STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555068	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Blossom Care Center	1990 Fruitdale Avenue San Jose, CA 95128

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promote the patient rights for one of five residents (Resident 2). This failure had the potential to negatively affect Resident 2's psychosocial wellbeing and sense of security.Findings:Review of Resident 2's undated admission Record indicated, she was admitted to the facility on [DATE], with diagnoses including hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body), type II diabetes mellitus (high levels of sugar in the blood), pneumonia (infection in the lungs), sepsis (the body's response to a severe infection).Review of Resident 2's Notice of Room or Roommate Change, dated 4/6/26, indicated the reason for Resident 2's room change was renovations. The notice indicated Resident 2 will be moved from patient room (PR) CC to PR DD.During an interview with the Administrator (ADM), on 4/15/26 at 12:04 p.m., the ADM confirmed PR CC was occupied by another residents. The ADM also stated Resident 2 was not returned to PR CC to minimize the impact of moving residents back and forth.Review of the Social Service Note, dated 4/9/26, indicated SSD asked resident if she'd like to stay in current room or move to different.During a concurrent interview and record review with the Director of Social Services (DSS), on 4/15/26 at 12:56 p.m., the DSS confirmed that she used different room when Resident 2 was asked if she wanted to move rooms.During an interview with Resident 2's Responsible Party (RP), on 5/1/26 at 12:23 p.m., the RP stated that she told the Admissions Director (AD) to move Resident 2 back to the room once the work was done. The RP also stated that two days later the PR CC was occupied by a different resident.During an interview with the AD, on 5/1/26 at 1:19 p.m., the AD stated Resident 2's RP asked if Resident 2 can be moved back to PR CC once work in the room was done. The AD stated the RP was told that they cannot assure that Resident 2 will be moved back to PR CC once work is done to the room.During an interview with the Director of Nursing (DON), on 5/7/26 at 11:22 a.m., the DON stated they will work with the family to find an appropriate room. During a telephone interview with the DON, on 5/14/26 at 1:39 p.m., the DON stated Resident 2 was in PR CC from 4/11/23 until 5/16/24 when she was transferred to an acute care facility. The DON also stated that Resident 2 was in PR EE from 5/27/24 to 5/28/24 after she was transferred back to the facility from acute care facility. The DON further stated that Resident 2 was moved back to PR CC on 5/29/24 until 4/6/26. The DON also stated that he has not heard the staff ask Resident 2 if she wanted to move back to PR CC.Review of the undated facility's policy and procedures (P&P), titled Resident Rights, indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; b.be treated with respect, kindness, and dignity.

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an appropriate and safe discharge process for one of three residents (Resident 1) when:1. Failure to provide the Notice of Proposed Transfer/Discharge as soon as practicable before the discharge;2. Failure to assess and identify Resident 1's living situation; and3. Failure to coordinate and confirm home health services.These failures resulted in Resident 1 being discharged without a confirmed discharge destination and follow-up services, placing the resident at risk for unmet medical needs, interruption in care, and harm. Resident 1 was found on 4/2/26, 13 days after discharge from the facility, in a fast food place with left facial droop (uneven appearance of the face), slurred speech (slow speech or mumbling), left upper and lower extremity (a limb of the body, e.g., arm or leg) weakness and was brought to the emergency department by ambulance. Findings:Review of Resident 1's undated admission Record indicated the resident was admitted to the facility on [DATE] with a diagnoses including benign neoplasm of cerebral meninges (a non-cancerous growth on the protective lining that surrounds the brain), other specified disorders of the brain (any condition that affects how the brain works), muscle weakness generalized (loss of strength in the muscles that results in inability to do specific tasks), acute pulmonary insufficiency following thoracic surgery (a complication that caused breathing issue), type II diabetes mellitus (high levels of sugar in the blood). Resident 1 was discharged from the facility on 3/20/26.Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 3/5/26, indicated a BIMS (Brief Interview for Mental Status, tool used to screen memory and thinking skills, score range 0-15) score of 15 (Resident 1's thinking skills are normal).Review of Resident 1's MDS Functional Abilities (assessment on how much help a resident need to perform daily life activities), dated 3/5/26, indicated Resident 1 required supervision or touching assistance (steadying and/or touching assistance) to partial/moderate assistance (lift, holds, or support trunk or limbs) to complete self-care and mobility activities.Review of Resident 1's Discharge Summary from an acute care hospital, dated 3/3/26, indicated an admission diagnosis of brain mass (a growth in the brain) and status post left pterional craniotomy (a surgical procedure that removes a piece of the skull to access the brain) for tumor resection on 2/19/26.Review of Resident 1's Resident Centered Social History and Discharge Planning Assessment, dated 3/6/26, indicated Post-discharge interventions were discussed and are expected to be needed to enhance safety and prevent readmission including assisted living facility options and home health options.Care planning intervention: coordinate home health and/or in-home support services.Review of Resident 1's Notice of Medicare Non-Coverage (NOMNC, an official document given to Medicare beneficiaries at least two days before their covered services are scheduled to end), dated 3/16/26, indicated Medicare coverage for skilled nursing care services will end on 3/20/26 and discharge date will be on 3/21/26. Resident 1 signed the notice that indicated she was notified that coverage of the services will end on the date on the notice.Review of Resident 1's Social Service Note, dated 3/16/26, indicated, Resident stated that due to transportation arrangement issue, resident would like to do a patient-driven discharge on 3/20 instead.Review of Resident 1's Notice of Proposed Transfer/Discharge (a mandatory written document used in skilled nursing facilities to notify residents of an upcoming transfer or discharge, usually 30 days in advance), indicated effective date of transfer/discharge: [DATE]. Resident 1 signed the Notice of Proposed Transfer/discharge on [DATE] that indicated she received a written copy of the notice.Review of Resident 1's Discharge Summary and Post-Care Instructions, dated 3/20/26, did not indicate the discharge location address and home health services agency name and contact information.During an interview with the Director of Social Services (DSS), on 4/15/26 at 12:40 p.m., the DSS stated that Resident 1 was given the NOMNC on 3/16/26 and was informed that the discharge date was 3/21/26. The DSS also stated that Resident 1 wanted to be discharged on (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	3/20/26. The DSS further stated that home health services including physical therapy, occupational therapy, and nursing were set up. The DSS also stated Resident 1 was safe to be discharged home.During a concurrent interview and record review with the DSS, on 4/15/26 at 3 p.m., the DSS confirmed that the Discharge Summary and Post-Care instructions given to Resident 1 on 3/20/26 did not have the discharge location address and home health services agency name and contact information.During an interview with the DSS, on 4/17/26 at 11:54 a.m., the DSS stated that Resident 1 did not specifically say that she wanted to go home. The DSS also stated that Resident 1 was still trying to figure out her home situation because Resident 1's family member (FM) A was in Los Angeles. The DSS further stated that Resident 1 was trying to figure out if FM B will be home when Resident 1 gets home.During a record review on 4/17/26 at 11:54 a.m., the DSS provided a copy of a note written on a home care agency note pad. It indicated [name] from [Home Health Agency] confirmed they received HH referral & auth *DC 3/20/26. [name] mentioned that they successfully spoke w/ [Resident 1] on the phone more than once. There was no date or name of the writer on the note.During a concurrent interview and record review with the Licensed Vocational Nurse (LVN), on 4/17/26 at 12:44 a.m., the LVN confirmed that the Discharge Summary and Post-Care Instructions, dated 3/20/26, did not indicate the discharge location address and home health services agency name and contact information. The LVN also stated that the form should be complete.During a telephone interview with FM A, on 4/20/26 at 9:04 a.m., FM A stated that Resident 1 was locked out and kicked out of FM B's residence. FM A also stated Resident 1 had no key to the house. FM A stated that FM B was not in the house and was in a skilled nursing facility. FM A further stated that she informed the facility staff that she was looking for a place for Resident 1 to stay after discharge and not to discharge the resident.During a telephone