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	05/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to protect a resident's right to be free from sexual abuse when Certified Nursing Assistant (CNA) C witnessed Resident 5 placed his male genital (penis) inside Resident 4's mouth. This failure resulted in nonconsensual sexual act that put Resident 4 at risk for sexually transmitted infection, injury and psychosocial distress.FINDINGS: A review of Resident 4's medical record indicated an admission date of 1/18/2018. Resident 4's son had Power of Attorney (a legal document that allows a resident to appoint someone else to manage financial, legal, or medical affairs) and was the responsible party for Resident 4's finances and care. Resident 4's diagnoses included but were not limited to, contracture of muscle right and left lower leg (the permanent, abnormal shortening or stiffening of muscles, tendons, ligaments, or skin, causing joint stiffness and restricting movement); paroxysmal atrial fibrillation (an irregular, often rapid heart rate that comes and goes, starting and stopping on its own); generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things-such as health, finances, or family); unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance ((a mental health condition characterized by a loss of contact with reality, where an individual's thoughts and perceptions are significantly disrupted); mood disturbance (when a person loses touch with reality, making it hard for them to know what is real and what is not), and anxiety (a decline in mental abilities-like memory, reasoning, and communication-severe enough to interfere with daily life); major depressive disorder, recurrent, unspecified (a mental health condition characterized by a persistent feeling of deep sadness, emptiness, or loss of interest in activities); and other frontotemporal neurocognitive disorder (a progressive brain disease that shrinks the areas responsible for personality, behavior, and language). A review of Resident 4's Minimum Data Set (MDS, an assessment tool), dated 3/9/26, indicated a brief interview for mental status score of 12 [BIMS - an assessment to test a person's cognition level, a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 patient is cognitively intact].A review of Resident 4's Physician Orders included but were not limited to, Admit to [Name of Hospice Company] Hospice [a specialized type of care focused on comfort, quality of life, and dignity for patients with terminal illnesses rather than curing them] with DX [diagnosis] terminal diagnosis of: Advanced frontotemporal dementia, sepsis age related physical debility on 3/27/26. In short, Resident 4 was in Hospice Care. Morphine Sulfate (concentrate) Solution 20 mg/ml [milligram/milliliter, a unit of measurement] Give 0.25 ml by mouth every 6 hours as needed for BTP [Breakthrough Pain, transitory, intense flare of pain that occurs on top of otherwise stable, controlled chronic pain]. A review of Resident 5's medical record indicated an admission date of 4/23/25 and a discharge date of 4/7/26. Resident 5's diagnoses included but were not limited to polyneuropathy [a condition where multiple peripheral nerves throughout the body are damaged simultaneously, causing widespread symptoms]; hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease [a condition where long-term high blood pressure damages both the kidneys and the heart simultaneously]; atherosclerotic heart disease of native coronary artery without angina pectoris (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[hardening of original arteries that supply blood to your heart due to plaque buildup, causing narrowing]; unspecified dementia, unspecified severity, with other behavioral disturbance.A review of Resident 5's Minimum Data Set (MDS, an assessment tool), dated 1/8/26, indicated a brief interview for mental status score of 4 [BIMS, an assessment to test a person's cognition level, a score of 0 to 7 indicates severe cognitive impairment, 8- 12 moderate cognitive impairment, 13-15 patient is cognitively intact]. A review of Resident 5's Order Summary Report indicated, Active orders as of 1/5/2026, 2/01/2026, 3/02/2026 and, 4/01/2026 all these monthly orders indicated, Order Summary1. ATTEMPTED TO REDIRECT. 2. 1:1 INTERVENTION. 3. SPOKEN IN CALM MANNER. 9. ENCOURAGE TO EXPRESS FEELINGS/CONCERNS. 