

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/25/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent one of 17 sampled residents (Resident 82) from multiple falls from August 2024 to May 2025 when:1. Resident 82 had a total of nine fall incidents as follows: a. Unwitnessed fall on 8/20/24 at 10:00 a.m. with no injuryb. Unwitnessed fall on 11/11/24 at 1:34 p.m. resulting to injury (abrasion-a superficial scrape or wound to the skin or other body tissue, caused by rubbing or friction against the surface) to right knee.c. Unwitnessed fall on 12/5/24 at around 11:00 a.m. with no injuryd. Unwitnessed fall on 4/12/25 at 12:30 a.m., with low spine back pain and swelling on the [NAME]. Two unwitnessed falls on 4/24/25 at 7:30 a.m. and 3:30 p.m. with no injuries notedf. Unwitnessed fall on 5/1/25 at 12:59 p.m. with major injury resulting to a compression fracture (type of bone fracture that occurs when a vertebra (bone in the spine) is crushed or compressed) of the first lumbar vertebra (L1, a bone in the lower back) requiring hospitalization on 5/3/25.g. Unwitnessed fall on 5/6/25 at 12:15 p.m., with no injury.h. Unwitnessed fall on 5/9/25 at 6:42 a.m., with no injury.2. The facility did not develop Resident 82's resident-centered care plan (short term care plan, an individualized care document created to focus on the unique needs specific to the resident's fall incident situation) on 8/11/24, 11/11/24; and did not update Resident 82's comprehensive care plan (long-term care plan, a detailed document that outlines a resident's healthcare goals, interventions, and expected outcomes that serves as a roadmap for coordinating and managing resident's care across various healthcare settings and providers) when Resident 82 had fall incidents on 8/11/24, 11/11/24, 4/12/25, 5/1/25, 5/6/25 and 5/9/25 fall incidents.3. The facility did not implement the post-fall rehabilitation assessment recommendations dated 4/14/25 to perform Physical therapy (PT, healthcare practice that uses physical interventions to improve mobility, reduce pain and restore function after an injury or illness) evaluation, and ST (speech therapy, healthcare profession that focuses on evaluating and treating disorders related to speech, language and communication) evaluation, and the Interdisciplinary Team (IDT, staff from different disciplines who work together to plan and provide care) recommendations on 4/13/25 for physical therapy and referral to social services for psychological support for behavior management after an unwitnessed fall incident that occurred on 4/12/25 that resulted to low back pain with swelling.4. The facility did not implement the Fall Risk Evaluation- Actioned/Clinical Suggestions dated 4/12/25 to provide rubber-soled shoes (footwear where the bottom part (the sole) is made from rubber, a flexible and durable material that provides excellent traction, cushioning, and water resistance) or non-skid slippers (footwear designed to prevent or reduce slips, trips, and falls), for ambulation and utilize personal/pressure sensor alarms (a safety device that creates a loud sound or sends an alert to staff when resident gets out of bed).5. Resident 82's Fall Risk Evaluation and Post Fall Evaluation dated 5/1/25, and the Post Fall Evaluation on 5/6/25 were incomplete and inaccurate.6. There was no IDT conference record - Fall Management Follow - up or IDT conference notes meeting after two episodes of unwitnessed fall incidents on 4/24/25 (one fall happened at 7:30 a.m. and another at 3:30 p.m.).7. The IDT did not identify the specific risk/causative factors that may have contributed to each of Resident 82's fall incidents, and to monitor whether the interventions (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555831	Facility ID: 555831 If continuation sheet Page 1 of 34

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were effective to prevent falls from recurring. These failures placed Resident 82 at continued risk for falls, resulting to nine fall incidents, from August 2024 to May 2025. Resident 82 had a unwitnessed fall on 5/1/25 with a compression fracture (type of bone fracture that occurs when a vertebra (bone in the spine) is crushed or compressed) of the first lumbar vertebra (L1, a bone in the lower back) requiring hospitalization on 5/3/25. Findings: A review of Resident 82's Face Sheet (summary page of a patient's important information), he was admitted to the facility on [DATE] and re- admitted on [DATE] with diagnoses including Dementia (a progressive state of decline in mental abilities), Schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior), anxiety disorder (medical condition includes symptoms of intense anxiety or panic that are directly caused by a physical health problem), lack of coordination, abnormalities of gait (a person's manner of walking) and mobility. Review of Resident 82's MDS since admission on [DATE], and prior to his fall on 4/12/25, indicated he had a Brief Interview for Mental Status (BIMS, an assessment tool for cognition) score of 13 (a score of 13 to 15 indicates the resident is cognitively intact). Review of Resident 82's Quarterly MDS, Section GG (function and mobility assessment) dated 2/28/25, indicated Resident 82 had weakness in both lower extremities (legs, ankles, feet). He required partial/moderate assistance with sit-to-stand and bed-to-chair transfers, substantial/maximal assistance (requires staff to provide more than half the effort) with tub/shower transfer and walking 10 feet was not attempted due to medical or safety concerns. The MDS further indicated he was independent in propelling his wheelchair at least 50 feet with two turns, and 150 feet in a corridor. Review of Resident 82's Comprehensive Fall Risk Care Plan (CP) initiated on 12/5/24 indicated Resident 82 was at high risk for falls due to: confusion, gait/balance problems, lower extremity weakness, impaired communication, dementia, schizoaffective disorder, psychoactive medications (drug that alter brain function and produces changes in mood, perception, behavior, or consciousness) and abnormal mobility. 1. a Review of Resident 82's Post fall Evaluation, dated 8/20/24, indicated resident was found at 10:00 a.m. lying on his left side. 1. b Review of Resident 82's Post Fall Evaluation dated 11/11/24, indicated he had an unwitnessed fall on 11/11/24 at 1:34 p.m. at the courtyard resulting to injury (abrasion-a superficial scrape or wound to the skin or other body tissue, caused by rubbing or friction against a surface) to right knee. 1. c Review of Resident 82's SBAR dated 12/5/24 indicated around 11:00 a.m., Certified nursing assistant (CNA) reported to licensed nurse that Resident 82 was found sitting on the floor next to his wheelchair in the hallway and he stated that he slides from his wheelchair. 1. d Review of Resident 82's Change of Condition (COC) dated 4/12/25 indicated, @ [at] 12:30 a.m., the patient had an unwitnessed fall near his bedside. He explained he fell because he tried to walk. When CNA came into his room, he was found in the prone position with his head and neck rising above the floor. He c/o [complained of] back pain in the lower back near the spine with the pain level 8 out of 10 [pain level of 7-10 indicates severe pain] . 1. e Review of Resident 82's Rehab (Rehabilitation) Post-Fall/Incident Assessment, dated 4/28/25, indicated that Resident 82 had two unwitnessed falls on 4/24/25 at 7:30 a.m. and 3:30 p.m. Both falls occurred next to Resident 82's wheelchair when he tried to get up and walk. 1. f Review of Resident 82's Situation, Background, Assessment, Recommendation (SBAR, an assessment tool used to facilitate prompt and appropriate communication of a problem), dated 5/01/25 indicated, Resident 82 was found sitting on the floor, trying to stand up and he slid on the floor and was assisted back to his wheelchair by one CNA after licensed nurse did the head - to-toe assessment. During a concurrent interview and record review on 8/25/25 at 4:36 p.m., with the Director of Nursing (DON), the DON reviewed Resident 82's SBAR and verified Resident 82 had a fall on 5/1/25, was sent out to acute hospital on 5/3/25 due to increased lower back pain. Resident 82's acute hospital CT (Computed tomography, a detailed x-ray of bones) done on 5/3/25 indicated, Acute fracture of the L1 superior endplate (top surface of L1 vertebra) with 20% loss of height and 2 mm (millimeter, unit of measurement) retropulsion (a bone fragment has pushed backward). Review of Resident 82 Discharge Summary from the acute hospital, dated 5/3/25, indicated that Resident 82 had CT scan (Computed tomography, a detailed x-ray of bones, soft (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	tissues, organs and blood vessels). The CT scan indicated an acute fracture of the L1 superior endplate (top surface of L1 vertebra) with approximately 20% loss of height and 2 millimeters of retropulsion (a bone fragment has pushed backward).Review of the Minimum Data Set (MDS, a standardized assessment tool), Significant Change in Status assessment dated [DATE], indicated Resident 82 now needed supervision or touching assistance to propel his wheelchair 50 feet with two turns, and 150 feet in a corridor.Review of Resident 82's Provider Follow up Note progress notes, dated 8/14/25, indicated that Resident 82 had mobility and daily activity impairments after the lumbar fracture from previous falls. Resident 82 now has gait impairment, deconditioning (a state of reduced physical fitness and functional capacity that occurs as a result of prolonged inactivity or disuse and generalized weakness. 1. g Review of Resident 82's SBAR progress notes, dated 5/6/25, indicated Resident 82 was found lying on the floor in the facility's lobby. Resident 82 denied the pain or hitting his head, and no injuries were noted.1. h Review of Resident 82's SBAR progress notes, dated 5/9/25, indicated Resident 82 had another unwitnessed fall in his room while attempting to self-transfer from bed to wheelchair without calling for help. No injuries were noted.During a concurrent interview and record review on 8/25/25 at 2:30 p.m. with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 82's clinical records and confirmed that Resident 82 had multiple falls on 8/20/24, 11/11/24, 12/5/24, 4/12/25, 4/24/25 (two falls), 5/1/25, 5/6/25, and 5/9/25.2. During a concurrent interview and record review with the ADON on 8/25/25 at 3:51 p.m., the ADON acknowledged there was no short-term care plan developed after the fall on 8/20/24 and 11/11/24. The ADON stated, the charge nurses are responsible for creating the actual fall care plan or short-term care plan after each episode of fall. The ADON upon further review of Resident 82's care plans, she confirmed the comprehensive care plan was not updated when Resident 82 fell on 8/20/24,11/11/24, 4/12/25, 5/1/25, 5/6/25 and 5/9/25. The ADON stated, the IDT were responsible for updating the comprehensive care plan and add new interventions after each episode of fall. