STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555831	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Herman Health Care Center	2295 Plummer Avenue 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on an interview and record review, the facility failed to ensure medications were administered as ordered by the medical doctor (MD) for 1 of 2 sampled Resident (Resident 1). This failure had the potential to adversely affect the health and well- being of Resident 1. Findings: A Record review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's FS indicated Resident admitted with diagnoses included dementia (loss of ability to think, remember, and reason to levels that affect daily life and activities), alcohol abuse (disorder when can't stop drinking even when its puts health and safety at risk), cognitive communication deficit (condition with trouble reasoning and making decisions while talking), and encephalopathy (disturbance of brain function). Review of Resident 1's physician's medication orders indicated divalproex (to treat mental illness) 250 mg (mg: milligrams, unit of measurement of mass equal to a thousandth of a gram) twice a day ordered on 5/30/2024, trazodone (to treat mental or mood disorders) 100mg daily, ordered on 5/30/2024, and melatonin (to treat delayed sleep phase and sleep disorders) 3 milligrams at bedtime every day, ordered on 5/21/2024. Review of Resident 1's electronic medication administration record (EMAR: a legal document for medication administration record) for June 2024 indicated: Blank EMAR documentation on 6/7/2024, 6/13/2024, 6/15/2024, 6/17/2024, 6/19/2024, 6/22/2024 and 6/23/2024 for administration of divalproex at 4:00 p.m. Blank EMAR documentation on 6/6/2024, 6/7/2024, 6/13/2024, 6/17/2024, 6/18/2024, 6/19/2024, 6/22/2024, and 6/23/2024 for administration of trazodone and melatonin at 9:00 p.m. During a concurrent review of EMAR for June 2024 for Resident 1 and interview with registered nurse supervisor (RN S) on 6/24/2024 at 3:31 p.m., RN S confirmed blank EMAR for above three medications and dates indicated above. RN S stated if EMAR left blank without license nurse's initial that means medications were not administered to resident 1. RN S further stated licensed nurses should have administered and documented EMAR for medications as ordered for Resident 1. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with director of nursing (DON) on 6/24/2024 at 3:39 p.m., DON confirmed licensed nurses did not administer medications as ordered for Residents 1. DON stated if license nurse did not initial after administered medications indicated medications were not given to Resident 1. DON further stated licensed nurses should have administered medications as ordered and completed EMAR documentation for Resident 1. Review of facility's P&P titled, Administering Medications, revised December 2012, the P&P indicated, Medications must be administered in according with orders, including nay required time frame. The individual administering the medication must initial the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46552 Based on interview, and record review, the facility failed to ensure to follow psychiatric nurse practitioner (PNP: licensed as nurse practitioner or clinical nurse specialist, provides the full range of mental health care needs)'s recommendations and medication regimen review (MRR: a thorough evaluation of medication regimen for resident with the goal of promoting positive outcomes) for 2 of 2 sampled Residents (Resident 1 and 2) when; 1. Failed to follow up for PNP's recommendations for medication, and blood tests (common tests healthcare providers use to monitor overall health or help diagnose medical condition) for Resident 1; 2. Failed to follow up for MRR request for Resident 1; and 3. Failed to follow up for psychologist (a trained mental health professional who specializes in the study and treatment of mind and behavioral disorders)'s recommendations for Resident 2. These failures had the potential to effect on health and psychosocial well-being for Resident 1 and 2. Findings: Review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to facility on 5/21/2024. Review of Resident 1's FS indicated Resident admitted with diagnoses included dementia (loss of ability to think, remember, and reason to levels that affect daily life and activities), alcohol abuse (disorder when can't stop drinking even when its puts health and safety at risk), cognitive communication deficit (condition with trouble reasoning and making decisions while talking), and encephalopathy (disturbance of brain function). 1. Review of PNP's recommendations dated 6/11/2024, indicated, risperidone (antipsychotic medication to treat mental health disorders) 0.25 mg (milligram: a unit of mass equal to one thousandth of a gram) BID (twice a day) and labs for TSH (thyroid stimulating hormone, a chemical produced by gland in the brain), CBC (complete blood work: a test, used to diagnose and monitor numerous diseases), CMP (comprehensive metabolic panel: a blood test that gives body's fluid balance), valproic acid (medication to used to treat mental disorders] level in blood) level (blood test to measure valproic acid level), and ammonia (a toxic waste product made by the body during digestion) level (blood test to measure ammonia level in blood) signed and undated by MD (medical doctor) for Resident 1. 2.Review of offsite medication review form dated 6/16/2024 for Resident 1 indicated facility sent MRR request for Behavioral changes-unusual behavior patterns, to facility's consulting pharmacy (delivering medications and providing pharmacy services to facility) via fax (send or receive documents electronically). Review of clinical documentation for Resident 1 indicated there was no documented evidence for approved PNP's recommendations for medication and blood work have been ordered for Resident 1. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of clinical documentation for Resident 1indicated there was no documented evidence of facility received MRR request response from consulting pharmacist or facility followed up for response for MRR for Resident 1. Review of Resident 2's FS indicated Resident 1 was admitted to facility on 4/30/2024. Resident 2's FS also indicated Resident 2's admission diagnoses included alzeimer's disease (a progressive disease that destroys memory and other important mental functions). Review of Resident 2's psychologist notes dated 6/19/2024 indicated, Consider Follow-up by Psychiatry (a branch of medicine concerned with study, diagnosis, and treatment of mental illness). Review of Resident 2's clinical documentation indicated there was no documented evidence for psychiatry follow up for Resident 2. During an interview with registered nurse supervisor (RN S) on 7/24/2024 at 3:09 p.m., RN S confirmed PNP's recommendations for medication and blood work were not ordered for Resident 1. RN S also confirmed MRR not been followed up for Resident 1 after requested on 6/16/2024. RN S acknowledged psychologist recommendations not been followed up for Resident 2. RN S stated nursing staff should have followed PNP's recommendations and MRR response from pharmacy for Resident 1. RN S also stated nursing staff should have followed up with psychiatry for Resident 2. During an interview with facility's director of nursing (DON) on 7/24/2024 at 3:39 p.m., DON acknowledged nursing staff did not follow PNP's recommendations and requested MRR response from pharmacy for Resident 1. DON also acknowledged psychologist recommendations for psychiatry not been followed for Resident 2. DON stated nursing staff should have carried over MD approved PNP's recommendations for medication and blood work for Resident 1. DON also stated nursing staff should have followed up with pharmacy for MRR response for Resident 1 and followed up with psychiatry for Resident 2. Review of facility's policy and procedure (P&P) titled, Physician Services, revised February 2021, the P&P indicated, Physician orders and progress notes are maintained in accordance with facility policy. Consultative services are made available from community-based consultants or from a local hospital or medical center. Review of facility's P&P Medication Utilization and Prescribing- Clinical Protocol, revised April 2018, the P&P indicated, The consultant pharmacist can help by reviewing facility medication usage patterns and trends and by intensifying medication reviews of individuals taking medications that present clinically significant risks.