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	04/22/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide necessary services to maintain grooming and personal care to one of two sampled residents (Resident 1) when Resident 1's skin in bilateral (involving or affecting two side, or parts) lower legs especially the heel areas were very white, and scaly (a symptom where the top layer of skin becomes, dry, rough, and sheds in flakes, often resembling fish scales) due to dryness, and her fingernails and toenails were long.These failures had the potential to affect Resident 1's health and well-being.Findings:1a. Review of Resident 1's clinical record titled, admission Record, dated 2/25/2026, indicated Resident 1 was admitted to the facility with diagnoses including respiratory failure (a condition when lungs cannot release oxygen to blood causing shortness of breath) with hypoxia (occurs when oxygen level in the body organs are low), methicillin resistant staphylococcus aureus infection (MRSA - a bacteria that does not respond to antibiotics), tracheostomy status (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube), 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).Review of Resident 1's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment, dated 1/26/2026, indicated Resident 1 had long term memory (the brain's system for storing, managing, and retrieving information for long periods - from a few minutes to a lifetime) and short-term memory (a temporary storage space that holds limited amount of information for a few seconds to minutes) problems. Further review indicated Resident 1 was dependent on all her activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent observation and interview with licensed vocational nurse A (LVN A) on 3/4/2026 at 11:58 a.m., inside Resident 1's room, Resident 1 was observed in bed, eyes opened and her bilateral lower legs' skin, especially the heels were white and scaly due to dryness. LVN A confirmed above observation and stated certified nursing assistants (CNAs) should have moisturized Resident 1's skin. LVN A further stated, if the CNAs could not moisturize residents' skin, licensed nurses should do it.During a concurrent observation and interview with registered nurse B (RN B) on 3/20/2026 at 10:54 a.m., inside Resident 1's room, Resident 1's bilateral lower legs and heels' skin were white, and scaly. RN B confirmed observation and stated CNAs should have moisturize Resident 1's skin during ADL care.During an interview with certified nursing assistant C (CNA C) on 3/26/2026 at 10:18 a.m., CNA C stated we (CNAs) should moisturize residents' skin after ADL care.During a phone interview with the director of nursing (DON) on 4/2/2026 at 10:37 a.m., DON stated the CNAs should moisturize residents' skin during ADL care, after bed bath, showers, and when needed.During a review of the facility's policy and procedure titled, Bath, Shower/Tub, date revised 2/2018, indicated, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.The following equipment and supplies will be necessary when performing this procedure. 1. Portable bath chair; 2. Lotion.1b. During a concurrent observation and interview with RN B on 3/20/2026 at 10:54 a.m., inside Resident 1's room, Resident 1 was in bed and the following were observed: Resident 1's left first/great toenail was long, thick, light yellow in color; the left second toenail had brown/black discoloration, long and curved; the right first/great toenail (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	04/22/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was long and thick; and both right and left fingernails were long and thick. RN B confirmed the observations and stated, oh yes, they are long. RN B stated CNAs should have trimmed Resident 1's fingernails and toenails. RN B further stated Resident 1 did not have diabetes (a disease that occurs when the blood sugar is too high).During an interview with the director of subacute (DSA) on 3/20/2026 at 11:06 a.m., the DSA stated their podiatrist (a doctor who specializes in caring for feet and ankles) visited the facility once a month and their CNAs trimmed their resident's toenails (if not complicated) and fingernails every Saturday. The DSA further stated CNAs and licensed nurses (LNs) were responsible for nail trimming, and they could also do it during shower days. The DSA confirmed Resident 1's shower days were every Wednesday and Sunday night.Review of Resident 1's clinical record titled, Order Summary Report, order dated 8/25/2025, indicated there was an order for podiatry appointment.During an interview with social services D (SS D) on 3/20/2026 at 11:32 a.m., SS D stated Resident 1 had an insurance which did not cover the facility's podiatrist, and the family was responsible to pay privately. SS D further stated Resident 1?s family owed their podiatrist $130 and would never provide the service until the family would pay. SS D confirmed the administrator was not aware about this concern, and they never notified him to address the concern.During a concurrent interview with nursing supervisor (NS) and record review on 3/20/2026 at 2:55 p.m., NS reviewed Resident 1's Shower Day Skin Inspection record dated 3/18/2026 which was completed by Resident 1's CNA. It indicated Resident 1 had a shower on 3/18/2026, her fingernail did not need clipping, and her toenails for need clipping was left unmarked. NS confirmed both fingernails and toenails should have been marked, yes for need clipping.During concurrent observation and interview with licensed vocational nurse E (LVN E) on 3/26/2026 at 10:20 a.m., inside Resident 1's room, Resident 1's toenails were still long, and thick. LVN E confirmed above observation and stated the podiatrist did not visit yet.During a phone interview with the DON on 4/2/2026 at 10:37 a.m., the DON stated nail trimming should have been done by LNs or CNAs if residents did not have any problem that would not require them to trim residents' fingernails and toenails. DON further stated CNAs or LNs should trim residents' toenails if a resident was not diabetic. DON stated CNAs should notify the LNs if a diabetic resident needed toenail trimming and LNs should notify SS. DON further stated SS should have brought up this concern in their daily morning meetings to get some guidance on how to proceed.Review of Resident 1's podiatry note dated 4/1/2026, indicated, Nails are long and thickened x 1' [one inch long]. R [right] hallux [big toe] nail has a bruise [or contusion, a common injury resulting from broken small blood vessels that leak blood into surrounding tissues].L [left] 2nd toe has a mild ingrown [a nail that has grown abnormally into the surrounding skin/flesh, often causing pain, inflammation, and infection].During a review of the facility's policy and procedure titled, Fingernails/Toenails, Care of, date revised 2/2018, indicated, Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Watch for and report any changes in the color of the skin around the nail bed,.Stop and report to the nurse supervisor if there is evidence of ingrown nails.or nails are too hard or too thick to cut with ease.During a review of the facility ?s policy and procedure titled, Foot Care, date revised 10/2022, indicated, Residents are provided with foot care and treatment in accordance with professional standards of practice.Residents are assisted in making appointments and with transportation to and from specialists (podiatrist.) as needed. Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes.During a review of the facility's policy and procedure titled, Activities of Daily Living (ADL), Supporting, date revised 3/2018, indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (. grooming.).