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 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.The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Review of the facility's revised policy dated 3/2022, titled Care Planning-Interdisciplinary Team, indicated the interdisciplinary team is responsible for the development of the resident care plans. The comprehensive person-centered care plans are based on resident assessments and developed by an Interdisciplinary Team (IDT).3. Review of Resident 82's Change of Condition (COC) dated 4/12/25 indicated, @ [at] 12:30 a.m., the patient had an unwitnessed fall near his bedside. He explained he fell because he tried to walk. When CNA came into his room, he was found in the prone position with his head and neck rising above the floor. He c/o [complained of] back pain in the lower back near the spine with the pain level 8 out 10 [pain level of 7-10 indicates severe pain] . During a concurrent interview and record review on 8/25/25 at 3:45 p.m., with the ADON, she reviewed Resident 82's Post fall evaluation dated 4/12/25 and indicated Resident 82 had unwitnessed fall with injury - had pain in the lower back over the spine with swelling in his back measuring 2 centimeters (cm, unit of length) in length by 1 cm. width by 0.2 cm depth and the location of fall was in his room because he wanted to get up to walk.During an interview and concurrent record review with the director of nursing (DON) on 8/25/25 at 5:20 p.m., the DON confirmed Resident 82 had an unwitnessed fall on 4/12/25. The DON reviewed the IDT Conference Record dated 4/13/25, it indicated interventions to include Physical Therapy (PT) and referral to social services for psychosocial support for behavior management. The DON confirmed the PT was not done and it was ordered on 5/9/25. Review of Resident 82's Rehabilitation Post - Fall /Incident Assessment, done on 4/14/25, it indicated the following: Resident 82 had an unwitnessed fall that occurred in the resident's room and attempting to get up and walk. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Injury details: lower back pain with swelling. Resident 82 could not recall details of the incident, bed mobility level of assistance is limited, does not demonstrate proper safety techniques during transferring task, could not demonstrate proper safety techniques during task, could not use call light properly, could not recall and demonstrate the proper use of call light after one hour, does not have a proper safe sitting/standing balance, does not demonstrate sufficient strength and correct posture while setting, preferred to ambulate using his own wheelchair against the therapist recommendations, using wheelchair for ambulation and transfers. The assessment also included, Recommendations: PT evaluation and ST evaluation. During a phone interview on 8/25/25 at 5:27 p.m., with the Regional Director of Rehabilitation (RDR), the RDR stated, Physical Therapy could only do PT evaluation and treatment if we received an order from the attending physician for Physical therapy treatment and evaluation. The RDR also stated she was not aware of an order for PT and ST evaluation after Resident 82 had a fall on 4/12/25. She also stated, Nursing staff did not communicate to her that PT and ST evaluation should be done. The RDR further stated PT staff cannot evaluate or treat Resident 82 without an order for PT evaluation. During a concurrent interview and record review on 8/25/25 at 5:41p.m., with the Social Service Director (SSD) she reviewed Resident 82's IDT Conference Record Fall Management Follow-Up notes, dated 4/13/25 that indicated Resident 82 had a fall on 4/12/25. One of the interventions included Referral to social service for psychosocial support for behavior management and recommendations included Social Service Consult. The SSD stated she was not present during the IDT conference on 4/13/25, and no one informed her about the interventions and recommendations for social referral and social service consultation. Review of the facility's policy dated 3/2018, titled Falls and Fall Risk, Managing, indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and cause to try to prevent the resident from falling and try to minimize complications from falling. The staff with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors (s) of falls for each resident at risk or with a history of falls. 4. Review of Resident 82's Fall Risk Evaluation, dated 4/12/25, he had a balance problem while walking, decreases muscular coordination, change in gait pattern when walking through doorway, jerking or unstable when making turns, requires use of assistive device (walker, wheelchair), balance problem while standing and fall risk score was 14 (high risk of falling). The fall risk evaluation included Clinical Suggestions such as: Utilize personal/pressure sensor alarms and rubber soled or non-skid slippers. During an observation on 8/18/25 at 9:28 a.m., Resident 82 was in his room, lying in bed watching TV and verbally responsive. Resident 82 stated he's okay. Noted with landing pad at the left side of bed, and sitter at bedside. There were no personal/pressure sensor alarms seen attached to bed. During a concurrent interview and record review with the ADON on 8/25/25 at 3:24 p.m., the ADON stated, rubber-soled shoes or nonskid slippers worn for ambulation and utilize personal/pressure sensor alarms should have been included as interventions for fall prevention in the IDT and care plan. The ADON further stated, if the intervention was not placed in the care plan, it was not done. Review of the facility's policy dated 3/2018, titled Falls and Fall Risk, Managing, indicated, Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist staff in identifying patterns and routines of the resident. 5. During a concurrent interview and record review with the ADON on 8/25/25 at 4:23 p.m., the ADON reviewed Resident 82's Post Fall Evaluation, dated 5/1/25. The ADON acknowledged this evaluation was incomplete and inaccurate. The ADON verified the missing entries about the location and reason for the fall including the pre (before) and post (after) Fall Risk Score. The ADON stated this evaluation should be complete with no entries left blank. The ADON also verified the Fall Risk Evaluation dated 5/1/25 was inaccurate with a Fall risk score of 9 (a score of 10 and above is high risk) instead of 15 because the question regarding the history of falls in the past three months- the response was b indicating 1-2 falls in past 3 months. The correct response should be c which is 3 or more falls in past 3 months. The assessment also inaccurately responded, No in the item: Change in Condition in the last 14 days. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The ADON verified there was a change in condition when Resident 82 had a fall on 4/24/25 (about 7 days before this assessment/evaluation). The Fall Risk Evaluation also indicated, if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented in the care plan. Further review with the DON on 8/25/25 at 4:38 p.m., the Post Fall Evaluation, dated 5/6/25, the DON confirmed the date and time of fall, reason for the fall, and pre and post fall risk scores were left blank. The DON stated all the areas in this assessment for the Post fall Evaluation should have been completed. 6. Review of Resident 82's Rehab (Rehabilitation) Post-Fall/Incident Assessment, dated 4/28/25, indicated that Resident 82 had two unwitnessed falls on 4/24/25 at 7:30 a.m. and 3:30 p.m. Both falls occurred when resident was found next to his wheelchair when he tried to get up and walk. During a concurrent interview and record review with the ADON on 8/25/25 at 10:40 a.m., the ADON confirmed there was no IDT Conference Record/Fall Management Follow up conducted after Resident 82 fell twice on 4/24/25. The ADON stated after each fall the facility should conduct an IDT care conference/meeting to know what interventions the resident needs and IDT would do an investigation to find the root cause of the fall/s. She also stated the IDT care conference for fall management should have been done because this is part of our policy and procedure. 7. During an interview with the ADON on 8/25/25 at 10:40 a.m., the ADON stated, every fall we conduct an IDT conference, to know what interventions the patient needs, we should do the IDT investigation to find the root cause. The ADON upon review of Resident 82's clinical records could not find any documented evidence that the causes or risk factors for Resident 82's falls were identified and discussed by the IDT to help prevent further fall episodes or injuries. The ADON further stated, the IDT are responsible for updating the comprehensive care plan, we should have added new interventions with each episode of fall and remove interventions if it did not work. Further review with the DON on 8/25/25 at 4:38 p.m., the Post Fall Evaluation, dated 5/6/25, the DON confirmed the date and time of fall, reason for the fall, and pre and post fall risk scores were left blank. The DON stated all the areas in this assessment for the Post fall Evaluation should have been completed. Review of the facility's policy dated 3/2018, titled Falls and Fall Risk, Managing, indicated Based on previous evaluations and current data. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to maintain a clean home-like environment, placing residents at risk for low self-esteem and living in an unkempt environment when: 1.Toilet room next to Resident 74 ?s Room, smelled feces and has feces on top of the toilet seat with smeared brownish substance around the toilet seat, toilet paper on top of the toilet seat and scattered small pieces of toilet paper on the toilet floor; and 2. Resident 73,74 and 76's window blinds were broken. Findings:1.During an initial tour of the facility on 8/18/25 at 9:25 a.m., toilet room next to Resident 74 ?s room observed with feces top of the toilet seat approximately 9 centimeters (cm, unit of measurement) and has smeared brownish substance around the toilet seat, and one piece of toilet paper was on top of the toilet seat and scattered small pieces of toilet paper on the toilet floor .During a concurrent observation and interview on 8/18/25 at 9:30 a.m., with the Activity Director (ACTD), she confirmed the above observation and stated that housekeeper and nursing staff were responsible for cleaning the toilet.During interview on 8/21/25 at 11:26 a.m., with the Environmental Services/Account manager (ESAM), he acknowledged the above observation and stated that the toilet seat cover should have been cleaned by the facility staff, should be free from feces odor, feces or other dirty substances. The ESAM further stated that the facility should provide a homelike environment to the residents in the facility.2. During an initial tour of the facility on 8/18/25 at 9:22 a.m., observed Resident 73,74 and 76's window blinds were broken.During a concurrent observation and interview on 8/20/25 at 10:36 a.m., with the Director of Maintenance (DOM), he acknowledged the above observation and stated Resident 73,74 and 76's window blinds need to be replaced.Review of the facility's Policy & Procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, Resident are provided with a safe, clean comfortable and homelike Environment .The facility staff and management maximizes, to the extent possible , the characteristics of the facility that reflect a personalized homelike setting that includes Clean, sanitary and orderly Environment ,personalized furniture and room arrangement .