

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 04/18/2025
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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview and record review, the facility failed to ensure dignity and privacy was upheld for residents when: 1. Resident 23's privacy curtain was not fully drawn when Resident 23 removed her facility gown; 2. Assistant Director of Nursing (ADON) A referred to Resident's clothing protector as bibs in front of approximately 15 residents; and, 3. Certified Nursing Assistant (CNA) B was observed to assist feeding Resident 194 while standing over her. These failures had the potential for adverse effects on the psychosocial well-being and health of Resident 23, Resident 194 and approximately 14 others residents in the dining room during mealtime. Findings: 1. Review of Resident 23's clinical record titled, Admission Record, dated 4/16/2025, indicated Resident 23 was admitted to the facility with diagnoses including obstructive hydrocephalus (a condition where the normal flow of cerebrospinal fluid [CSF - a clear, colorless liquid that surrounds and cushions the brain and spinal cord] is blocked within the ventricles [fluid-filled spaces] of the brain), benign neoplasm (a non-cancerous growth of cells) of spinal cord, other specified disorders of brain, dysphagia (difficulty swallowing) , and encounter for attention to gastrostomy (a surgical procedure that creates an opening (stoma) into the stomach for the insertion of a feeding tube). Review of Resident 23's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 23's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 00 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During an observation on 4/16/2025 at 9:15 a.m., inside Resident 23's room, the privacy curtain was half drawn and Resident 23 was observed in bed, half naked, and right upper chest was exposed. There were no family members observed at bedside. Resident 23's bed was located near the bedroom door, and she could easily be seen by her roommates' visitors in beds B and C. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation with certified nursing assistant F (CNA F) on 4/16/2025 at 9:39 a.m. inside Resident 23's room, CNA F confirmed above observation and stated Resident 23 stripped off her facility gown. CNA F further confirmed Resident 23's privacy curtain was half drawn. During an interview with social services G (SS G) on 4/17/2025 at 11:30 a.m., SS G confirmed Resident 23 had a behavior of pulling off her clothes and stated they did not have a plan of care for such behavior. During another interview with CNA F on 4/18/2025 at 8:43 a.m., CNA F stated staff should make sure Resident 23 was checked frequently especially if her family member was not at bedside to prevent her from pulling off her facility gown and exposing herself to other residents and visitors. During a review of the facility's policy and procedure titled, Dignity, date revised 2/2021, it indicated, Residents are treated with dignity and respect at all times . Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. addressing the underlying motives or root causes for behavior . 46939 2. During an observation on 4/14/25, at 12:21 p.m., in Station 5's second dining room, ADON A was observed assisting residents with set up of lunch time meal. ADON A was observed speaking with other staff members in the second dining room asking, Where are the bibs?, get some more bibs. During an interview on 4/14/25, at 12:22 p.m., with ADON A, ADON stated, she asked the other staff members for more bibs for the residents, to place them on before they eat. 3. During an observation on 4/14/25, at 1:01 p.m., in Station 5's second dining room, CNA B was observed assisting Resident 194 to eat lunch while standing over the resident. During an interview on 4/14/25, at 1:02 p.m., with CNA B, CNA B stated, she assisted Resident 194 to eat lunch while standing, and they are supposed to sit down while assisting residents to eat. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2021, the P&P indicated, Each resident shall be free cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's P&P titled, Assistance with Meals dated 2022, the P&P indicated, Dining Room Residents: 3. Resident who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44583 Based on observation, interview, and facility's document review, the facility failed to maintain resident's rights to privacy and confidentiality to one of 36 sampled residents (Residents 23) and one unsampled resident (Resident 397) when Resident 23 and Resident 397's personal information and care instructions were posted in the room visible to roommate's visitors. This failure had the potential to compromise resident's rights. Findings: 1. During an observation on 4/14/2025 at 10:08 a.m., inside Resident 23's room, Resident 23 was in bed, with right hand mitten in placed, half naked with upper chest exposed and with caregiver at bedside. Two care instructions were observed posted above Resident 23's head of bed's wall. The first care instruction post indicated, Head of bed elevated at least 40 degrees during feeding. The second care instruction post indicated, -LEFT SIDE WEAKNESS -KEEP LEFT ARM ELEVATED - TURN AND REPOSITION EVERY 2 HOURS. During a concurrent observation and interview with assistant director of nursing I (ADON I) on 4/15/2025 at 9:08 a.m., inside Resident 23's room, the care instructions were still posted above Resident 23's head of bed's wall. ADON I confirmed above observation and stated it should have been covered. 2. During an observation on 4/14/2025 at 10:34 a.m., inside Resident 397's room, Resident 397 was in bed and a care instruction was posted above her head of bed's wall. The care instruction post indicated, CHOKING RISK - NO FOOD BY MOUTH. During a concurrent observation and interview with licensed vocational nurse K (LVN K) on 4/15/2025 at 9:11 a.m., inside Resident 397's room, the care instruction was still posted. LVN K confirmed above observation and stated Resident 397's care instruction should not be posted. During an interview with director of nursing (DON) on 4/18/2025 at 12:11 p.m., DON stated resident's care instructions should be covered when posted. During a review of the facility's policy and procedure titled, Dignity, date revised 2/2021, it indicated, Staff protect confidential clinical information. Examples include the following . b. Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room . Discreet posting of important information for safety reasons is permissible (e.g. taped to the inside of the closet door).		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46939 Based on interview and record review the facility failed to protect two of 36 sampled residents (Resident 21 & Resident 445) from physical abuse. When: 1. Resident 231 was observed to physically hit Resident 21 2. Resident 231 was observed to physically hit Resident 445 These failures resulted in Resident 21 & Resident 445 to be physically abused by Resident 231. Findings: 1. During a review of the facility's SOC 341 (mandated report of suspected dependent adult/elder abuse form) dated 4/12/25, indicated an abuse allegation was reported to the California Department of Public Health (CDPH). SOC 341 indicated, Victim [Resident 21].suspected abuser [Resident 231]. SOC 341 indicated, At approximately 8:05 AM on 4.12.25, Resident [231] had hit another resident [Resident 21] in the face and pushed her to the floor. CNA had witnessed the incident and immediately ran over, called for help and separated both residents. SOC 341 indicated, Reported Type of Abuse Physical. Abuse resulted in Minor medical Care During a review of Resident 231's Change in Condition assessment dated [DATE], Assessment indicated, 0715 [7:15 a.m.] received resident awake, alert, and responsive. Ups and ambulates along the hallway of the unit with anger outburst with staff, pacing around the unit.0805 [8:05 a.m.] Resident was walking down the hallway when he struck another resident [Resident 21] in the face and pushed her to the ground. Resident [231] also tried to hit the charge nurse and chased her. Resident is not easily redirectable. Resident becomes very aggressive toward staff and other residents. CNA witnessed the incident. During a review of Resident 21's Change in condition assessment dated [DATE], assessment indicated, Resident was hit in the face by another resident. Redness to the left side of face. During an interview on 4/17/25 at 9:42 a.m, with Certified Nursing Assistant (CNA) C, CNA C stated, she saw Resident 231 walking in the hallway toward the activity room and Resident 21 was walking back to her room. CNA C stated, they crossed paths (Resident 21 and 231) and out of nowhere Resident 231 slapped Resident 21 on the side of the face without being provoked and just kept walking. CNA C stated Resident 21 fell on to the floor from being slapped by Resident 231. CNA C stated, she had witnessed Resident 231 be aggressive in the past, she stated she observed him try to pick up a chair and hit her when cleaning his meal tray after a meal. During a review of the Facility's Investigative Report for Resident 21 and Resident 231's abuse incident dated, 4/15/25, report indicated, from witness account interviews. The incident occurred between Resident [231] and Resident [21] as they crossed paths in the hallway. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of the facility's SOC 341 dated 4/15/25, report indicated, Victim [Resident 445] . Suspected Abuser [Resident 231]. At approximately 3:30 PM on 4.14.25. CNA was also present during the time of incident. Here is his account of the events: Resident [231], (perpetrator) was not in activities room. Resident [231] had then ran into the activities room, sat on the table where Resident [445] (victim) was sitting and slapped resident twice on her head. reported type of abuse physical. During a review of Resident 445's Change in condition assessment dated [DATE], assessment indicated, Resident was hit by another resident in the activity room. at approximately 3:15 pm. [Resident 445] was sitting in the activity room watching tv and [Resident 231] went into the room and suddenly without provocation he hit her in the leftforehead [sic]. [Resident 445] sustained a redness on the LEFT forehead. During an interview on 4/16/25, at 3:15 p.m., with Certified Nursing Assistant (CNA) H, CNA H stated, he was in the activity room on 4/15/25 at around 3:15 p.m., and witnessed Resident 231 come into the activity room table where Resident 445 was sitting calmly. CNA H stated, he saw Resident 231 out of nowhere slap Resident 445 several times. During a review of the Facility's Abuse investigation report dated, 4/17/25, report indicated, At approximately 3:30 PM on 4.15.25 Resident [445] was sitting in the activities room participating. CNA was present during the time of the incident and these are his accounts of the event: Resident [231] was not in the dining room participating in activities. Resident [231] ran into the activities room, sat on the table where Resident [445] was sitting and slapped resident [445] twice on her head. During a review of the facility's Policy & Procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2021, the P&P indicated, Resident have the right to be free from abuse. this includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The resident abuse, neglect and exploitation program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse. by anyone including. other residents.