11. TAKEN TO ACTIVITIES . , with Order Date 8/15/2025 and Start Date 8/15/2025. This order indicated Resident 5 was to be on 1:1 intervention. A review of Resident 5's Order Summary Report: Active Orders as of 4/1/2025 indicated, Resident 5'S medication included:Oxcarbazepine Oral tablet 300 mg, give 1 tablet by mouth two times a day for MOOD DISORDER M/B (manifested by) SUDDEN ANGRY OUTBURST, with Order Date 3/10/2026 and Start Date of 3/10/26.PROZAC Oral Capsule 20 mg (Fluoxetine HCL) Give 1 capsule by mouth one time a day for DEPRESSION M/B INTENSE AFFECTION TO OTHERS AND SEEKING OUT COMPANY OBSESSIVELY, with Order Date 3/31/2026 and Start Date 4/01/2026. Further review of Resident 5's Order Summary Reports : Active Orders as of 1/5/2026, 2/012026 and 3/02/2026, all included order forOxcarbazepine Oral tablet 300 mg, give 1 tablet by mouth two times a day for MOOD DISORDER M/B (manifested by) SUDDEN ANGRY OUTBURST, with Order Date of 1/2/2026 and Start Date of 1/3/2026. All Active Orders as of 1/5/2026, 2/01/2026, 3/2/2026 and 4/01/2026 included and indicated, Behavior Monitoring (Oxcarbazepine) Document Number of Episodes per shift or target behavior [Specify] SUDDEN ANGRY OUTBURST every shift. Order date 10/03/2025 and start date of 10/03/2025 A review of Resident 5's Care Plan with Date Initiated 8/15/2025 indicated, Focus: The resident has mood disorder problem(s) r/t (related to) DX. OF DEMENTIA M/B (manifested by) SUDDEN ANGRY DISORDER. 8/15/25: Resident started on Oxcarbazepine for MOOD DISORDER. 10/13/25: Resident with behavior of taking/getting staff personal property such as cell phone, other resident's clothing. >>> GETTING CLOSE and PROTECTIVE TO OTHER RESIDENT. A review of Resident 5's Care Plan with Date initiated 3/31/26 indicated, Focus: Resident has DEPRESSION M/B [manifested by] intense affection to others and seeking out company obsessively. A review of Resident 5's Care Plan with Date Initiated 4/3/26 indicated Focus: [name of Resident 5] was observed standing with inappropriate exposure and contact involving the other resident. This is the care plan initiated for the abuse which occurred on 4/3/26. A review of Resident 5's Care Plan with Date Initiated 4/7/26 indicated, Focus: ALTERCATION [Name of Resident 5] Room no. to CNA 1 on 1 sitter With intervention INCLUDING Fax SOC 341 (Reports of Suspected Dependent Adult/Elder Abuse) to CDPH, Ombudsman & Law Enforcement. This Intervention has a Date Initiated 4/8/26 However, a review of the SOC 341 received at the State Agency only indicated it was faxed to the State Agency and cross- reported to Ombudsman but it did not indicate the abuse incident was reported to Law Enforcement during the date of occurrence and it did not indicate it was also faxed to the Ombudsman. During an interview on 4/9/26 at 3:18 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated that CNA C reported Resident 5 was seen on 4/3/26 in Resident 4's room with his pants down by Resident 4's bedside. The ADM also stated the staff reported Resident 5's genitals touched Resident 4's head. The DON stated CNA C witnessed and reported the sexual abuse. During a phone interview on 4/13/26 at 2:09 p.m. with CNA C, CNA C stated that on 4/3/26 at around lunch time, she noted Resident 5 was not in his room or dining area. CNA C then stated she noticed Resident 4's room was closed and she walked inside the room with CNA D without making any noise and saw Resident 5 standing by Resident 4's top left bedside. CNA C also stated Resident 4 was asleep with eyes closed and Resident 5's male genital (penis) was inside Resident 4's mouth. CNA C stated Resident 5 was asked to get outside of Resident 4's room. CNA C also stated staff were aware of Resident 5's behaviors such as entering other residents' rooms and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grabbing clothes and staff were supposed to supervise him. CNA C stated Resident 5 can walk without assistance, can eat by himself and was able to get to the bathroom unassisted. CNA C stated she did not mention the sexual abuse to anyone and waited for the supervisor to report the incident. CNA C also stated she was not aware who was their Abuse Coordinator. During a phone interview on 5/4/26 at 3:15 p.m. with the DON, the DON stated CNA D was with CNA C when the sexual abuse was witnessed on 4/3/26 in Resident 4's room. The DON also stated CNA C