

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055866	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Plum Tree Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to follow their policy and procedure (P&P) for answering the call light for one of five sampled resident rooms when:1 .Resident 1 stated call light response time was more than 20 minutes at times;2. Resident 2 stated call light response time was more than 10 minutes at times;3. Observation of call light response time was five minutes for Resident room [ROOM NUMBER]. This failure had the potential to affect residents' care, health conditions and well-being of residents in sampled resident rooms.Findings:1.During an observation and interview with Resident 1 on 7/29/2026 at 12:10 p.m., in Resident 1's room, Resident 1 stated she had to wait long time to receive incontinent and other care needs, staff were taking more than 20 minutes to answer her call light most of the times. During an interview with Resident 1's significant family member (SFM) who was in Resident 1's room on 7/29/2026 at 12:20 p.m., Resident 1's SFM stated Resident 1 was nice enough to say 20 minutes to wait, Resident 1 waited more than 30 minutes for her call light to be answered by staff for several times. Resident 1's SFM also stated after waiting 30 minutes, she herself went out to the hallway to find a certified nursing assistant (CNA) to assist Resident 1 before any staff answered Resident 1's call light.Review of Resident 1's face sheet (FS, a document that gives resident's information in a quick glance) indicated Resident 1 was admitted to facility on 7/21/2026.Review of Resident 1's FS indicated Resident 1's diagnoses included intertrochanteric left femur fracture (broken left hip at the top of the thigh bone) with routine healing and need for assistance with personal care.Review of Resident's brief interview for mental status (BIMS) assessment dated [DATE] indicated Resident 1's BIMS score of 15/15 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition).Review of Resident 1's bowel/bladder assessment dated [DATE] indicated Resident 1 was incontinent (being unable to control urine and bowel movement) of bowel and bladder with approaches included to provide incontinent care after each incontinent episode.Review of Resident 1's care plan for ADL (active daily living, basic and routine tasks required for a resident) self-care performance deficit, dated 7/21/2026 indicated with intervention to provide appropriate self-performance and support needed during ADL care and encourage to use of call light for assistance.2.During an interview with Resident 2 on 7/29/2026 at 12:28 p.m., at Resident 2's bedside, Resident 2 stated she had to wait long time for staff to answer her call light. Resident 2 also stated depending on the time and the day, it takes more than 10 minutes for staff to answer her call light and to attend to her care needs. Resident 2 further stated staff were answering call lights right away today since state person was in the building.Review of Resident 2's FS indicated Resident 2 was admitted to facility on 7/11/2026.Review of Resident 2's FS indicated Resident 2's diagnoses included cerebral infarction affecting right dominant side (brain tissue death caused by blocked blood flow with right sided weakness) and need for assistance with personal care.Review of Resident 2's s minimum data set (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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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MDS, resident assessment tool) assessment dated [DATE] indicated Resident 2's BIMS score of 15/15, intact cognition.Review of Resident 2's admission data collection and baseline care plan tool document dated 7/11/2026 for bowel/bladder assessment indicated Resident 2 was incontinent of bowel and bladder with approaches included to provide incontinent care and peri care (cleaning of genital and anal areas, personal hygiene) after each incontinent episode.Review of Resident 2's care plan for ADL self-care performance deficit, dated 7/11/2026 indicated with intervention to provide appropriate self-performance and support needed during ADL care and encourage to use of call light for assistance.3. During an observation for Resident room [ROOM NUMBER] on 7/29/2026 at 1:08 p.m., noted call light was on at 1:08 p.m. Observed license vocational nurse A (LVN A) went inside Resident room [ROOM NUMBER], answered the call light at 1:13 pm, five minutes after call light was on.During an interview with LVN A on 7/29/2026 at 1:15 p.m., LVN A confirmed call light was on for five minutes for Resident room [ROOM NUMBER] before she answered. LVN A stated staff should answer call light as soon as it was on. LVN A also stated staff should have answered this call light without waiting for five minutes.During an interview with facility's director of staff development (DSD) on 7/29/2026 at 1:58 p.m., in DSD's office, DSD stated staff should answer residents' call light as soon as possible. DSD also stated Resident waiting for staff to answer resident's call light for 5 minutes was too long a wait to attend to care needs for any resident in the facility.During an interview with facility's interim director of nursing (IDON) on 7/29/2026 at 2:03 p.m., IDON stated facility staff should answer residents' call light as soon as light turned on.Review of facility's P&P titled, Answering the Call Light, revision date September 2022, the P&P indicated, Answer the resident call system immediately.		