

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2026
NAME OF PROVIDER OR SUPPLIER  Los Altos Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  809 Fremont Avenue Los Altos, CA 94024	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record reviews, the facility failed to implement the discharge plan for one out of three residents (Resident 1) when the facility staff (Social Services and/or Case Manager) did not send a referral for home health services (HH, healthcare provided in the client's home) to a Home Health Agency (HHA). The failure had the potential to compromise the health and safety of Resident 1. A review of Resident 1's clinical record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including difficulty in walking, not elsewhere classified and muscle weakness. During a review of Resident 1's document titled, discharged summary/Post Discharge Plan of Care, effective date 11/10/25, indicated in IV. Rehab/Discharge Potential. B. rehab, B2. Comments: Pt (Patient) is independent in bed mobility and transfers. Pt (Patient) is supervision for ambulation with FWW (Front-wheeled walkers, are mobility aids with two front wheels and rear glides, designed to be pushed forward without lifting, making them ideal for users with limited strength or partial weight-bearing needs.), independent with w/c (wheelchair). Pt (Patient) to continue with home health services. During a review of Resident 1's physician assistant (PA) notes, dated 11/12/25, indicated, .35 minutes spent to discharge a patient and review medication and order PT/OT and needed equipment and ordering medication to outpatient pharmacy. During a review of facility discharged resident list, indicated Resident 1 was discharged to Private home/apt (apartment) with no home health services effective date 11/14/25. During a review of Resident 1's Case Manager (CM) notes, dated 11/12/25, indicated, Pt (Patient) will be discharging to home with HH/R/PT/OT [HH - Home Health, R- Rehab - PT -(Physical Therapy) and OT - (Occupational Therapy), are rehabilitation services designed to improve mobility, function, and quality of life after injury or illness]. During a phone interview on 11/26/25 at 2:01 p.m., with Family Member (FM), the FM stated Resident 1 was discharged home on [DATE], the FM stated when they're leaving, they were told they will be contacted about the home health service (HH, healthcare provided in the client's home). The FM stated there was no HH visit since Resident 1 was discharged from the facility. The FM further stated he tried calling the facility staff but no call back. During a concurrent interview and record review on 12/16/25 at 1:18 p.m., with the Social Services (SS), she reviewed Resident 1's discharged summary/Post Discharge Plan of Care, effective date 11/10/25, she stated Resident 1 was discharged from facility to home with the home health. SS was asked if she send a referral for HH, she stated she did not know about the HH referral, the Case Manager (CM) knows more about the referral for HH PT/OT. During a concurrent interview and record review on 12/16/25 at 1:45 p.m., with the CM, she reviewed Resident 1 discharge plan she stated, normally before the patient is discharge the HH is set up, they go with the rehab department recommendation if they need HH, they will fax or email the referral. The CM further stated she did not send a referral for HH, she further stated usually is the SS for HH referral. During a concurrent interview and record review on 12/16/25 at 12:39 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 1</p> <p>(continued on next page)</p>

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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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>clinical records, the ADON confirmed home health was marked on Resident 1's discharged summary/Post Discharge Plan of Care, effective date 11/10/25. ADON stated he thinks it should be set up for home health. The ADON further stated he did not see any documentation for HH referral. During a current interview and record review on 1/22/26 at 1:37 p.m., the DON stated Social Service and Case Manager are responsible for referral for HH, the DON reviewed and confirmed Resident 1's PA notes, dated 11/12/25, indicated, review medication and order PT/OT and needed equipment and ordering medication to outpatient pharmacy. During an interview on 1/14/25 at 12:45 p.m., with the Administrator (ADM), he stated the person responsible for HH referral is either the case manager or the social services. During a follow-up interview on 1/22/26 at 2:18 p.m., with the Director of Nursing (DON), the DON confirmed the facility discharged residents list, indicated Resident 1 was discharged Private home/apt (apartment) with no home health services, effective date 11/14/25. These interviews with the DON and ADM indicated vague and overlapping duties and responsibilities between the Social Services and Case Manager and created confusion which affected the discharge of Resident 1 who was not provided with a referral to a HHA by either the SS or the CM. Resident 1 ended up being discharged home without any home care services at all. During a review of SS job description titled, Director of Social Services indicated, Administrative Functions: Plan, develop, organize, implement, evaluate and direct the social service programs of the facility. Refer resident/families to appropriate social service agencies when the facility does not provide the services or needs of the resident. Ensure social service progress notes are informative and descriptive of the services provided and of the resident's response to the service. Develop and maintain a community and social services referral file of agencies and organizations that assist residents. Participate in community planning related to the interests of the facility and the services and needs of the resident and family. During a review of CM job description, titled Case Manager indicated, Duties and Responsibilities .Identify post-discharge needs such as nursing and therapy services, medical equipment, home modification or activities of daily living (ADLs) assistance. According to the State Operations Manual, Appendix PP -Long Term Care Facilities, F627 - S483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p>		