

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 12/23/2024
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to provide services according to professional standards for one of three sampled residents (Resident1) when:</p> <ol style="list-style-type: none"> 1. Resident 1's baseline care plan (a basic initial care plan created for a patient upon admission to a healthcare facility, outlining the most essential care needs and instructions until a more comprehensive care plan can be developed) related to dysphagia (difficulty in swallowing) and tube feeding (a flexible tube inserted through nose or belly to provide nutrients) were not developed in a timely manner; 2. Nurses did not notify dietitian or the attending physician when Resident 1 was admitted with tube feeding formula not in facility stocks; and 3. Licensed vocational nurse A (LVN A) signed the IV ATB administered by a registered nurse (RN) for Resident 1. <p>These failures had the potential to compromise Resident 1's quality of care.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 1's clinical record titled, Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (primary cancer) of esophagus (a muscular tube that moves food from the throat to the stomach), secondary malignant neoplasm (a primary cancer that has spread to other parts of the body) of unspecified lung, liver, intrahepatic bile duct, and digestive organs, severe protein-calorie malnutrition (a condition that occurs when the body doesn't get enough protein, calories, and other nutrients), dysphagia, and gastrostomy status (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). <p>Review of Resident 1's clinical record titled, 48 HR BASELINE CARE PLAN, indicated, the dietary/nutritional status plan of care was completed by the registered dietitian (RD) on 7/8/2024, 72 hours after admission. Further review of the baseline care plan indicated Resident 1's problem with dysphagia and use of tube feeding were developed on 7/10/2024, 5 days after Resident 1's admission.</p> <p>(continued on next page)</p>

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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with registered dietitian E (RD E), and record review on 10/31/2024 at 1:02 p. m., RD E reviewed Resident 1's baseline care plan and list of care plans. RD E stated baseline care planning should be done 48 hours upon resident's admission. RD E did not validate the other RD's nutritional baseline care plan's completion date. RD E stated, I did not want to speak for the other writer. Whatever is written there is what it is.</p> <p>During a concurrent interview and record review with social worker F (SW F), on 10/31/2024 at 2:05 p.m., SW F reviewed Resident 1's baseline care plan. SW F confirmed he was a member of the baseline care planning team, and he coordinated the meeting with the rest of the team. SW F stated the baseline care plan should be done or completed 48 hours upon resident's admission. SW F confirmed Resident 1's nutritional baseline care plan was signed as completed on 7/8/2024.</p> <p>During interview with assistant director of nursing B (ADON B) on 12/23/2024 at 11:06 a.m., ADON B stated, the admission nurse should have initiated resident's care plan especially if there was an order for tube feeding due to dysphagia.</p> <p>During a review of the facility's policy and procedure titled, Care Plans - Baseline, date revised December 2016, indicated, To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. The Interdisciplinary Team [IDT - a group of health care professionals from diverse fields who work toward a common goal for residents] will review the healthcare practitioner's orders (.dietary needs, medications .) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: .Dietary orders .The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.</p> <p>2. During a phone interview with Resident 1's family member (FM) on 10/31/2024 at 10:49 a.m., Resident 1's FM stated the facility was supposed to provide Resident 1's formula for tube feeding. Resident 1's FM further stated, Resident 1 was admitted in the evening of 7/5/2024 and she learned that the facility did not have the tube feeding formula ordered for Resident 1. Resident 1's FM went back to the hospital and asked for the tube feeding formula. Resident 1's FM stated the hospital provided four bottles. Resident 1's FM further stated the facility staff told her that they would order the formula, but it would take time for it to be delivered.</p> <p>During a review of Resident 1's Order Summary Report, it indicated an order dated 7/5/2024 of TwoCAL HN (2.0 Calories, High Nitrogen liquid formula) to be given at 45 milliliters (ml, volume of measurement) per hour (/hr) for 24 hrs thru GT.</p> <p>During a concurrent observation and interview with director of nursing (DON) on 10/31/2024 inside Station AA's nutritional formula's storage, DON confirmed there was no available TwoCAL HN formula. DON stated the supervisor, or the admitting nurse should have called the registered dietitian (RD) if the ordered formula was not available to obtain an alternative.</p> <p>During an interview with assistant director of nursing G (ADON G) on 10/31/2024 at 3:06 p.m., ADON G stated nurses have a list of formula alternatives that the RD had provided to them. ADON G further stated, the admitting nurse should have called the RD if the alternative in the list was appropriate for Resident 1's use and they should have called the physician to get an order.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with assistant director of nursing B (ADON B) on 12/23/2024 at 11:06 a.m., ADON B stated nurses should have called the doctor upon Resident 1's admission to get an order for an alternative formula for tube feeding. ADON B further stated, the RD should have been called as well.