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	03/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safety for one of nine sampled resident (Resident 1). Resident 1 was evaluated and identified at risk for elopement (unauthorized and unsupervised departure from facility), the facility failed to develop a person-centered care plan (an individualized, collaborative document that focuses on a resident specific needs, goals, interventions, and preferences) and failed to implement person-centered interventions with effective strategies to prevent elopement for Resident 1. This failures resulted in Resident 1 eloped from the facility on 12/14/2025 and unable to locate Resident 1 as of 3/9/26. 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 12/10/2025. This FS also indicated Resident 1 was assigned to a conservator (a person appointed by a judge to manage the financial affairs, personal care or both for a resident who cannot care for him/herself due to physical or mental limitations).Review of Resident 1's diagnoses included paranoid schizophrenia (a chronic mental health disorder by intense, irrational delusions [false beliefs] and auditory hallucination [hearing voices and sounds in the absence of external stimulus, perceived as real sounds]), schizoaffective disorder, bipolar type (a chronic mental health condition combining hallucinations, delusions, and episodes of manic [elevated mood, high energy and activity] and depression [low energy and intense sadness], and history of stimulant abuse (medication or substances, not intended for use). Review of Resident 1's order summary report indicated an order for Depakote (a medication used to treat bipolar disorder) 2500 MG (milligrams, a unit of mass or weight, equal to one thousandth of a gram) by mouth at bedtime, dated 12/10/2025, olanzapine (antipsychotic medication [a class of medication capable of affecting the mind, emotions, and behaviors] used to treat schizophrenia) 10 MG every day, 20 MG at bedtime, and 5 MG every 24 hours as needed by mouth, dated 12/10/2025, Invega (antipsychotic medication used to treat schizophrenia) 234 MG/1.5 ML [milliliters, a unit of liquid equal to one thousandth of a liter]) intramuscularly [IM, injection used to deliver medication deep into specific muscles]) one time on 1/2/2026 for maintenance dose, dated 12/10/2025, and ziprasidone (antipsychotic medication used to treat schizophrenia) 80 MG by mouth two times a day, dated 12/10/2025.Review of Resident 1's minimum data summary (MDS, resident assessment tool) dated 12/14/2025, section C for brief interview for mental status (BIMS) indicated Resident 1's BIMS score of 12/15 (score of 0-7: severely impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition), moderately impaired cognition.Review of Resident 1's primary care physician (PCP, a medical doctor assigned as the first point contact for general health conditions and needs)'s documentation for Resident 1's history and physical, dated 12/11/2025 indicated, Resident 1 did not have capacity to understand and make healthcare decisions.Review of Resident 1's elopement evaluation dated 12/10/2025 indicated, elopement score value of 2 (score value of 1 or higher indicates, risk of elopement), Resident 1 was identified as at risk for elopement.Review of all documented care plans for Resident 1 indicated, there was no documented evidence of facility developed and implemented person centered care plan for risk for elopement with person-centered interventions and effective strategies to prevent elopement for Resident 1.Further review of Resident (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555831	A. Building B. Wing	03/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's clinical documentation of nurse's notes, MD's orders and electronic medication administration record (EMAR, an electronic system to track, manage, and document a resident's medication administration) during 12/10/2025 to 12/14/2025, while Resident 1 was in facility, indicated, there was no documented evidence of facility developed and implemented interventions and strategies to maintain safety and prevent elopement for Resident 1, who was identified as at risk for elopement on 12/10/2025.Review of Resident 1's change in condition (any significant physical, mental or functional condition change from a resident's baseline status) document dated 12/14/2025 indicated, at 4:45 p.m., facility's nursing staff noted Resident 1 was walking in courtyard, outside the facility's building (closed surroundings). At 5:20 p.m., a license nurse went to Resident 1's room to give scheduled medications, noted Resident 1 was not in room. Facility staff was not able to locate Resident 1 in the facility during the search conducted for Resident 1. Registered nurse A (RN A) informed facility's management (administrator and director of nursing) and local police department via telephone for missing Resident 1.Review of Resident 1's nursing alert note dated 12/14/2025, at 6:45 p.m., indicated, facility was contacted local hospitals (health care setting provides services for acutely ill, injured and emergency health conditions) near the facility via telephone. Facility was confirmed that Resident 1 was not admitted in any one of these hospital during this telephone communication with local hospitals.Review of Resident 1's nursing alert note dated 12/15/2025 at 2:20 p.m., indicated facility nursing staff searched downtown, local train station, liquor and gas stations, parks, and surrounding restaurants looking for Resident 1. This document also indicated, facility's staff was unable to locate Resident 1 during above searched areas.Review of Resident 1's nursing alert note dated 12/15/2025, at 4:25 