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that 3 of 6 sampled residents (Residents 1, 15 and 37) were free from unnecessary medications, when:1. Resident 1 and Resident 15 were prescribed the psychotropic medication (medications that affect the mind, emotions, and behavior) Lorazepam without an end date; and2. Resident 37 was prescribed Haldol (antipsychotic medication, used to treat nervous, emotional, and mental conditions), but did not have the specific indication or behavioral manifestation for its use. These failures resulted in residents receiving unnecessary medications and had the potential to affect their clinical conditions negatively. Findings: A review of Resident 1's medical record indicated that he was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM, a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to maintain normal blood sugar levels), schizophrenia (a brain disorder that affects how a person thinks, feels, and behaves), schizoaffective disorder (a mental health condition that includes symptoms of both schizophrenia and a mood disorder), and dementia (a decline in memory, thinking, and reasoning severe enough to interfere with daily life) with psychotic disturbance. A review of Resident 1's physician orders dated 8/21/25 indicated that lorazepam oral tablet 0.5 mg (milligram, a unit of measurement for weight in the metric system) &mdash; administer one tablet by mouth every 4 hours as needed for anxiety manifested by agitation/restlessness; no end date due to end-of-life care; start date 8/21/2025. A review of Resident 15's medical record indicated he was admitted to the facility in 4/5/2024 with diagnoses including type 2 DM, schizoaffective disorder (bipolar type), major depressive disorder, and generalized anxiety disorder. A review of Resident 15's physician orders dated 2/10/25 indicated that Lorazepam oral concentrate 2 mg/mL (milligram/milliliter)&mdash; administer 0.5 mL by mouth every 4 hours as needed (PRN) for inability to relax, agitation, or anxiety; no end date due to end-of-life care; start date 2/10/2025. During a concurrent interview and record review with the Director of Nursing (DON) on 8/25/2025 at 1:29 p.m., the DON reviewed the Medical records for both Residents 1 and 15. She stated that PRN psychotropic medications, such as Lorazepam, should be limited to 14 days. During a phone interview with the facility consultant pharmacist (CP) on 8/25/2025 at 1:55 p.m., the CP stated that PRN psychotropic medications, including Lorazepam, need to include an end date, usually within 14 days, unless the prescribing physician justifies an extended duration. A review of the facility's Psychotropic Medication Use, revised July 2022, indicated psychotropic medications are not prescribed or given on a PRN basis unless that the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN order for psychotropic medications are limited to 14 days. Review of Resident 37's Face Sheet (summary page of a patient's important information) indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including Schizophrenia (a chronic mental health condition that affects a person's thoughts, perceptions, and behaviors), Anxiety (continued on next page)		

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness), Depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). Review of Resident 37's Physician's Order, dated 7/24/25, indicated Haloperidol (Haldol) 20 milligrams (mg, unit of weight), give 1 tablet by mouth two times a day for Schizophrenia. During a concurrent interview on 8/21/25 at 4:05 p.m., the Assistant Director of Nursing (ADON) stated that psychotropic medication orders should include the indication for use, including the target behavior or symptom. The ADON stated that Resident 37's order should include the specific behavior or symptom for the use of Haldol.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for four out of twenty-five sampled residents, (Residents 12, 36, 72, 73 and 76), when:1. For Resident 12, there was no care plan developed for her use of antibiotic;2. For Resident 36, Fall comprehensive care plan was not developed, and the short-term care plan was not person- centered;3. For Resident 72, the comprehensive Smoking Care plan was not initiated on time and was not person- centered;4. For Resident 73, the Fall comprehensive care plan was not initiated on time and the short-term care plan was not person centered; and 5. For resident 76, there was no pain care plan developed for her Lidocaine External patch 5 % patch (used to provide targeted pain relief by numbing the area where they are applied, medication, a local anesthetic, works by blocking nerve signals from reaching the brain).These failures had the potential to result in residents not receiving the interventions and monitoring necessary to maintain their highest level of well-being and failures to develop and/or follow care plans had the potential of not meeting the care needs of the residents. Findings: 1.During the observation of Resident 12 on 8/21/25 at 1:05 p.m., Resident 12 was sitting in her wheelchair outside in the smoking area, alert, comfortable and verbally responsive. Review of Resident 12's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 12 was readmitted to the facility on [DATE] with diagnoses including unspecified schizophrenia (serious mental health condition that affects how people think, feel and behave), unspecified bipolar disorder (mental health condition that causes extreme mood swings that include emotional highs, called mania and lows, known as depression) and adult failure to thrive (condition characterized by significant unintentional weight loss, muscle wasting and decreased activity levels in older adults). Review of Resident 12's order summary report dated 8/12/25 indicated, Resident 12 had an order Rifaximin (Xifaxan, antibiotic used to treat specific conditions of the digestive system) 550 milligrams (mg, unit of weight) oral tablet, give one tablet by mouth two times a day for liver disease (also known as hepatic disease is any of many diseases of the liver often manifested by swelling of the abdomen and legs and bruising easily), ordered and started on 3/17/25. Review of Resident 12's care plans indicated, she did not have a care plan for her use of Rifaximin for liver disease. During the concurrent review of Resident 12's care plans and interview with the minimum data set coordinator H (MDSC H, specially trained nurse who works primarily in long-term care facilities, assessing residents' needs, developing care plans and collaborating with a team of healthcare professionals to ensure comprehensive care) on 8/21/25 at 2:50 p.m., MDSC H verified that Resident 12 did not have a comprehensive, person-centered care plan for her use of the antibiotic for liver disease, and she should have one. MDSC H further verified that she would check on this concern. During the interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., the DON verified that Resident 12 should have a comprehensive, person-centered care plan for her use of antibiotic and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would follow up on it. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 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. The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. During an initial tour of the facility on 8/18/25 at 9:26 a.m., Resident 36 was sitting in his wheelchair, and was screaming inside his room. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 8/21/25 at 9:00 a.m., the ADON reviewed Resident 36's clinical records, and she stated Resident 36 was admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis of Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), adjustment disorder with anxiety (medical condition includes symptoms of intense anxiety or panic that are directly caused by a physical health problem) and Type 2 diabetes mellitus (high blood sugar). ADON reviewed the Comprehensive Care plans (CP) ADON confirmed that there was no Fall comprehensive care plan initiated on 2/7/25 when Resident 36 was admitted but fall risk short term care plan was initiated on 6/20/25 and was not person-centered. The ADON further stated that a comprehensive, person-centered care plan for fall should have been initiated due to Resident 36's history of multiple falls. 3. Review of Resident 72's clinical record indicated she was admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis of Schizoaffective disorder, Bipolar type, muscle weakness, Chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe) and other symptoms and signs involving cognitive functions and awareness. Resident 72's minimum data set (MDS, an assessment tool) dated 6/18/25 indicated her cognition (ability to remember, judge and use reason) with a brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 moderately impaired cognition. During a concurrent interview and record review on 8/20/25 at 11:55 a.m., with the ADON, the ADON reviewed the Comprehensive Care plans and confirmed that there was no smoking comprehensive care plan initiated when Resident 72 was admitted on [DATE], the smoking CP was initiated on 11/04/24 and not a person-centered CP. The ADON further stated Resident 72 should have a comprehensive, person-centered care plan initiated for smoking for Resident 72's safety when smoking. 4. Review of Resident 73's clinical record indicated he was admitted to the facility on [DATE] with diagnosis of Multiple sclerosis (a disease affecting the brain and spinal cord that disrupts the communication of the brain and the rest of the body), lack of coordination, depression (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning) and abnormalities of gait and mobility. Resident 73's MDS dated [DATE] indicated her cognition with a BIMS (brief interview for mental status, an assessment (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for cognition) score of 9 was moderately impaired cognition. During a concurrent interview and record review with the ADON on 8/21/25 at 1:29 p.m., the ADON reviewed resident 73's fall comprehensive care plan and she confirmed there was no comprehensive CP initiated when Resident 73 was admitted on [DATE], it was initiated on 2/13/25 due to history of falls in the facility and has short term fall care plan initiated on 8/4/25 after an unwitnessed fall. During a concurrent interview and record review with the Regional Quality Assurance and the MDS Consultant (RQA/MDSC), both staff reviewed Resident 73's fall care plan dated 8/4/25 and confirmed that Fall care plan was not person-centered care planning. The RQA/MDSC stated Resident 73 had unwitnessed fall on 8/4/25, after each fall, the licensed nurses need to reassess or do a fall risk evaluation, care plan for fall dated formulation or care planning interventions relevant to fall management must be conducted once a resident has been identified as at risk for fall, or immediately following a fall occurrence. He further stated that Resident 73's reassessment for fall was done on 8/4/25 with the score of 17 (score of 10 and greater is high risk for fall) and there were no new interventions indicated in the fall intervention Care plan dated 8/4/25. He stated there should have been a person-centered fall care plan for Resident 73 based on fall risk assessment clinical suggestions dated 8/4/25. 