STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056037	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Hills Post Acute	370 Noble Court Morgan Hill, CA 95037

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure to schedule, conduct, and document interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals to their residents) care conference with resident/resident's representative (RP, an individual chosen by resident to act on behalf of resident for day today and healthcare decision making for resident) for four out of four sampled residents (Resident 1, 2, 3, and 4) when:There was no documentation for initial and quarterly IDT care conference for Resident 1;There was no documentation for initial IDT care conference for Resident 2; There was no documentation for quarterly IDT care conferences for Resident 3;There was no documentation for quarterly IDT care conferences for Resident 4.This failures had the potential for lack of opportunity for resident/ RP's right to participate in development and implement person-centered (individual care, treatments, and goals to resident's cultural, personal values, and lifestyle) plan of care decisions for Resident 1, 2, 3, and 4.Findings:1.Review of Resident 1's face sheet (FS, a document that gives resident's information at a quick glance) indicated Resident 1 was admitted to facility on 1/25/2026. Review of this FS also indicated Resident 1 was assigned a significant family member (SFM) as Resident 1's RP.Review of Resident 1's minimum data set (MDS, resident assessment tool) assessment dated [DATE] indicated Resident 1's brief interview for mental status (BIMS) score of 10/15 (score of 0-7, severely impaired cognition, 8-12, moderately impaired cognition, 13-15, intact cognition), moderately impaired cognition.Review of Resident 1's clinical documentation indicated there was no documented evidence for initial or quarterly IDT care conferences were scheduled or conducted with Resident 1's RP.During an interview with the MDSC on 5/12/26 at 1:17 p.m., the MDSC stated facility's social service department was responsible to schedule, conduct, and document initial and quarterly IDT care conference with resident/resident's RP.During an interview with facility's social service director (SSD) on 5/12/2026 at 1:40 p.m., SSD confirmed there was no documented evidence for initial and quarterly IDT care conferences were scheduled and conducted with Resident 1's RP. SSD stated social service department should have scheduled and conducted initial and quarterly IDT care conferences with Resident 1's RP to facilitate open communication and discuss plan of care for Resident 1.2. During an interview with Resident 2 on 5/18/2026 at 12:50 p.m., Resident 2 stated facility staff did not arrange or invite to attend care conference after admitted to facility. Resident 2 also stated her SFM requested a meeting today (5/18/2026) with facility team to discuss some concerns. Resident 2 further stated her SFM requested this meeting, not initiated by facility.Review of Resident 2's FS indicated Resident 2 was admitted to facility on 4/23/2026. Review of this FS also indicated, Resident 2 self-responsible for daily decision making.Review of Resident 2's MDS assessment dated [DATE] indicated, Resident 2's BIMS score of 15/15, intact cognition.Review of Resident 2's clinical documentation indicated, there was no documented evidence for initial IDT care conference scheduled or conducted for Resident 2.During an interview with facility's SSD on 5/18/2026 at 1:20 p.m., SSD confirmed there was no documented evidence for initial IDT care conference scheduled and conducted for Resident 2 after admitted to facility on 4/23/2026. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSD stated Resident 2 should have completed initial care conference to discuss plan of care needs. SSD also said IDT care conference scheduled for today (5/18/2026) with Resident 2 and her SFM.3. Review of Resident 3's FS indicated Resident 3 was admitted to facility on 7/17/2025. Review of this FS also indicated, Resident 3 was assigned a SFM as Resident 3's RP.Review of Resident 3's MDS assessment dated [DATE] indicated Resident 3's BIMS score of 7/15, severely impaired cognition. Review of Resident 3's clinical documentation indicated, there was no documented evidence for quarterly IDT care conferences scheduled or conducted with Resident 3's RP after admitted to facility on 7/17/2025.During an interview with facility's SSD on 5/18/2026 at 1:29 p.m., SSD confirmed there were no quarterly IDT care conferences scheduled or conducted with Resident 3's RP for Resident 3. SSD stated social service department should have scheduled and conducted quarterly IDT care conferences to discuss plan of care with RP for every quarter.4. Review of Resident 4's FS indicated Resident 4 was admitted to facility on 12/17/2024. Review of this FS also indicated Resident 4 was assigned a SFM as Resident 4's RP.Review of Resident 4's MDS assessment dated [DATE], staff assessment for mental status indicated, Resident 4 had short term memory problem (inability to retain and recall recent information or events) and long term memory problem (inability to retain or recall information for an extended period). Review of Resident 4's clinical documentation indicated there was no documented evidence for quarterly IDT care conferences scheduled or conducted with Resident 4's RP after Resident 1 admitted to facility on 12/17/2024. During an interview with facility's SSD on 5/18/2026 at 1:32 p.m., SSD confirmed there was no documented evidence for quarterly IDT care conferences scheduled or conducted with RP for Resident 4. SSD stated social service staff should have scheduled, discussed plan of care, and documented for Resident 4 for each quarter.During an interview with facility's administrator (ADMN) on 5/18/2026 at 2:33 p.m., ADMN stated facility's SSD responsible to schedule, conduct, and document initial and quarterly IDT care conferences for all residents in the facility. ADMN also stated SSD should have scheduled and completed initial IDT care conference within 72 hours after admission and every quarter thereafter for residents. ADMN further stated potentially missing open communication and discussing plan of care with resident/resident's RP if facility did not do IDT care conferences.Review of facility's policy and procedure (P&P) titled, Interdisciplinary Team meeting Policy, created date 4/21/2025, the P&P indicated, a. IDT meetings shall occur: i.Upon admission for initial care planningii. Quarterly in conjunction with required assessmentsa. Documentation shall include but not be limited to:i. Date of meetingii. Participantsiii. Issues discussediv. Care plan updates (if applicable)v. Follow -up actions (if applicable)b. Documentation shall be maintained in the resident's medical record in accordance with facility policies and regulatory requirements.Review of facility's P&P titled, Director of Social Services, revised July 2024, the P&P indicated, Participate in care planning meetings and help develop goals and objectives addressing each resident's identified problems and needs.