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	05/01/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include specific and resident-centered interventions in the post fall care plan in a timely manner for 1 of 2 sampled residents (Resident 1).This failure put Resident 1's at risk for potential fall and injury. Findings:Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), mild intellectual disability (limitation in mental functioning and skills), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and muscle weakness, and cognitive communication deficit (difficulty in communication). Review of X-ray of left shoulder on the day admission [DATE]) indicated, a degenerative change (a natural, age-related wear and tear body tissues such as joints and cartilage over time).Review of Resident 1's minimum data set (MDS, a federally mandated resident assessment tool) dated 3/20/26 indicated his brief interview for mental status score (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 6 which means he had a severe cognitive impairment (profound problems in remembering things, concentrating, making decisions and solving problems). He had no impairment of both upper arms and lower legs but needed some partial assistance in using toilet from another person. He used wheelchair to translocate from one location to another. Review of Resident 1' Fall Risk Assessment (FRA, an assessment to determine a resident's risk of falling) dated 3/21/26, indicated he had a score of 15 which means he was at high risk for potential fall. Review of Resident 1's medical record indicated that Resident 1 had the first incident of unwitnessed fall on 3/23/26 at 2:15 p.m. in facility's courtyard. Resident 1 was found lying in prone position. Resident 1 was transferred to the hospital by Physician's order for further evaluation and treatment. Resident 1 sustained contusion of right knee. Review of Resident 1's FRA after the unwitnessed fall on 3/23/26 indicated a score of 11 which means he was at high risk for potential fall. Review of Resident 1's second incident of unwitnessed fall at the facility indicated that on 3/27/26 at 10:30 p.m., during initial round of Licensed Vocational Nurse A (LVN A) Resident 1 was found face down on the left side of his bed. There were no injuries observed. LVN A asked Resident 1 what happened, Resident 1 stated I don't know, I've been here for a while. Review of Resident 1's post fall care plan after the incident of second fall dated 3/27/26 indicated, will prevent Resident 1 injury through individualized care plans, ensuring a safe environment and educating Resident 1/families to manage risk. Monitor vital signs, neurological assessment, assess for any injuries, assess cause of fall incident and conduct a comprehensive fall risk assessment. The care plan did not include additional specific/detailed resident-centered interventions to prevent potential fall from happening again. Review of Resident 1's medical record indicated that an updated post fall comprehensive resident-centered care plan with specific interventions was developed/created by the facility on 4/2/26, 6 days after Resident 1's second episode of fall on 3/27/26.Review of Resident 1's medical record indicated that on 4/1/26 at 2:19 p.m., Resident 1 had third incident of witnessed fall in the common bathroom. Resident 1 fell on the floor facing forward from wheelchair. Resident 1 sustained scratch on right cheek and complained of dizziness. Resident 1 was sent to hospital for (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
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation. Resident 1 did not remember what happened on the fall incident on 4/1/26.During an interview with the Certified Nursing Assistant B (CNA B) on 4/6/26 at 1:24 p.m., stated she was assisting Resident 1 in the common bathroom for toileting. Resident was sitting in a wheelchair, but his upper body was leaning forward with his buttocks situated on the edge of the wheelchair. CNA B supported Resident 1's upper body with both CNA B's hands from the back of wheelchair. CNA B tried to assist and encouraged Resident 1 to straighten his body and scoot back to prevent sliding from wheelchair but Resident 1 was resistive and uncooperative. CNA B immediately called for help from another staff. CNA C and another staff immediately came for help but Resident 1 already slid from the wheelchair to the floor. Resident was transferred to the hospital for evaluation. Review of Resident 1's Hospital Discharge summary dated [DATE] indicated discharge diagnoses that included Anterior (front side) dislocation of left shoulder. A successful closed reduction (medical procedure used to return a dislocated joint) of left shoulder was done on the same day on 4/1/26.Review of the subsequent X-ray of Resident 1's left shoulder dated 4/7/26 indicated there was no acute facture or dislocation. Mild osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage).During an interview and review of Resident 1's medical record with the Assistant Director of Nursing (ADON) on 4/13/26 at 9:41 a.m., she confirmed there was no specific/detailed resident-centered care plan developed by the facility after Resident 1's fall on 3/27/26 prior to falling again on 4/1/26. She acknowledged new specific interventions should have been created and included in the post fall care plan for Resident 1.During an interview and review of Resident 1's medical record with the Director of Nursing (DON) on 4/13/26 at 10:18 a.m., she confirmed there was no additional specific/detailed resident centered care plan interventions developed by the facility on 3/27/26 to minimize or prevent the risk of Resident 1's from falling again on 4/1/26. DON acknowledged the facility should have updated and developed a resident-centered care plan after the fall on 3/27/26.Review of the revised facility's policy and procedure dated 03/2018 titled, Managing Falls and Fall Risk indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try minimizing complications from falling . If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. Review of the revised facility's policy and procedure dated 3/12/21 titled, Job Description: Licensed Vocational Nurse indicated, contributes to formulation /review of nursing care plans weekly and PRN (as needed).