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	04/21/2026

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 0684 Level of Harm - 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 interview and record review, the facility failed to provide services according to professional standards for one of two sampled residents (Resident 1) when registered nurse A (RN A) and licensed vocational nurse B (LVN B) re-inserted Resident 1's gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) without proper training and demonstration of competency in this procedure, using a bigger size of GT and did not have a detailed confirmation of GT placement (verifying if the tube is in the stomach using methods like checking for stomach contents, easy rotation of the tube, and lack of leakage. The most common method is attaching a syringe, pulling back to see gastric content, and performing a air bolus test, where 5-10 milliliters [ml - volume of measurement] of air is injected while listening to the stomach with a stethoscope [Medscape [DATE] - Gastrostomy Tube Replacement Technique]).These failures resulted in Resident 1's desaturation (drop of oxygen concentration), abdominal distension (visible or measurable swelling and enlargement of the abdomen beyond its normal size), respiratory distress (difficulty breathing, labored breathing, or the need for increased effort to breathe, often resulting in low oxygen levels) due to GT malpositioning (the feeding tube is not properly located within the stomach, having been misplaced during reinsertion), cardiac arrest (a medical emergency where the heart suddenly stops beating, cutting off blood flow to the brain and body) and Resident 1 was sent to acute hospital via 911 where Resident 1 ended up in the hospital's intensive care unit (ICU - a specialized hospital department with high-level monitoring and advanced life support for patients with life-threatening illnesses or injuries) with severe septic shock (a life-threatening stage of sepsis, caused by infection which resulted to a rapid drop in blood pressure and organ failure) due to catastrophic intra-abdominal process (or abdominal catastrophe, a sudden, severe, and life-threatening medical emergency involving the organs within the belly that requires immediate surgical intervention) from misplaced G tube. Resident 1's misplaced GT had the potential to affect her quality of life due to considerable pain, and possible multiple surgeries to address the problem. Resident 1 passed away on [DATE] at 11:55 p.m.Findings:Review of Resident 1's clinical record titled, admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (a long-term progressive condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide) with hypoxia (a dangerous condition where the body tissues and organs do not receive enough oxygen to function properly), dependence on respirator status (use of ventilator, a life-support machine that breathes for patients who cannot breathe sufficiently on their own), Ogilvie syndrome (also called acute colonic pseudo-obstruction, a sudden, severe swelling [dilatation] of the large intestine without any physical blockage), and encounter for attention to gastrostomy.Review of Resident 1's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1 had short term memory (a temporary storage space that holds limited amount of information for a few seconds to minutes) and long term memory (the brain's system for storing, managing, and retrieving information for long periods - from a few minutes to a lifetime) problem.Review of Resident 1's nursing alert charting dated [DATE], indicated that at 4:00 p.m., Resident 1's GT was out and RN A (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	did not find Resident 1's GT size which was 16 French (Fr - is a medical measurement used to determine the outer diameter of catheters, or tubes. A higher French number means a wider tube; a lower number means a narrower tube). Further review indicated that RN A re-inserted Resident 1's GT with use of 20 Fr and the stoma site (surgically created opening in the tummy) had a scant amount of bleeding. It indicated, confirmed GT placement by 2 nurses. G tube was in. MD [medical doctor] notified. stated ok to continue feeding.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 [DATE] at 12:30 p.m., indicated Resident 1's oxygen level was low, and had abdominal distension. It indicated at 1:20 p.m. Resident 1 had respiratory distress, 911 was called, CPR (Cardiopulmonary Resuscitation, an emergency lifesaving procedure performed when the heart stops beating or breathing ceases) was initiated by facility staff while waiting for 911 to arrive, and she was transferred out to the hospital for further evaluation.During an interview with licensed vocational nurse C (LVN C) on [DATE] at 1:17 p.m., LVN C stated there should always be two nurses in re-insertion of GT wherein one nurse should push 10 ml of air through the GT into the stomach and the other nurse should listen for the whooshing sound with use of stethoscope in the resident's abdomen. LVN C further stated, this validation of placement should have been done twice and there should have been a standing order of x-ray to confirm the correct placement of GT.During a concurrent observation and interview with LVN C on [DATE] at 1:25 p.m., inside the facility's central supply room, LVN C showed the difference between Fr 20 and F16 of GT. LVN C confirmed, GT Fr 20 had bigger tube which could hold 7-10 ml of sterile water (a highly purified water free from viable microorganisms, bacteria, and viruses), while