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 44583 Based on interview and record review, the facility failed to ensure a pre-admission screening and resident review (PASARR, a federal requirement to help ensure that individuals who have mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was accurately completed for one of 36 sampled residents (Resident 28). This failure had the potential for inaccurate care and services provided to residents with a mental disorder, intellectual disability, or related conditions. Findings: Review of Resident 28's clinical record titled, Admission Record, indicated Resident 28 was admitted to the facility with diagnoses including acute respiratory failure (lungs are unable to adequately deliver oxygen to the blood) with hypoxia (a condition where there is an insufficient amount of oxygen in the body's tissues or organs), influenza (a highly contagious respiratory illness caused by influenza viruses), emphysema (a chronic lung disease), and schizotypal disorder (a mental health condition characterized by unusual thoughts and behaviors, difficulty forming close relationships, and a tendency toward odd beliefs and perceptions). Review of Resident 28's clinical record titled, Order Summary Report, dated 4/1/2025, indicated Resident 28 had a prescription of Trazodone (an antidepressant medication used to treat depression, anxiety, or a combination of depression or anxiety) for depression (a common mental health condition characterized by a persistent low mood, loss of interest in activities, and other symptoms that can significantly interfere with daily life) manifested by inability to sleep. Further review indicated, Resident 28 was being monitored for episodes of schizotypal disorder manifested by social anxiety such as 1. more interest of activity done alone or 2. Not wanting to get out of bed. Review of Resident 28's PASARR dated 1/31/2025, indicated Resident 28's Level I Screening was negative for serious mental illness. Further review indicated in question, 9. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? the answer, no was marked. For question, 11. Has the individual been prescribed psychotropic medications for Serious Mental Illness? the answer, no was marked. During a concurrent interview with minimum data set director (MDSD) and record review on Resident 28's admission record, order summary report and PASARR on 4/17/2025 at 9:18 a.m., MDSD confirmed Resident 28's diagnoses of schizotypal disorder, with behavior monitoring and was taking an antidepressant. MDSD confirmed a staff from the hospital was the one who completed Resident 28's PASARR and stated numbers 9 and 11 should have been marked, yes. MDSD stated MDS nurses should always review resident's PASARR for accuracy prior to coding it in resident's comprehensive MDS (a federally mandated resident assessment tool) assessment. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Admission Criteria, date revised 3/2019, indicated, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .If the level I screen indicates that the individual may meet the criteria for MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to develop and implement individualized, resident-centered care plan for one of 36 sampled residents (Resident 23) when a care plan for Resident 23's behavior of pulling off her clothes or facility gown was not developed and implemented. This failure had the potential to result in not having to identify the specific care and services necessary to meet Resident 23's needs. Findings: Review Resident 23's clinical record titled, Admission Record, dated 4/16/2025, it indicated Resident 23 was admitted to the facility with diagnoses including obstructive hydrocephalus (a condition where the normal flow of cerebrospinal fluid [CSF - a clear, colorless liquid that surrounds and cushions the brain and spinal cord] is blocked within the ventricles [fluid-filled spaces] of the brain), benign neoplasm (a non-cancerous growth of cells) of spinal cord, other specified disorders of brain, dysphagia (difficulty swallowing) , and encounter for attention to gastrostomy (a surgical procedure that creates an opening (stoma) into the stomach for the insertion of a feeding tube. Review of Resident 23's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 23's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 00 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During an initial observation on 4/14/2025 at 10:08 a.m., inside Resident 23's room, Resident 23 was in bed, with right hand mitten in placed, half naked with upper chest exposed and with caregiver at bedside. During another observation on 4/16/2025 at 9:15 a.m., inside Resident 23's room, the privacy curtain was half drawn and Resident 23 was observed in bed, half naked, and her right upper chest was exposed. Resident 23's bed was located near the bedroom door, and she could easily be seen by her roommates' visitors in beds B and C. During a concurrent interview and observation with certified nursing assistant F (CNA F) on 4/16/2025 at 9:39 a.m. inside Resident 23's room, CNA F confirmed above observation and stated Resident 23 stripped off her facility gown. CNA F further confirmed Resident 23's privacy curtain was half drawn. During an interview with social services G (SS G) on 4/17/2025 at 11:30 a.m., SS G confirmed Resident 23 had a behavior of pulling off her clothes and stated they did not have a plan of care for such behavior. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview with CNA F on 4/18/2025 at 8:43 a.m., CNA F stated staff should make sure Resident 23 was checked frequently especially if her family member was not at bedside to prevent her from pulling off her facility gown. During a concurrent interview with registered nurse R (RN R) and review of Resident 23's list of care plans on 4/18/2025 at 10:19 a.m., RN R confirmed Resident 23 had a behavior of stripping off her facility gown and they did not have a plan of care in placed. During an interview with director of nursing (DON) on 4/18/2025 at 12:27 p.m., DON confirmed Resident 23's behavior of stripping off her facility gown and stated the behavior should have been care planned to identify appropriate interventions. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, date revised 3/2022, indicated, The interdisciplinary team [IDT - a group of health care professionals from diverse fields who work toward a common goal for residents], in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49345 Based on interview and record review, the facility failed to ensure one (Resident 241) out of one sampled resident received treatment and care in accordance with professional standards of practice when Resident 241's vital signs were not checked and due medications were not given. This failure had the potential to compromise Resident 241's physical health condition. Findings: A review of Resident 241's medical record indicated diagnoses of, Paroxysmal Atrial Fibrillation (an irregular, fast heartbeat that comes and goes), Acute on chronic combined systolic and diastolic heart failure (a sudden worsening of a long-standing heart condition where the heart muscle has both problems contracting [systolic] and relaxing [diastolic] properly). A review of Resident 241's Physician Orders indicated, Diltiazem Hcl Oral Tablet 30 MG [milligram, unit of measurement] give 1 tablet by mouth three times a day for HTN [hypertension, high blood pressure]. Hold if SBP [systolic blood pressure, the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood throughout the body] is less than 100 or pulse less than 60 on 1/13/25 and Carvedilol oral tablet 25 MG give 1 tablet by mouth two times a day for HTN. Hold if SBP is less than 100 or pulse is less than 60. Given with food. on 1/14/25. A review of Resident 241's Record of Death indicated, date of admission was 1/13/25 and date and time of death was 1/16/25 at 1:05 a.m. During a concurrent interview and record review on 4/17/25 at 3:46 p.m. with the Director of Nursing (DON), the DON verified Resident 241's progress notes indicated that Resident 241 was found unresponsive on 1/16/25 at 12:37 a.m. The DON verified the medication Carvedilol was last given at 9 a.m. on 1/15/25 and Diltiazem was last given at 1 p.m. on 1/15/25. The DON verified Resident 241's blood pressure was last checked on 1/15/25 at 11:09 a.m. and pulse was last checked on 1/15/25 at 6 p.m. and the DON verified pulse was elevated at 103 beats per minutes. The DON verified there was no documentation why Carvedilol and Diltiazem were not given in the afternoon and why vitals signs were not checked in the afternoon of 1/15/25. The DON stated, it should be documented. A review of facility's policy and procedure (P&P) entitled Guidelines for Obtaining Vital Signs revised February 2018, the P&P indicated, the purpose of this procedure is to assure that vital signs are obtained whenever appropriate. Vital Signs will include temperature, blood pressure, respiration and presence or absence of pain . A review of facility's P&P entitled, Charting and Documentation revised July 2017, the P&P indicated, .2. The following information is to be documented in the resident medical record: .b. Medications administered .7. Documentation of procedures and treatments will include care-specific details, including: .e.whether the resident refused the procedure/treatment;		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview and record review, the facility failed to ensure services were provided to prevent and/or heal pressure ulcers (damage to the skin or