STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055866	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plum Tree Care Center	2580 Samaritan Drive San Jose, CA 95124

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 0689 Level of Harm - 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** 46939 Based on interview and record review, the facility failed to provide assistance to prevent an accident for one of three sampled residents (Resident 1). Resident 1's functional ability for bending and picking up objects on the floor was not assessed to determine the ability to bend and Rehab Aide A (RAA) did not provide assistance by holding the gait belt (a device that helps caregivers safely move and support patients who have mobility issues) during therapy exercise. This failure resulted in Resident 1 having a fall and was sent to the hospital with a forehead laceration (a cut in the skin or underlying tissue that's usually caused by blunt trauma). Findings: During a review of Resident 1's undated Facesheet (document used to reference a resident's medical and contact information), indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of need for assistance with personal care, other abnormalities of gait [pattern of limb movement when walking] and mobility. During a review of Resident 1's Fall Risk Evaluation, dated 7/19/24, evaluation indicated, Resident 1 was assessed to be at a Moderate Risk of fall (Scored 15). Fall risk evaluation also indicated, to evaluate residents balance while standing, sitting and during transitions. Resident 1 was not able to attempt the transfer without physical help. Resident 1 has impaired balance. On problem: Resident 1 was at risk for fall r/t[related to] generalized weakness. Resident 1 approach r/t impaired gait/balance was to use gait belt and physical therapy (PT) recommended devices. During a review of Resident 1's Fall Risk Care Plan dated 7/20/24 indicated, At risk for falls r/t generalized weakness, hx [history] of falls, DX [diagnosis of] Renal Cancer. The care plan tasks indicated to anticipate and meet resident's needs r/t impaired gait/balance. During a review of Resident 1's MDS (Minimum Data Set- an assessment tool) Section GG, dated 7/25/24, MDS indicated, for eating, toileting, bathing self, dressing upper and lower body, putting on footwear and personal hygiene, as Dependent-Helper does ALL of the effort. The MDS also indicated, P. Picking up object for ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor, it was indicated 88 which means Resident 1 was not attempted due to medical condition or safety concerns. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's MDS Section C dated 7/25/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mentals Status: assessment used to determine cognitive status: ability to reason and think about one's environment) a score of 14 which means cognitively intact (13-15 cognitively intact). During a review of Resident 1's Physical Therapy (PT) Evaluation & Plan of Treatment, dated 7/22/24, evaluation indicated, pt[patient] has been nonambulatory [sic] for over a year and half. picking up object-Not attempted due to medical conditions or safety concerns. During a review of Resident 1's Physical Therapy Treatment Encounter Note dated, 7/23/24, note indicated, Other Picking up object=Not attempted due to medical conditions or safety concerns. During a review of Resident 1's Physical Therapy Treatment Encounter Note dated, 7/24/24, note indicated, Other Picking up object=Not attempted due to medical conditions or safety concerns. During a review of Resident 1's Physical Therapy Treatment Encounter Note dated, 7/25/24, note indicated, Other Picking up object=Not attempted due to medical conditions or safety concerns. During a review of Resident 1's Physical Therapy Treatment Encounter Note dated, 7/26/24, note indicated, Response to Tx [treatment]: .can be impulsive at times. Other Picking up object=Not attempted due to medical conditions or safety concerns. During a review of Resident 1's Physical Therapy Treatment Encounter Note dated, 7/29/24 note indicated, Response to Tx. Resident 1 demo'd [demonstrated] impulsivity and had x1 [one time] LOB [loss of balance] episode while sitting in WC [wheelchair], attempting to reach anteriorly [front of body] and fell on to floor. During a review of Resident 1's SBAR [Situation, Background, Assessment, and Recommendation, is a structured communication framework that can help teams share information about the condition of a resident to the Doctor], dated 7/29/24 indicated Resident fell while doing therapy, (with therapy staff). Resident fell from wheelchair to the floor face down. Assessment done by UM [unit manager] and LN [licensed nurse], Laceration to left side of forehead (2.9 centimeter), redness to neck and both knees. Steri-strips [plastic bandages covered in a gentle skin glue that helps pull the edges of the wound together] applied to forehead. The primary care provider responded with the following feedback and the recommendations was to send the resident [Resident 1] to ER (emergency room) for further evaluation. Time of 1640 [4:40p.m.]. Record review of Resident 1's After Visit Summary (AVS) from Acute Hospital dated 7/29/24, AVS indicated, Reason for visit Fall.Diagnosis Forehead laceration, sutured.suture removal in 7 days. During a review of Resident 1's Progress note dated 7/29/24, at 8:51 p.m., note indicated, Resident [1] came back from hospital @2050 [8:50 p.m.], per [hospital] report, [Resident 1] has 4 sutures to the L [left] side of forehead laceration. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/14/24, at 10:34 a.m., with Rehab Aide A (RAA), RAA stated he was assisting Resident 1 for her scheduled Physical Therapy session on 7/29/24 and when Resident 1 fell on the floor. RAA also stated he was preparing the cones for Resident 1's physical therapy exercise, which included staying seated in the wheelchair and reaching to the floor to pick up the object/cone from the floor. RAA stated, the Physical Therapy Assistant (PTA) was working remotely and monitored the therapy via an iPhone, which was held by the Director of Rehab. RAA stated he was standing on the right side of Resident 1 and the PTA was instructing Resident 1 what to do. The PTA stated to Resident 1 to reach forward to pick up the cone, Resident 1 reached forward and fell forward out of the wheelchair onto the floor face first. RAA stated, he was not fast enough to catch Resident 1 before she fell . RAA stated, he was not sure of what level of assistance should have been provided for Resident 1. RAA stated, he was not holding onto Resident 1's gait belt at the time of fall. During an interview on 8/14/24, at 11 a.m., with Director of Rehab (DOR), DOR stated, she was present during the fall on 7/29/24 and was holding the camera for the PTA to observe Resident 1. DOR stated, on the day of the fall 7/29/24, she was assisting Resident 1 with therapy. DOR stated, the PTA was working with Resident 1 remotely and RAA was assisting Resident 1. DOR was unable to explain what Resident 1 was doing during the time of the fall. During an interview on 8/16/24 at 11:25 a.m., with PTA, PTA stated she was working remotely with Resident 1 and when Resident 1 fell on [DATE]. The RAA assisted her on 7/29/24 during therapy exercise. PTA stated, the DOR was there to assist Resident 1 related to impulsive behavior from prior therapy exercise. PTA stated, the DOR was not providing care, and DOR was holding the iPhone pointed at Resident 1 in front of her. PTA stated, she was not aware of the exact assistance Resident 1 required, but it should have been found in the therapy notes. PTA stated she was not able to see if Resident 1 was wearing a gait belt when Resident 1 fell on [DATE]. During an interview on 8/16/24, at 3:16 p.m., with Resident 1, Resident 1 stated regarding her fall The cones were too far away. Resident 1 stated, It was their fault. During an interview on 9/9/24, at 1:25 p.m., with DOR, DOR stated, she understands that the Physical Therapist did not evaluate Resident 1's ability to pick up an object because it was likely unsafe at the time of assessment. DOR stated, on 7/29/24 The RAA should have held onto the gait belt during the therapy exercise. During a review of the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, dated 2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. During a review of the facility's P&P titled, Telehealth Policy and Procedure, dated 2024, the P&P indicated, To establish guidelines for the use of telehealth in delivering therapy services within a skilled nursing facility (SNF), ensuring these services are provided safely, effectively, and in compliance with legal and ethical standards.