5. During an observation on 8/18/25at 9:31 a.m., Resident 76 was sitting in her wheelchair in the hallway and her back was halfway exposed from the tail bone up to the upper part of her back and exposed to public view in the hallway during patch administration by the Licensed Vocational Nurse L (LVN L). During a concurrent interview and record review on 8/21/25 at 9:34 a.m., with the ADON, she reviewed Resident 76's clinical records and stated that the physician order dated 4/2/25 indicated Lidocaine (used to provide targeted pain relief by numbing the area where they are applied, medication, a local anesthetic, works by blocking nerve signals from reaching the brain) External patch 5 % apply to lower back topically one time a day for lower back pain 12 hours on and 12 hours off and remove per schedule. The ADON further stated that Resident 76's had diagnosis of lower back pain, sciatica (pain or other symptoms&mdash;like numbness, tingling, or weakness&mdash;that occur when pressure is applied to or irritation affects one or more of the five nerve roots that form the sciatic nerve (sciatic nerve is the largest nerve in the body, extending from the lower back down to the foot) . During a concurrent interview and record review with the ADON, on 8/21/25 at 10:32 a.m., the ADON reviewed Resident 76's Care Plans (CP) and stated there was no care plan for pain that was initiated when the physician ordered the Lidocaine patch 5% on 4/2/25 up to this date 8/21/25. The ADON further stated that the pain care plan should have been initiated to address the pain issue of Resident 76. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 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. The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post direct care staffing numbers, and nursing staff responsible for direct care to residents for two days (8/16/25-8/17/25) in the main entrance of the facility by the receptionist area and in each three halls of the facility. This failure resulted in residents and visitors not knowing the accurate number of hours of staff working and which staff were scheduled. During an initial tour of the facility on 8/18/25 at 8:40 a.m., observed there were no posting of direct care staffing numbers, and nursing staff responsible for direct care to residents in the main entrance of the facility for 3 days 8/16/25, 8/17/25 and 8/18/25. Last date posted was 8/15/25. During an observation on 8/18/25 at 8:45 a.m., in Hall BB. No staff schedule or direct patient care hours were seen posted. During an observation on 8/18/25 at 8:50 a.m., in Hall CC. No staff schedule or direct patient care hours were seen posted. During an observation on 8/18/24 at 9:00 a.m., in Hall AA. No staff schedule or direct patient care hours were seen posted. During a concurrent observation and interview on 8/18/25, at 9:05 a.m., with ACR he confirmed that the staff schedule or direct patient care hours last date posted was 8/15/25 and there were no postings for 8/16/25, 8/17/25 and for today 8/18/25 they will post it in the main entrance of the facility and three halls of the facility. During a concurrent observation and interview on 8/15/24, at 9:05 a.m., with the Assistant Director of Nursing (ADON), at the receptionist area in the main entrance of the facility and confirmed that there was no staffing schedule, or direct patient care hours were posted for 8/16/25, 8/17/25 even today's date 8/18/25 and the last date posted was 8/15/25. The ADON stated that the Director of Staff Development (DSD) is responsible for posting it in all three hallways and in the main entrance of the facility by the receptionist. ADON further stated that the information is supposed to be posted. During a concurrent interview and record review with the DSD on 8/22/25, at 11:38 a.m., the DDS acknowledged the above observations and stated that direct care staffing numbers, and nursing staff responsible for direct care to residents should have been posted in the three halls of the facility and main entrance of the facility by the receptionist area daily for seven days. During a review of the facility's Policy & Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 2022, the P&P indicated, Direct care daily staffing number (the number of nursing personnel responsible for providing direct patient care to residents) are posted in the facility to every shift.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure palatability and nutritive value of cooked foods were maintained when: 1. The pureed (smooth, thick liquid or paste made by crushing or grinding solid foods and often made using a food processor and has a consistency that's thicker than juice) and regular (no modifications to food texture or consistency) green beans tasted bland; and 2. They cooked the yellow corn in the stove for an extended period (approximately 2 hours). These failures of decreased food palatability could lead to decrease in food consumed by residents, and the food cooked in the stove for extended period could lose nutritive value, that could lead to decreased nutrient intake for the ninety-four facility residents receiving food from the kitchen. Findings: 1. During the test tray tasting on 8/21/25 at 1:05 p.m., two surveyors tasted the pureed green beans and it tasted bland. During the concurrent pureed tasting and interview with kitchen supervisor (KS) on 8/21/25 at 1:06 p.m., KS tasted the pureed green beans, and he acknowledged that it tasted bland and would check on it. During the continued test tray tasting on 8/21/25 at 1:10 p.m., tasted the regular green beans and it also tasted bland. During the concurrent food tasting and interview with KS on 8/21/25 at 1:11 p.m., KS tasted the regular green beans, and he verified that it tasted bland and would also check on it. During the interview with the registered dietitian (RD) on 8/22/25 at 2:41 p.m., RD verified that foods from the facility kitchen should not taste bland and would follow up on it. 2. During the concurrent initial kitchen tour observation and interview with KS on 8/18/25 at 9:25 a.m., they were already cooking the yellow corn in the heated stove, for lunch. KS verified that they should have started cooking the yellow corn near the tray line (a healthcare food service method where workers assemble food trays for residents on a moving assemble line) preparation for lunch which would start at 11:30 a.m. and they started cooking the yellow corn too early and for an extended period. KS further verified that he would follow up on this concern. During the interview with RD on 8/22/25 at 2:41 p.m., RD verified that the yellow corn was cooked too early, and it should have been cooked near the tray line preparation and not for an extended period to preserve the nutritive value and would check on it. During the interview with the director of nursing (DON), on 8/25/25 at 10:27 a.m., DON verified the above concerns and would follow up on them. Review of the facility's policy and procedure titled, Food and Nutrition Services, revised October 2017 indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure kitchen equipment was maintained and food items were stored and prepared in accordance with professional standards for food safety when: 1. The outside of the ice machine had white deposits on the sides, 2. The temperature log of the refrigerator and freezer were not filled out properly and 3. The kitchen staff did not wear his face mask properly while helping with the tray line (a healthcare food service method where workers assemble food trays for residents on a moving assemble line) preparation. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contamination (transfer of harmful bacteria, viruses, allergens, or other contaminants unintentionally, from one person, object, or place to another, with harmful effect) of food, for the ninety-four residents who received foods from the facility kitchen. Findings: 1. During the an initial kitchen tour observation and concurrent interview with the kitchen supervisor (KS) on 8/18/25 at 9:22 a.m., observed white deposits were found outside the ice machine, on the sides. The KS verified that there should be no white deposits in there and would have the maintenance clean the ice machine and would follow up on it. Review of the facility's policy titled, Ice Machines and Ice Storage Chests, revised January 2012 indicated, Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. 2. During the initial kitchen tour observation and concurrent interview with cook I (COOK I) on 8/18/25 at 9:16 a.m., observed that there were already temperature logs for the afternoon shift of today's refrigerator and freezer temperature logs. COOK I verified that they should not log the temperatures ahead of time and should have monitored them properly. He further verified that they should not log the temperatures of the refrigerator and freezer ahead for the afternoon shift in the morning. During the interview with the KS on 8/18/25 at 9:17 a.m., the KS verified that the kitchen staff was not properly logging in today's temperatures of the refrigerator and freezer for the afternoon shift because it was done ahead of time since it's still morning shift. The KS further verified that he would follow up on it since the staff was not doing it right. Review of the facility's policy and procedure titled, Refrigerators and Freezers, revised November 2022 indicated, This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. 3. During the concurrent tray line preparation observation and interview with cook G (COOK G) on 8/21/25 at 11:50 a.m., observed that COOK G was not wearing his face mask properly. His face mask was not covering his nose and only covering his mouth. COOK G verified that he was not wearing his face mask properly and corrected it right away. During the interview with the registered dietitian (RD) on 8/22/25 at 2:41 p.m., the RD verified all the above concerns and would follow up on them. During the interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., the DON verified the above concerns and would check on these concerns. Review of the Santa [NAME] County Public Health Orders titled, General Recommendations for Wearing a Mask, updated 10/21/24 indicated, .The mask should completely cover your nose and mouth and fit snugly against the sides of your face, leaving no gaps.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program to prevent the spread of infections when:1.The Housekeeping (HK) J was wearing a pair of gloves and was holding a wet floor mop in the hallway Infront of the opened food cart with lunch trays for the residents eating in the dining room;2. A licensed Nurse entered a contact precaution room without wearing gloves to administer medications;3. There was one fly flying around the dining area near the table of Residents 105 and 32 and 4a. Laundry staff R (LS R) did not perform hand hygiene (the process of cleaning and disinfecting one's hands to remove dirt, germs, and bacteria) between handling soiled and clean laundry. b. Certified nursing assistant K (CNA K) did not perform hand hygiene between resident care tasks. c. Facility staff did not properly store respiratory (the process of breathing) equipment. These deficient practices had the potential to result in cross-contamination and the spread of infection and had the potential for residents to be at increased risk of healthcare-associated infections. Findings: 1.During a dining observation on 8/18/25 at 12:13 p.m., HK J was wearing a pair of gloves and was holding a wet floor mop in the hallway Infront of the opened food cart with lunch trays for the residents eating in the dining room. During a concurrent observation and interview on 8/18/25 at 12:14 p.m., with the HK J together with an interpreter certified nursing assistant K (CNA K) , HK J acknowledged the above observation and stated that she needs to mop the floor Infront of the food cart that was opened because the floor was dirty and she was waiting for the CNA's to finish the lunch trays distribution for the Residents in the dining area in order for her to start mopping the floor. HK J further stated that