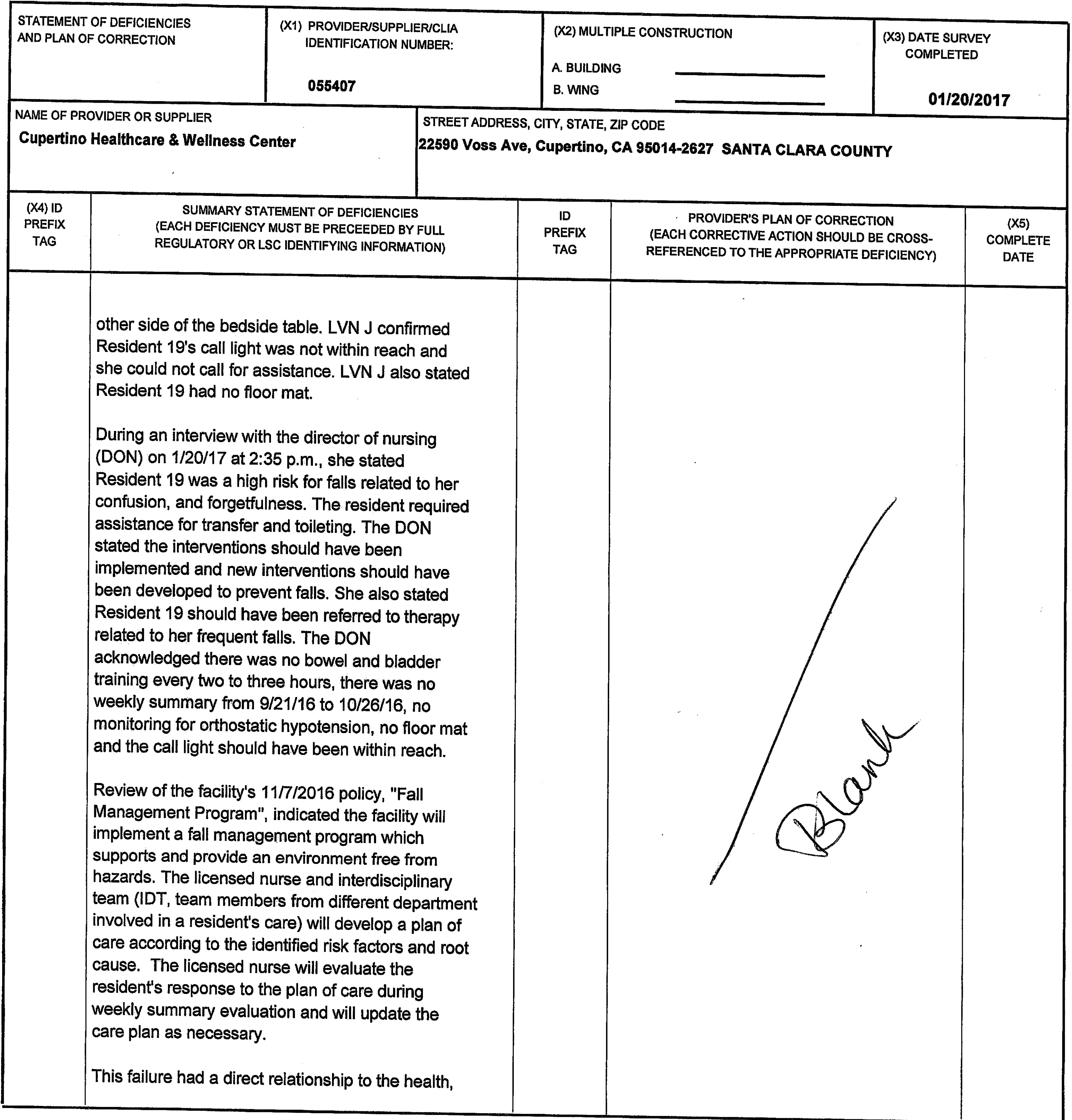
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	and encourage her to move slowly when changing position. Review of Resident 19's SBAR dated 10/22/16, indicated the resident had an unwitnessed fall when the resident used the bedside commode, lost her balance and fell. Resident 19 complained of pain, dizziness, a lump was noted on the back of the head, and the resident was sent to an acute hospital. Review of Resident 19's Fall Risk Assessment dated 10/22/16, indicated she had a score of 14. A score of 10 or above represents a high risk for falls. Review of Resident 19's acute hospital diagnosis dated 10/22/16, indicated the resident had a diagnosis of a hematoma (a collection of blood outside of blood vessels) of the scalp. Review of Resident 19's post fall interdisciplinary assessment dated 10/24/16, indicated the resident tried to use the bedside commode, lost her balance and fell. The intervention to prevent a fall included to monitor orthostatic hypotension (decrease in blood pressure) upon return from the acute hospital. There was no evidence the resident was monitored for orthostatic hypotension. Review of Resident 19's SBAR dated 10/25/16, indicated the resident had an unwitnessed fall. When the resident fell, the resident complained of dizziness, and a bump on the left side of her left eye. The resident was sent to an acute hospital. Resident 19's acute hospital diagnosis dated		Blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/20/2017
NAME OF PROVIDER OR SUPPLIER **Cupertino Healthcare & Wellness Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY**		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	10/25/16 indicated the resident had a left clavicle fracture. Review of Resident 19's post fall interdisciplinary assessment dated 10/24/16, indicated the resident got up from bed, forgot to use the call light, tried to use her bedside commode but lost her balance and fell. The intervention to prevent a fall included to remind the resident with each contact to call for assistance, educate regarding the risk, and consequence of doing an independent transfer. Review of Resident 19's SBAR dated 1/9/17, indicated the resident had an unwitnessed fall when she was found sitting on the floor with a right shin (lower extremities) abrasion (scrape). Review of Resident 19's post fall interdisciplinary assessment dated 1/9/17, indicated the resident rolled off the edge of the bed. The intervention to prevent a fall was to put a floor mat at the resident's bedside. Review of Resident 19's Fall Risk Prevention and Management care plan dated 11/30/16, indicated Resident 19 had a risk for fall related to history of falls, decreased endurance and medications, e.g., Propranolol (blood pressure medication), Dilantin (for seizure), and Melatonin (medication to control the sleep and wake cycle). During an observation and interview with licensed vocational nurse J (LVN J) on 1/20/17 at 8:05 a.m., Resident 9 was lying on her bed, with the bedside commode nearby. The call light was bent to the		Blank	