reported the incident to the Unit Manager (UM) and the UM reported it to the ADM on 4/7/26. The DON stated it should have been reported earlier. During a phone interview on 5/6/26 at 10:57 a.m. with the UM, the UM stated CNA C reported the sexual abuse incident to her on 4/3/26 at 12:15 p.m. The UM also stated Resident 4's responsible party was not informed of the sexual abuse on 4/3/26. The UM stated she reported the sexual abuse incident to their Abuse Coordinator, the ADM on 4/7/26. The UM stated their Abuse Reporting Protocol indicated it should have been reported within two hours to the Ombudsman, California Department of Public Health, and the police. A review of facility's 5 Day Investigation Report submitted on 4/10/26 to California Department of Public Health indicated, .Event Description: On 4/7/2026 at approximately 12:25 pm, a report was received from staff regarding an alleged inappropriate physical interaction involving resident and a female resident. Per report, the resident was observed standing with exposed genitalia and physical contact occurred with the female resident in the head area. The alleged event was reported to have occurred in room [number/letter] on 4/3/2026 at around 12:00 pm . A review of facility's policies and procedures (P&P) entitled Resident Rights revised December 2016, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .c. be free from abuse, neglect, misappropriation of property, and exploitation; . A review of facility's policies and procedures (P&P) entitled Abuse and Neglect- Clinical Protocol revised March 2018, the P&P indicated, Definitions.3. ?Sexual abuse' is defined.as ?non-consensual sexual contact of any type with a resident.A review of facility's policies and procedures (P&P) entitled Abuse Investigation and Reporting dated October 2022, the P&P indicated, .Reporting:.2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; orTwenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.

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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 interview and record review, the facility failed to ensure an alleged violation involving sexual abuse was reported immediately when the Unit Manager (UM) failed to immediately report a witnessed sexual abuse on Resident 4 by Resident 5 on 4/3/26. The UM failed to call the Police, notify the State Agency (CDPH - California Department of Public Health) and the Ombudsman on 4/3/26 when the sexual abuse occurred and within the timeframe defined by regulations. This failure resulted in delayed investigation of the abuse allegation and put residents at risk of possible violations such as abuse, neglect, exploitation or mistreatment with or without injuries.FINDINGS: A review of Resident 4's medical record indicated an admission date of 1/18/2018. Resident 4's son had Power of Attorney (a legal document that allows a resident to appoint someone else to manage financial, legal, or medical affairs) and was the responsible party for Resident 4's finances and care. Resident 4's diagnoses included but were not limited to, contracture of muscle right and left lower leg (the permanent, abnormal shortening or stiffening of muscles, tendons, ligaments, or skin, causing joint stiffness and restricting movement); paroxysmal atrial fibrillation (an irregular, often rapid heart rate that comes and goes, starting and stopping on its own); generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things-such as health, finances, or family); unspecified dementia (a decline in mental ability-including memory, language, and reasoning-severe enough to interfere with daily life), unspecified severity, without behavioral disturbance, psychotic disturbance (a mental health condition characterized by a loss of contact with reality, where an individual's thoughts and perceptions are significantly disrupted); mood disturbance (when a person loses touch with reality, making it hard for them to know what is real and what is not), and anxiety (body's natural response to stress characterized by feelings of fear, dread, and uneasiness); major depressive disorder, recurrent, unspecified (a mental health condition characterized by a persistent feeling of deep sadness, emptiness, or loss of interest in activities); and other frontotemporal neurocognitive disorder (a progressive brain disease that shrinks the areas responsible for