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	07/09/2025

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 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 interviews, and record review, the facility failed to implement their abuse policy and procedure for one of one resident (Resident 1) when the facility did not report Resident 1's injury of unknown source. This failure resulted in Resident 1's injury of unknown source not reported to required agencies (California Department of Public Health [CDPH], law enforcement agency, and Long-Term Care Ombudsman). This failure had the potential to compromise the safety of the residents in the facility. Findings: Review of Resident 1's clinical record titled, admission Record, dated 4/17/2025, indicated Resident 1 was admitted to the facility with diagnoses including COVID-19 (Coronavirus disease, an infectious disease caused by the SARS-CoV-2 virus, which can be very contagious, and spread quickly), hemiplegia (paralysis of one side of the body), and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (commonly referred to as stroke) affecting right dominant side (refers to the side of the body that tends to be stronger, faster, and more precise for tasks like writing, throwing, or brushing teeth), dysphagia (difficulty in swallowing), and encounter for attention to gastrostomy (a surgical procedure that creates a stoma [an opening] in the stomach, usually for the purpose of inserting a gastrostomy tube [G-tube/GT - this tube allow for the delivery of nutrition, fluids, and medications directly to the stomach]) Review of Resident 1's admission minimum data set (MDS- a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1's speech was clear, she had the ability to make herself understood and had the ability to understand others. Resident 1's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 11 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a phone interview with Resident 1's family member (FM) on 4/2/2025 at 12:54 p.m. Resident 1's FM stated she was called to let her know that Resident 1 had a discoloration to the right side of face, and right side of ear. Resident 1's FM further stated she was told a feeding pump fell on Resident 1's face, and she never believed them because the feeding pump was positioned to the left side of Resident 1's bed. Resident 1's FM stated the bruise could also be seen inside Resident 1's right ear. (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
	055750	A. Building B. Wing	07/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's clinical record titled, SBAR [situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents] & INITIAL COC [change of condition]/ALERT CHARTING & SKILLED DOCUMENTATION, dated 3/3/2025, indicated, Describe the problem/symptom: right side of face skin discoloration, right side eye discoloration .pt received with discoloration on right side of face and right ear .pt unaware of what happened .no falls reported. Further review indicated, discoloration to right side of face and ear eye 3.3 x 2.5 [measurement of length by width] ear 4.5 x 3.2. Review of Resident 1's clinical record titled, IDT [interdisciplinary team, a team composed of members from different departments involved in resident's care] - SKIN INTEGRITY (PRESSURE INJURY, OTHER WOUNDS), dated 3/6/2025, indicated Resident 1 had a right ear and right eye discoloration. It further indicated, Risk factors: -MUSCLE WEAKNESS (GENERALIZED) .Chronically bed bound .Fragile compromised skin integrity -High risk for unavoidable d/t [due to] risk factors .IDT determined resident noted to be combative pulling on feeding tubes and GT. Review of Resident 1's clinical record titled, ALERT CHARTING, dated 3/5/2025 at 11:30 a.m., indicated, . Noted before breakfast served swelling on right side of face ice compress applied and monitor patient . Review of Resident 1's medication administration record (MAR - (MAR - a daily documentation record used by a licensed nurse to document medications, treatments given to a resident and resident's monitoring), dated 2/2025 and 3/2025, indicated Resident 1 had a behavior monitoring for verbalization of anxiousness and yelling leading to exhaustion. Further review indicated Resident 1 did not demonstrate these behaviors in 2/2025 and 3/2025. During a phone interview with licensed vocational nurse A (LVN A) on 4/17/2025 at 10:06 a.m., LVN A confirmed she worked with Resident 1 on 3/3/2025, in the evening shift and found Resident 1 with right eye and right ear bruising. LVN A stated, the cause of bruising was undetermined. LVN A further stated, Resident 1 was not even restless during the shift, there was no behavior and Resident 1 told her that she did not know what happened. LVN A confirmed she reported her findings to the doctor and to the unit manager (assistant director of nursing B - ADON B). LVN A confirmed she did not report her findings to the police or to the state because there is nothing suspicious. During a concurrent interview with assistant director of nursing C (ADON C) and record review on 4/17/2025 at 10:17 a.m., ADON C reviewed Resident 1's IDT dated 3/6/2025 and March 2025 MAR. ADON C confirmed she was a part of the IDT on 3/6/2025 and stated the possible contributing factor of Resident 1's discoloration to the face was not included in the IDT notes. ADON C further confirmed she did not know how Resident 1 sustained the discoloration to the right side of the face. ADON C confirmed the following: Resident 1 was not on any anticoagulant medications (AC - medications that prevent blood from clotting too easily which can increase the risk of bleeding or bruising); Resident 1 did not have any documented behavior in March 2025; and there was no care plan related to Resident 1's bruising. When ADON C was asked if she should have reported Resident 1's bruising with no known cause, ADON C stated she did not want to decide if she should have reported it and would just ask the team's decision. ADON C confirmed she was aware that she was a mandated reported [an individual who holds a professional position that is required by law to report suspected or known instances of abuse to state agencies and local law enforcement]. (continued on next page)