she should not be wearing gloves, hold the floor mop and clean the floor during lunch tray distribution due to infection control issue. A review of Resident 54's clinical record indicated the following physician orders: a. Contact/Isolation Precautions: Every shift for C. difficile, start date 8/18/2025. b. Vancomycin oral capsule 125 mg (milligram, a unit of measurement for weight in the metric system): Give one capsule by mouth every 6 hours for C. difficile for 10 days, start date 8/19/2025. During an observation on 8/19/2025 at 5:39 p.m., Licensed Vocational Nurse (LVN) D was preparing medications for Resident 54 in the hallway. LVN D entered Resident 54's room, which was under contact precautions, wearing a gown but without gloves, and administered vancomycin 125 mg one capsule with her other medications. During an interview with LVN D on 8/19/2025 at 5:53 p.m., LVN D acknowledged that she should have worn gloves when entering a room under contact precautions to prevent the spread of infection. During an interview with the Director of Nursing (DON) on 8/25/2025 at 1:27 p.m., the DON stated that nurses entering rooms under contact precautions are required to wear full personal protective equipment (PPE), including gowns and gloves, to prevent the spread of infection. A review of the facility's policy and procedure titled Isolation-Categories of Transmission-Based Precautions revised September 2022, indicated .contact precautions are implemented for residents (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	known or suspended to be infected with microorganisms that can be transmitted by direct contact with environmental surfaces or resident-care items in the resident's environment. staff and visitors wear gloves (clean, non-sterile) when entering the room. During lunch observation in the dining area on 8/18/25 at 12:20 p.m., there was one fly flying around near the meal trays of Residents 105 and 32. Resident 105 was sitting at the table eating her lunch. Resident 105 was frightened when the fly flying around the table, got near her meal tray but did not say anything. Resident 32 was in her wheelchair, also eating lunch, beside Resident 105, totally fed by certified nursing assistant L (CNA L). Resident 32 was confused and could not verbalize. The fly also went near her tray. During the concurrent lunch observation in the dining area and interview with CNA L on 8/18/25 at 12:20 p.m., CNA L was sitting between Residents 105 and 32. She was feeding Resident 32 for her lunch. CNA L verified that there was a fly flying around the dining area and it should not be there. She further verified that she would tell the nurse about it. Review of Resident 105's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 105 was admitted to the facility on [DATE] with the primary diagnosis of unspecified encephalopathy (brain disease that alters brain function or structure that maybe caused by infection, tumor, and stroke). Review of Resident 32's admission record indicated, Resident 32 was readmitted to the facility on [DATE] with the primary diagnosis of metabolic encephalopathy (condition where the brain does not function properly due to underlying metabolic disturbances). During the interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., the DON acknowledged that there should be no insects or flies flying around the dining area and would follow up on it. Review of the facility's policy and procedure titled, Pest Control, revised May 2008 indicated, Our facility shall maintain an effective pest control program. This facility maintains an ongoing pest control program to ensure that the building is kept free of insects. 4a. During an observation on 08/18/2025 at 9:05 a.m., while in the facility hallway, observed laundry staff (LS) pushing a laundry cart while wearing gloves. LS transferred dirty laundry items into a bin. LS returned to the laundry area, still wearing the same gloves, and opened the dryer containing clean clothes. LS was about to touch the clean laundry with the same gloved hands, the surveyor intervened. During a concurrent interview, the LS stated he was supposed to wash his hands and change gloves after handling dirty items. LS pointed to a nearby sink used for handwashing. 4b. During an observation of 8/18/25 at 12:54 p.m., observed Certified Nursing Assistant K (CNA K) delivering meal trays. CNA K entered Resident 2's room, placed Resident 2's meal tray on the bedside table, touched the bed control to raise the bed, applied a towel for Resident 2. CNA K then entered Resident 54's room. Resident 54 was sitting in the wheelchair, CNA K applied Resident 54's nasal cannula (a thin, flexible tube that is inserted into the nostrils to deliver oxygen to a patient), and served Resident 54's meal tray. CNA K did not perform hand hygiene (the process of cleaning and disinfecting one's hands to remove dirt, germs, and bacteria) between tasks. (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, CNA K acknowledged that she should have performed hand hygiene in between tasks and before providing care to another resident. 4c. During an observation on 8/18/25 at 2:00 p.m., observed Resident 33 lying in bed. A nasal cannula was found stored inside the bedside cabinet drawer, not stored properly. In the same room, Resident 38 was observed lying in bed, asleep. There was a suction machine at the bedside, and the attached suction tubing was lying on the floor. During an interview with the Infection Preventionist (IP) on 8/25/25 at 5:00 p.m., the IP was made aware of the above observations. IP stated that facility staff are expected to perform hand hygiene between resident care tasks, after handling soiled laundry, and before touching clean laundry. The IP acknowledged Resident 33's nasal cannulas and Resident 38's suction tubing were not stored properly. IP stated it should be stored in a protective bag to prevent contamination. Review of facility's policy, Handwashing/Hand Hygiene dated 8/2019, indicated .All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . According to the Centers for Disease Control and Prevention (CDC) Guidelines indicated respiratory equipment such as nasal cannulas and suction tubing must be cleaned, dried and and stored in a closed or protected environment to prevent contamination (Source: CDC Guidelines).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to maintain resident's privacy or dignity for one of 25 sampled residents (Resident 76) when her back was halfway exposed from the Coccyx or tailbone (the last bone at the bottom (base) of the spine) up to the upper part of her back to public view in the hallway. This failure had the potential to affect Resident 76's self-esteem and self-worth. Findings: Review of Resident 76's clinical record indicated she had diagnosis of lower back pain, sciatica (pain or other symptoms-like numbness, tingling, or weakness-that occur when pressure is applied to or irritation affects one or more of the five nerve roots that form the sciatic nerve (sciatic nerve is the largest nerve in the body, extending from the lower back down to the foot) , Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The physician order dated 4/2/25 indicated Lidocaine (used to provide targeted pain relief by numbing the area where they are applied, medication, a local anesthetic, works by blocking nerve signals from reaching the brain) External patch 5 % apply to lower back topically one time a day for lower back pain 12 hours on and 12 hours off and remove per schedule. Resident 76's minimum data set (MDS, an assessment tool) dated 7/02/25 indicated her cognition (ability to remember, judge and use reason) with a brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 was intact. During an observation on 8/18/25 at 9:31 a.m., Resident 78 was sitting in her wheelchair in the hallway, her back was halfway exposed from the tail bone up to the upper part of her back to public view in the hallway during patch administration by licensed vocational nurse O (LVN O). During an interview on 8/18/25 at 9:43 a.m., with LVN O , she acknowledged the above observation and stated that she should have brought Resident 78 to her room to protect Resident 76's body parts exposure during medication administration. During an interview on 8/18/25 at 1:12 p.m., Resident 76 confirmed the above observation and stated that assigned Nurses in the facility was putting her patch on her back in the hallway, and was not offered by the nurse to go inside her room for privacy. Review of the facility's Policy & Procedure (P&P) titled, Dignity , dated February 2021, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are always treated with dignity and respect.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse to the appropriate agencies, including the California Department of Public Health (CDPH), within the required timeframe involving two of six sampled residents (Residents 37 and 91). This failure to report allegations of abuse placed Residents 37 and 91 at risk of potential abuse. Findings: Review of Resident 37's Face Sheet (summary page of a patient's important information) indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including Schizophrenia (a chronic mental health condition that affects a person's thoughts, perceptions, and behaviors), Anxiety Disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness), Depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). Review of Resident 37's Minimum Data Set (MDS, a standardized assessment tool), dated 7/25/25, indicated Resident 37 had a Brief Interview for Mental Status (BIMS, an assessment tool for cognition) score of 10, indicating Resident 37 had a moderate cognitive impairment (decline in one or more cognitive abilities, such as memory, attention, language, reasoning, and problem-solving.) Review of Resident 91's Face Sheet indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Unspecified Severity, with Agitation (form of dementia that cannot be specified by its type or cause, has not been classified by severity and involves agitated behaviors such as restlessness, shouting, aggression, or physical violence), Cognitive Communication Deficit (a group of impairments that affect a person's ability to communicate effectively due to underlying cognitive difficulties). Review of Resident 91's MDS dated [DATE], indicated Resident 91 had a BIMS score of 5, indicating Resident 91 had a severe cognitive impairment (significant decline in cognitive abilities that interferes with daily functioning and independence.) During an observation and interview on 8/18/25 at 2:06 p.m., in resident's room. Resident 37 was sitting in the wheelchair. Resident 37 stated his roommate had tried to hit him during the night. Resident 37 reported he told the staff at the time of the incident, and staff offered him a room change, which he declined. Resident 37 became agitated when asked further questions. During an interview with Licensed Vocational Nurse P (LVN P) on 8/21/25 at 12:18 p.m., LVN P stated Resident 37 had told her a couple of weeks ago that his roommate wanted to hit him. LVN P stated she did not document the allegation because nothing happened. LVN P stated she did not notify the Director of Nursing (DON) or the Administrator (ADM), but reported it to the Social Service Director (SSD). LVN P stated a room change was offered, but Resident 37 declined. During a concurrent interview and record review with the SSD on 8/22/25 at 11:00 a.m., the SSD stated she was not made aware of Resident 