interview with the Agency Director (AD) of a home health agency (HHA), on 4/21/26 at 9:39 a.m., the AD stated that the referral for home health services was received via fax and imported to their intake department on 3/20/26 at 1:31 p.m. The AD further stated the following: On 3/20/26 at 2:08 p.m., HHA did an initial reach out to Resident 1's insurance company. At 6:37 p.m. on 3/20/26, HHA sent an urgent authorization request to the insurance company. On 3/21/26 at 2:49 p.m., the intake coordinator (IC) called Resident 1, however Resident 1 was not available. The IC then informed the HHA that Resident 1 was homeless. On 3/23/26 at 2:33 p.m., the IC called Resident 1 to check in and indicated Resident 1 was not sure when will she be ready. On 3/25/26 at 1:08 p.m., the IC called Resident 1 to check in, and Resident 1 informed the IC that she was living in the street and does not have a place set up. Resident 1 indicated to the IC that she was not in any type of facility and not sure what was happening or when Resident 1 can be seen. The IC also indicated that Resident 1 has been looking for a place but cannot find a place that would accept her. On 3/25/26 at 1:18 p.m., the HHA considered Resident 1 a non-admit and that HHA will not proceed to provide services to Resident 1 because the HHA does not have a way to find or see the resident.During a telephone interview with the Social Services Assistant (SSA), on 4/20/26 at 1:19 p.m., the SSA stated that the HHA informed her that Resident 1 was safe. The SSA stated she does not recall when she spoke with the HHA.During a telephone interview with the SSA, on 4/21/26 at 9:45 a.m., the SSA stated that the HHA referral was sent on 3/20/26. The SSA also stated that the best practice in the facility was to send the HHA referral prior to discharge. The SSA further stated that the facility will start coordinating the HHA referral any time before the resident leaves the facility.During an interview with the Facility Driver (FD), on 4/21/26 at 12:51 p.m., the FD stated that he does not remember what happened after he dropped off Resident 1 in the specified address.During an interview with the DSS, on 5/6/26 at 12:28 p.m., the DSS stated that the reason for Resident 1's discharge was that insurance issued the last covered date. The DSS stated that Resident 1 was not asked prior to discharge on [DATE] if there were any changes to the home situation. The DSS stated Resident 1 did not approach her which indicated that the home situation has not changed. The DSS further stated that family support involved FM A and FM B but did not talk to them. The home situation was not discussed prior to discharge date because Resident 1's discharge plan has not (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	changed. The DSS stated the facility was not required to call Resident 1 after discharge. The DSS also stated that the FD informed the DSS that Resident 1 was dropped off at the address that was in the Notice of Proposed Transfer/Discharge.Review of HHA's Client Coordination Note Report, dated 3/21/26, indicated Pt is homeless - she will call us back when she finds out where she will be staying.Review of Resident 1's HHA's Client Coordination Note Report, dated 3/23/26, indicated Called patient to check in, she said she is still recovering and is not sure when she will be ready. She appreciated the call and said it would be a slow recovery - she was getting another call so we disconnected. Pending servicing address. Pending address/screen/MD conf.Review of Resident 1's HHA's Client Coordination Note Report, dated 3/25/26, indicated Called patient to follow up and check in. She said she is living on the street and does not have a place set up for her. She said she is not in any kind of facility and is not sure what was happening with us or when we can see her. She stressed she has nowhere for us to see her at this time, has been looking but cannot find a place that can accept her. She will keep us updated if anything changed. I asked to follow up with her later, she agreed.Review of Resident 1's HHA's Client Coordination Note Report, dated 3/25/26, indicated Reason for HH non admit. Comments: patient does not have a place to reside where we can provide services.Review of Resident 1's acute care hospital (ACH) AA's ED (Emergency Department) final report, dated 4/2/26, indicated Resident 1 was brought in by ambulance to the ER (Emergency Room) after being found on the floor by EMS (Emergency Medical Services, trained personnel that provide care and transport) of a fast food place with left facial droop, left-sided weakness and slurred speech. Resident 1 was admitted to the ICU (Intensive Care Unit, a specialized unit for extremely ill or severely injured patient that required