underlying tissue as a result of prolonged pressure) for two residents (Residents 190 and 546) when staff did not turn and reposition the residents every two hours. This failure had the potential to delay wound healing, worsening pressure ulcers and the development of new pressure ulcers for Resident 190 and Resident 546. Findings: 1. During multiple observations on 4/16/25 at 9:38 a.m., 11:40 a.m., 1:45 p.m., and 4:00 p.m., Resident 190 was lying in bed positioned on his back and was not able to turn himself. During multiple observations on 4/17/25 at 8:40 a.m., 10:45 a.m., 12:15 p.m., and 2:30 p.m., Resident 190 was lying in bed positioned on his back and was not able to turn himself. Review of Resident 190's medical record indicated he was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including aphasia (slight or serious difficulty with language or speech) following cerebral infarction (stroke, damage to the brain due to lack of oxygen), chronic respiratory failure (condition in which your blood doesn't have enough oxygen or has too much carbon dioxide, left side hemiplegia and hemiparesis (complete paralysis [inability to move part or all of the body], partial paralysis or muscle weakness on one side of the body), stage 4 (a deep wound reaching the muscles, ligaments, or bones) pressure ulcer (an area of skin that breaks down when something keeps rubbing or pressing against the skin) of the sacral/coccyx (the triangular shaped bone at the base of the spine) region and pressure induced deep tissue damage of left heel. Review of Resident 190's Minimum Data Set (MDS, an assessment tool), dated 3/17/25, indicated he was admitted with pressure ulcers. The MDS also indicated Resident 190 was severely impaired in cognition with communication deficit. The MDS further indicated Resident 190 had impairment of both sides of upper and lower extremities requiring extensive assistance with bed mobility (moving in bed) and non-ambulatory (unable to walk). Review of Resident 190's Weekly Skin Assessment Report indicated on 4/9/25, Resident 190 was noted to have a 7.1 cm (centimeter, a unit of measurement) by 4.7 cm by 0.7 coccyx pressure ulcer. During a wound treatment observation and concurrent interview with the Wound Treatment Nurse (WTN) on 4/18/25 at 9:20 a.m., Resident 190 had an open wound in the coccyx area. The WTN measured the open area and stated the size remained unchanged from observation and treatment on 4/16/25. The WTN also stated recommendations were given to staff to continue turning and positioning of the resident every two hours or as needed to promote healing of the wound. Review of Resident 190's Care Plan dated 1/22/25 and revised on 3/4/25 indicated Resident 190 was at risk for pressure injury, development and skin breakdown related to chronic venous insufficiency (leg veins that don't allow blood to flow back up to the heart), hemiplegia and hemiparesis with intervention to turn and position every two hours and as needed. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/25 at 1:20 p.m., with Certified Nursing Assistant BB (CNA BB), CNA BB stated residents were supposed to be turned and positioned every two hours to help wound healing but further stated Resident 190, Didn't need it. Review of the CNA Task Log dated 4/16/25 and 4/17/25 for Resident 190 indicated Resident 190 had been turned and repositioned every two hours. During an interview on 4/17/25 at 1:25 p.m., with the Assistant Director of Nursing C (ADON C), the ADON C stated bedridden (unable to get out of bed) residents or residents with pressure wounds were turned and positioned every two hours or as needed as a standard of practice to promote healing of pressure wounds and for prevention of pressure wounds. 2. During multiple observations on 4/16/25 at 8:00 a.m., 10:05 a.m., 12:00 p.m., 2:00 p.m., and 4:00 p.m., Resident 546 was lying on her back in bed and was not able to turn herself. During multiple observations on 4/17/25 at 8:47 a.m., 10:50 a.m., 12:10 p.m., 2:12 p.m., and 4:10 p.m., Resident 546 was lying in bed positioned on her back and was not able to turn herself. Review of Resident 546's medical record indicated Resident 546 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection that affects one or both lungs), respiratory failure (condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), diabetes (a condition which affects the way the body processes blood sugar), embolism (blockage of a blood vessel by a clot of blood or an air bubble that has traveled from another location) and thrombosis (formation of a blood clot within a blood vessel) of veins of lower extremities. Review of Resident 546's MDS dated [DATE], indicated Resident 546's cognitive status was severely impaired with communication deficit. The MDS further indicated Resident 546 had impairment of both sides of upper and lower extremities. Review of Resident 546's Weekly Skin Assessment Report dated 4/9/25, indicated Resident 546 was noted to have a pressure ulcer to the coccyx area measuring 4.2 cm by 3.5 cm by 2.8 cm. During a wound treatment observation and concurrent interview on 4/18/25 at 10:45 a.m. with the WTN, Resident 546 had an open wound in the coccyx area. The WTN measured the open wound area and stated the size remained unchanged from observation and treatment on 4/16/25. The WTN stated the wound was very deep and Resident 546 had a history of pressure ulcers closing and re-opening. The WTN stated frequent reminders were given to staff to keep Resident 546 from constantly lying on her back for long periods of time to promote healing of wound tissue. During an interview on 4/18/25 at 11:00 a.m., with (CNA CC), CNA CC stated Resident 546 had not received a wedge pillow (pillow used to relieve pressure points) and was not able to reposition Resident 546 on her side properly using the soft pillows. During an interview on 4/18/25 at 1:00 p.m. with the Director of Staff Development (DSD), the DSD stated an in-service was conducted on 1/24/25 on the topic of skin breakdown and turning and positioning. The DSD stated the evaluation of teaching was discussion only. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled, Repositioning revised 5/2013, indicated, General Guidelines: 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief . 3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning . 5. Positioning the resident on an existing pressure ulcer should be avoided since it puts pressure on tissue that is already compromised and may impede healing. Interventions: .3. Residents who are in bed should be on at least an every two hour (q2 hour) repositioning schedule. 4. For residents with a Stage 1 or above pressure ulcer, an every two hour (q2 hour) repositioning schedule is inadequate.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 44577 Based on observation, interview, and record review, the facility failed to provide necessary podiatry services for one of 36 sampled residents (Resident 215) when the toenails were longer than Resident preferred causing pain and concern for ingrown toenails or infection. This failure had the potential to affect the resident's foot health and contribute to injury and/or infection. Review of Resident 215's clinical records indicated Resident 215 had multiple diagnoses including hemiplegia (a symptom that involves the loss of the ability to move on one-side of body) and hemiparesis (one-sided weakness), and diabetes (high blood sugar). Resident 215's cognitive function is intact Review of Resident 215's order summary, dated 11/14/24, indicated Resident 215 may have Podiatry evaluation, Tx, and follow up every 61 days and prn (as needed). During an interview on 4/14/25 at 9:40 a.m. with Resident 215, Resident 215 stated, she requested to see the podiatrist, they showed her a paper stating saying the podiatrist saw her, but he never did. During a concurrent observation Resident 215's nails were noted to be long, thick and growing inward. During an interview on 4/16/25 at 10:25 a.m. with Social Services (SS) G, the SSG explained, when residents request podiatry services it is noted in a binder at the nurse's station. Resident 215 requested on 4/4/25 and will be scheduled for their next visit. During a concurrent observation and interview with SSG in Resident 215's room with Resident 215, SSG confirmed Resident 215's nails were long and did not look like they were seen on a recent visit by the podiatrist. Resident 215 stated she was not seen by the podiatrist. During an interview on 4/18/25 at 1:28 p.m. with Resident 215, Resident 215 was sitting in the wheelchair with her shoes on. Resident 215 stated she would remember someone working on her toes. They feel the same, the toes are still bothering her, she feels sharp pain, has a history of ingrown toenails so is concerned that will happen and does not want them infected. She is a diabetic. During review of the facility's policy & procedures titled Foot Care dated revised October 2022, indicated, Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions (e.g., diabetes, peripheral vascular disease, immobility, etc.) . Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes .Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals. Foot disorders that require treatment include corns, neuromas, calluses, hallux valgus (bunions), digiti flexus (hammertoe), heel spurs, and nail disorders.