37's allegation until 8/18/25. The SSD provided a Behavior Note Progress Note, dated 8/15/25 at 20:03, which indicated: Resident 37 insisting his roommate hit him while he was taking a nap just now. If his roommate does it again, he is going to punch him in the face. The SSD stated the note showed an abuse allegation and confirmed it should have been reported immediately to the ADM, CDPH, police, and Ombudsman (a neutral advocate for residents of long-term care facilities, acting independently to protect their health, safety, welfare, and rights). During a concurrent interview and record review with the DON on 8/22/25 at 3:50 p.m., the DON stated she was not aware of Resident 37's allegation regarding his roommate until 8/18/25. The DON reviewed the 8/15/25 Behavior Note, the DON confirmed the Behavior Note was an abuse allegation that should have been reported immediately to CDPH, the police, and Ombudsman. During a concurrent interview and record review with the ADM on 8/25/25 at 3:18 p.m., the ADM stated he was not aware of Resident 37's allegation until 8/18/25. The ADM confirmed the allegation should have been reported immediately as per the facility's abuse policy. Review of the facility's policy, titled Abuse Reporting and Investigation, updated 5/2025, indicated The Facility staff will report ALL allegations of abuse .as (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required by law and regulations to the appropriate agencies within 2 hours .For incidents involving resident on resident abuse that did not result in bodily harm where the alleged abuser is a resident diagnosed with Dementia, the facility is required to notify the ombudsman and local law enforcement in writing within 24 hours. The facility must still report to appropriate agencies within 2 hours .		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, the resident's discharge minimum data set (MDS, a standardized assessment and care screening tool) assessment was transmitted within 14 days after the assessment reference date (ARD, the specific end point of look-back periods in the MDS assessment process) for one (Resident 43), out of twenty-five sampled residents. This deficient practice had the potential to result in delayed services for the resident. Findings: Review of Resident 43's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 43 was initially admitted to the facility on [DATE] and was discharged on 5/23/25. Resident 43 was then readmitted on [DATE]. Review of the Centers for Medicare and Medicaid Services (CMS, a federal agency within the United States Department of Health and Human Services that administers the Medicare program) submission report indicated that the Assessment Completed Date for section Z0500B (assessment completion date) for Resident 43's MDS was more than 14 days after A2300 (assessment reference date). During the concurrent review of Resident 43's clinical records and interview with minimum data set coordinator H (MDSC H, specially trained nurse who works primarily in long-term care facilities, assessing residents' needs, developing care plans and collaborating with a team of healthcare professionals to ensure comprehensive care) on 8/22/25 at 9:46 a.m., MDSC H verified the late submission of the discharge MDS assessment, and she further verified of receiving the CMS final validation report warning for late completion of the assessment, more than 14 days after the assessment reference date. During the interview with the director of nursing (DON), on 8/25/25 at 10:27 a.m., DON acknowledged the above concern and would check on it. A review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual indicated, the MDS must be transmitted (submitted and accepted into the QIES ASAP system) electronically, no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate smoking assessment and complete smoking assessment were done every three months for two of 19 sampled residents who smoke (Residents 37 and 72). These failures had potential to cause accident/harm to these residents and potential to compromise the facility's ability to develop and implement resident-centered care plans and interventions. Findings: 1. Review of Resident 37's Face Sheet (summary page of a patient's important information) indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including Schizophrenia (a chronic mental health condition that affects a person's thoughts, perceptions, and behaviors), Anxiety Disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness), Depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). During an observation on 8/21/25 at 1:00 p.m., Resident 37 was observed smoking outside while wearing a protective apron and under staff supervision. Review of Resident 37's Smoking Assessments, dated 1/18/25 and 4/18/25, but indicated no quarterly smoking assessment was completed for July 2025. During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 8/21/25 at 2:58 p.m., the ADON stated smoking assessments are completed at admission and quarterly. The ADON acknowledged Resident 37's quarterly smoking assessment for July 2025 was missed and should be completed. Review of the facility's policy and procedure titled, Smoking Policy- Residents, revised August 2022 indicated, Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes Current level of tobacco consumptions, ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation . A resident's ability to smoke safely is re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. Any smoking &ndash; related privileges, restrictions and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 2. Review of Resident 72's clinical record indicated she was admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis of Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychotic disorder with delusion (a mental health condition characterized by a loss of contact with reality, involving symptoms like hallucinations (seeing, hearing, or feeling things that aren't there), delusions (false, fixed beliefs), disorganized thinking, and disorganized or abnormal behavior) and other symptoms and signs involving cognitive functions and awareness, muscle weakness, reduced mobility and obesity. Resident 72's minimum data set (MDS, an assessment tool) dated 6/18/25 indicated her cognition (ability to remember, judge and use reason) with a brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 moderately impaired cognition. During a concurrent interview and record review on 8/20/25 at 12:22 p.m., with the Assistant Director (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (ADON), She reviewed Resident 72's smoking and safety assessment evaluation dated 6/17/25 and stated that smoking care planning section, clinical suggestions and smoking safety notes were blank. ADON further stated it should have been completed and accurately assessed. During a concurrent interview and record review with Minimum Data Set Coordinator Q (MDSC Q) on 8/20/25 at 12:54 p.m., MDSC Q reviewed Interdisciplinary Team (IDT, staff from different disciplines who work together to plan and provide care) smoking assessment conference dated 6/2/25 indicated Resident 72 is an independent smoker and is safe to smoke independently based on smoking assessment, smoking assessment is completed and up to date and reviewed by IDT per risk assessment , for the section smoking care planning indicated continued non-compliance may lead to unexpected burn related fire property or possibly death and for additional interventions indicated Resident 72 has history of non- compliance with smoking schedule and IDT will continue to re-evaluate resident and monitor any changes. MDSC Q stated that Resident 72 needed one person supervision during smoking for safety and he confirmed that the IDT assessment was inaccurate for Resident 72's smoking and safety assessment evaluation dated 6/17/25 was inaccurate also.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the resident with Level 1 (involves completion of an evaluation to determine if the individual has, or is suspected of having serious mental illness, intellectual disability, developmental disability or related condition) preadmission screening and resident review (PASARR, federal requirement under the Medicaid program or public health insurance program that provides health care coverage to low-income individuals, families and people with disabilities, to screen all applicants and residents for serious mental illness, intellectual or developmental disabilities, and related conditions before they are admitted to the nursing facility) was coded accurately and those with positive Level 1 PASARR were evaluated for Level 2, for three of twenty-five sampled residents, (Residents 22, 92 and 72) when:1.For Residents 22 and 92, there were no documentations that Level 2 PASARR screening (comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has mental disorder, intellectual disability or related condition, determines the appropriate setting for the individual and recommends specialized services and/or rehabilitative services the individual needs) were done after positive Level 1 evaluation; and 2. For Resident 72, Level 1 PASARR was not coded correctly. These failures had the potential for the residents, not being comprehensively evaluated, which could result in not receiving the care and services in the most appropriate setting, necessary for their optimal health and well-being.Findings:1.Review of Resident 22's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 22 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (mental disorder characterized by persistently low or depressed mood or decreased interest in pleasurable activities), chronic post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it) and unspecified epilepsy (brain condition that causes recurring seizures), not intractable, with status epilepticus (serious neurological emergency that occurs when seizures last a long time or happen in close succession without recovery in between).Review of Resident 22's Level 1 PASARR screening indicated that she was positive for serious mental illness and Level 2 screening was recommended. Review of Resident 22's clinical records indicated, there was no documentation that Resident 22 was evaluated for level 2 PASARR. During the concurrent review of Resident 22's clinical records and interview with minimum data set coordinator H (MDSC H, specially trained nurse who works primarily in long-term care facilities, assessing residents' needs, developing care plans and collaborating with a team of healthcare professionals to ensure comprehensive care) on 8/21/25 at 2:13 p.m., MDSC H verified that Resident 22 had Level 1 PASARR screening which showed that she was positive for serious mental illness and Level 2 screening was recommended. MDSC H further verified that there was no documentation that she was screened for Level 2 PASARR. During the interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., the DON verified that Resident 22 should have been screened for Level 2 PASARR as recommended by her Level 1 screening but there was no documentation that she was evaluated for Level 2 and would follow up on it.1b. Review of Resident 92's admission record indicated, Resident 92 was readmitted to the facility on [DATE], with diagnoses including unspecified dementia (loss of memory), moderate, with psychotic disturbance (severe mental disorder that cause abnormal thinking and perceptions), paranoid schizophrenia (type of mental health disorder characterized