STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555483	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor Nursing Center	120 Jose Figueres Avenue San Jose, CA 95116

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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:1.Occupational therapist A (OT A) did not perform hand hygiene (HH - to clean the hands, including washing with soap and water or using an alcohol-based hand rub [like hand sanitizer]) after removal of gloves and before donning (putting on) of a new pair of gloves and did not change gloves after assisting Resident 2 with toileting; and2.Certified nursing assistant B (CNA B) did not perform hand hygiene after touching Resident 3's environment.These failures had the potential to compromise resident's health and safety, and spread infections to residents, staff, and visitors.Review of Resident 1's clinical record titled, admission Record, dated 4/4/2025, indicated Resident 1 was admitted to the facility with diagnoses including fracture of unspecified part of neck of left femur (a break in the bone just below the hip joint), fibromyalgia (a chronic condition that causes widespread musculoskeletal pain, fatigue, and sleep problems) and chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe).Review of Resident 1's admission/5-day minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).During a phone interview with Resident 1 on 4/2/2025 at 1:15 p.m., Resident 1 stated she had some concerns with infection control while she was admitted at the facility. Resident 1 further stated a certified nursing assistant (CNA) went inside her room wearing gloves, picked up her used commode (a piece of furniture that serves as a portable toilet, often used by individuals with mobility limitations), empty it in the bathroom, then CNA returned the commode to her bedside with same gloves on and started to touch her stuff inside the room. Resident 1 stated when she asked the CNA if her gloves were clean, the CNA asked her if she wanted her to change her gloves.1.During an observation on 4/4/2025 at 10:38 a.m., at the hallway across Room AA, the OT A was wearing a pair of gloves and assisted Resident 2 in walking to the bathroom with use of front wheeled walker (FWW - a mobility aid with two wheels at the front and two legs at the back). OT A went inside the bathroom with Resident 2 and after a few minutes, OT A went out of the bathroom, waiting with the same gloves on. OT A was observed to remove the right-hand gloves, did not perform HH, donned a new glove to her right hand, touched and moved Resident 2's wheelchair, touched the bedside drawer handle and took clothes for Resident 2 and went back to the bathroom. At 10:44 a.m., OT A stepped out of the bathroom still wearing the same gloves, stood outside the bathroom door. OT A changed her gloves without HH and went back to the bathroom. At 10:49 a.m., OT A was observed assisting Resident 2 to walk out of the bathroom wearing the same pair of gloves and had Resident 2 sat at the edge of the bed. OT A touched Resident 2's FWW to set aside and started to assist Resident 2 with some arm exercises with the same pair of gloves. At 11:01 a.m., Resident 2's exercise with OT A was completed. OT A folded the FWW with the use of the same pair of gloves.During an interview with OT A on 4/4/2025 at 11:03 a.m., OT A confirmed the above observations and stated she should have performed HH whenever she changed her gloves. OT A stated she should have changed her gloves after she assisted Resident 2 with toileting.During a review of the facility's policy and procedure titled, Personal Protective Equipment - Using Gloves, date revised 9/2010, indicated, Objectives 1. To prevent the spread of infection.Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient.Wash hands after removing gloves.2. During an observation on 4/4/2025 at 10:54 a.m., at the hallway across Room AA, CNA B entered Room AA and spoke to OT A then went beside Resident 3's bed. CNA B observed touching and held Resident 3's overbed table and started to talk to Resident 3. After talking to Resident 3, CNA B stepped out of Room AA without performing HH, touched the shower room's doorknob across Room AA and went inside the shower room.During a follow up interview with CNA B on 4/4/2025 at 10:56 a.m., CNA B confirmed the above observations, and stated she should always perform HH every time she stepped out of the resident's room.During an interview with the director of nursing (DON) on 4/4/2025 at 11:09 a.m., DON confirmed the glove usage was a barrier for infection control and stated gloves should be changed after exiting the bathroom. DON further stated, Hand hygiene should be performed before exiting the room, that's why we have hand sanitizer right outside the door.During an interview with the infection preventionist (IP) on 7/9/2025 at 12:06 p.m., IP confirmed they