constant monitoring) for acute stroke (lack of blood flow to a part of the brain), septic shock (blood pressure drops to a dangerous low level caused by a severe infection), acute UTI (Urinary Tract Infection, infection of the bladder or kidney) and acute respiratory failure (lungs cannot release enough oxygen into the blood).Review of Resident 1's ACH AA's Discharge Summary final report, dated 4/6/26, indicated Given patient's recent brain surgery patient would not be a good candidate for anticoagulation (medication used to stop the blood from forming), decision was made to transfer patient for possible thrombectomy (a procedure to remove a blood clot). discharged to another ACH on 4/6/26.Review of Resident 1's acute care hospital ACH AA's Consult Note final report, dated 4/3/26, indicated currently at a homeless shelter.Review of Resident 1's acute care hospital ACH BB's admission H&P (History and Physical, initial and comprehensive assessment of the patient), dated 4/7/26, indicated MRI brain later demonstrated two acute parietal infarcts (damage to a part of the brain as a result of a sudden loss of blood supply to the brain). Her course was complicated by persistent hypotension (low blood pressure) requiring ICU admission.Given the severity of her PE (pulmonary embolism, blood clot in the lungs), inability to anticoagulated, and ongoing hemodynamic instability (not enough blood flow in the body) .decision was made to transfer the patient for urgent pulmonary thrombectomy.The patient is homeless.Review of Resident 1's ACH BB's physician progress note, dated 4/11/26, indicated Patient was discharged to SNF in San [NAME] and discharged to her car in Manteca. Patient is homeless and was living out of her car.Review of the DSS's Essential Duties & Responsibilities, undated, indicated Care Planning: Evaluate social and family information and psychological needs to develop comprehensive care plans; establish courses of action by exploring options and setting goals with families. Discharge Planning: Coordinate with the interdisciplinary team and outside agencies to ensure safe transitions, including arranging equipment and agency referrals.Review of the SSA's key responsibilities, undated, indicated Assist residents and families with care planning, transitions, and psychosocial needs; help complete required documentation, assessments, and progress notes in compliance with state and federal regulations; communicate with interdisciplinary team members to ensure resident needs are met; participate in discharge planning and community resource coordination.Review of the facility's policy and procedures (P&P), titled Transfer or Discharge for Resident in Facility Less Than Thirty (30) Days, undated, indicated When a resident has not resided in the facility for thirty (30) days, written (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	notice of an impending transfer or discharge will be given as soon as it is practicable but before the transfer or discharge.According to AFL 25-17 (All Facilities Letter, an official notice issued by the California Department of Public Health to all licensed or certified health facilities providing essential updates, guidance, and policy changes that must be followed to maintain compliance with state and federal regulations), dated 5/28/25, indicated The facility's notice must include all of the following at the time notice is provided.the specific location (address if the location is a residence) to which the resident is to be transferred or discharged .Notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:.a resident has not resided in the facility for 30 days.In these exceptional cases, the notice must be provided to the resident, resident's representative(s) if appropriate, and LTC Ombudsman as soon as practicable before the transfer or discharge.Review of the facility's P&P, titled Discharge Summary and Plan, undated, indicated The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting.The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge.Residents are periodically assessed for their interest in returning to the community. If the resident indicates an interest in returning to the community, the facility inquires about support in place. This may include the capacity of the resident's caregivers at home. The facility makes referrals to local agencies, the local ombudsman, and support services that can assist in accommodating the resident's post-discharge preferences, as appropriate. Referrals made for this purpose, and the response to these referrals, are documented in the medical record.Review of the California Department of Aging Long-Term Care Residents' Rights, dated 2026, indicated The facility must provide notice and ensure safe transfer or discharge.