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 44583 Based on observation, interview and record review, the facility failed to ensure that proper care and treatment services for oxygen (O₂, a colorless, odorless gas) use was provided for three of 12 sampled residents (residents on oxygen therapy) when: 1. Residents 28's and Resident 152's O₂ concentrator's (a device which concentrates the oxygen from ambient air) filters had some grayish substance build up; and, 2. Resident 212 was administered the wrong dosage of oxygen. These deficient practices had the potential for Residents 28, 152, and 212 to have complications related to improper treatment while receiving O₂ therapy. Findings: 1a. Review of Resident 28's clinical record titled, Admission Record, indicated Resident 28 was admitted to the facility with diagnoses including acute respiratory failure (lungs are unable to adequately deliver oxygen to the blood) with hypoxia (a condition where there is an insufficient amount of oxygen in the body's tissues or organs), influenza (a highly contagious respiratory illness caused by influenza viruses), emphysema (a chronic lung disease), and schizotypal disorder (a mental health condition characterized by unusual thoughts and behaviors, difficulty forming close relationships, and a tendency toward odd beliefs and perceptions). Review of Resident 28's clinical record titled, Order Summary Report, dated 4/1/2025, it indicated an order of continuous use of oxygen for Resident 28. Further review revealed an order dated 2/1/2025, May use O₂ CONCENTRATOR. Check concentrator filter weekly & wash or change every Friday or PRN (as needed). During an observation inside Resident 28's room on 4/14/2025 at 11:17 a.m., Resident 28 was in bed and on oxygen therapy at 2 liters (unit of volume) per minute (lpm) thru a nasal cannula (NC - a tubing used to deliver oxygen from the machine through the nostrils). The oxygen concentrator's filter located at the back of the device was observed with thick grayish substance build up. 1b. Review of Resident 152's clinical record titled, Admission Record, indicated Resident 152 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), chronic obstructive pulmonary disease (COPD - a disease that affects airflow in the lungs and makes it difficult to breathe), and respiratory failure with hypoxia. Review of Resident 152's clinical record titled, Order Summary Report, dated 4/17/2025, indicated an order of Resident 152's continuous use of oxygen. Further review revealed an order dated 2/14/2025, May use O₂ CONCENTRATOR. Check concentrator filter weekly & wash or change every Friday or PRN. as needed AND every night shift every Sat [Saturday] Check & wash or change. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation inside Resident 152's room on 4/14/2025 at 10:39 a.m., Resident 152 was in bed, and on oxygen therapy at 2 lpm thru NC. The oxygen concentrator's filter located at the back of the device was observed with thick grayish substance build up. During a concurrent interview with infection preventionist (IP) and photo review of Resident 28 and 152's oxygen concentrator's filters on 4/14/2025 at 11:30 a.m., IP confirmed both resident's oxygen filters had grayish substance build up. IP stated he was not sure who was supposed to check and clean the oxygen concentrator's filters. During an interview with director of nursing (DON) on 4/18/2025 at 12:07 p.m., DON stated the cleaning or changing of oxygen filters should have been done weekly by nurses or the central supply staff. During a review of the facility's policy and procedure titled, Departmental (Respiratory Therapy) - Prevention of Infection, date revised 11/2011, indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .among residents and staff .Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. 46939 2. During a observation on 4/14/25 at 9:40 a.m., in Resident 212's room. Resident 212 was wearing a nasal cannula (a device that gives you oxygen through your nose.) through an oxygen concentrator (medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen.) with a dose of 5 liters per minute. During a review of resident 212's Oxygen Order Details dated 3/4/25, order indicated, OXYGEN: May have O2 [oxygen] at 2 L/min [liter per minute] via nasal cannula without humidifier for SOB [shortness of breath] R/T [related to] DX. [diagnosis of] COPD [Chronic Obstructive Pulmonary Disease]. During a concurrent observation and interview on 4/14/25, at 1:52 p.m., with Licensed Vocational Nurse (LVN) J, in Resident 212's room. Resident 212 was observed wearing her nasal cannula with her oxygen concentrator set to 5 L/min. LVN J stated, she knows Resident 212's oxygen should be set to 2 L/min per the order, but it is set to 5 L/min. During a review of Resident 212's Care Plan dated, 12/17/24, Care Plan indication, [Resident 212] has Chronic Obstructive Pulmonary Disease. (COPD) .Interventions Administer oxygen as ordered. During a review of National Institute of Health's National Library of Medicine's article titled, Harms of over oxygenation in patients with exacerbation of chronic obstructive pulmonary disease, dated 2017, article indicated, Too much oxygen can be dangerous for patients with chronic obstructive pulmonary disease (COPD) with (or at risk of) hypercapnia (increased carbon dioxide in the blood). During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration dated 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physicians orders or facility protocol for oxygen administration.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49345 Based on observation, interview and record review, the facility failed to ensure staff had appropriate competencies to provide nursing care for one (Resident 192) out of seven sampled residents when Resident 192 was not assisted by staff when requested. This failure had the potential for physical injury and psychosocial distress. Findings: During a concurrent observation and interview on 4/14/25 at 10:55 a.m. with Resident 192 in her room, Resident 192 was trying to transfer from the bed to the wheelchair. Resident 192 pressed the call light. Certified Nurse Aide (CNA) X entered the room, turned off the call light button near Resident 192 and left the room. During an interview on 4/14/25 at 10:58 a.m. with CNA X, CNA X verified she did not assist Resident 192 when she entered the room and turned off the call light. During an interview on 4/17/25 at 9:37 a.m. with Case Manager (CM) N, CM N stated they have to ask the residents if they need help before turning off the call light and then assist the residents. During an interview on 4/17/25 at 4:04 p.m. with the Director of Nursing (DON), the DON stated staff must address the needs of residents whenever they press the call light. A review of Resident 192's medical record indicated diagnoses of Primary Osteoarthritis of right and left ankles and feet (a condition where the protective cartilage that cushions the ends of bones in joints wears down over time, causing the bones to rub against each other and leading to pain, stiffness, and limited movement), bilateral primary osteoarthritis of hip, muscle weakness, and difficulty in walking. A review of Resident 192's Minimum Data Set (MDS, an assessment tool), dated 2/14/25, indicated a brief interview for mental status score of 14 [BIMS, a tool used to assess cognition (knowing, learning, and understanding), a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact]. A review of facility's policy and procedure (P&P) entitled Answering the Call Light revised September 2022, the P&P indicated, .Steps in the procedure 1. Answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name a. If the resident needs assistance, indicate the approximate time it will take for you to respond .c. If the resident's request is something you can fulfill, complete the task within five minutes if possible.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50135 Based on observation, interview and record review the facility failed to post direct care staffing numbers, and nursing staff responsible for direct care to residents in a prominent place in each of four nursing stations of the facility. This failure had the potential for residents and visitors not knowing the accurate number of hours of staff working and which staff were scheduled and available to care for their needs. Findings: During an observation on 4/16/25 at 10:00 a.m., in Hallway 2, no staff schedule or direct patient care hours were posted and accessible to residents. During an observation on 4/16/25 at 10:05 a.m., in Hallway 3, no staff schedule or direct patient care hours were posted and accessible to residents. During an observation on 4/16/25 at 10:10 a.m., in Hallway 4, no staff schedule or direct patient care hours were posted and accessible to residents. During an observation on 4/16/24 at 10:15 a.m., in Hallway 5, no staff schedule or direct patient care hours were posted and accessible to residents. During an observation and interview on 4/17/25 at 2:10 p.m. with the Director of Nursing (DON), the DON verified the staffing information was not posted in all the hallways and stated the direct daily patient care hours and staffing schedules were posted only in Hall 1 which was closest to the main entrance to the facility. The DON stated the patient care hours and staffing schedules had never been posted anywhere else in the facility.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51865 Based on interview and record review, the facility failed to ensure the accurate accountability of controlled medications (medication with a high potential for abuse and addiction) when: 1. Controlled medications were signed out of the Controlled Drug Record (CDR, an inventory or count sheet) but not documented on the medication administration record (MAR) as administered for four out of five residents (Residents 15, 61, 81, and 114). 2. Records of wasted controlled medications did not contain the co-signature from another nurse for four randomly selected residents (Resident 81, 294, 295, and 296) as per facility policy and procedures. These failures had the potential result to the misuse and abuse of controlled substance medications. Findings: 1. During the survey, the CDRs for five random residents receiving as-needed controlled medications were selected for review. During the interview on 4/16/25 at 10:48 a.m., the Assistant Director of Nursing (ADON) C explained the process of administering a controlled medication. The steps included assessing the resident for pain, checking the physician's order, signing it out of the CDR, administering the medication, and documenting the administration on the MAR. During a concurrent interview and record review with ADON C, the following were identified: a. Resident 114 had a physician's order, dated 1/8/25, for oxycodone (a potent narcotic for pain) 15 milligrams (mg, unit of measurement), 1 tablet every 4 hours as needed (PRN) for moderate pain. On 04/16/25 at 10:51 a.m., a review of Resident 114's CDR for oxycodone 15 mg and the April 2025 MAR with ADON C indicated the nursing staff signed out of the CDR, but did not document on the MAR to show the medication was administered to Resident 114 on two occasions: on 4/1/25 at 1100 and 4/5/25 at 2100. ADON C confirmed this finding and stated it should be documented on the MAR. b. Resident 61 had a physician's order, dated 3/18/25, for oxycodone 5 mg, 2 tablets every 8 hours as needed for mild/severe pain and this dosage was increased to every 4 hours on 4/8/25. On 04/16/25 at 10:54 a.m., a review of Resident 61's CDR for oxycodone 5 mg and the April 2025 MAR with ADON C indicated the nursing staff signed out of the CDR but did not document the medication administration on the MAR on four occasions: on 4/3/25 at 1230; 4/11/25 at 1353; 4/11/25 at 2220; and 4/12/25 at 2100. ADON C confirmed this finding and stated it should be documented. