STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555635	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Care Center	340 Northlake Drive San Jose, CA 95117

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans to address a resident to resident altercation, for one of three sampled residents (Resident 3). This failure had the potential to result in the resident not receiving the interventions necessary to maintain their highest level of well-being.Findings:Review of Resident 3's clinical record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (brain damage caused by lack of oxygen), alcohol dependence, anxiety disorder (a disorder that causes people to feel panicked for long periods of time), and type II diabetes mellitus (a disorder that causes elevated blood sugar levels).Review of Resident 3's minimum data set (MDS, a required assessment for all skilled nursing facility residents to get reimbursed by Medicare) Section C-Cognitive Patterns indicated Resident 3 had a brief interview for mental status (BIMS, a score to evaluate cognitive status of residents) score of four.Review of Resident 3's chart indicated on 8/29/25, Resident 3 was seen in the hallway of the facility yelling and grabbing another resident's arm. Resident 3 and the other resident were separated after the altercation. On 9/4/25, Resident 3 was discharged to another facility.During a concurrent interview and record review with the director of nursing (DON) on 9/12/25 at 12:37 p.m., the DON said the interdisciplinary team, which consists of herself and other department such as social services and rehabilitation, typically updates a resident's care plan after any incident takes place. The DON also confirmed there was no care plan entry for Resident 3.Review of facility policy titled Comprehensive Care Plans, revised 12/19/22, indicated .The comprehensive care plan will describe at a minimum, the following.The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Review of facility policy titled Care Plan Revisions Upon Status Change, revised 12/19/22, indicated .The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.The care plan will be updated with the new or modified interventions

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555635	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Care Center	340 Northlake Drive San Jose, CA 95117

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for one out of 3 sampled residents (Resident 1), when there were multiple days for which there was no evidence of documentation of resident behavioral charting after a staff-to-resident incident. This failure had the potential to compromise the resident's health, safety, and overall well-beingFindings:Review of Resident 1's clinical record indicated Resident 1 was admitted to the facility with diagnoses including cerebral infarction (also known as a stroke, an attack in the brain caused by lack of blood flow), mood disorder, and major depressive disorder with psychotic symptoms (a mental disorder that affects mood).Review of Resident 1's clinical record indicated on 8/29/25, Resident 1 had an altercation with a certified nurse assistant (CNA). Resident 1 had called his daughter after a CNA had cared for him, and said the CNA had push him. Resident 1's daughter called adult protective services (APS), and the police were called. Resident 1 told the police that he pushed the CNA first, and the CNA pushed back. During a concurrent observation and interview with Resident 1 on 8/29/25 at 1:54 p.m., Resident 1 was seen in his room, lying in bed, with no visible injuries. Resident 1 said he grabbed the CNA and the CNA pushed him off. Resident 1 also said he had yelled at the CNA.During a concurrent interview and record review with the director of nursing (DON) on 9/12/25 at 12:33 p.m., the DON said the nursing staff should be documenting on residents who have an incident with a staff member or other resident for 72 hours. The DON confirmed that there was only one documented entry for Resident 1 in the 72 hour period after the incident on 8/29/25, on 8/31/25.Review of facility policy titled Abuse, Neglect and Exploitation, revised 12/19/22, indicated .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to. Increased supervision of the alleged victim and residents.