GT Fr 16 could hold 3-5 ml of sterile water. LVN C stated, if they ran out of GT Fr 16 and the resident needed Fr 16, we tried to use the smaller size, we do not want to use a bigger one because it might rupture something.During a phone interview with RN A on [DATE] at 1:44 p.m., RN A stated she was assigned to Resident 1 on [DATE] when the GT was pulled out. RN A further stated, she couldn't find GT Fr 16 and used Fr 20 instead. She stated she just assisted Resident 1's GT reinsertion, and it was LVN B who reinserted the GT. RN A stated, they both verified the placement of the GT. RN A confirmed there was a scant amount of bleeding in the GT site.During a phone interview with the medical doctor (MD) on [DATE] at 10:59 a.m., the MD confirmed she had given the order on [DATE] to reinsert Fr 20 GT because the facility did not have Fr 16. MD stated they usually would use the closest size, which was Fr 18, but they did not have it at that time. MD further stated since Resident 1 had the GT for a long time, she did not order to transfer her out to hospital for GT reinsertion. When asked how the GT was checked for placement, the MD stated there should be a residual (the amount of formula, fluid, and secretions remaining in the stomach) and they could gradually introduce the feeding tube formula (a specialized liquid mixture providing comprehensive nutrition-protein, carbohydrates, fats, vitamins, and minerals-directly to the stomach) at 15 ml for an hour until they reached the desired feeding rate (the specific, prescribed speed at which the liquid formula is delivered through a feeding tube). MD further stated, it is a standard practice. MD stated there was no need to perform an x-ray but because of the incident with Resident 1, the facility have to do a KUB (Kidneys, Ureter, and Bladder - a diagnostic imaging test that captures a single image of the abdominal area while the patient is lying on his/her back) x-ray before nurses could use the GT to make sure it was in the right place.During a phone interview with LVN B on [DATE] at 3:35 p.m., LVN B confirmed he re-inserted Resident 1's GT. LVN B stated there was no available Fr 16, and he used Fr 20 because that was the only available size. LVN B further stated they verified the GT placement when there was stomach content drawn from the GT and there was a whooshing sound when he injected 40 ml of air into the GT. LVN B stated he did not have to document anything because he was not the nurse assigned to Resident 1.During a concurrent interview with the director of staff development (DSD) and record review of five licensed nurses' employee files (RN A, LVN B, RN D, RN E, and RN F) on [DATE] at 1:20 p.m., the DSD confirmed RN A (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and LVN B did not have a training and competency checklist for reinsertion of GT, until [DATE]. DSD stated RN D, RN E, and RN F were mostly assigned in the subacute area and did not have the training and competency checklist for reinsertion of GT. The DSD further stated, these nurses were not allowed to re-insert the GT unless they had the training and competency in reinsertion of GT.Review of Resident 1's clinical record from the hospital titled, ICU's [intensive care unit] Advance Care Planning, dated [DATE], indicated, Patient with severe septic shock due to catastrophic intrabd [intraabdominal] process from misplaced G tube.Review of Resident 1's acute hospital clinical record titled, MICU [Medical Intensive Care Unit] RESIDENT PROGRESS NOTE, dated [DATE], indicated Resident 1, who was BIBA [brought in by ambulance] from SNF [skilled nursing facility] following cardiac arrest, found to have septic shock likely 2/2 [secondary to] intraabdominal infection [a bacterial or fungal infection that occurs inside the abdominal cavity, often caused by the leakage of stomach contents] in setting of malpositioned PEG (Percutaneous Endoscopic Gastrostomy tube, also known as GT, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). Further review indicated, the abdomen was significantly distended and tense [the abdomen is swollen, stretched out, and rigid due to internal pressure] . It indicated Resident 1's result of abdomen CT scan (computed tomography scan - noninvasive diagnostic imaging procedure used to detect diseases, injuries, and infections), The PEG enters into the peritoneum [a serous membrane that lines the abdominal cavity], and there is free fluid and contrast within the peritoneal cavity [the presence of abnormal fluid floating freely inside the abdominal space surrounding organs] .Review of Resident 1's Death Summary, dated [DATE], indicated, Per surgery, while ex lap [exploratory laparotomy, a major surgical procedure involving a large incision in the abdomen, allowing doctors to physically examine organs to diagnose and treat issues] could address PEG misplacement, it would likely require multiple surgeries and would not improve quality of life but add considerable pain to patient's remaining life. Further review indicated that Resident 1 passed away on [DATE] at 11:55 p.m.During a review of the facility's policy and procedure titled, Changing a Percutaneous endoscopic Gastrostomy (PEG) Tube, date revised 11/2018, indicated, PEG tube replacement must be performed by a licensed nurse who has received training and demonstrated competency in this procedure.The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed.3. The name and title of the individual(s) who performed the procedure. 4. All assessment data obtained during the procedure. 5. How the resident tolerated the procedure.