personality, behavior, and language). A review of Resident 4's Minimum Data Set (MDS, an assessment tool), dated 3/9/26, indicated a brief interview for mental status score of 12 [BIMS, an assessment to test a person's cognition level, a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. A review of Resident 4's Physician Orders included but were not limited to, Admit to [Name of Hospice Agency] Hospice [a specialized type of care focused on comfort, quality of life, and dignity for patients with terminal illnesses rather than curing them] with DX [diagnosis] terminal diagnosis of: Advanced frontotemporal dementia, sepsis age related physical debility on 3/27/26. In short, Resident 4 was in Hospice Care. Morphine Sulfate (concentrate) Solution 20 mg/ml [milligram/milliliter, a unit of measurement] Give 0.25 ml by mouth every 6 hours as needed for BTP [Breakthrough Pain, transitory, intense flare of pain that occurs on top of otherwise stable, controlled chronic pain]. A review of Resident 5's medical record indicated an admission date of 4/23/25 and a discharge date of 4/7/26. Resident 5's diagnoses included but were not limited to polyneuropathy [a condition where multiple peripheral nerves throughout the body are damaged simultaneously, causing widespread symptoms]; hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease [a condition where long-term high blood pressure damages both the kidneys and the heart simultaneously]; atherosclerotic heart disease of native coronary artery without angina pectoris [hardening of original arteries that supply blood to your heart due to plaque buildup, causing narrowing]; unspecified dementia, unspecified severity, with other behavioral disturbance. A review of Resident 5's Minimum Data Set (MDS, an assessment tool), dated 1/8/26, indicated a brief interview for mental status score of 4 [BIMS, a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment to test a person's cognition level, a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. A review of Resident 5's Order Summary Report indicated, Active orders as of 1/5/2026, 2/01/2026, 3/02/2026 and, 4/01/2026 all these monthly orders indicated, Order Summary1. ATTEMPTED TO REDIRECT. 2. 1:1 INTERVENTION. 3. SPOKEN IN CALM MANNER. 9. ENCOURAGE TO EXPRESS FEELINGS/CONCERNS. 11. TAKEN TO ACTIVITIES . , with Order Date 8/15/2025 and Start Date 8/15/2025. This order indicated Resident 5 was to be on 1:1 intervention. A review of Resident 5's Order Summary Report: Active Orders as of 4/1/2025 indicated, Resident 5'S medication included:Oxcarbazepine Oral tablet 300 mg, give 1 tablet by mouth two times a day for MOOD DISORDER M/B (manifested by) SUDDEN ANGRY OUTBURST, with Order Date 3/10/2026 and Start Date of 3/10/26.PROZAC Oral Capsule 20 mg (Fluoxetine HCL) Give 1 capsule by mouth one time a day for DEPRESSION M/B INTENSE AFFECTION TO OTHERS AND SEEKING OUT COMPANY OBSESSIVELY, with Order Date 3/31/2026 and Start Date 4/01/2026. Further review of Resident 5's Order Summary Reports : Active Orders as of 1/5/2026, 2/012026 and 3/02/2026, all included order forOxcarbazepine Oral tablet 300 mg, give 1 tablet by mouth two times a day for MOOD DISORDER M/B (manifested by) SUDDEN ANGRY OUTBURST, with Order Date of 1/2/2026 and Start Date of 1/3/2026. All Active Orders as of 1/5/2026, 2/01/2026, 3/2/2026 and 4/01/2026 included and indicated, Behavior Monitoring (Oxcarbazepine) Document Number of Episodes per shift or target behavior [Specify] SUDDEN ANGRY OUTBURST every shift. Order date 10/03/2025 and start date of 10/03/2025 A review of Resident 5's Care Plan with Date Initiated 8/15/2025 indicated, Focus: The resident has mood disorder problem(s) r/t (related to) DX. OF DEMENTIA M/B (manifested by) SUDDEN ANGRY DISORDER. 8/15/25: Resident started on Oxcarbazepine for MOOD DISORDER. 