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	04/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices was implemented when licensed vocational nurse E (LVN E) used a non-dedicated battery-operated blood pressure apparatus (BP app - a manual or automated devices intended for general, or multi-user rather than a specialized, single patient, or permanently installed in the room) to Resident 1 who was on Contact Precaution [infection control measures used in healthcare to prevent the spread of germs passed by direct touching (patient) or indirect touching (contaminated surfaces/equipment)], and did not clean and sanitize (a substance designed to reduce or eliminate germs, bacteria, and microorganisms on surfaces or skin to safe levels) the equipment before leaving the room.This failure had the potential to compromise resident's health and safety, and spread infections to residents, staff, and visitors.Findings:Review of Resident 1's clinical record titled, admission Record, dated 2/25/2026, indicated Resident 1 was admitted to the facility with diagnoses including respiratory failure (a condition when lungs cannot release oxygen to blood causing shortness of breath) with hypoxia (occurs when oxygen level in the body organs are low), methicillin resistant staphylococcus aureus infection (MRSA - a bacteria that does not respond to antibiotics), tracheostomy status (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube), 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).Review of Resident 1's Order Summary Report, indicated a physician's order dated 1/1/2025, indicated, CONTACT PRECAUTIONS SECONDARY TO DX [diagnosis]: Carbapenemase-producing organisms [CPO - are highly-resistant bacteria that produce enzymes (carbapenemases) which pose an urgent public health threat, causing difficult-to-treat infections] every shift.During an observation on 2/25/2026 at 11:08 a.m., in Station AA, in front of Resident 1's room, there was a facility made Contact Isolation signage posted at Resident 1's entrance door.During an interview with licensed vocational nurse A (LVN A) on 2/25/2026 at 11:11 a.m., LVN A confirmed Resident 1 was on contact isolation due to having microorganism resistant to antibiotics.During an interview with registered nurse F (RN F) on 2/25/2026 at 11:14 a.m., RN F stated she was assigned to Resident 1, and the resident was on contact isolation due to CRO [carbapenem-resistant organisms are highly drug-resistant bacteria, often found in healthcare settings that cause infections] in her urine.During an observation on 3/26/2026 at 10:20 a.m., inside Resident 1's room, the following were observed: LVN E donned (put on) gown and gloves before she entered the room, carried the battery operated BP app which she took from the medication cart, placed the device on Resident 1's foot part of the bed, and wrapped the BP cuff on Resident 1's right lower leg to obtain the blood pressure. After LVN E took Resident 1's blood pressure, she carried the device, removed her gown and right glove, she hugged the device into her chest with her right forearm and removed the left glove with use of right hand, carried the BP app with her bare hands, took it out of the room without cleaning and sanitizing the equipment, and placed it on top of the medication cart.During an interview with LVN E on 3/26/2026 at 10:45 a.m., LVN E confirmed above observations. LVN E stated there was no dedicated BP app in Resident 1's room and there was another contact isolation room that had one that family brought from home. LVN E further stated there should have been a dedicated BP app in each contact isolation room. She stated she should have cleaned and sanitized the BP app she used before she took it out of Resident 1's room.During an interview with the director of sub-acute (DSA) on 3/26/2026 at 11:00 a.m., the DSA stated they have a dedicated BP app which they were charging at the hallway. The DSA further stated they cleaned the dedicated BP app after each usage. The DSA confirmed the LVN E should have used the dedicated BP app for contact isolation residents.During an interview with the infection preventionist (IP) on 3/26/2026 ay 1:40 p.m. the IP stated nurses should always use the dedicated BP app in contact isolation rooms.During a review of the Centers for Disease Control and Prevention (CDC) signage for Contact Precautions, it indicated, EVERYONE (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	04/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MUST: Use dedicated or disposable equipment.During a review of CDC's Infection Control titled, Transmission-Based Precautions, dated 4/3/2024, indicated, Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission.Use disposable or dedicated patient-care equipment (e.g. blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on an another patient.During a review of the facility's policy and procedure titled, Multidrug-Resistant Organisms [MDRO - bacteria or fungi resistant to one or more classes of antimicrobial drugs], date revised 8/2019, indicated, Dedicate non-critical medical items to use on individual residents known to be infected or colonized with an MDRO .Enhanced Environmental Measures 1. Non-critical equipment is dedicated to the MDRO cohort unit and is not utilized outside of the designated area. When resident-specific equipment is not feasible, unit-dedicated equipment is used and cleaned and disinfected between each resident use in accordance with facility infection prevention and control policies to minimize risk of cross-contamination.