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	06/11/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on interview and record review, the facility failed to notify the physician promptly for one of one resident (Resident 1) when Physical Therapist (PT, who promote, maintain, or restore health through patient education, physical intervention, disease prevention, and health promotion) A did not communicate with Resident 1's charge nurse when the resident fell during her physical therapy session and sustained minor injuries. This failure had the potential to result in a delay of assessment and possible treatment to Resident 1. Findings: Review of Resident 1's face sheet (a document that gives a resident's information at a quick glance) dated 6/11/24 indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses of oral surgical aftercare, cancer, reduced mobility. Review of Resident 1's SBAR & INITIAL COC/ALERT CHARTING & SKILLED DOCUMENTATION (a documentation for change of a resident's conditions) dated 4/24/24 at 3:53 p.m. indicated, Date & Time Problem or Symptom Started: 04/24/2024 12:00 [p.m.], Resident's son informed writer and ADON [Assisted Director of Nursing] that resident fell during therapy outside of the facility. Resident noted with a small excoriation on bilateral knees. Resident denies pain. MD [Medical Doctor] and RR [responsible representative] notified. During an interview on 6/11/24 at 1:02 p.m. with the Director of Rehab (DOR), the DOR stated rehab staff would report to the DOR and let the charge nurse know if a resident fell during a therapy session, a change in condition for fall would be completed, the therapist would complete a rehab post fall assessment. IDT (interdisciplinary team, a group of healthcare professionals) would meet to discuss new interventions, such as rehab recommendations. The DOR further stated the therapist did not reported to the nursing staff because Resident 1's son reported the incident before him. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 1:57 p.m. with ADON B, ADON B stated on 4/24/24, Resident 1 went out with PT A around noon, but Resident 1's fall was reported by a family member a little before 3, it was almost change of shift. The charge nurse and ADON B went to assess the resident for injury right away after they found out the fall, no major injury was noted, they notified the MD and performed treatment to Resident 1's knees. PT A should have informed the nursing department for any changes of a resident right away, not sure why it was not reported timely. ADON B further stated due to the delay of reporting, there could potentially cause a delay of assessment and treatment. During an interview on 6/11/24 at 4:32 p.m. with the Director of Nursing (DON), the DON stated PT A should not expect the family member to notify the nursing staff about the fall, he should have communicated with the nurses. During an interview on 6/12/24 at 3:30 p.m. with PT A, PT A stated Resident 1's PT session was between 11 [a.m.] to 12 [p.m.] on 4/24/24, Resident 1's son was also present. When they were walking outside of the facility, Resident 1 tripped on the sidewalk, she then landed on her hands and knees. PT A checked on the resident, did not notice any injury at that time, Resident 1 did not complain of any pain, so they keep on walking. After the physical therapy session, PT A took the resident back to the nursing station, but he did not notify the charge nurse about the fall because he didn't think it was a reportable event. He further stated rehab therapists should report any changes to the nursing staff as soon as possible. Review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing revised March 2018 indicated, Definition: According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Review of the facility's P&P titled Change in a Resident's Condition or Status revised February 2021 indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).