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	06/26/2025

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement their discharge planning process in including residents for their preparation to effectively transition them to post-discharge care for two of three sampled residents (Residents 1 and 2). Resident 1 and 2's records did not contain discharge care plans, interdisciplinary team (IDT, members of healthcare team that meets to discuss and plan resident care) meeting note addressing discharge planning, and referrals being sent to and accepted from shelters (temporary housing) and home health agencies (organization that provides skilled nursing and other therapeutic services to individuals in their homes). This failure resulted in unsafe discharges and placed residents at health and safety risks. Resident 2 after discharge was found sleeping outside a liquor store and admitted to a hospital. Findings: Review of Resident 1's record indicated he had diagnoses including dementia (memory problem) with agitation, failure to thrive (progressive loss of physical and functional abilities, often accompanied by weight loss, poor appetite and inactivity) and anxiety (mental disorder). Review of Resident 1's hospital History and Physical Note, dated 9/21/24, indicated the resident was non-English speaking, had a history of behavior change, agitation and violent behavior against caregiver, had visual hallucinations (seeing images that are not actually present) and was highly suspicious for insidious progression of dementia. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 11/11/24, indicated his Brief Interview for Mental Status (BIMS) was 3, indicating he had severe cognitive impairment in daily decision-making skills. Resident 1's MDS, dated [DATE] and 1/23/25, indicated there were no active discharge plan for the resident to return to the community. Review of Resident 1's Psychosocial Note, dated 11/8/24 at 2:19 p.m., indicated Resident 1 was being taken care of by a longtime friend, became physically violent over the 10 years, hurt the friend/caregiver and the caregiver wanted no contact with Resident 1. Review of Resident 1's Psychosocial Note, dated 1/20/25 at 2:56 p.m., indicated the resident stated he would like to be back in his hometown community. (continued on next page)

