STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555757	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milpitas Care Center	120 Corning Avenue Milpitas, CA 95035

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop person -centered care plan that included target symptoms, measurable objectives, and interventions for five of five sampled residents (Resident 1, 2, 3, 4, and 5) when:1. No care plan for rehabilitation ((treatments and interventions aimed at improving functional abilities and quality of life) services/treatments for Resident 1, 2, 3, 4, and 5. Above failures had the potential to result in not meeting sampled residents' needs and plan of care.Findings: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 5/1/2014 and discharged from facility 1/7/2021.Review of Resident 1's diagnoses included muscle weakness (a reduction in strength, able to contract and perform tasks).Review of Resident 1's order summary report indicated Resident 1 had an order for PT (physical therapy, a healthcare field where movement experts help to restore, maintain, and improve physical function, mobility and quality of life) 5x/week (5 times per week) x12 weeks (for 12 weeks), dated 11/27/2020 and OT (occupational therapy, a healthcare field that develop, recover, and maintain the skills needed for daily living) 2x/week x12 weeks, dated 11/27/2020.Review of Resident 1's care plans indicated there was no documented evidence of person centered care plan for PT and OT services/treatments.Review of Resident 2's FS indicated, Resident 2 was admitted to facility on 10/16/2020 and discharged from facility on 12/7/2020.Review of Resident 2's diagnoses included muscle weakness and abnormalities of gait and mobility (an irregular walking pattern).Review of Resident2's order summary report indicated there was an order for PT 5x/week x 12 weeks, dated 10/23/2020, OT 2x/week x 4 weeks, dated 11/12/2020, and ST (speech therapy, a healthcare specialty, that helps to improve communication, and swallowing ability) 2x/week x 4 weeks, date ordered on 10/24/2020.Review of Resident 2's care plans indicated there was no documented evidence of individualized care plan for PT, OT, and ST treatment/services.Review of Resident 3's FS indicated Resident 3 was admitted to facility on 10/21/2025 and discharged from facility on 11/19/2025.Review of Resident 3's diagnoses included abnormalities of gait and mobility.Review of Resident 3's order summary report indicated an order for PT 5x/week x 12 weeks, dated 10/30/2025 and OT 1x/week x 8 weeks, dated 11/10/2025.Review of Resident 3's care plans indicated there was no documented evidence of care plans for PT and OT treatment/services.Review of Resident 4 FS indicated Resident 4 was admitted to facility on 10/30/2025 with diagnoses included abnormalities of gait, mobility and dysphagia (difficulty swallowing). Resident 4 currently residing in facility.Review of Resident 4's order summary report indicated an order for PT 5x/week x 12 weeks, dated 10/30/2025 and ST 2x/week x 4 weeks, dated 11/4/2025.Review of Resident 4's care plans indicated there was no documented evidence of care plans for PT and ST treatment/services.Review of Resident 5 FS indicated Resident 5 was admitted to facility on 11/5/2025 with diagnoses included abnormalities of gait and mobility. Resident 5 currently residing in facility.Review of Resident 5's order summary report indicated an order for PT 5x/week x 12 weeks, dated 11/21/2025.Review of Resident 5's care plans (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated there was no documented evidence of care plans for PT treatment/services.During a concurrent record review of care plans for therapy for above residents and interview with facility's minimum data set (resident clinical and functional assessment tool) coordinator (MDSC) on 11/21/2025 at 1:38 p.m., MDSC confirmed there were no care plans for PT, OT, and ST for all above residents for services and treatments as ordered. MDSC stated therapy staff responsible to initiate and implement care plans for therapy services and treatments provided as ordered for above residents. MDSC also stated therapy staff should have initiated person centered care plan for each therapy when resident was received or currently receiving.During an interview with director of nursing (DON) on 11/21/2025 at 2:22 p.m., DON confirmed there were therapy treatments as ordered for Resident 1, 2, 3, 4, and 5. DON stated therapy staff responsible to initiate care plans for therapy services and they should have initiated care plans when provided services to residents.During an interview over the telephone with facility's director of rehabilitation (DOR) on 11/21/2025 at 2:45 p.m., DOR stated therapy staff should have initiate the care plans separate for therapy as it should be. Review of facility's P&P titled, Care Planning- Interdisciplinary Team, revised September 2013, the P&P indicated, The care plan is based on the resident's comprehensive assessment and is developed by a care planning/ interdisciplinary team which includes, but is not necessarily limited to the following personnel: Therapists (speech, occupational, recreational, etc.), as applicable;

