| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555524 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Health Care Ctr at the Forum at Rancho San Antonio | 23600 via Esplendor<br>Cupertino, CA 95014 |

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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's legal representative (LR) who was Resident 1's son ( LR, is an individual authorized under state law to act on behalf of a resident in a facility, such as a nursing home or assisted living. They manage affairs, make decisions, or access information. including court-appointed guardians, conservators, or agents under a power of attorney) had the rights to exercise the resident's rights for one of three sampled residents (Resident 1) when his documentation of Advance Health Care Directive (AHCD , is a legal document that outlines your medical treatment preferences-such as life-sustaining care-if you become too sick or injured to communicate them yourself ) was not verified and implemented when Resident 1's representative had been delegated authority to make health care decisions for Resident 1 immediately as stipulated in the Advanced Directive dated 5/31/22 . This failure potentially limited the legal representative of Resident 1's rights for participating in Resident 1's planning of care, treatment and discharge or to be informed in advance of any resident's condition change. Review of Resident 1's admission record indicated he was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, is a progressive lung disease that damages the airways and air sacs, making it hard to breathe).During a review of Resident 1's minimum data set (MDS, a federally mandated resident assessment tool), dated 3/14/26, it indicated his brief interview for mental status scored 15, (BIMS score of 13 to 15, indicates that an individual's cognition is intact).Review of Resident 1's Advance Health Care Directive dated 5/31/22, it indicated that Resident 1 chose the option to make his agent's authority effective immediately (5/31/22) by his son. During several telephone interviews on 5/8/26 at 8:24 a.m., 5/13/26 at 8:42 a.m. and 5/13/26 at 2:16 p.m., with the LR, he stated that he had the durable power of attorney (DPOA, is a legal document that lets you appoint a trusted person or the agent or proxy-a person you choose to speak for you, to make medical decisions on your behalf if you become incapacitated and cannot communicate your wishes. It ensures your health preferences are honored, covering issues like surgery, life support, and end-of-life care) and he also signed all the consent forms for Resident 1 since after admission in the facility; however, he did not receive any notification regarding care conferences, was not involved in any discharge planning and was not notified on Resident 1's change in condition. The LR further stated there was miscommunication between him and the facility. During an interview on 5/13/26, at 4:18 p.m. and 5/14/26 at 10:50 a.m., with the director of social services (DSS) and the director of nursing (DON), the DSS stated, the DPOA would not be activated or enforced at a current time since Resident 1's cognition was intact and able to make decisions for himself. However, the DSS admitted that she did not review or check the DPOA documentation regarding Resident 1's AHCD received on 4/9/26. The DSS stated she was unaware that Resident 1 delegated legal authority to LR for making health care decisions immediately upon its signing on 5/31/22. The DON confirmed that the LR did not come to the facility after signing the documentations during Resident 1's admission. During Resident 1's initial care conference on 3/16/26, Resident 1 indicated not to have his son to be invited because he did not want to overwhelm him. During an interview on 5/14/26, at 10:05 a.m., with Resident 1 and with the DON at bedside, Resident 1 stated that he did not want to revoke the<br>(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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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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | existence of advanced directive nor change the appointment of an agent (his son) for making health care decisions for him. He indicated that he wanted his son to make health care decisions for him.During a telephone interview with the DON on 5/14/26, at 2:06 p.m., he stated Resident 1 had mentioned one time he did not want his son to be involved in his care on 4/8/26. but there was no documented evidence that the interdisciplinary team meeting (IDT, a group of professionals from various disciplines who work in collaboration to address a patient with multiple physical and psychological needs) reviewed Resident 1's AHCD that clearly indicated Resident 1's son as the health care decision maker effective 5/31/22.Review of the facility's policy and procedure (P&P) titled, Advance Directive, revised 9/2022, the P &P indicated, Advance directives are honored in accordance with state law and facility policy. Prior to upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and /or his or her legal representative, about the existence of any written advance directives. Upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker. |