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

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's Psychosocial Note, dated 1/21/25 at 11:12 a.m., indicated the resident had stated he would like to be transferred to a lower level of care, had no income, no family involved in care, and referrals were to be made to a home health agency and case manager for housing. Review of Resident 1's record did not contain discharge care plan, IDT discharge planning notes, referrals with information indicating resident status and acceptance from the shelter and home health agency. During an interview on 1/29/25 at 4:15 p.m., the regional social services director (RSSD) stated Resident 1 was discharged to a homeless shelter and the IDT met weekly discussing resident discharges. The RSSD also stated when a resident was being discharged there should be progress notes addressing discharge planning. During an interview on 3/27/25 at 12:30 p.m., the social services director (SSD) who documented Resident 1's Psychosocial Notes stated there should have been and were no discharge care plans, no IDT notes, no referrals and acceptances letter from shelters and home health agencies and no notes indicating resident participation in discharge planning. During a follow-up interview on 4/24/25 at 1:40 p.m., the RSSD stated as part of the discharge process the facility sends information such as resident history and physical, rehabilitation notes to shelters and home health agencies, and makes arrangements for sheltered individual as to where to meet for home services. When asked for supportive documentation the RSSD stated everything is done verbally over the phone. No discharge referral or documentation were provided. Resident 1's discharge documentation was requested from the assistant director of nurses (ADON) and/or SSD on 3/27/25, 4/24/25 and 5/15/25 and were not provided. Review of Resident 1's physician's order, dated 1/22/25, indicated the resident may be discharged to home with home health services. Resident 1 was discharged on 1/23/25 at 1:36 p.m. to a shelter. Review of Resident 1's face sheet (document that provides an overview of a residents' information and medical history) indicated the resident was readmitted to the facility on [DATE]. Review of Resident 1's Physician Note, dated 2/6/25 at 12:25 p.m., indicated Resident 1 was readmitted due to dementia and was unable to care for himself. During an interview on 1/30/25 at 11:50 a.m., a staff member (SM) A from Resident 1's shelter stated when residing in the shelter individuals needs to check in daily by 5 p.m. and leave the next day by 9 a.m. and if a person had problem behavior they may not have a bed to return to. The SM A also said the shelter rarely received referral or accepted admission of elderly skilled nursing residents, they are a red flag. 2. Review of Resident 2's record indicated he had diagnoses including alcohol-induced dementia and anxiety. Resident 2's MDS, dated [DATE] indicated his BIMs was 8, indicating he had moderate difficulty with daily decision-making skill. Resident 2's MDS, dated [DATE], indicated no to active discharge planning in returning to the community. (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's Psychosocial Note, dated 11/5/24 at 1145 a.m., indicated the SSD spoke to a Resident 2's family member who stated the family could not care for the resident at home and Resident 2 could not be in a facility that is not locked. Review of Resident 2's Psychosocial Note, dated 1/20/25 at 2:56 p.m., indicated the resident stated he would like to be back to his hometown community, his income was unknown, family uninvolved and the resident would be linked to county resources. Review of Resident 2's Psychosocial Note, dated 1/23/25 at 11:22 a.m., indicated the resident was informed he would be picked up at 9 a.m. (date not specified) for discharge. There was no documentation Resident 2 was informed in advance of where he was going, behavioral expectations of the shelter, and no documentation community resource information was provided. The record also did not contain a discussion indicating whether the resident could manage living in a community without income and social support and if he understood and would abide by the shelter's rules. Review of Resident 2's Psychosocial Note, dated 1/23/25 at 11:31 a.m., written by the RSSD, indicated a family member stated he did not want to be involved and to just call when the resident is dead. It also indicated the discharge plan was to educate Resident 2 upon discharge of resources in the community and to attend programs to help him find permanent housing and mental/behavioral help. There was no documentation Resident 2 was provided with community resource information besides the name and telephone number of the home health agency. Resident 2's record also lacked an assessment determining capability of obtaining assistance from community resources. Resident 2 was discharged from the facility to a shelter on 1/24/25 at 10 a.m. During an interview on 1/31/25 at 12:15 p.m., the regional clinical consultant (RCC) stated discharge planning began on admission, residents' capabilities, goals and interventions were to be identified and documented in progress or IDT notes. During an interview on 3/27/25 at 12:30 p.m., the SSD who documented Residents 2's Psychosocial notes except on the Psychosocial Note on 1/23/25 at 11:31 a.m., acknowledged there were no discharge care plans, IDT discharge planning notes, information of community resources provided, referrals and acceptances from shelters and home health agencies and no notes indicating resident participation in discharge planning. During an interview on 5/12/25 at 10:38 a.m., the administrator (ADM) stated the role of the ADM was to oversee residents' discharges were safe and to document ADM participation in resident progress and or IDT notes. The ADM stated he did not document discharge planning notes for Residents 1 and 2. During an interview on 5/14/25 at 2:30 p.m., the medical director (MD) stated did not know Resident 1 and 2 were discharged to shelters and given the residents' circumstances i.e., no income or family support the discharges may not have been safe. On 1/29/25, 4/24/25 and 5/15/25 the ADON and SSD were asked for discharge documentation i.e. faxed information to shelter and home health agency, community resources given to Resident 2 and were not provided. (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's Hospitalist Discharge summary, dated [DATE] at 11:42 a.m., indicated the resident was brought to the hospital after found sleeping outside a liquor store, he was gravely disabled (unable to obtain basic survival needs of food, clothing and shelter due to a mental health condition), he was currently homeless and complained about his living situation being out in cold weather and did not have any family or friends to turn to. Review of the Facility-Initiated Transfer or Discharge policy, dated October 2022, indicated a post-discharge plan was developed for each resident prior to his or her discharge. This plan was to be reviewed by a member of the interdisciplinary team with the resident at least 24 hours before discharge. Sufficient preparation and orientation for the resident prior to an immediate facility-oriented discharge included explaining to the resident where he/she was going and why, taking steps to minimize anxiety or depression, and nursing notes were to include documentation of appropriate orientation and preparation prior to discharge. The policy also indicated information were to be communicated included the basis for discharge, all special instructions or precautions for ongoing care such as comprehensive care plan goals, resident status, diagnoses and allergies, medications. Review of the Comprehensive Person-Centered Care Plans policy, revised in March 2022, indicated each resident had the right to participate in the planning process and in establishing goals and outcomes of care.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely notify a representative of the Office of the State Long-Term Care Ombudsman (an entity that serves as an impartial advocate for individuals or groups who have concerns or complaints about a particular organization) regarding discharges for two of two sampled residents (Residents 1 and 2). The facility faxed discharge notices on the day of discharge. This failure resulted in missed opportunities for an ombudsman to advocate if residents had concerns about their discharge. Findings: 1. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 11/11/24, indicated his Brief Interview for Mental Status (BIMS) was 3, indicating he had severe cognitive impairment in daily decision-making skills. Resident 1's Psychosocial Note, dated 1/20/25 at 2:56 p.m., indicated the resident would like to be back in his hometown community. Review of the Notice of Proposed Transfer/Discharge form dated 1/24/25 indicated the ombudsman's office was notified about Resident 1's discharge on [DATE]. Review of an Alert Note, dated 1/24/25 at 9:30 a.m., indicated Resident 1 was picked up by transport and discharged . 2. Review of Resident 2's MDS dated [DATE], indicated his BIMS was 8 indicating moderate cognitive impairment. Resident 2's Psychosocial Note, dated 1/21/25 at 11:12 a.m., indicated the social services director (SSD) met with the resident and the resident stated he would like to be transferred to a lower level of care. Review of an Alert Note, dated 1/23/25 at 1:07 p.m., indicated Resident 2 was discharged from the facility. During an interview on 3/27/25 at 11:13 a.m., the SSD who reviewed the discharge notices stated notices should not be sent on the day of discharge, going forward they will be sent earlier. The Transfer or Discharge, Facility-Initiated policy, dated October 2022, indicated under Notice of Transfer or Discharge (Planned) a copy of the notice was sent to the Office of the State Long-Term Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.