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	07/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to document reason to withheld medications and failed to notify primary care physician (PCP) when withheld medications for one of three sampled resident (Resident 2) to meet professional standards. This failure had the potential to affect Resident 2's medical condition and well-being. Review of Resident 2's face sheet (FS: a documenta that gives resident's information at a quick glance) indicated Resident 2 was admitted to facility on 4/30/2025 and discharged home on 5/21/2025. Resident 2 was self-responsible for daily decision making.Review of Resident 2's diagnoses included tachycardia (a rapid heartbeat that may be regular or irregular), depression (a mood disorder that causes persistent feeling of sadness and loss of interest in day to day activities), anxiety (persistent worry and fear about everyday situations), and headache (a painful sensation in any part of the head ranging from sharp to dull).Review of Resident 2's minimum data set (MDS, clinical and functional assessment tool) dated 5/21/2025 indicated Resident 2's brief interview for mental status (BIMS) score of 15/15 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition and 13-15: intact cognition), intact cognition.Review of Resident 2's order summary report indicated medication auvelity (used to treat depression) 45-105 MG (mg-milligram, a unit of mass or weight equal to one thousandth of a gram) two times a day for depression, dated 4/30/2025.Review of Resident 2's order summary report also indicated medication ivabradine (used to treat certain heart conditions) 5 MG one time a day for angina (a type of chest pain caused by reduced blood flow to the heart, dated 5/1/2025.Review of Resident 2's order summary report further indicated medication emgality (used to treat headache in adults) 120 mg inject subcutaneously (inject into fatty tissue just underneath the skin) every 30 day (s) for migraine (a health condition that is more just a bad headache with nausea, vomiting or sensitivity to light and sound), dated 5/13/2025.Review of Resident 2's electronic medical record (EMAR, a digital system used to document medication administration to residents) for May 2025 indicated medication auvelity was documented as 3 at 0900 on 5/3/2025, 1 dose. Medication ivabradine was documented as 3 at 0900 on 5/8/2025, 5/17/2025, 5/18/2025 and at 2100 on 5/8/2025, 5/16/2025, and 5/17/2025, total 6 doses. Medication emgality was documented as 3 at 0900 on 5/13/2025, one dose.Review of Resident 2's EMAR chart codes/follow up codes for 3, indicated Hold/Progress notes MD (medical doctor) Notification. Further review of nursing progress notes indicated there was no documented evidence for the reason to withheld above medications and no documented evidence of notification to Resident 2's PCP when withheld above medications.During a telephone interview with Resident 2 on 6/3/2025 at 3:51 p.m., Resident 2 stated did not receive multiple medications for several days when Resident 2 was in facility. Resident 2 was told by nursing staff some of medications not available to give as ordered for several days during Resident 2's stay in facility. During a concurrent record review of Resident 2's EMAR for May/2025 and interview with license vocational nurse A(LVN A) on 7/16/2025 at 11:23 a.m., LVN A confirmed above medications during those days and timings were held, not administered to Resident 2 as indicated in EMAR. LVN A also confirmed EMAR documented code for 3 means license nurse held the medication. LVN stated nurse should document the reason and notify PCP when hold any ordered medication to residents. LVN A also stated progress notes dated 5/8/2025 indicated medication ivabradine not available to give, possible reason for the several medications were held multiple times due to lack of supply of medications for Resident 2.During a concurrent record review of Resident 2's EMAR for May/2025, progress notes, and interview with facility's director of nursing (DON) on 7/16/2025 at 12:23 p.m., DON confirmed above medications were withheld, not administered to Resident 2. DON also confirmed there were no documented evidence for reason to withheld multiple medications and notification to PCP for Resident 2. DON stated license nursing staff should have documented the reason and notified PCP when withheld medications for Resident 2. DON also stated potential to affect for Resident 2's medical condition when medications were withheld and not been notified to Resident 2's PCP.Review of facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated, any explanatory note on the reverse side of the MAR (medication administration record) must be entered when drugs are withheld, refused, or given other than at scheduled times. (Note: The director of nursing serves and attending physician must be notified when two (2) consecutive doses of a medication are refused or withheld.)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to ensure to notify blood work results to primary care physician (PCP) and resident's responsible party (RP: individual person designated to make decisions and receive information on behalf of a resident) for one of three sampled resident (Resident 1). This failure had the potential to compromise to address Resident 1's medical condition and well-being.Review of Resident 1's face sheet (FS: a document that provides resident's information at a quick glance) indicated Resident 1 was admitted to facility on 4/3/2024. Review of Resident 1's diagnoses included diabetes type 2 (DM 2: high sugar levels in blood) and congestive heart failure (CHF: chronic condition in which heart does not pump blood as well as it should).Review of Resident 1's FS also indicated significant family member was assigned as Resident 1's RP.Review of Resident 1's physician order summary report indicated Resident 1 had an order for blood test for complete blood count (CBC: number and type of cells in the blood, common blood test used to assess overall health and screen for various health conditions) and comprehensive metabolic panel (CMP: a blood test to screen for certain medical conditions and monitor effects of medications) dated 4/22/2025 and 4/29/2025.Review of CMP blood test results dated 4/22/2025 and 4/29/2025 indicated out of range high levels of glucose (sugar in blood), blood urea nitrogen (BUN: amount of waste product formed when liver [a body organ plays a vital role for overall health and survival] breaks down protein [acting as a building block for muscles, bones, skin, and blood] also indicates kidney [a vital body organ filtering waste and extra fluid from blood to produce urine] function), BUN/creatinine (Cr: a chemical found naturally in the body) ratio (a blood test that measures the levels of two substances in the blood, urea and creatinine to assess kidney function) and carbon dioxide (key indicator of how lungs [body organs essential for breathing and sustaining life], kidneys and metabolic processes [the set of all chemical reactions that occur in a living organism to maintain life] are functioning). Review of CBC blood test results dated 4/22/2025 and 4/29/2025 indicated high levels of RDW (red cell distribution width, measures the size of red blood cells), absolute monocytes (type of blood cells indicate various conditions including infections), absolute basophils (type of cells, high level indicates body's reaction or fighting an infection), and low level of hemoglobin (essential protein component to maintain overall health, found in red blood cells). Review of Resident 1's nursing notes indicated there was no documented evidence of notification to PCP and RP for above 4/22/2025 and 4/29/2025 out of range CBC and CMP blood test results for Resident 1.During an interview with facility's director of nursing (DON) on 7/16/2025 at 2:58 p.m., DON confirmed license nursing staff did not inform PCP and RP for 4/22/2025 and 4/29/2025 abnormal blood work results for Resident 1. DON stated license staff should inform PCP and RP when received blood test results. DON also stated license staff should have informed blood test results to PCP for further plan of care as needed to meet Resident 1's medical condition and informed RP as needed.Review of facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, undated, the P&P indicated, A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff). Facility staff should document information about when, how, and to whom the information was provided and response.