STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods Post-Acute	1267 Meridian Avenue San Jose, CA 95125

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to maintain a complete medical record for one of three sampled residents (Resident 1) when:There were multiple days for which there was no documentation that Resident 1's scheduled skin treatments were provided;There were multiple days for which there was no documentation that Resident 1 was provided assistance for certain activities of daily living (ADLs); andThere were multiple days for which there was no documentation of Resident 1's meal intake (percentage of food the resident ate during each meal).These failures had the potential to compromise the facility's ability to ensure adequate care and monitoring were provided to maintain Resident 1's health and well-being at the highest practicable level.Findings:1.) Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including Huntington's disease (a disorder that destroys the areas of the brain that control movement, thinking, and mental health).Review of Resident 1's Order Summary Report indicated she had a physician's order, dated 7/18/24, to cleanse cellulitis (a skin infection) to LUE (left upper extremity) with NS (normal saline, a sterile salt water solution), pat dry, apply hydrocortisone 1% cream (medication used to relieve skin irritations), and leave open to air BID (two times a day). Resident 1 also had a physician's order, dated 7/18/24, to cleanse rash to entire body with NS, pat dry, and apply zinc oxide (a skin protectant) and hydrocortisone 1% cream BID.Resident 1's treatment administration record (TAR) was reviewed. From 7/18/24 to 8/24/24, there were nine days (ten scheduled treatments) for which there was no documentation that the facility provided treatment to Resident 1's LUE cellulitis as ordered. Further review of the TAR indicated that from 7/18/24 to 9/16/24, there were 11 days (12 scheduled treatments) for which there was no documentation that the facility provided treatment to Resident 1's entire body rash as ordered.During an interview and concurrent record review with licensed nurse A (LN A) on 5/18/26, at 12:49 p.m., LN A confirmed that when nurses provide skin treatments, they should document this on the TAR. LN A confirmed there were multiple days for which there was no documentation that the facility provided treatments to Resident 1's LUE cellulitis and entire body rash as ordered. 2.) Resident 1's Documentation Survey Report was reviewed. There was a section on this report designated for staff to document the type of assistance they provided to Resident 1 for eating, oral hygiene, and toileting hygiene. From 4/1/24 to 4/28/25, there were 63 days (67 shifts) for which staff did not document that assistance was provided to Resident 1 for these ADLs.During an interview and concurrent record review with LN B on 5/18/26, at 12:32 p.m., LN B confirmed that when staff provide ADL assistance to a resident, they should document this in the electronic health record (EHR). LN B confirmed there were multiple days/shifts for which there was no documentation that staff provided Resident 1 with assistance for the ADLs mentioned above. 3.) Resident 1's Documentation Survey Report was reviewed. There was a section on this report designated for staff to document the percentage of food Resident 1 ate during each meal. From 4/1/24 to 4/28/25, there were 36 days (67 meals) for which staff did not document the percentage of food Resident 1 ate.During an interview and concurrent record review with LN B on 5/18/26, at 12:35 p.m., LN B reviewed Resident 1's Documentation Survey Report and confirmed there were multiple days/meals (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods Post-Acute	1267 Meridian Avenue San Jose, CA 95125

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for which staff did not document the percentage of food Resident 1 ate.Review of the facility's policy titled Charting and Documentation, revised 7/2017, indicated all services provided to the resident shall be documented in the resident's medical record. The policy further indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.