by persistent delusions and hallucinations) and major depressive disorder, single episode, severe with psychotic features (loss of touch with reality). Review of Resident 92's Level 1 PASARR screening indicated that she was positive for suspected mental illness and Level 2 screening was needed. Review of Resident 92's clinical records indicated, there was no documentation that Resident 92 was evaluated for Level 2 (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR.During the concurrent review of Resident 92's clinical records and interview with MDSC H on 8/22/25 at 12:13 p.m., MDSC H verified that Resident 92 had Level 1 PASARR screening which showed that she was positive for suspected mental illness and Level 2 screening was required. MDSC H further verified that there was no documentation that she was screened for level 2 PASARR. During the interview with the DON on 8/25/25 at 10:27 a.m., the DON verified that Resident 92 should have been referred and screened for Level 2 PASARR since her Level 1 screening indicated that she was positive for suspected mental illness and she would follow up on it. 2. Review of Resident 72's clinical record indicated she was admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis of Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), Bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), psychotic disorder with delusion (a mental health condition characterized by a loss of contact with reality, involving symptoms like hallucinations (seeing, hearing, or feeling things that aren't there), delusions (false, fixed beliefs), disorganized thinking, and disorganized or abnormal behavior) and other symptoms and signs involving cognitive functions and awareness.During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 8 /20/2025 at 01:27 p.m., ADON reviewed Resident 72's diagnoses and Level I PASARR, dated 03/17/2021, and stated the resident had Diagnoses of Schizoaffective disorder, Bipolar type, psychotic disorder with delusion and other symptoms and signs involving cognitive functions and awareness. ADON further stated, the resident 72's Level I PASARR should have been resubmitted because it was not accurate and the importance of Level I PASARRs was to determine if residents required a Level II Evaluation. Review of a facility's policy and procedure titled, Pre-admission Screening and Resident Review (PASARR), dated December 2017 indicated, All residents will be screened on admission and annually thereafter. To ensure that all facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated.A positive level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR level 2, which must be conducted prior to admission to a nursing facility.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the preadmission screening and resident review (PASARR, federal requirement under the Medicaid program or public health insurance program that provides health care coverage to low-income individuals, families and people with disabilities, to screen all applicants and residents for serious mental illness, intellectual or developmental disabilities, and related conditions before they are admitted to the nursing facility) was done and accurately implemented to two of twenty-five sampled residents, (Residents 85 and 6) when: 1. For Resident 85, there was no level 1 PASARR screening (involves completion of an evaluation to determine if the individual has, or is suspected of having serious mental illness, intellectual disability, developmental disability or related condition) and 2. For Resident 6, the level 1 PASARR screening was not accurately done. These failures had the potential to cause the delay, in the care of the residents and not receiving the care and services in the most appropriate setting, necessary for their optimal health and well-being. Findings: 1. Review of Resident 85's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 85 was readmitted to the facility on [DATE], with diagnoses including schizoaffective disorder (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), bipolar type (includes bouts of hypomania or mania or abnormally elevated energy level and sometimes major depression or feeling of sadness), unspecified dementia (loss of memory), unspecified severity with agitation (state of physical and psychological restlessness) and unspecified anxiety (feeling of fear, dread and uneasiness) disorder. Review of Resident 85's clinical records indicated that she had no level 1 PASARR screening. There was no documentation that Resident 85 was evaluated for her mental health condition. During the concurrent review of Resident 85's clinical records and interview with minimum data set coordinator H (MDSC H, specially trained nurse who works primarily in long-term care facilities, assessing residents' needs, developing care plans and collaborating with a team of healthcare professionals to ensure comprehensive care) on 8/22/25 at 11:43 a.m., MDSC H verified the above diagnoses of Resident 85 and further verified that there was no documentation that she was screened for level 1 PASARR. During the interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., DON verified that Resident 85 should have been screened for level 1 PASRR but there was no documentation of the screening and would follow up on it. 2. Review of Resident 6's admission record indicated, Resident 6 was admitted on [DATE] with diagnoses including Dementia (loss of memory), Schizophrenia (a serious mental health condition that affects how people think, feel and behave), Anxiety (feeling of fear, dread and uneasiness). Review of Resident 6's PASARR level 1 dated 2/14/25, indicated negative for Serious Mental Illness (SMI). The form indicated No under the section asking about diagnosed mental disorders such depressive disorder, anxiety, schizophrenia. During a concurrent interview and record review on 8/21/25 at 4:10 p.m., the Assistant Director of Nursing (ADON) confirmed the PASSR Level 1 was inaccurate because Resident 6 was admitted with (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Herman Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2295 Plummer Avenue San Jose, CA 95125	
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis of Schizophrenia. The ADON stated the PASSR Level 1 was completed at the hospital. The ADON stated nursing staff should have reviewed the PASRR Level 1 upon admission for accuracy, but this was not done. Review of a facility's policy and procedure titled, Pre-admission Screening and Resident Review (PASARR), dated December 2017 indicated, All residents will be screened on admission and annually thereafter. To ensure that all facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. PASARR level 1 screening is to be completed before the individual is admitted to the facility. If it is not completed by the sending institution, it should be completed by nursing staff prior to admission.		

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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 observation, interview, and record review, the facility failed to ensure a care plan (CP) was revised based on preferences and needs of the residents for two of 25 sampled residents (Resident 72 and 73. This failure had the potential for Resident 72 and 73 not to receive the necessary care and services to achieve the highest practicable well-being and communicate necessary interventions to the staff. Findings: 1. Review of Resident 72's clinical record indicated she was admitted to the facility on [DATE] and re admitted on [DATE] with diagnosis of Schizoaffective disorder, Bipolar type, muscle weakness, Chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe) and other symptoms and signs involving cognitive functions and awareness. Resident 72's minimum data set (MDS, an assessment tool) dated 6/18/25 indicated her cognition (ability to remember, judge and use reason) with a brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 moderately impaired cognition. During a concurrent interview and record review on 8/20/25 at 11:55 a.m., with ADON, She reviewed Resident 72's smoking CP dated 11/04/24 and could not provide any documentation to indicate that smoking care plan was revised or reviewed every three months or quarterly. ADON further stated it should have been revised every quarter. 2. Review of Resident 73's clinical record indicated he was admitted to the facility on [DATE] with diagnosis of Multiple sclerosis (a disease affecting the brain and spinal cord that disrupts the communication of the brain and the rest of the body), lack of coordination, depression (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning) and abnormalities of gait and mobility. Resident 73's MDS dated [DATE] indicated her cognition with a BIMS score of 9 was moderately impaired cognition. During a concurrent interview and record review with ADON on 8/21/25 at 1:29 p.m., ADON reviewed resident 73's fall comprehensive care plan which was initiated on 2/13/25 due to the history of falls in the facility and could not provide any documentation that Fall comprehensive care was revised or reviewed every three months and should have been revised or reviewed. A review of facility policy, Care Plans, Comprehensive Person -Centered Revised date March /2020, 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 .The interdisciplinary team reviews and updates the care plan when the desired outcome is not met, at least quarterly, in conjunction the required quarterly MDS assessment, when there has been a significant change in the resident's condition and when resident has been readmitted to the facility from a hospital stay.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice for one of twenty-five sampled residents, (Resident 22), when for Resident 22: 1.The care plan for the risk of elopement was not followed;2. There was MDS assessment inaccuracy; and3. The care plan was not person-centered.These failures caused the resident to have an episode of elopement and potentially, not attaining or maintaining the highest practicable physical, mental and psychosocial well-being.Findings: 1.During the concurrent lunch observation and interview of Resident 22 on 8/18/25 at 12:18 p.m., Resident 22 was sitting in the dining area table, eating her lunch. Resident 22 was alert, calm and verbally responsive and stated that she was fine.Review of Resident 22's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 22 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (mental disorder characterized by persistently low or depressed mood or decreased interest in pleasurable activities), chronic post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it) and unspecified epilepsy (brain condition that causes recurring seizures), not intractable, with status epilepticus (serious neurological emergency that occurs when seizures last a long time or happen in close succession without recovery in between). Resident 22 went to the hospital on 7/19/25 and came back on 7/23/25.Review of Resident 22's risk for elopement care plan indicated that the goal was for Resident 22, not to leave the facility unattended and it was not followed since resident went out of the facility unattended.Review of Resident 22's progress notes indicated, Resident 22 had an episode of elopement on 8/14/25. She went out of the facility by herself.During an interview with certified nursing assistant M (CNA M) on 8/22/25 at 4:01 p.m., CNA M verified that another staff should have watched Resident 22 when she was on lunch break at that time of elopement on 8/14/25, to avoid the incident to happen and further verified that the care plan was not followed. During an interview with licensed vocational nurse N (LVN N) on 8/14/25 at 3:36 p.m., LVN N verified the elopement of Resident 22 on 8/14/25. LVN N further verified that her care plan was not followed and would ensure Resident 22 would not be left unattended.During the concurrent review of Resident 22's care plans and interview with minimum data set coordinator H (MDSC H, specially trained nurse who works primarily in long-term care facilities, assessing residents' needs, developing care plans and collaborating with a team of healthcare professionals to ensure comprehensive care) on 8/21/25 at 1:58 p.m., MDSC H verified that the risk for elopement care plan of Resident 22 was not followed. 