

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Vasona Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16412 Los Gatos Boulevard Los Gatos, CA 95032	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686</p> <p>Based on interview and record review, the facility failed to ensure the Ombudsman (resident advocate) office was notified of a hospital transfer for one of four sampled residents (Resident 2). This failure had the potential to result in Resident 2 not having someone to advocate for his admission, transfer, and discharge rights.</p> <p>Findings:</p> <p>Review of Resident 2's medical record indicated he was admitted to the facility on [DATE] and had the diagnosis of metabolic encephalopathy (a brain condition caused by chemical imbalances in the blood).</p> <p>Review of Resident 2's Progress Notes, dated 3/4/24, indicated Resident 2 refused medication and had increased confusion. According to the Progress Notes, Resident 2 was saying he was going to go home and did not know where he was. The Progress Notes further indicated the doctor ordered for Resident 2 to be sent to the hospital.</p> <p>Review of Resident 2's Hospital Transfer Form, dated 3/4/24, indicated Resident 2 was sent to the hospital at 6:00 p.m. There was no documentation in the medical record that indicated the facility notified the Ombudsman office about Resident 2's hospital transfer.</p> <p>During an interview with social services staff B (SS B) on 3/29/24 at 1:49 p.m., she stated social services should notify the Ombudsman office of hospital transfers on a weekly basis. SS B stated the facility practice was for social services to fax the Ombudsman office a list of residents who were transferred to the hospital during the week. SS B explained when social services fax this information, they should receive a fax confirmation sheet, which confirms the information was actually sent.</p> <p>During a follow-up interview and concurrent record review with SS B on 3/29/24 at 2:45 p.m., SS B presented a fax cover sheet addressed to the Ombudsman office, dated 3/12/24, that was titled Discharge Notifications to the Ombudsman for the period March 3-9, 2024. Attached to the fax cover sheet was a list of residents that included Resident 2; however, there was no fax confirmation sheet for Resident 2. SS B confirmed there was no fax confirmation sheet and acknowledged there was no evidence that the information regarding Resident 2's hospital transfer was actually faxed to the Ombudsman office.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Ombudsman office staff D (OOS D) on 4/8/24 at 9:19 a.m., OOS D reviewed office records and confirmed the Ombudsman office did not receive any faxes notifying them of Resident 2's hospital transfer on 3/4/24. OOS D added that for March of 2024, the Ombudsman office only received faxed notification from the facility for residents transferred to the hospital from 3/17/24 to 3/29/24.</p> <p>The facility's policy titled Transfer or Discharge Notice, revised 12/2016, indicated a transfer or discharge notice will be given to the resident or representative as soon as practicable when an immediate transfer or discharge is required by the resident's urgent medical needs. The policy further indicated, A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686</p> <p>Based on interview and record review, the facility failed to ensure one of four sample residents (Resident 1) received medication as ordered. This failure had the potential to compromise the resident's health and well-being.</p> <p>Findings:</p> <p>Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] and had the diagnosis of alcohol dependence.</p> <p>Review of Resident 1's Order Summary Report indicated he had a physician order, dated 9/16/23, for Zenpep (medication used to treat inflammation of the pancreas, which is often caused by alcohol use) 5000-24000 units (does measurement) one capsule by mouth with meals.</p> <p>Review of Resident 1's medication administration record (MAR), dated 9/2023, indicated Resident 1 was scheduled to receive Zenpep every day at 7:30 a.m., 11:30 a.m., and 4:30 p.m. From 9/21/23 to 9/24/23, there were ten scheduled doses of Zenpep for which the documentation did not indicate the medication was administered to Resident 1. For these scheduled doses, licensed nurses documented 9 on the MAR. Further review of the MAR indicated a documentation of 9 meant to See Nurse Notes.</p> <p>Review of Resident 1's Progress Notes, dated 9/21/23 to 9/24/23, indicated licensed nurses did not administer the above scheduled doses of Zenpep to Resident 1 because the medication was unavailable. The Progress Notes indicated a licensed nurse contacted the pharmacy regarding Resident 1's unavailable Zenpep on 9/24/23 at 6:06 p.m.</p> <p>During an interview and concurrent record review with registered nurse A (RN A) on 4/30/24 at 1:26 p.m., she stated if a resident's scheduled medication is not available in the facility, licensed nurses should follow up with the pharmacy. RN A added that licensed nurses can request that the pharmacy send a STAT (rushed) delivery of the medication. RN A reviewed Resident 1's medical record and confirmed multiple scheduled doses of Zenpep were not administered to Resident 1 from 9/21/23 to 9/24/23 because the medication was unavailable. RN A also confirmed there was no documentation that the facility followed up with the pharmacy until 9/24/23. RN A acknowledged Resident 1 may not have missed as many doses of Zenpep if the facility had followed up with the pharmacy sooner.</p> <p>The facility's policy titled Administering Medications, revised 4/2019 indicated, Medications are administered in a safe and timely manner, and as prescribed.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686</p> <p>Based on observation, interview, and record review, the facility failed to provide food in accordance with Standing Orders for one of four sampled residents (Resident 1). This failure had the potential to compromise the resident's nutritional status.</p> <p>Findings:</p> <p>Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] and had diagnoses including diabetes (a disease that affects the body's ability to control blood sugar), anemia (a deficiency of healthy red blood cells), and hyperlipidemia (an abnormally high level of fats in the blood).</p> <p>Review of Resident 1's lunch tray slip (a piece of paper that shows what food items the resident is supposed to receive for lunch), dated 4/30/24, indicated Resident 1 had Standing Orders for 6 ounces (oz, unit of measurement) of coffee, two servings of 8 oz of milk, 8 oz of water, half a cup of diet pudding, and 6 oz of soup.</p> <p>During an observation and concurrent interview with licensed vocational nurse E (LVN E) on 4/30/24 at 12:59 p.m., Resident 1 was in his room with his lunch tray in front of him. Resident 1's lunch tray did not have any soup, and did not have a second serving of milk. LVN E acknowledged these food items were not on Resident 1's tray and asked LVN G to get them.</p> <p>During an interview with dietary staff C (DS C) on 4/30/24 at 1:19 p.m., she stated the Standing Orders on Resident 1's lunch tray slip were not physician orders. DS C explained the Standing Orders were more like Resident 1's preferences. DS C confirmed the food items listed on the lunch tray slip under Standing Orders should have been provided on Resident 1's lunch tray.</p>		