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident 81 had a physician's order, dated 4/26/23, for hydrocodone acetaminophen 5-325 MG (a narcotic medication to treat pain), 1 tablet by mouth every 8 hours as needed for severe pain. On 04/16/25 at 10:58 a.m., a review of Resident 81's CDR for hydrocodone/acetaminophen 5/325 and the March and April 2025 MARs with ADON C indicated the nursing staff signed the medication out of the CDR but did not document the administration on the MAR on three occasions: on 3/20/25 at 0240; 4/5/25 at 0804; and 4/9/25 at 2015. ADON C stated it should be documented. d. Resident 15 had a physician's order, dated 3/5/25, for hydrocodone/acetaminophen 5/325 mg, 1 tab by mouth every 4 hours as needed for moderate to severe pain. On 04/16/25 at 11:02 a.m., a review of Resident 15's CDR for hydrocodone/acetaminophen 5/325 mg and the April 2025 MAR indicated the nursing staff signed out of the CDR but did not document the medication administration on the MAR to show the medication was administered to Resident 15 on seven occasions: on 4/6/25 at 1800; 4/9/25 at 0130; 4/10/25 at 2130; 4/11/25 at 1800; 4/11/25 at 2210; 4/12/25 at 0430; and 4/13/25 at 1900. ADON C confirmed this finding and stated it should be documented. During a concurrent interview and record review on 4/16/25 at 11:05 a.m., ADON C verified controlled substance medications were not fully accounted for four out of five residents. A review of the facility's policy and procedures (P&P) titled Administering Medications, dated 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. 2. During a concurrent interview and record review with the Director of Nursing (DON), on 04/15/25 at 10:28 a.m., a random review of the controlled medication disposition records, dated 8/29/24 and 11/7/24, indicated wasted medications without a counter signature from another nurse, as follows: a. One tablet of Resident 296's oxyCODONE 5 mg was wasted without a co-signature from another nurse on 5/31/24 at 1100. b. Half tablet of Diazepam (medication to treat anxiety) 5 mg for Resident 295 was wasted without a co-signature from another nurse on 9 occasions: on 7/14/24 at 1700; 7/15/24 at 0830; 7/15/24 at 1700; 7/16/24 at 0830; 7/16/24 at 1700; 7/17/24 at 0830; 7/17/24 at 1700; 7/18/24 at 0849 and 7/18/24 at 1700. c. A film of buprenorphine (a potent pain medication) 900 micrograms for Resident 294 was wasted without a co-signature from another nurse on 6/7/24 at 2020. During the interview and record review with the DON above, she stated that the CDR for wasted medications requires two signatures. The DON confirmed the finding and stated, I did not catch that. d. During an inspection of Station 2 Medication Cart B on 4/15/25 at 12:22 p.m., a review of the CDR for Resident 81's hydrocodone/acetaminophen 5/325 mg with Registered Nurse (RN) D, indicated a tablet was wasted on 2/24/25 at 0808 without a co-signature. RN D confirmed that there should be a double signature on the CDR for this wastage. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Controlled Substances, dated November 2022, the P&P indicated, The system of reconciling the receipt, dispensing and disposition of controlled substances include Medication Administration Record and the Waste and/ or disposal of controlled medication are done in the presence of the nurse and witness who also signs the disposition sheet.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 51865 Based on interview and record review, the facility failed to ensure 1 out of 36 sampled residents (Residents 105) was free from unnecessary medications when there was inadequate monitoring for the resident's vitamin B12 (a supplement to treat vitamin B12 deficiency) and vitamin D (an essential vitamin that your body uses for normal bone development and maintenance) level as ordered. This resulted in inadequate monitoring related to medication management for the resident. Findings: A review of record of Resident 105's Admission Record, dated 4/17/25, indicated the resident was admitted with diagnoses including deficiency of other specified B group Vitamins and history of falls. A review of Resident 105's clinical record indicated the following physician's orders: - Cyanocobalamin (vitamin B12) tablet 1,000 micrograms (mcg, unit of measurement) PO once a day for vitamin B12 deficiency, order dated 3/20/22; - Vitamin D3 tablet, 2,000 units by mouth one time a day, dated 3/20/22; - Vitamin D Level every 6 months in April and October of each year, dated 4/12/23. A review of Resident 105's clinical record indicated no laboratory results for vitamin D for April and October 2024; and no vitamin B 12 level since it was ordered on 3/20/22 (more than 2 years ago). During a concurrent interview and record review with Assistant Director of Nursing (ADON) A, on 4/16/25 at 4:26 p.m. ADON A was asked to provide Resident 105's vitamin D level for April and October 2024, a per the physician's order. ADON A reviewed Resident 105's clinical record and stated she could not find any. ADON A also stated she had the help of other staff to look for the vitamin D lab results but there was none. Regarding the vitamin B12, ADON A stated there had not been a vitamin B12 level drawn since it was ordered on 3/20/22. ADON A acknowledged the vitamin D levels were not carried out as ordered; and Resident 105 has a diagnosis of B group vitamins deficiency and received vitamin B12 medication administration without monitoring for vitamin B12 level. A review of facility's policy and procedure titled Medication Utilization and Prescribing - Clinical Protocol, dated April 2018, indicated, The physician and staff will identify significant factors that may affect medication effectiveness and The physician and staff will evaluate the effectiveness and effects of the medication in a resident's regimen.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44577 Based on observation, interview and record review, the facility failed to ensure food was palatable for residents when food was served overcooked and lacked flavor for residents on Regular Diet. This failure had the potential to affect meal and food intake which could impair the nutrition status of residents. Findings: During a dining observation on 4/16/25 at 1:10 p.m. in Resident 346's room, Resident 346 open his meal tray to expose a plate that included mash potatoes. Resident 346 tasted the potatoes and immediately said they had no flavor they, Do not taste good. During a concurrent interview Resident 346 stated, I will not eat those, there is no flavor . 49345 During an interview on 4/14/25 at 10:55 a.m. with Resident 192, Resident 192 stated food was terrible, and vegetables were mushy. During an interview on 4/15/25 at 9:34 a.m. with Resident 61, Resident 61 stated food did not taste good. During a concurrent dining observation and interview on 4/15/25 at 12:13 p.m. with Resident 192, Resident 192 stated carrot was mushy. Resident 192 did not eat all the carrots on her plate. During a concurrent dining observation and interview on 4/15/25 at 1:00 p.m. with Resident 25 stated food lacked flavor. Resident 25 also stated carrots were overcooked. Resident 25 pressed his fork on the carrots on his plate and were easily mashed. During a lunch test tray conducted on 4/16/25 at 1:32 p.m. with the Dietary Manager (DM), Dietary Director (DD), Registered Dietician (RD) S, and Registered Dietician (RD) L, Regular Diet and Pureed Diet lunch trays were presented and both had mashed potato. DM and DD verified mashed potato lacked flavor. A review of facility's ordered diet list indicated 105 residents were on Regular diet, including pureed texture. A review of facility's policy and procedure (P&P) entitled Food Preparation dated 2023, the P&P indicated, Policy: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance .		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44577 Based on observations, interviews, and record reviews, the facility failed to ensure evening snacks were offered to all residents. This failure had the potential to affect the nutritional and psychosocial wellbeing of residents who may receive snacks at the facility. Findings: During the Resident Council Meeting on 4/16/25, the Residents attending stated they have never have received snacks, the kitchen is closed after 7pm. 1a. During an interview on 4/17/25 at 1:33 p.m. with Resident 17, Resident 17 stated, Dinner comes about 6 p.m. and breakfast comes about 9 a.m., sometimes I want a snack at night, when I ask for one, they do not provide it. 1b. During an interview on 4/18/25 at 7:49 a.m. with Registered Nurse (RN) T, RN T stated, Residents do not ask for snacks, if needed we can get an order. There are no snacks available at night. 1c. During an interview on 04/18/25 at 2:34 p.m. with Resident 83, Resident 83 stated, I request snacks, and they are not provided. 44583 2. During an interview with Resident 400 on 4/14/2025 at 11:07 a.m., Resident 400 stated she was not getting any bedtime snacks. Resident 400 further stated, I am diabetic. I need to have a snack at night. During a concurrent interview with both registered dietician L (RD L) and registered dietician S (RD S) and record review of Resident 400's clinical records on 4/16/2025 at 2:34 p.m., RD L confirmed Resident 400 had diagnosis of diabetes mellitus (DM - a condition which affects the way the body processes blood sugar). RD L stated bedtime snack would come out of the kitchen around 8:00 p.m. and they (both RDs) monitor the bedtime snacks for residents with DM. RD L continued to review Resident 400's order summary report and stated Resident 400's order was just may have HS (at bedtime) snack at bedtime . RD L further stated, nurses should be the one to provide Resident 400's snack if she would ask for it. Both RD L and RD S stated they only prepared snacks for residents with physician's order. During a follow up interview with Resident 400 on 4/18/2025 at 1:37 p.m., Resident 400 complained that she did not get her bedtime snack on 4/17/2025. Resident 400 further stated she asked the certified nursing assistant assigned to her, but she was told that they did not have a bedtime snack for her. Resident 400 confirmed there were two dieticians who spoke to her about her bedtime snacks' preferences on 4/16/2025 but was still not getting her bedtime snacks. