STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055750	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute	1601 Petersen Avenue San Jose, CA 95129

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on interview, and record review, the facility failed to promote respect and dignity for one of one resident (Resident 1) when Social Services (SS) A told Resident 1 she would call 911 (a telephone number for emergencies) for a 5150 (the number of the section of the Welfare and Institutions Code, which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled) assessment when the resident was trying to advocate for her roommate. This failure had the potential to negatively affect the resident's dignity and psychosocial well-being. Findings: Review of Resident 1's face sheet (a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of type 1 diabetes (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), major depression disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), pancreatic cancer (cancer that begins in the organ lying behind the lower part of the stomach - pancreas), absence of both upper limbs below elbows and both legs above knees. Review of Resident 1's Minimum Data Set (MDS, a clinical assessment tool), dated 3/19/24, indicated Resident 1 had a brief interview for mental status [BIMS, a tool used to assess cognition (knowing, learning, and understanding things)] score of 15 [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. During an interview on 4/22/24 at 12:00 p.m. with Resident 1, Resident 1 stated she was trying to advocate for her roommate who was having a fever on 4/14/24, however [SS A's name] came to the room and told Resident 1 that she was going to call 911 and tell them Resident 1 was 5150, and they were going to take her away. She also stated [SS A's name]'s statement made her feeling threatened. So she called the police herself because she did not think she should be treated that way. She further stated nobody came to her to clarify anything after the incident, and the management did not address the issue. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055750	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER Westwood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 Petersen Avenue San Jose, CA 95129	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24 at 2:04 p.m. with Licensed Vocational Nurse (LVN) B, LVN B stated the resident had to be danger to self and danger to others to qualify for 5150, someone had to have the qualification to assess the resident and to diagnose. She further stated Resident 1 had been sweet to her, she never had any problem taking care of Resident 1. During an interview on 4/22/24 at 2:44 p.m. with SS C, SS C stated Resident 1 was alert an oriented, and very expressive. On 4/14/24, Resident 1's roommate was having a fever, the facility informed the roommate's sister, so the sister came to visit in the afternoon, Resident 1 was telling the sister Everyone here is garbage, everyone is lying, they are not taking care of [roommate's name]! [SS B's name] is lying! SS B and the sister had to step outside of the room to talk because Resident 1 would not stop talking. During an interview on 4/22/24 at 3:03 p.m. with SS A, SS A stated SS C needed help with Resident 1's situation, so she went to the room and told Resident 1, If your behavior continued to persist, I am going to have to call 911, police then will come out and potentially do a 5150 assessment on you, and potentially to send you out. She further stated she was not sure how to deescalate the situation besides bringing up 5150 in that moment, because Resident 1 had made multiple staffs cry that day. And it was like that with her almost every day. During an interview on 4/22/24 at 3:26 p.m. with the SS Director (SSD), the SSD stated she had directed SS A not to have communications with Resident 1, because SS A was not Resident 1's assigned social services staff. She further stated SS A should have not made the 5150 statements towards Resident 1, as it could potentially cause distress. During a review of the facility's policy and procedure (P&P) titled, Resident Rights , revised 12/2016, the P&P indicated, ' 'Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; h. be supported by the facility in exercising his or her rights; i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; Based on interview, and record review, the facility failed to promote respect and dignity for one of one resident (Resident 1) when Social Services (SS) A told Resident 1 she would call 911 (a telephone number for emergencies) for a 5150 (the number of the section of the Welfare and Institutions Code, which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled) assessment when the resident was trying to advocate for her roommate. This failure had the potential to negatively affect the resident's dignity and psychosocial well-being.