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	07/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADON B on 4/17/2025 at 10:51 a.m., ADON B confirmed Resident 1's discoloration to the right side of face was reported to her. ADON B stated Resident 1 had a history of pulling the GT and when she asked Resident 1 of what happened, Resident 1 stated she did not know what happened. ADON B confirmed she investigated the possible cause of the discoloration on Resident 1's face and stated Resident 1's feeding pole fell on to Resident 1 and she confirmed nobody witnessed it. When asked why nobody witnessed the incident, ADON B stated Resident 1 was able to pull the feeding pole back up. When asked if she should have reported the unusual bruise on Resident 1's face, ADON B stated this case was new to her, and it should have been reported to CDPH, but she would find out the answer. During an interview with director of nursing (DON) on 4/17/2025 at 11:05 A.M., DON stated ADON B reported Resident 1's bruise, and she would pull her GT. DON further stated, it was a quick decision that it was the pump [feeding pump] that fell on her. DON confirmed it was not reported to state agencies because she heard' from staff that they determined the cause of the injury. During an interview with social services (SS) on 4/17/2025 at 11:19 a.m., SS stated he did not get a report about the bruise with unknown cause. Informed SS that he was a part of the IDT held in 3/6/2025, SS stated he could not recall the IDT because they had a lot. During an interview with the facility's administrator (ADM) on 4/17/2025 at 11:51 a.m., ADM stated ADON B talked to him about Resident 1's bruise and Resident 1 had a history of pulling of tubes, throwing meal trays, and making frantic movements. ADM confirmed that whenever an SBAR was made, the IDT would review them the following day. ADM further confirmed he did not investigate the cause of Resident 1's injury and he did not report it to state agencies. When asked about Resident 1's SBAR was completed on 3/3/2025 which was a Monday, why did the IDT reviewed it on 3/6/2025 (3 days after), ADM stated that he would get back to the nurse surveyor and he would talk to ADON B. During an interview with licensed vocational nurse D (LVN D) on 4/30/2025 at 10:45 a.m., LVN D confirmed he took care of Resident 1, and she did not have any behavior except the refusal to eat. During a concurrent interview with registered nurse E (RN E) and record review on 4/30/2025 at 11:03 a.m., RN E reviewed Resident 1's March 2025 evaluations and nurse's progress notes and confirmed Resident 1 had bluish discoloration on 3/3 to the right side of her face. RN E further confirmed she was not sure how Resident 1 sustained the bruise to her face. When asked if the unknown cause of Resident 1's bruise should have been reported, RN E stated, no, but she was aware that everyone was a mandated reporter. RN E confirmed that no one witnessed that a feeding pole fell on to Resident 1 and if it happened, Resident 1 would not be able to pull the pole back up. During an interview with certified nursing assistant F (CNA F) on 4/30/2025 at 12:21 p.m., CNA F confirmed he was assigned to Resident 1 on 3/3/2025, in the morning shift, and stated Resident 1 had periods of refusal with medications, to be changed and with meals. CNA F further stated, I don't think she can pull her GT because her right side is weak. She can only move the left arm. CNA F confirmed Resident 1 did not have any discoloration on her face in the morning of 3/3/2025. (continued on next page)

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	07/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with licensed vocational nurse G (LVN G) on 4/30/2025 at 12:38 p.m., LVN G confirmed he worked with Resident 1 in March 3/2025 when he was still a CNA. LVN G stated, Resident 1 refused to eat but she never hit anyone. LVN G further stated, he noticed Resident 1 had a purplish discoloration to her face when he helped another CNA to reposition Resident 1 in bed. LVN G stated he did not ask what happened to her face because he assumed it was already reported. During a concurrent interview with licensed vocational nurse H (LVN H) on 7/9/2025 at 10:14 a.m., LVN H reviewed Resident 1's ALERT CHARTING notes on 3/5/2025, and LVN H confirmed she was the one who documented about the swelling and discoloration on Resident 1's face. LVN H stated she did not know how Resident 1 sustained that discoloration, and she did not report it because it was up to the administration's decision. LVN H further stated, nurses just had to do the SBAR and report to MD. During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, date revised April 2021, indicated, All reports of resident abuse including injuries or unknown origin) .are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse .or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman . d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials . Immediately is defined as: .b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Verbal/written notices are submitted via special carrier, fax, e-mail, or by telephone . Upon receiving any allegations of abuse, .or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .The administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.