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with licensed vocational nurse U (LVN U) on 4/18/2025 at 2:17 p.m., LVN U stated kitchen staff provided resident's bedtime snacks. LVN U confirmed nurse stations did not have a storage for resident's snacks. 49345 3a. During an interview on 4/15/25 at 9:34 a.m. with Resident 61, Resident 61 stated, no snacks were available when it was past 8 p.m. or when the kitchen was already closed. 3b. During an interview on 4/18/25 at 1:30 p.m. with Resident 25, Resident 25 stated snacks at bedtime were never offered. 3c. During an interview on 4/18/25 at 02:09 p.m. with Resident 192, Resident 192 stated, she was not given snacks at bedtime when she asked for it. Resident 192 also stated bedtime snacks were never offered. During an interview on 4/17/25 at 4:27 p.m. with the Dietary Manager (DM), DM stated snacks were delivered to nurse stations at 8:00 p.m. for residents based on their physician orders. The DM also stated there were no kitchen staff by 9:30 p.m. During an interview on 4/18/25 at 12:18 p.m. with Registered Nurse (RN) O, RN O stated, only residents with physician order for bedtime snacks were given snacks at bedtime. RN O also stated bedtime snacks were not available for residents without physician order for bedtime snacks when the kitchen was closed. During an interview on 4/18/25 at 12:20 p.m. with Certified Nurse Aide (CNA) P, CNA P stated bedtime snacks were delivered only for residents with physician order for bedtime snacks. During a concurrent interview and record review on 4/18/25 at 2:53 p.m. with the Dietary Director (DD), the DD verified the list of residents (Total, 41) with orders for snacks at bedtime. The DD stated, Not everyone needs bedtime snacks. A review of facility's policy and procedure (P&P) entitled, Nourishment Policy dated 2023, the P&P indicated, . Bedtime snacks of a nourishing quality will be offered routinely to all residents unless contraindicated .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen for food preparation and food storage methods, according to standards of practice and facility policy when: 1. Frozen [NAME] (a type of fish) was stored in the freezer without use by date and opened cereals without open and used by dates. 2. Metal container was stored wet. 3. Pureed food was prepared in a sink These failures had the potential to expose residents to contaminants that could cause foodborne illness. Findings: 1a. During the initial kitchen observation on 4/14/25 at 9:11 a.m. with the Dietary Manager (DM), an opened box of frozen [NAME] was found in the freezer without use by date. The DM stated the [NAME] can be used for six months and must be labeled with the use by date. 1b. During an initial kitchen observation on 4/14/25 at 9:22 a.m. with the DM, DM verified two opened cereals in plastic bags without labels for open and use by dates were found in the dry pantry. A review of facility's policy and procedure (P&P) entitled Labeling and Dating of Foods dated 2023, the P&P indicated. Policy: All food items in the storeroom, refrigerator, and freezer need to be labeled and date. Procedure: .Newly opened food items will need to be closed and labeled with an open date and use by the date A review of facility document entitled Dry Goods Storage Guidelines dated 2023, the document indicated Ready To Eat Cereals can be stored for six months unopened on the shelf and two months when opened on shelf. 2. During an observation in the kitchen for pureed food preparation on 4/16/25 at 9:56 a.m. with Dietary Aide (DM) M and Registered Dietician (RD) L, DM M took a metal container and drops of water were visible as DM M took it from a stack under a table. RD L verified the container was wet. RD L stated container must be dry when stacked. 3. During an observation in the kitchen for pureed food preparation on 4/16/25 at 9:58 a.m. with Dietary Aide (DM) M, Registered Dietician (RD) L, and Dietary Director (DD), DM M was preparing pureed meat. DM M put a metal container in the food preparation sink and poured the pureed meat into the container. The sink was visibly wet. DD stated it was best practice to scoop pureed food into a container instead of putting the container in the sink. DM M proceeded to scoop pureed food into the container. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure (P&P) entitled Food Preparation dated 2023, the P&P indicated, Policy: Food shall be prepared by methods that conserve nutritive value, flavor and appearance		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to maintain an accurate and systematically organized documentation in accordance with accepted professional standards and practices for one of five sampled residents (residents with peek-a-boo mittens [a type of mitten, often used in healthcare settings, that have a flap on the top that allows for easy inspection of the hand without removing the mitten and designed to prevent patients from removing medical equipment attached to them]) when Resident 23's used of peek-a-boo mitten was not documented in all her weekly summaries (a concise report that provides an overview of a resident's care and progress over the past week). This failure resulted an inaccurate and inappropriate documentation of Resident 23's weekly summaries. Findings: Review Resident 23's clinical record titled, Admission Record, dated 4/16/2025, it indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including obstructive hydrocephalus (a condition where the normal flow of cerebrospinal fluid [CSF - a clear, colorless liquid that surrounds and cushions the brain and spinal cord] is blocked within the ventricles [fluid-filled spaces] of the brain), benign neoplasm (a non-cancerous growth of cells) of spinal cord, other specified disorders of brain, dysphagia (difficulty swallowing) , and encounter for attention to gastrostomy (GT - a surgical procedure that creates an opening (stoma) into the stomach for the insertion of a feeding tube. Review of Resident 23's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 23's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 00 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Review of Resident 23's clinical record titled, Order Summary Report, dated 4/16/2025, indicated an order for the use of Resident 23's peek-a-boo hand mitten for prevention of pulling out her GT. During an initial observation on 4/14/2025 at 10:08 a.m., inside Resident 23's room, Resident 23 was in bed, with right hand peek-a-boo mitten was in placed, half naked with upper chest exposed and with caregiver at bedside. During a concurrent interview with director of nursing (DON) and record review of Resident 23's weekly summaries for peek-a-boo hand mitten used, DON confirmed Resident 23's used of peek-a-boo hand mitten and any related comments for its usage were not documented in the following weekly summaries dated: 2/4/2025; 2/9/2025; 2/16/2025; 2/23/2025; 3/2/2025; 3/9/2025; 3/16/2025; 3/23/2025; 3/30/2025; 4/6/2025; and 4/13/2025. DON stated nurses should have checked the Restraint box because Resident 23 had been using the hand mitten since admission and nurses should have documented any behavior or observations on Resident 23's used of the hand mitten. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Charting and Documentation, date revised 7/2017, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44577 Based on observation, interview, and record review, the facility failed to ensure their infection prevention practices were implemented when: 1. A urinary catheter (a semi-flexible plastic tube, one end inserted into the bladder [body organ that stores urine] and the other end is attached to a bag that collects urine) drainage bag touched the floor; 2. Hand hygiene (the practice of cleaning your hands to prevent the spread of germs and illness) and the removal/change of isolation gowns (a type of personal protective equipment (PPE) used in healthcare settings to protect healthcare personnel and patients from the spread of infection or illness, particularly from contact with blood and body fluids) was not completed between tasks; 3. There was no notification to the Dialysis center of the resident's isolation precautions (measures taken to protect both patients and healthcare personnel from infection by isolating individuals who are either infected or potentially infected with a contagious disease) and type of infection. 4. The shared room for Residents 28 and 195 had no appropriate notification from Centers for Disease Control and Prevention (CDC - a set of measures aimed at preventing the spread of infections that can be transmitted through direct or indirect contact with a patient or their environment] Contact Precaution posted on the room entrance door for staff and visitors to be aware of the precaution and there was no easily accessible isolation cart (a cart used in healthcare settings to store supplies needed when caring for patients in isolation to prevent the spread of infectious diseases) placed right outside the room for quick access to needed items; 5. Certified nursing assistant Y (CNA Y) did not don (put on) the proper personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) prior to entrance to the contact isolation room, and used the purple top Super Sani -Cloth (a disinfectant chemical wipes for cleaning) wipes for hand hygiene after stepping out of the COVID-19 (an infectious disease caused by a virus) isolation room; 6. Registered nurse Z (RN Z) wore a double mask: N-95 (a type of PPE, a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air) mask on top of a surgical mask (known as a face mask, a loose fitting, disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment) before entrance to a COVID-19 isolation room; 7. Certified nursing assistant AA (CNA AA) did not don the proper PPE prior to entrance in the contact isolation room of Resident 195 with clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) infection and did not wash hands with soap and water upon exiting the room; 8. Certified Nursing Assistant B (CNA B) failed to perform hand hygiene when assisting Resident 194 during meal time; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Licensed vocational nurse U (LVN) did not wear gloves during Resident 217's urine bag care and did not perform hand hygiene before doing another task; 10. Pulmonary nurse (PN) did not wear proper PPE inside Resident 60's room who was on Contact Precaution; 11. Resident 127's oxygen nasal cannula was exposed and placed at the side of bed; 12. Physical therapy assistant (PTA) did not wear proper PPE during therapy treatment with Resident 