

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 06/04/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled resident (Resident 1) was free from sexual abuse (sexual act that is committed or attempted by another person who is incapable of appraising the nature of the act or unable to give consent) when certified nursing assistant E (CNA E) did not separate female Resident 1 from male Resident 2.</p> <p>As a result of above failure, Resident 1's naked waist down body and Resident 1's private area were exposed to Resident 2.</p> <p>Findings:</p> <p>Review of Resident 1's undated face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to facility on 6/13/2023.</p> <p>Review of Resident 1's FS indicated diagnoses included schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods and behaviors), bipolar disorder (a mental illness that causes clear shifts in a person's mood, energy, activity levels, and concentration), anxiety (persistent, excessive fear or worry for day to day situations), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily living), dementia (loss of thinking, memory, language and reasoning skills) and hospice care (a specialized care designed to provide comfort and support to individuals with terminal illness).</p> <p>Review of Resident 1's minimum data set (MDS: Resident's clinical and functional assessment tool) assessment dated [DATE] indicated Resident 1's brief interview for mental status (BIMS) score of 8 of 15 which means 8-12 with moderately impaired cognition.</p> <p>Review of Resident 1's medical doctor (MD)'s progress notes dated 3/20/2025 indicated, orientation to person only, not to place or time.</p> <p>Review of Resident 1's document for change in condition (CIC: a document used to document and report a change in a resident's physical and mental health) evaluation dated 3/18/2025 indicated, Resident (Resident 1) was found in Unit 1 in one of the male resident's (Resident 2) bed laying down with no pants or brief on. The male resident was standing next to her.</p> <p>Review of Resident 2's FS indicated Resident 2 was admitted to facility on 1/30/2025 with diagnoses of dementia and anxiety.</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
---	-------	-----------

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 06/04/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's MDS assessment dated [DATE] indicated, Resident 2's BIMS score of 12 of 15, which means 8-12 with moderately impaired cognition</p> <p>Review of Resident 2's document for CIC evaluation dated 3/18/2025 indicated, Resident (Resident 2) was seen with a female resident (Resident 1) in his bed. Resident (Resident 1) had no clothes waist down and laying down with Resident (Resident 2)'s bed while the male resident was standing up fully clothed, but belt buckle undone.</p> <p>During concurrent observation and interview with CNA B on 3/20/2025 at 11:30 a.m., noted CNA B was watching Resident 1 in Resident 1's room. CNA B stated she was monitoring Resident 1 one on one basis to prevent Resident 2 was not approaching Resident 1 to prevent further altercations.</p> <p>During an interview with LVN D on 3/20/2025 at 3:35 p.m., LVN D (licensed vocational nurse D) stated CNA E came to LVN D, (LVN D that time was in another unit adjacent to Resident 2's unit) CNA E reported saying that Resident 1 and Resident 2 were in Resident 2's room when CNA E tried to separate both, Resident 2 became aggressive and threatened to hit CNA E on 3/18/2025 around 4:30 p.m. LVN D stated CNA E did not separate both residents, left the Resident 2's room to report to LVN D. Few minutes later when LVN D walked into Resident 2's room, LVN D noted privacy curtain was around Resident 2's bed, Resident 1 was laying in Resident 2's bed with no clothes waist down, naked. LVN D also stated Resident 2 was standing at the foot of the bed with fully clothes on, belt buckle undone. LVN D further stated Resident 1's waist down naked body and Resident 1's private area were exposed to Resident 2. LVN D confirmed there were no staff in the room when he arrived at Resident 2's room. LVN D also stated he was able to get help from another staff, separated both residents, dressed Resident 1 and made her to leave the room. LVN D also stated CNA E should not have left both male and female residents together in room without staff's presence before left the room report to him. LVN D further stated CNA E should have stayed with both residents or separated both residents to prevent sexual abuse altercation (a dispute or conflict involving sexual activity or interactions including inappropriate looking) between Resident 1 and Resident 2.</p> <p>During an interview with CNA E on 3/20/2025 at 3:55 p.m., with the presence of facility's director of staff development (DSD), CNA E stated she noticed Resident 1 sitting on Resident 2's bed, fully clothed. When CNA E tried to separate both residents, Resident 2 became aggressive, threatened to hit CNA E with belt and asked CNA E to leave the room. CNA E got scared, called for help, no staff came. CNA E left the room and walked to another unit to report to charge nurse (charge nurse was in other unit that time). CNA E also stated she did not separate both residents before she left to report to charge nurse. CNA E also stated she should have waited for help to come or separated both residents before she left Resident 2's room to prevent sexual abuse altercation between Residents 1 and 2.</p> <p>During an interview with DSD on 3/20/2025 at 4:14 p.m., DSD stated CNA E should have not have left Resident 1 and 2 in a room for Resident 1's safety and prevent sexual altercation. DSD also stated this sexual abuse altercation could have been prevented if CNA E did not leave Resident 2's room or separated Resident1 from Resident 2.</p> <p>During an interview with facility's assistant director of nursing (ADON) on 3/20/2025 at 4:20 p.m., ADON stated CNA E should not have left both male and female residents in a room together alone to prevent sexual altercation and safety of the female resident.</p> <p>(continued on next page)</p>		

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 06/04/2025
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)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with facility's director of nursing (DON) on 4/18/2025 at 1:32 p.m., nursing staff should have separated both residents to prevent and residents were free from sexual abuse altercations. Review of facility's policy and procedure (P&P) titled, Abuse Prevention Program, revised December 2016, the P&P indicated, Our Residents have the right to be free from abuse.		