10/13/25: Resident with behavior of taking/getting staff personal property such as cell phone, other resident's clothing. >>> GETTING CLOSE and PROTECTIVE TO OTHER RESIDENT. A review of Resident 5's Care Plan with Date initiated 3/31/26 indicated, Focus: Resident has DEPRESSION M/B [manifested by] intense affection to others and seeking out company obsessively. A review of Resident 5's Care Plan with Date Initiated 4/3/26 indicated Focus: [name of Resident 5] was observed standing with inappropriate exposure and contact involving the other resident. This is the care plan initiated for the abuse which occurred on 4/3/26. A review of Resident 5's Care Plan with Date Initiated 4/7/26 indicated, Focus: ALTERCATION [Name of Resident 5] Room no. to CNA 1 on 1 sitter With intervention INCLUDING Fax SOC 341 (Reports of Suspected Dependent Adult/Elder Abuse) to CDPH, Ombudsman & Law Enforcement. This Intervention has a Date Initiated 4/8/26 However, a review of the SOC 341 received at the State Agency only indicated it was faxed to the State Agency and cross- reported to Ombudsman but it did not indicate the abuse incident was reported to Law Enforcement during the date of occurrence and it did not indicate it was also faxed to the Ombudsman. During an interview on 4/9/26 at 3:18 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated that CNA C reported Resident 5 was seen on 4/3/26 in Resident 4's room with his pants down by Resident 4's bedside. The ADM also stated the staff reported Resident 5's genitals touched Resident 4's head. The DON stated CNA C witnessed and reported the sexual abuse to the Supervisor (UM) on 4/3/26. The ADM further stated that the UM reported this sexual abuse to him (ADM - who is the Abuse Coordinator) on 4/7/26. During a phone interview on 4/13/26 at 2:09 p.m. with CNA C, CNA C stated that on 4/3/26 at around lunch time, she noted Resident 5 was not in his room or dining area. CNA C then stated she noticed Resident 4's room was closed and she walked inside the room with CNA D without making any noise and saw Resident 5 standing by Resident 4's top left bedside. CNA C also stated Resident 4 was asleep with eyes closed and Resident 5's male genital was inside Resident 4's mouth. CNA C stated Resident 5 was asked to get outside of Resident 4's room. CNA C also stated staff were aware of Resident 5's behaviors such as entering other residents' rooms and grabbing clothes and staff were supposed to supervise Resident 5. CNA C stated Resident 5 can walk without assistance, can eat by himself and was able to get to the bathroom unassisted. CNA C stated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she did not mention the sexual abuse to anyone and waited for the supervisor to report the incident. CNA C also stated she was not aware who was their Abuse Coordinator. During a phone interview on 5/4/26 at 3:15 p.m. with the DON, the DON stated CNA D was with CNA C when the sexual abuse was witnessed on 4/3/26 in Resident 4's room. The DON also stated CNA C reported the incident to the Unit Manager (UM) and the UM reported it to the ADM on 4/7/26. The DON stated it should have been reported earlier. During a phone interview on 5/6/26 at 10:57 a.m. with the UM, the UM stated CNA C reported the abuse to her on 4/3/26 at 12:15 p.m. The UM also stated Resident 4's responsible party was not informed of the incident on 4/3/26. The UM stated she reported the incident to their Abuse Coordinator, the ADM on 4/7/26. The UM stated their Abuse Reporting Protocol indicated it should have been reported within two hours to the Ombudsman, California Department of Public Health, and the police. A review of facility's 5 Day Investigation Report submitted on 4/10/26 to California Department of Public Health indicated, .Event Description: On 4/7/2026 at approximately 12:25 pm, a report was received from staff regarding an alleged inappropriate physical interaction involving resident and a female resident. Per report, the resident was observed standing with exposed genitalia and physical contact occurred with the female resident in the head area. The alleged event was reported to have occurred in room [Room no.] on 4/3/2026 at around 12:00 pm. A review of facility's policies and procedures (P&P) entitled Resident Rights revised December 2016, the P&P indicated, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . c. be free from abuse, neglect, misappropriation of property, and exploitation; . A review of facility's policies and procedures (P&P) entitled Abuse and Neglect- Clinical Protocol revised March 2018, the P&P indicated, Definitions.3. ?Sexual abuse' is defined.as ?non-consensual sexual contact of any type with a resident.A review of facility's policies and procedures (P&P) entitled Abuse Investigation and Reporting dated October 2022, the P&P indicated, .Reporting:.2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; orTwenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.