</p> <p>Review of Resident 1's Nutrition/Dietary Progress Notes, dated 7/10/2024, indicated the new tube feeding formula with same calorie and protein contents from the previously ordered formula was just initiated, five days after Resident 1's admission.</p> <p>3. During a concurrent interview with licensed vocational nurse A (LVN A) and record review on 10/31/2024 at 1:37 p.m., LVN A reviewed Resident 1's July 2024 medication administration record (MAR). LVN A confirmed he initialed the 7/11/2024 Vancomycin administration at 22:28 p.m. LVN A further confirmed the registered nurse (RN) was the one who administered Resident 1's Vancomycin. LVN A stated the RN should have initialed the MAR.</p> <p>During a concurrent interview with DON and record review on 10/31/2024 at 2:23 p.m., DON reviewed Resident 1's July 2024 MAR. DON confirmed LVN A should not have initialed the IV administration in the MAR. DON stated the RN who administered the IV medication should be the one to document the medication administration in Resident 1's MAR.</p> <p>During an interview with ADON G on 10/31/2024 at 3:06 p.m., ADON G stated RNs should be the one to document or initial the administered IV ATB in the MAR. ADON G further stated, Based on what our DON in-serviced us, that RNs should click the medication they administered.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, date revised April 2019, indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: .The signature and the title of the person administering the drug.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on interview and record review, the facility failed to provide the pharmaceutical services to meet the needs of residents when:</p> <ol style="list-style-type: none"> 1. Licensed nurses did not administer the ordered intravenous (IV, to deliver a medication into a vein) antibiotic (ATB, a medicine that inhibits the growth of or destroys bacteria) in a timely manner as documented for three of three sampled residents (Residents 1, 2 and 3); and 2. Licensed nurse used other resident's normal saline (NS - a sterile solution containing 0.9% sodium chloride [salt] in water) to mix the Vancomycin for one of three sampled residents (Resident 1). <p>These failures resulted in medication not given to Resident's 1, 2, and 3 as per their scheduled time and had a potential to affect their health and safety.</p> <p>Findings:</p> <p>1a. Review of Resident 1's clinical record titled, Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (primary cancer) of esophagus (a muscular tube that moves food from the throat to the stomach), secondary malignant neoplasm (a primary cancer that has spread to other parts of the body) of unspecified lung, liver, intrahepatic bile duct, and digestive organs, severe protein-calorie malnutrition (a condition that occurs when the body doesn't get enough protein, calories, and other nutrients), dysphagia, and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>Review of Resident 1's clinical record titled, Order Summary Report, indicated an order of Vancomycin (a type of ATB) 500 milligrams (mg - unit of measurement) thru IV every 12 hours for infection. Further review indicated, the order was obtained on 7/11/2024 at 12:56 p.m. and with start time at 6:00 p.m.</p> <p>During a phone interview with Resident 1's family member (FM) on 10/31/2024 at 10:49 a.m., Resident 1's FM stated Resident 1 did not receive the ordered IV ATB on 7/12/2024 until 12:30 p.m.</p> <p>During a concurrent interview with licensed vocational nurse A (LVN A) and record review on 10/31/2024 at 1:37 p.m., LVN A reviewed Resident 1's July medication administration record (MAR) and nursing progress notes. LVN A confirmed Resident 1 was on his care on 7/11 and 7/12/2024. LVN A confirmed the first dose of Vancomycin was administered at 10:28 p.m. on 7/11 and the second dose was administered on 7/12/2024 at around 12:00 p.m. as documented in the progress note. LVN A stated both administration times were late. LVN A further stated nurses had a window period to administer the medication which was one hour before or one hour after the medication due time. LVN A confirmed whatever was documented was the real time the medication was administered. LVN A confirmed the Vancomycin was not available on 7/12/2024 at 6:00 a.m.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with director of nursing (DON) and record review on 10/31/2024 at 2:23 p.m., DON reviewed Resident 1's MAR. DON confirmed the first dose or start dose of Resident 1's Vancomycin should have been on 7/11/2024 at 6:00 p.m. DON stated they have Vancomycin available in their emergency kit (E-Kit).</p> <p>During an interview with assistant director of nursing B (ADON B) and record review on 12/23/2024 at 11:06 a.m., ADON B reviewed Resident 1's MAR and nursing progress notes. ADON B confirmed she was the manager on 7/12/2024. ADON B stated, Resident 1 had an infection and had an order of IV Vancomycin. ADON B confirmed the Vancomycin was administered late on 7/12/2024. ADON B stated medication could be administered one hour before or one hour after the scheduled time. ADON B confirmed Resident 1's scheduled time for Vancomycin administration should have been at 6:00 p.m. on 7/11/2024 and 6 a.m. on 7/12/2024. ADON B stated the facility had an E-Kit for IV ATB and Vancomycin 500 mg was available. ADON B further stated, the registered nurse should have taken one Vancomycin 500 mg from the E-Kit for Resident 1 to receive the ATB on time.</p> <p>During a review of the facility's policy and procedure titled, Medication Ordering and Receiving From Pharmacy Provider dated 9/2010, indicated, New medications, except emergency .are ordered as follows . Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a non-controlled medication prior to pharmacy delivery.</p> <p>1b. Review of Resident 2's clinical record titled, Admission Record, indicated Resident 2 was admitted to the facility with diagnoses including chronic respiratory failure, methicillin resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) infection, klebsiella pneumoniae (a type of bacteria that can cause infections to lungs, urinary tract and bloodstream), and Escherichia coli (E. coli - a type of bacteria that is commonly found in the intestines of humans and animals).</p> <p>Review of Resident 2's MAR, scheduled for December 2024, indicated an order dated 12/21/2024 to start at 8:00 p.m. for Vancomycin IV 500 mg every 12 hours for Sepsis (blood infection).</p> <p>During a concurrent phone interview with DON and record review of Resident 2's MAR on 12/24/2024 at 11:49 a.m., DON reviewed Resident 2's MAR. DON confirmed Resident 2's administration time for Vancomycin on 12/21/2024 was at 8:00 p.m. DON further confirmed Resident 2's Vancomycin was given at 10:51 p.m. DON stated she was not aware why the documentation was late. DON stated nurses should follow their policy to document the administration of medication once given to residents.</p> <p>During a phone interview with registered nurse C (RN C) on 12/30/2024 at 11:34 a.m., RN C confirmed she took care of Resident 2 on 12/21/2024. RN C confirmed medication should be given one hour before or one hour after the medication due time. RN C stated Resident 2's IV access was clogged on 12/21/2024 at 8:00 p.m. RN C further stated, she called for an IV nurse to insert a peripherally inserted central catheter (PICC - a thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart) to Resident 2. RN C confirmed she documented everything in alert charting to support her statement.</p> <p>During a review of Resident 2's alert charting documentation dated 12/22/2024 at 12:58 a.m., it indicated no justification of Vancomycin's late administration on 12/21/2024. Further review indicated, there was no PICC line inserted to Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview with medical record director (MRD) on 12/30/2024 at 11:58 a.m., MRD stated she couldn't find any other documentations on 12/21/2024 except the one sent dated 12/22/2024.</p> <p>1c. Review of Resident 3's clinical record titled, Admission Record, indicated Resident 3 was admitted to the facility with diagnoses including chronic osteomyelitis, right ankle and foot, encounter for adjustment and management of vascular (relating to the vessels of the body, especially the arteries and veins, that carry blood and lymph) access device) and personal history of MRSA infection.</p> <p>Review of Resident 3's MAR, scheduled for December 2024, indicated an order dated 12/07/2024 for Vancomycin IV 500 mg once a day for osteomyelitis of foot and to be administered every 9:00 p.m.</p> <p>During a concurrent phone interview with DON and record review of Resident 3's MAR on 12/24/2024 at 11:49 a.m., DON reviewed Resident 3's MAR. DON confirmed Resident 3's administration time for Vancomycin on 12/9/2024 was supposed to be at 9:00 p.m. DON further confirmed Resident 3's Vancomycin was given 12/10/2024 at 01:36 a.m. DON stated she was not aware why the documentation was late. DON stated nurses should follow their policy to document the administration of medication once given to residents.</p> <p>Registered nurse D (RN D) who was assigned to administer Resident 3's IV Vancomycin was contacted on 12/30/2024 at 11:53 a.m. but did not answer. A second call was attempted at 2:08 p.m., RN D did not answer.</p> <p>Review of Resident 3's alert charting on 12/9 and 12/10/2024, indicated there was no documentation of any reasoning when the medication was administered late on 12/9/2024 at 9:00 p.m.</p> <p>During a phone interview with MRD on 12/30/2024 at 11:58 a.m., MRD stated she couldn't find any other documentations on 12/9 and 12/10/2024 except the ones reviewed.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, date revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience .7. Medications are administered withing one (1) hour of their prescribed time, unless otherwise specified .</p> <p>2. During a phone interview with Resident 1's FM on 10/31/2024 at 10:49 a.m., Resident 1's FM stated Resident 1 received other IV ATB from another resident. Resident 1's FM further stated she was not sure if it was the right medication for Resident 1 because the IV bag had a different name.</p> <p>During an interview with DON on 10/31/2024 at 2:23 p.m., DON confirmed the nurse used other resident's NS to mixed Resident 1's Vancomycin. DON stated the nurse administered the right ATB ordered but used other resident's NS to Resident 1.</p> <p>During an interview with assistant director of nursing G (ADON G) on 10/31/2024 at 3:06 p.m., ADON G confirmed the nurse used NS from a discharged resident to mixed Resident 1's Vancomycin.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with ADON B on 12/23/2024 at 11:06 a.m., ADON B confirmed she checked Resident 1's IV Vancomycin during infusion due to Resident 1's FM complaint on 7/12/2024. ADON B stated Resident 1 received the right medication, but it was just mixed with other resident's NS. ADON B confirmed the NS bag had another resident's name labeled on it. ADON B stated the nurse should have used the NS available in the E-Kit instead of using another resident's NS.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, date revised April 2019, indicated, The individual administering the medication checks the label THREE (3) times to verify the right resident .Medication ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy .</p>