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for progress notes, charting and documentation for therapy services (treatments and interventions aimed at improving functional abilities and quality of life) / treatments for five out of five sampled residents (Resident 1,2,3,4, and 5).This failure had potentially effect on plan of care, monitor functional progress, and communication for above sampled residents.Findings: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 5/1/2014 and discharged from facility 1/7/2021.Review of Resident 1's diagnoses included muscle weakness (a reduction in strength, able to contract and perform tasks).Review of Resident 1's order summary report indicated Resident 1 had an order for PT (physical therapy, a healthcare field where movement experts help to restore, maintain, and improve physical function, mobility and quality of life) 5x/week (5 times per week) x12 weeks (for 12 weeks), dated 11/27/2020 and OT (occupational therapy, a healthcare field that develop, recover, and maintain the skills needed for daily living) 2x/week x12 weeks, dated 11/27/2020.Further review of Resident 1's electronic medical record (digital, real time version of resident's medical documentation) indicated there was no documented evidence for PT and OT treatment/services received. Review of Resident 2's FS indicated, Resident 2 was admitted to facility on 10/16/2020 and discharged from facility on 12/7/2020.Review of Resident 2's diagnoses included muscle weakness and abnormalities of gait and mobility (an irregular walking pattern).Review of Resident2's order summary report indicated there was an order for PT 5x/week x 12 weeks, dated 10/23/2020, OT 2x/week x 4 weeks, dated 11/12/2020, and ST (speech therapy, a healthcare specialty, that helps to improve communication, and swallowing ability) 2x/week x 4 weeks, date ordered on 10/24/2020.Further review of Resident 2's electronic medical record indicated there was no documented evidence for PT, OT, and ST treatment/services received.Review of Resident 3's FS indicated Resident 3 was admitted to facility on 10/21/2025 and discharged from facility on 11/19/2025.Review of Resident 3's diagnoses included abnormalities of gait and mobility.Review of Resident 3's order summary report indicated an order for PT 5x/week x 12 weeks, dated 10/30/2025 and OT 1x/week x 8 weeks, dated 11/10/2025.Review of Resident 3's electronic medical record indicated there was no documented evidence for PT and OT treatment/services received.Review of Resident 4 FS indicated Resident 4 was admitted to facility on 10/30/2025 with diagnoses included abnormalities of gait, mobility and dysphagia (difficulty swallowing). Resident 4 currently residing in facility.Review of Resident 4's order summary report indicated an order for PT 5x/week x 12 weeks, dated 10/30/2025 and ST 2x/week x 4 weeks, dated 11/4/2025.Review of Resident 4's electronic medical record indicated there was no documented evidence for PT and ST treatment/services for Resident 4.Review of Resident 5 FS indicated Resident 5 was admitted to facility on 11/5/2025 with diagnoses included abnormalities of gait and mobility. Resident 5 currently residing in facility.Review of Resident 5's order summary report indicated an order for PT 5x/week x 12 weeks, dated 11/21/2025.Review of Resident 5's electronic medical record indicated there was no documented evidence for PT treatment/services for Resident 5.During a concurrent record review of therapy treatment notes for therapy for above residents and interview with facility's minimum data set (resident clinical and functional assessment tool) coordinator (MDSC) on 11/21/2025 at 1:38 p.m., MDSC confirmed there were no documented evidence for OT, PT and ST treatment and services notes available in facility's electronic clinical documentation system. MDSC stated therapy notes should have documented in electronic medical record system by therapy staff after each therapy session for residents.During an interview with facility's medical record director (MRD) on 11/21/2025 at 2:04 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., MRD confirmed there was no documented evidence for PT, OT, and ST treatment/service notes and care plans for all above residents. MRD stated she does not have access for any therapy documentation for all residents. MRD also stated therapy treatment and service documentation should have been part of the resident's electronic medical record and facility staff should have access as needed.During an interview with license vocational nurse (LVN) on 11/21/2025 at 2:15 p.m., LVN stated unable to access PT, OT and ST documentation for residents. LVN also stated it would be nice to have access to therapy documentation for residents to know how the residents were making progress with their functional status to communicate with residents or resident's significant family members as needed.During an interview with director of nursing (DON) on 11/21/2025 at 2:22 p.m., DON confirmed there were no therapy treatment documentation available with facility's electronic medical record. DON stated facility staff should have access to review therapy documentation for residents as needed.During an interview over the telephone with facility's director of rehabilitation (DOR) on 11/21/2025 at 2:45 p.m., DOR confirmed therapy treatment and service's documentation not included in facility's electronic documentation. DOR stated takes long time to load these documentation to facility's electronic documentation system, only providing these documents upon request by resident, family member or facility. DOR also stated these documents part of the resident's medical record, and should have been included in facility's medical record system. Review of facility's P&P titled, Progress Notes, revised April 2007, the P&P indicated, Progress notes shall be maintained for each resident who is receiving specialized rehabilitation services.Review of facility's P&P titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: Treatments or services performed;