2. During the concurrent review of Resident 22's clinical records and interview with MDSC H on 8/22/25 at 8:57 a.m., MDSC H reviewed the minimum data set (MDS, a standardized assessment tool used to evaluate the health and functional capabilities of nursing home residents) assessments and other clinical records of Resident 22 and she verified that there was no significant change of condition MDS assessment for Resident 22 for the significant change in her health condition. MDSC H further verified that there was MDS inaccuracy because Resident 22 had a change of condition.Review of the facility's policy and procedure titled, Resident Assessments, revised March 2022 indicated, A comprehensive assessment of every resident's needs is made at intervals designated by Omnibus Budget Reconciliation Act (OBRA of 1987, evaluations required to ensure quality care and protect the rights of nursing facility residents, particularly those with mental illness or developmental disabilities).OBRA required assessments - conducted for all residents in the facility:.Significant Change in Status Assessment (SCSA)(Comprehensive).3. During the concurrent review of Resident 22's care plans and interview with MDSC H on 8/22/25 at 8:57 a.m., MDSC H reviewed the care plans of Resident 22 and she verified that they were not person-centered and would update them.During an interview with the director of nursing (DON) on 8/25/25 at 10:27 a.m., the DON acknowledged the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above concerns and would check on these issues. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022 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. The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of five emergency kits (e-kits; kits containing medications and supplies for immediate use during a medical emergency) was replaced in a timely manner. This failure resulted in two medications (a total of 16 tablets) expiring, which had the potential to make medications unavailable for use during an emergency. Findings: 1. During an inspection of Medication Cart (MC) 1 with Licensed Vocational Nurse (LVN) E on [DATE] at 10:29 a.m., an e-kit was found containing two expired controlled medications (16 tablets total) with an expiration date of [DATE]. a. Oxycodone/acetaminophen 10/325 mg (milligram, a unit of measurement for weight in the metric system), quantity 8, expiration date [DATE]. b. Morphine Sul ER (Morphine Sulfate Extended Release) 15 mg, quantity 8, expiration date [DATE]. During an interview with LVN E on [DATE] at 10:35 a.m., LVN E confirmed the above observations and stated that nurses should order replacements prior to the expiration date and ensure all medications in the e-kit are within their expiration dates. During an interview with the Director of Nursing (DON) on [DATE] at 12:48 p.m., the DON stated that nurses should have ordered a new e-kit to replace the existing one before its expiration date. A review of the facility's policy and procedure titled Medication and Treatment orders, revised [DATE], indicated . Drugs and biologicals that are required to be refilled must be ordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure the refills are readily available .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a 9.68 percent (%) medication error rate, with three medication errors out of 31 opportunities observed during the medication administration for three of the five residents (Residents 107, 41, and 55). when1. Resident 107's lactulose oral solution (a colonic acidifier that works by increasing stool water content and softening the stool) was not available during medication administration.2. Resident 41' polyethylene glycol 3350 powder was not available during medication administration.3. Resident 55's lactulose oral solution was not available during medication administration, and the nurse used another resident's medication instead.These failures had the potential to compromise the health and safety of the residents.Findings:1. A review of Resident 107's clinical record indicated a physician's order, for lactulose oral solution 10 mg/mL(milligram/milliliter), give 30 mL(milliliter, a unit of volume in the metric system) by mouth two times daily for hepatic encephalopathy, starting on 8/15/2025.During an observation on 8/19/2025 at 8:24 a.m., Licensed Vocational Nurse (LVN) A was preparing medications for Resident 107 in the hallway. Lactulose oral solution was not available in the medication cart. LVN A confirmed that the lactulose oral solution could not be administered at that time.During an interview with LVN A on 8/21/2025 at 8:19 a.m., LVN A stated that the lactulose oral solution arrived on 8/20/2025 and acknowledged that the medication should have been ordered before it ran out.2. Review of Resident 41's clinical record indicated a physician's order, for polyethylene glycol 3350 powder, 17 grams by mouth two times daily for bowel management, may mix with water or juice, hold for loose stools, starting 8/1/2024.During an observation on 8/19/2025 at 8:40 a.m., LVN B was preparing medications for Resident 41 in the hallway. Polyethylene glycol 3350 powder was not available in the medication cart. LVN B confirmed that Polyethylene glycol 3350 powder could not be administered at that time.During an interview with LVN B on 8/19/2025 at 11:26 a.m., LVN B stated that the polyethylene glycol 3350 powder arrived at 11:15 a.m. and confirmed this was a medication error because it was not administered within the one-hour window of the scheduled time (between 9:00-10:00 a.m.).3. Review of Resident 55's clinical record indicated a physician's order, for lactulose oral solution 10 mg/mL, 15 mL by mouth two times daily for high ammonia levels, starting 7/14/2025.During an observation on 8/19/2025 at 5:10 p.m., LVN C was preparing medications for Resident 55 in the hallway. Lactulose oral solution was not available in the medication cart. LVN C prepared lactulose from Resident 18's supply.During an interview with LVN C on 8/19/2025 at 5:25 p.m., LVN C confirmed that he should not use Resident 18's medication for Resident 55.During an interview with the Director of Nursing (DON) on 8/25/2025 at 1:21 p.m., the DON stated that nurses should order medications before they run out and should never use another resident's medication. The DON emphasized that proper medication administration requires the right resident, right medication.A review of the facility's policy and procedure titled Administering Medications, revised April 2019, indicated Medications are administered in accordance with prescribed orders, including required time frame.Medications are administered within one hour of their prescribed time. the individual administering the medication checks the label 3 times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.A review of the facility's policy and procedure titled Medication and Treatment orders revised July 2016, indicated .Drugs and biologicals that are required to be refilled must be ordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure the refills are readily available.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling when: 1. Expired medications were not removed from the medication refrigerator to prevent medication errors. 2. A bottle of lactulose oral solution (a colonic acidifier that works by increasing stool water content and softening the stool) was sticky in the medication cart. 3. One tuberculin purified protein derivative (PPD) vial and five bottles of multi-dose medications were not labeled with an open date. These deficient practices had the potential to result in residents receiving medications with reduced potency or unsafe properties, as well as medication errors due to improper labeling or failure to remove expired medications from active stock. Findings: 1. During a visit to the Medication room [ROOM NUMBER] with Licensed Vocational Nurse (LVN) E on 8/18/2025 at 9:50 a.m., a vial of tuberculin (PPD) in the medication refrigerator was labeled with an open date of 6/22/2025 (expired on 7/21/2025). During an interview with LVN E on 8/18/2025 at 9:51 a.m., LVN E confirmed the observation and stated that the vial of tuberculin (PPD) should be labeled with the open date and discarded 28 days after opening. A review of the facility's Policy and Procedure (P&P) titled Medication Labeling and Storage, revised February 2023, indicated: Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days. 2. On 8/18/2025 at 12:08 p.m., inspection of Medication Cart (MC) 2 with LVN F identified that one bottle of lactulose oral solution was sticky. During an interview with LVN F on 8/18/2025 at 12:11 p.m., LVN F confirmed the observation and stated that nurses should clean the bottle after each use. A review of the facility's Policy and Procedure (P&P) titled Medication Labeling and Storage, revised February 2023, indicated: The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. a. During a visit to the Medication room [ROOM NUMBER] with LVN E on 8/18/2025 at 9:55 a.m., identified that an open vial of tuberculin (PPD) was not labeled with an open date. LVN E confirmed this finding and stated the vial should be labeled with the open date and discarded 28 days after opening. b. On 8/18/2025 at 12:11 p.m., inspection of Medication Cart (MC) 2 with LVN E, identified five bottles of multi-dose medications that were not labeled with an open date: 1) one bottle of lactulose oral solution 2) one bottle of calcium 3) Two bottles of multivitamin and multimineral supplement for women 50+ 4) one bottle of Ibuprofen. During an interview with LVN E on 8/18/2025 at 12:18 p.m., LVN E confirmed that all the above bottles should be labeled with the open date. A review of the facility's P&P titled Administering Medications, revised April 2019, indicated: the expiration/beyond-use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the following multi-resident rooms provided less than 80 square feet per resident. Findings:[NAME] Hall Rooms:Room Total Sq. Ft. Sq. Ft/Bed No. of Beds 8 306 76.56 4 9 323 76.56 4 10 306 76.56 4 11 323 76.56 4 17 306 76.56 4 19 306 76.56 4 22 306 76.56 4 24 306 76.56 4 25 306 76.56 4 26 306 76.56 4 27 306 76.56 4 28 306 76.56 4 29 306 76.56 4 30 306 76.56 4 31 306 76.56 4 32 306 76.56 4 33 306 76.56 4 34 342 76.5 4 35 342 76.5 4 36 342 76.5 4 37 342 76.5 4 38 323 76.5 4 39 306 76.50 4None of the rooms were observed to inhibit the staff from providing care or the residents from receiving adequate care. The staff and the residents moved freely in the rooms. The residents and the staff stated the square footage of the rooms was not a concern.Continuance of the room waiver is recommended.		