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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555831 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Herman Health Care Center |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2295 Plummer Avenue<br>San Jose, CA 95125 |                                              |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG                                                                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46939</p> <p>Based on interview and record review, the facility failed to provide necessary activities of daily living (ADL-skills required to independently care for oneself, such as eating, bathing, and mobility) for one of three sampled residents (Resident 1) when Resident 1's shower sheets was not available and not documented for a period of one month (3/4/24-4/4/24). This failure had the potential to negatively affect Resident 1's physical and mental health.</p> <p>Findings:</p> <p>During an interview on 4/4/24, at 2:00 p.m., with Resident 1, Resident 1 stated she was not showered regularly according to her scheduled shower days. Resident 1 stated she is supposed to be showered on Mondays, Wednesdays, and Fridays. Resident 1 stated she was dependent on staff to bathe her due to weakness from a chronic medical condition and she was unable to bathe herself.</p> <p>During a concurrent interview and record review on 4/4/24, at 2:40 p.m., with Certified Nursing Assistant (CNA) A, the shower sheet binder dated 3/4/24 to 4/4/24 was reviewed. The shower sheet binder indicated, no documentation Resident 1 was showered for this time period. CNA A stated, there was no documentation that Resident 1 was showered for this period of 3/4/24 to 4/4/24. CNA A stated, we are supposed to fill out a shower sheet each time a resident was showered, and given a bed bath, or any refusal.</p> <p>During a review of Resident 1's Brief Interview for Mental Status (BIMS- tool used to screen and identify the cognitive condition of residents) dated 12/12/23. Resident 1 had a BIMS of 15, indicated the resident was cognitively intact, no impairment to memory, and thinking, or judgement.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment tool that measures health status in nursing home residents) Section GG, dated 3/5/24, MDS section GG indicated, the shower/bathe self which the ability to bathe self, including washing, rinsing, and drying self with a score of 01 that means Dependent-Helper does ALL of the effort.</p> <p>During an interview with Director of Nursing (DON) on 4/4/24 at 4:18 p.m., the DON confirmed the request for Resident 1's shower sheets was not documented and filled out for the period of 3/4/24 to 4/4/24.</p> <p>During a review of shower sheets requested dated 3/4/24-4/4/24, there was no documented evidenced Resident 1 receiving any type of shower or any refusal on 3/4/24 to 4/4/24 .</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a review of the facility's policy and procedure (P&amp;P) titled, Bath, Shower/Tub dated 2018, the P&amp;P indicated, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g, any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s).</p> |                                                                                        |                                              |