

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Herman Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185</p> <p>Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice for one of two residents investigated, (Resident 1), when Resident 1 was not provided with appropriate assistance with his activities of daily living (ADL, basic tasks individuals perform to take care of themselves on a daily basis) to prevent accident.</p> <p>This failure resulted in the safety of Resident 1, being compromised, thus having multiple falls.</p> <p>Findings:</p> <p>During a concurrent observation and interview of Resident 1 on 10/25/24 at 3:30 p.m., Resident 1 was laying in his bed, alert, calm and comfortable. He was watched one on one by a certified nursing assistant. Resident 1 was confused and could not recall his falling incidents.</p> <p>Review of Resident 1's admission record dated 10/15/24 indicated, Resident 1 was initially admitted to the facility on [DATE]. Resident 1's latest readmission was 9/24/24 with diagnoses including fracture (break or crack in a bone) of unspecified part of neck of left femur (thigh bone), subsequent encounter for closed fracture (a broken bone that does not break the skin) with routine healing, unspecified dementia (memory loss), unspecified severity with agitation (a state of anxiety) and adult failure to thrive (syndrome that involves a decline in a person's physical and mental health).</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's progress notes (legal documents that record a resident's health, care, and any changes in their condition) from 8/24/24 to 10/7/24 indicated, Resident 1 was seen walking around the hallway using his front wheel walker by himself, limping on his left leg on 8/24/24. Resident 1 was observed grimacing and in pain, pointing to his left leg. Resident had another fall on 8/25/24. Left hip x-ray was done on 8/25/24 which indicated that there was acute appearing, mildly impacted, about approximately 8.6 millimeters (mm, a metric unit of length) horizontal fracture (a break in the bone that runs perpendicular to the bone's width), seen through the sub capital left femoral neck fracture (fracture in the neck of the left thigh bone) with approximately 5.6 mm lateral step off of the distal fracture moiety (break in portion of the end of the bone). Resident 1 had diffused osteopenia (a condition where a person's x-ray shows a decrease in bone mineral density in all of thier bones. Further review of Resident 1's progress notes from 8/24/24 to 10/7/24 indicated, Resident 1 had two more falls. Resident 1 had a fall on 10/4/24, where Resident 1 was standing in his room, then turning around to sit in his bed and he fell . Resident 1 was sent out to the hospital emergency room and was diagnosed with contusion (bruise) of hip (the area on each side of the pelvis). Resident 1 had another fall on 10/7/24, where Resident 1 was ambulating outside, then he fell and had a skin tear (superficial wound) of his left thumb. He was on continued monitoring.</p> <p>Review of Resident 1's fall risk assessment (a clinical evaluation that helps identify a person's risk of falling) dated 3/31/24, indicated that Resident 1 had a fall risk assessment score of 14 meaning high risk for fall. Resident 1 had balance problems while standing and walking and had decreased muscular coordination.</p> <p>Review of Resident 1's fall intervention on 3/31/24 indicated the use of wheelchair with supervision.</p> <p>Review of Resident 1's minimum data set (MDS, a standardized, comprehensive assessment tool used to evaluate the health of residents in nursing homes) resident assessment and care screening of Resident 1 dated 6/13/24 indicated, that Resident 1 was coded 02, for his MDS, Sections GG0170D: Sit to stand and GG0170E: Chair or wheelchair/bed to chair or wheelchair transfer, indicating, Substantial/maximal assistance. The helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>Further review of Resident 1's MDS resident assessment and care screening of Resident 1 dated 9/27/24 indicated, that Resident 1 was coded 04, for his MDS, Sections GG0170D: Sit to stand, GG0170E: Chair or wheelchair/bed to chair or wheelchair transfer and GG0170K: Walk 150 feet, indicating, Supervision or touching assistance. Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>During an interview with the facility minimum data set coordinator (FMDSC) and the regional minimum data set coordinator (RMDSC) on 10/15/24 at 1:26 p.m., they verified that Resident was seen limping on 8/24/24 and had falls on 8/25/24, 10/4/24 and 10/7/24. FMDSC and RMDSC further verified that for the fall risk assessment of Resident 1 on 8/25/24, Resident 1 had balance problem while walking, unstable when making turns and requires assistive device. FMDSC and RMDSC then stated that for the section GG of Resident 1's MDS, Resident 1 needed supervision or touching assistance with sitting to standing and transferring from chair to bed or bed to chair.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the interview with the director of staff development (DSD) on 10/15/24 at 3:20 p.m., DSD verified that Resident 1 was seen limping on 8/24/24 and had fall with fracture on 8/25, fall with contusion of hip on 10/4/24 and fall with skin tear on his left thumb on 10/7/24.</p> <p>Review of Resident 1's interdisciplinary team conference record dated 4/1/24 indicated, to provide Resident 1 with frequent monitoring to anticipate needs.</p> <p>Review of Resident 1's at risk for fall care plan dated 3/1/24 indited, to assist Resident 1 with his activities of daily living (ADL).</p> <p>Review of Resident 1's ADL care plan dated 3/1/24 indicated, to assist Resident with activities of daily living as needed and to monitor resident for all ADL needs.</p> <p>Review of Resident 1's fall risk evaluation dated 8/25/24, indicated that resident 1 had balance problem while walking, change in gait pattern when walking through doorway and jerking or unstable when making turns.</p> <p>During an interview with the DSD on 11/20/24 at 11:32 a.m., DSD verified the above findings. She then stated that Resident 1 is on one on one monitoring right now.</p> <p>During the interview with the minimum data set consultant (MDSC) on 11/20/24 at 1:34 p.m., MDSC verified the above findings and will review on their plans for Resident 1.</p> <p>Review of the facility's policy titled, Fall Risk Assessment, revised March, 2018 indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including, ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition .</p>		