60 in the rehabilitation (rehab) therapy room (also called the gym); 13. Resident 31's oxygen tubing observed lying on floor; 14. Resident 50's oxygen tubing observed entangled in wheel of a steel pole; 15. The tips of two Residents (145 and 209) enteral feeding tubing were left uncapped and exposed; and 16. One of three licensed nurses (LVN E) cleaned and disinfected a shared glucometer (a portable devices that measure blood glucose levels) with the appropriate disinfectant. This failure had the potential to result in the spread of bloodborne infections such as hepatitis B (a serious liver infection caused by the hepatitis B virus that is most commonly spread by exposure to infected body fluids), hepatitis C (viral liver infection caused by the hepatitis C virus), human immunodeficiency virus (HIV, is a virus that attacks the body's immune system), and other infections among residents. These failures had the potential to result in the spread of infection throughout the facility. Findings: 1. During an observation and concurrent interview on 4/16/25 at 10:10 a.m. with the Infection Preventionist (IP) (a specialized healthcare professional whose primary role is to prevent and control the spread of infections within a healthcare setting) in the hallway near Resident 346's room, Resident 346 was sitting in the wheelchair with his urinary catheter bag touching the floor, under the wheelchair. The IP immediately adjusted the catheter bag, confirming the bag should not be touching the floor. Review of the facility's policy & procedure titled Catheter Care, Urinary, dated 8/2022, indicated, Infection Control . Be sure the catheter tubing and drainage bag are kept off the floor. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on 4/16/25 at 1:11 p.m., Certified Nursing Assistant (CNA) Q was in the room with Resident 26 and Resident 27. CNA Q was observed in a gown and gloves placing a meal tray on Resident 27's tray table and arranging it within reach of Resident 27. CNA Q then took a tray to Resident 26 and arranged the tray within reach. CNA Q returned to Resident 26, opening a container on her tray. CNA Q removed her gown and gloves and noted there was no trashcan available to dispose of the gown. She removed it from the room to dispose of it, then cleaned her hands with the nearest hand sanitizer. During a concurrent interview CNA Q confirmed she did not change her gown, change her gloves or clean her hands between the residents, also confirming one of the residents were on contact isolation (using specific practices to prevent the spread of infections that are transmitted through direct or indirect contact with a patient or their environment). CNA Q stated she should have had cleaned her hands and removed her gown between residents. Review of the facility's policy & procedure titled, Isolation - Categories of Transmission-Based Precautions, dated 9/2022 revised, indicated, The individual on contact precautions is placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options (e.g., Cohorting, placing with a low risk roommate) Staff and visitors wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves are removed and hand hygiene performed before leaving the room. c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 3. During an interview on 4/17/25 at 10:14 with the Infection Preventionist (IP), the IP stated, Resident 398 was positive for COVID -19 (an infectious disease caused by a virus). The IP stated the dialysis center was not notified of Resident 398's infection or isolation status, transport was endorsed and was to communicate with the dialysis center. During an interview on 4/18/25 at 1:02 p.m. with the IP, the IP stated, the dialysis center was not notified of Resident 398's type of isolation and infection because the resident was already on dialysis. Review of Resident 398's Medial Record, dated 4/9/25, the progress notes indicated, Resident 398 was admitted [DATE], after being hospitalized for a traumatic brain injury, was found to have COVID- 19. Resident 398 has a history of End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life)(ESRD), he is on dialysis, (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) that he received while in the hospital. During a review of the facility's policy and procedure titled, Isolation - Categories of Transmission-Based Precautions, dated Revised August 2013, indicated If the res ident is transported to another unit within the facility or to another facility, the infection preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions. 44583 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During a concurrent observation and interview with the facility's IP on 4/14/2025 at 11:28 a.m., in front of Residents 28 and 195 shared room, IP confirmed the shared room was on Contact Precaution because Resident 195 was positive for C-diff infection. The following were observed: a. there was no signage of Contact Precaution posted at the entrance door of the shared room, b. there was one signage of the Transmission Based Precautions [TBP - an additional infection control practices, beyond standard precautions, used when patients have documented or suspected infections that can spread through contact, droplet, or airborne routes] posted at the left side of the entrance door, above Residents 28 and 195's name. The signage was in a regular size of paper, which indicated a small, checked mark on Contact, and not easily visible to staff and visitors, c. no isolation cart located outside the shared room. IP confirmed above observations and stated he did not put a sign at the door because the door was always open. IP further stated, staff had access to the PPE located at the hallway's wall wherein staff who cared for a resident in contact isolation had to stepped out of the isolation room and obtain another PPE to care for the other resident. IP confirmed resident's environment inside the contact precaution isolation room were considered contaminated that was the reason staff and visitors should wear the proper PPE before they entered the room. During other observations on 4/15/2025 at 12:50 p.m. and 4/16/2025 at 8:35 a.m., in front of the shared room of Resident 28 and 195, there was still no visible sign of the Contact Precaution posted at the entrance door, and no isolation cart positioned outside the isolation room door for easy accessibility of staff and visitors. During a follow up interview with IP, in the presence of the director of nursing (DON) on 4/16/2025 at 8:37 p. m., IP confirmed they still used the same signage for contact precaution isolation rooms that they had used for years, and no signage posted at the door for contact precautions. IP confirmed they did not put an isolation cart to each of the contact precaution isolation rooms because it would be a lot at the hallway combined with the enhance barrier precaution (EBP - infection control measures that involve using gowns and gloves during high-contact resident care activities, in addition to standard precautions) rooms. During a review of the facility's policy and procedure titled, Isolation - Categories of Transmission-Based Precaution, date revised 9/2022, indicated, When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. 5. During an observation on 4/14/2025 at 12:48 p.m., in front of the shared contact precaution isolation room, CNA Y entered the contact precaution isolation room without donning isolation gown and gloves. CNA Y placed Resident 28's lunch tray on his overbed table and moved the overbed table closer to Resident 28. CNA Y stepped out of the room and washed her hands with soap and water at the hallway's sink. At 12:58, CNA Y was observed stepping out of the COVID-19 isolation room and used a purple top Super Sani-Cloth wipes to clean her hands then walked across the room's hallway and performed hand hygiene with the used of the hand sanitizer. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with CNA Y on 4/14/2025 at 1:03 p.m., CNA Y confirmed above observations and stated she did not wear PPE in the contact precaution room because she just served Resident 28's lunch tray. CNA Y stated she used the purple top Super Sani-Cloth to clean her hands because there was no hand sanitizer in the isolation cart, but she used a hand sanitizer which was across the room after. CNA Y confirmed the purple top Super Sani-Cloth wipes should not be used in bare skin. During an interview with DON on 4/18/2025 at 12:34 p.m., DON confirmed the purple top Super Sani-Cloth wipes should not be used for hand hygiene. DON stated the wipes should only be used for surface and equipment cleaning. During a review of CDC's Infection Control guidelines 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 personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon entry and properly discarding before exiting the patient room is done to contain pathogens. Review of the purple top Super Sani-Cloth wipes container label indicated it was a germicidal disposable wipe not intended for skin or baby wipe. Review of Super Sani-Cloth Germicidal Wipes Safety Data Sheet date revised 9/7/2023, indicated, Recommended use Use as a disinfectant on hard, non-porous surfaces. Read and understand the entire label before using. Use only according to label directions. It is a violation of Federal law to use this product in a manner inconsistent to label directions. Warning Hazard statements Causes serious eye irritation. May cause drowsiness or dizziness .Precautionary Statements - Prevention Wash face, hands, and any exposed skin thoroughly after handling. Description of first aid measures Skin contact Wash skin with water. Get medical attention if irritation develops or persists. 6. During an observation on 4/15/2025 at 9:21 a.m., outside the COVID-19 isolation room, RN Z donned an isolation gown, gloves and N-95 on top of the surgical mask before she entered the room. RN Z stepped out of the COVID-19 isolation room without her PPE and only the surgical mask left in placed. During an interview with RN Z on 4/15/2025 at 9:48 a.m., RN Z confirmed above observation and stated she wanted to make sure that both masks would give her protection. RN Z confirmed she was fit tested (a test used to confirm the fit of the N-95 to ensure that a tight seal forms on the wearer's face before it is used in the workplace) for the N-95 mask she wore. During an interview with IP on 4/16/2025 at 8:37 p.m., IP confirmed double masking was not allowed. IP stated staff should wear only N-95 mask whenever they entered the COVID-19 isolation room. During a review of CDC's Personal Protective Equipment guideline titled, How to Use Your N95 Respirator, dated 3/12/2025, indicated, Your N95 respirator must form a seal to your face to work properly. Your breath must pass through the N95 respirator and not around its edges .Gaps can also occur if your N95 respirator is too big, too small, or it was not put on correctly. 