

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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)		
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care to maintain a psychosocial well-being for one of one resident (Resident 1) when Resident 1 with diagnosis of post-traumatic stress syndrome (PTSD - a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or deeply stressful event) had to share a bathroom with male residents. This failure resulted in Resident 1's verbalization of feeling unsafe and had the potential to result in psychosocial distress (the emotional, mental, and social difficulties an individual experiences when overwhelming stress or painful events exceed their ability to cope). Findings: Review of Resident 1's clinical record titled, admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental illness that causes constant fear) and PTSD. Review of Resident 1's quarterly minimum data set (MDS - federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1'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 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Review of Resident 1's clinical record titled, Progress Note, dated 5/19/2026, indicated Resident 1 called the police regarding a naked person entering her room. Further review indicated the police came to the facility and requested that the patient who entered her room be moved to another room to prevent further incidents. During a concurrent observation and interview with Resident 1 on 5/20/2026 at 10:04 a.m., inside Resident 1's room, Resident 1 was observed walking towards her bed and then she sat at the edge of her bed. Resident 1 stated on 5/19/2026 at around 4:00 a.m., she woke up and found a naked man standing in front of her bathroom door and he was facing her at the end of her bed. Resident 1 further stated she was terrified, unable to move when she saw the naked man, and she thought she would be killed. Resident 1 started crying during the interview and stated that she thought the residents whom she was sharing the bathroom in the other room were unable to use the bathroom independently. Resident 1 stated she was abducted by two men before and was sexually assaulted. She further stated, why are men always after me? Resident 1 stated she did not feel safe at the facility after the incident. During an observation on 5/20/2026 at 10:44 a.m., inside Resident 1's bathroom, there was a toilet and another door that led this writer inside Resident 2 and Resident 3's room. During a concurrent observation and interview with Resident 2 on 5/20/2026 at 10:55 a.m., inside Resident 2 and Resident 3's shared room, Resident 3's bed was empty, and Resident 2 was in bed watching TV. There was a sink located inside their room. Resident 2 confirmed they (with Resident 3) shared the bathroom with Resident 1. Resident 2 stated Resident 3 was confused the other night when he walked inside their bathroom naked, and he ended up inside Resident 1's room. During an interview with licensed vocational nurse A (LVN A) on 5/20/2026 at 11:08 a.m., LVN A stated she was not sure if Resident 1 should share the bathroom with male residents and she was not aware of Resident 1's diagnosis of PTSD. LVN A further stated the admission staff and social services (SS) oversaw assigning rooms to their residents. During an interview with SS on 5/20/2026 (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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:29 p.m., SS stated he spoke with Resident 1 on 5/19/2026 about the incident and Resident 1 told him that the incident was pretty distressing to her, that a man was inside her room. SS further stated Resident 1 was not happy it happened. SS stated, we don't want male and female sharing a bathroom, but it was a temporary room changed. SS further stated he was aware of Resident 1's diagnosis of PTSD and she was a victim of domestic violence. During an interview with the assistant director of nursing B (ADON B) on 5/20/2026 at 1:48 p.m., the ADON B stated she was aware about the incident on 5/19/2026 with Resident 1. When asked if Resident 1 was made aware of sharing the bathroom with Resident 3 who could use the bathroom himself, the ADON B stated she was not sure and that was missed. During an interview with licensed vocational nurse C (LVN C) on 6/16/2026 at 9:16 a.m., LVN C confirmed the 5/19/2026 incident when Resident 3 went inside Resident 1's room through the shared bathroom. LVN C stated Resident 3 was transferred to Resident 2's room on 5/18/2026 because he was throwing poop to his previous roommate and was going to other resident's room peeing all over the place. LVN C stated Resident 1 was not supposed to share the bathroom with male residents. During a review of the facility's policy and procedure titled, Quality of Life -Accommodation of Needs, date revised August 2009, indicated, The resident's individual needs and preferences shall be accommodated to the extent, except when the health and safety of the individual or other residents would be endangered. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom.		