p.m., indicated, facility staff was informed by local police department that, Resident 1 was remained missing person status, not been located Resident 1 yet.Review of facility's investigation summary report dated 12/19/2025 indicated, on 12/14/2025 at 8:07 p.m., conservator stated over the telephone to facility he (conservator) was not surprised by Resident 1's elopement from facility. This report also indicated on 12/15/2025 at 10:35 a.m., over the telephone, conservator informed facility, Resident 1 would most likely be found in downtown in front of a liquor store due to Resident 1's extensive history of substance abuse (medication or substances, not intended for use) and based on Resident 1's prior elopement episodes.During observation of facility with facility's maintenance director (MD) on 12/23/2025 at 3:06 p.m., noted, three separate and stand-alone buildings (Building 1, 2, and 3) with residents rooms and an open courtyard in middle of these three buildings. Right, left and back side of these buildings surrounded by locked metal fences, approximately 6 feet tall. Also noted one brick wall approximately 8 feet tall, right side in the front of the facility with locked iron gate.During an interview with facility's MD on 12/23/2025 at 3:06 p.m., MD stated facility ?s front entrance gate was locked all the times and only staff had the access in and out to the facility through this gate using a key. MD also stated facility was provided a gate key to all staff. MD further stated that this facility's surroundings were secured and no in and out access from facility for all residents. MD confirmed metal fences were 6 feet tall and brick wall was 8 feet tall. MD further stated courtyard in middle of three buildings was also secured.During an interview with facility's certified nursing assistant A (CNA A) on 12/29/2025 at 2:50 p.m., CNA A confirmed Resident 1 had a behavior of wandering (aimless walking or attempts to leave a safe area) in facility. CNA A was also confirmed Resident 1 was at risk for elopement. CNA A stated she was not aware how Resident 1 was eloped from the facility. CNA A stated nursing staff did not supervise or monitor Resident 1 on routine basis for wandering and risk for elopement.During an interview with CNA B on 12/29/2025 at 3:06 p.m., CNA B stated Resident 1 was at risk for elopement and behavior of wandering. CNA B also stated only way Resident 1 could have had left the facility by jumped off the metal fence and walked away from facility since it was dark that evening on 12/14/2025. CNA B confirmed there was no continuous supervision and monitoring for wandering to prevent elopement provided by nursing staff for Resident 1. CNA B stated nursing staff should have monitored, supervised closely, and prevented elopement for Resident 1. During an interview with facility's (continued on next page)

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	03/09/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed vocational nurse C (LVN C) on 12/29/2025 at 3:12 p.m., LVN C confirmed Resident 1 was identified as at risk for elopement when admitted to facility on 12/10/2025. LVN C also confirmed Resident 1 had behavior of wandering in facility. LVN C further confirmed there were no documented evidence for facility developed and implemented interventions for monitoring and supervision to prevent Resident 1's elopement. LVN C stated Resident 1 was observed wandering in courtyard one hour before Resident 1 was eloped from facility on 12/14/2025. LVN C also stated Resident 1 could have jumped out of the metal fence and left the facility. LVN C further stated Resident 1 was tall, thin build and capable of jumping off the fence. LVN C further stated it was dark outside around 5 p.m. on 12/14/2025 could be the reason for staff were not able to notice when Resident 1 eloped from facility. LVN C stated this elopement could have been prevented if nursing staff were supervised and monitored Resident 1's where abouts on regular basis. During an interview with facility's director of nursing (DON) on 12/29/2025 at 3:58 p.m., DON confirmed Resident 1's nursing evaluation for at risk for elopement, dated 12/10/2025 indicated, Resident 1 was at risk for elopement. DON also confirmed no documented evidence of facility developed and implemented interventions for continuous, scheduled supervision and monitoring as needed to prevent elopement for Resident 1. DON stated nursing staff should have supervised, monitored and documented interventions and strategies to maintain safety and to prevent elopement for Resident 1. DON also stated elopement could be prevented if facility staff provided scheduled supervision and monitoring for Resident 1. DON further stated facility unable to identify how Resident 1 was eloped from facility on 12/14/2025 and facility was unable to locate Resident 1 since then. During a concurrent record review of Resident 1's all documented care plans and interview with facility's DON on 12/29/2025 at 4:05 p.m., DON confirmed there was no person centered care plan for at risk for elopement when facility identified Resident 1 was at risk for elopement on 12/10/2025. DON stated license staff should have developed and implemented a person centered care plan for at risk for elopement with interventions and strategies to maintain safety and prevent elopement for Resident 1 on 12/10/2025.During an interview with facility's assistant director of nursing (ADON) on 3/9/2026 at 3:29 p.m., ADON stated they cannot locate Resident 1.Review of facility's policy and procedure (P&P) titled, Wandering and Elopement, revised March 2019, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.Review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.