7. Review of Resident 195's physician order dated 3/25/2025, indicated an order of contact precautions secondary to the diagnosis of C-diff. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/15/2025 at 12:50 p.m., outside the shared contact precaution room of Residents 28 and 195, CNA AA entered the contact precaution room without donning an isolation gown and gloves. CNA AA set up Resident 195's lunch tray on top of his overbed table and moved the overbed table towards Resident 195. CNA AA stepped out of the room and used the hand sanitizer for hand hygiene. During a follow up interview with CNA AA on 4/15/2025 at 12:51 p.m., CNA AA confirmed above observations and stated she just dropped off Resident 195's lunch tray. CNA AA further stated Resident 195 was just on isolation because he was on chemotherapy (medicines used to treat cancer) medications, and she used the hand sanitizer because her hands were not visibly soiled. During an interview with IP on 4/16/2025 at 8:37 a.m. regarding used of hand sanitizer after lunch set up inside a C-diff (+) resident without gloves and gown, IP stated used of hand sanitizer was good enough as long as the staff hands were not visibly soiled. IP further stated staff should only washed their hands with soap and water when their hands were visibly soiled. IP confirmed staff should have worn isolation gown and gloves even when setting up Resident 195's lunch tray. During a review of CDC's guidelines titled, Preventing C. diff, dated 12/18/2024, indicated, Washing your hands with soap and water is the best way to prevent the spread of C. diff from person to person .C-diff can live on people's skin. In a healthcare setting *Make sure all healthcare professionals clean their hands before and after caring for you . *While caring for you and other patients with C. diff infection, healthcare professional will use certain precautions like wearing a gown and gloves. This will prevent the spread of C. diff to themselves and other patients. * Wash your hands with soap and water every time you use the bathroom and before you eat, 46939 8. During an observation on 4/14/25, at 1:01 p.m., in Station 5 dining room, CNA B was observed assisting a resident to eat, after a few minutes CNA B assisted Resident 194 without performing hand hygiene. During an interview on 4/14/25. At 1:02 p.m., with CNA B, CNA B stated, we are supposed to use hand hygiene before helping each resident to eat, I did not use hand sanitizer before helping Resident 194 from the previous resident. During an review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene dated, 2019, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections.7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .o. Before and after assisting resident with meals. 49345 9. During a concurrent observation and interview on 4/14/25 at 9:47 a.m. with Licensed Vocational Nurse (LVN) U at Resident 217's bedside, LVN U touched Resident 217's urine bag without gloves and proceeded to take Resident 217's water pitcher from the bedside table out of the room. LVN U stated he should have worn gloves before touching a resident's urine bag. LVN U also stated hand hygiene should have been done prior to touching Resident 217's pitcher. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility's policy and procedure (P&P) entitled Handwashing/ Hand Hygiene revised August 2019, the P&P indicated, .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: e. Before and after handling an invasive device(e.g., urinary catheters) 10. During an observation on 4/14/25 at 9:50 a.m., Pulmonary Nurse (PN) was inside Resident 60's side of the room providing treatment. PN was not wearing gown and gloves inside the room. A sign for Contact Precaution was posted on Resident 60's room by the entrance. The sign indicated, gown, gloves and mask must be worn prior to entry. During an interview on 4/14/25 at 9:55 a.m. with PN, PN stated she should have worn gown and gloves when she entered Resident 60's room. A review of facility's policy and procedure (P&P) entitled Departmental (Respiratory Therapy)- Prevention of Infection revised November 2011, the P&P indicated, The following equipment and supplies will be necessary when performing tasks related to this procedure: 2.Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed) . 11. During a concurrent observation and interview on 4/14/25 at 10:53 a.m. with Case Manager N (CM N) at Resident 137's bedside, an oxygen nasal cannula was exposed on Resident 137's side of the bed. Resident 137 stated oxygen was not in use. CM N stated, oxygen cannula not in use must be kept in a Ziploc bag (a type of flexible, plastic bag with a special seal that allows you to close it and reopen it multiple times) and labeled. 12. During a concurrent observation and interview on 4/15/25 at 2:06 p.m. with the DON and IP Resident 60 was in the Rehab Therapy Room getting treatment from a PTA. PTA was not wearing facial mask, gown, and gloves. The DON and IP verified Resident 60 was on Contact Precaution and Personal Protective Equipment (PPE) should have been worn by PTA while providing treatment to Resident 60. The DON verified PTA was in close contact with Resident 60 during the treatment. During an interview on 4/15/25 at 2:20 p.m. with the PTA, PTA stated she was aware that Resident 60 was on Contact Precaution. A review of facility's document entitled Job Description: Infection Control indicated, .Responsibility: Monitoring and surveillance: You will conduct regular inspections and surveillance to identify potential sources of infections, assess compliance with infection control measures . A review of facility's policy and procedure (P&P) entitled Isolation- Categories of Transmission-Based Precautions revised September 2022 indicated .7. Staff and visitors wear gloves (clean, non-sterile) a.While caring for a resident 50135 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. During a concurrent observation and interview on 4/14/25 at 4:20 p.m. in the room of Resident 31 with the Respiratory Therapist FF (RT FF), Resident 31 pointed to the end of her oxygen tubing that connects to her tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) lying on the floor. Resident 31 showed no signs or symptoms of distress. RT FF ran into the room of Resident 31 from the hallway while passing by the room. RT FF stated, Oh no! RT FF immediately checked Resident 31's oxygen saturation (the measurement of how well the lungs are working) then stated the oxygen tubing needed to be replaced with a new one to prevent any infections. 14. During a concurrent observation and interview on 4/14/25 at 2:15 p.m. in the room of Resident 50 with the Certified Nursing Assistant EE (RNA EE) Resident 50's oxygen tubing was observed entangled between the wheel of her roommate's intravenous pole (a medical device typically made of stainless steel used to support medical equipment). RNA EE stated the tubing, Should not be like that. RNA EE immediately untangled Resident 50's oxygen tubing from the wheel of the pole. A review of the facility's policy titled, Oxygen Administration, revised 10/2010, indicated, Steps in the Procedure .7. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. 15. During an observation on 4/14/25 at 1:38 p.m., the tips of the enteral feeding tubing (a flexible medical device used to deliver liquid food directly into the stomach or intestine) for Resident 145 and Resident 209 were exposed and not covered while feedings were turned off. During a concurrent observation and interview on 4/14/25 at 2:00 p.m. in the room of Resident 145 and Resident 209 with the Assistant Director of Nursing DD (ADON DD), ADON DD confirmed the tips of Resident 145's and Resident 209's enteral feeding tubing were exposed and not covered while feedings were turned off. The ADON DD stated the tips of the tubing should have plastic caps on them when the feedings are turned off to prevent the spread of infections. A review of the facility's policy titled, Infection Prevention and Control Program, revised 10/2018 indicated, . 11. Prevention of Infection: a. Important facets of infection prevention include . (3)educating staff and ensuring that they adhere to proper techniques and procedures. 51865 16. On 4/14/25 at 4:25 p.m., at Resident 497's bedside, LVN E was observed pricking the resident's right point finger to obtain a blood sugar reading by using the glucometer. On 4/14/25 at 4:27 p.m., LVN E was observed at the medication cart removing an alcohol wipe from the alcohol prep pad. LVN E used the alcohol wipe to clean and disinfect the glucometer, which she had just used on Resident 497, then placing the glucometer inside the medication cart. During an interview on 4/14/25 at 4:47 p.m., LVN E stated that she just finished the blood sugar checks on 4 residents using a shared glucometer and cleaned it with alcohol wipe between resident uses. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Infection Preventionist (IP) on 4/14/25 at 5:12 p.m., the IP stated alcohol wipe cannot be used for glucometer. The IP stated, It's not okay to use the alcohol wipes because it does not kill certain bacteria. They should use purple-top wipe [referring to the Super Sani-Cloth, which is a surface disinfectant cleaner] with 2 minutes dwell time. A review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022, the P&P indicated, Reusable items are cleaned and disinfected or sterilized between residents. A review of a publication by the United States Food and Drug Administration (FDA) titled Blood Glucose Monitoring Test Systems for Prescription Point-of-Care Use, dated September 29, 2020, it indicated in part, The disinfectant product you choose should be effective against HIV, Hepatitis B, and Hepatitis C viruses. Of these viruses, Hepatitis B virus is the most difficult to kill and prior outbreak episodes associated with blood glucose meters have been due to transmission of Hepatitis B viruses. Therefore, disinfection efficacy studies should be performed to demonstrate effectiveness of the chosen disinfectant against Hepatitis B virus. Please note that 70% ethanol [alcohol] solutions are not effective against viral bloodborne pathogens .		