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	other side of the bedside table. LVN J confirmed Resident 19's call light was not within reach and she could not call for assistance. LVN J also stated Resident 19 had no floor mat. During an interview with the director of nursing (DON) on 1/20/17 at 2:35 p.m., she stated Resident 19 was a high risk for falls related to her confusion, and forgetfulness. The resident required assistance for transfer and toileting. The DON stated the interventions should have been implemented and new interventions should have been developed to prevent falls. She also stated Resident 19 should have been referred to therapy related to her frequent falls. The DON acknowledged there was no bowel and bladder training every two to three hours, there was no weekly summary from 9/21/16 to 10/26/16, no monitoring for orthostatic hypotension, no floor mat and the call light should have been within reach. Review of the facility's 11/7/2016 policy, "Fall Management Program", indicated the facility will implement a fall management program which supports and provide an environment free from hazards. The licensed nurse and interdisciplinary team (IDT, team members from different department involved in a resident's care) will develop a plan of care according to the identified risk factors and root cause. The licensed nurse will evaluate the resident's response to the plan of care during weekly summary evaluation and will update the care plan as necessary. This failure had a direct relationship to the health,		Blank	

Event ID:MEE911 2/3/2017 8:55:05AM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055407	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	**22590 Voss Ave, Cupertino, CA 95014-2627 SANTA CLARA COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	safety, or security of residents.		Blank	

Event ID:MEE911 2/3/2017 8:55:05AM