

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 06/18/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</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 accurately complete a Minimum Data Set (MDS, an assessment tool) for one of three sampled residents (Resident 1). Failure to accurately assess had the potential compromise the facility's ability to develop and implement interventions to meet the resident's needs.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated she was admitted on [DATE] and had diagnoses including sepsis (a condition in which the body responds improperly to an infection), diabetes (a disease that affects the body's ability to control blood sugar), respiratory failure (a condition in which the body does not have enough oxygen or has too much carbon dioxide), muscle weakness, and difficulty in walking.</p> <p>Review of Resident 1's Progress Notes, dated 3/13/23, indicated Resident 1 had an unwitnessed fall in the facility.</p> <p>During an interview and concurrent record review with MDS nurse A (MDSN A) on 6/18/24, at 10:10 a.m., MDSN A reviewed Resident 1's clinical record and confirmed the resident fell on [DATE]. MDSN A stated this fall should have been coded on Resident 1's MDS, dated [DATE]. MDSN A reviewed Resident 1's MDS, dated [DATE], and confirmed section J1800 was coded No, indicating Resident 1 did not fall during the specified time frame. MDSC A confirmed section J1800 should have been coded Yes, to indicated Resident 1 fell during the specified time frame.</p> <p>The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2023, indicated for section J1800, Code 1, yes if the resident has fallen during the specified time frame.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 care and services were provided in accordance with professional standards of practice for two of three sampled residents (Residents 1 and 2) when:</p> <ol style="list-style-type: none"> 1. There was no documentation that the facility completed Skin & Wound Evaluations on a weekly basis for Resident 1; and 2. The facility did not consistently complete the Nursing Weekly Summary (an assessment form) for Residents 1 and 2. <p>These failures had the potential to compromise the facility's ability to identify the residents' needs and implement interventions accordingly.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 1's clinical record indicated she was admitted on [DATE] and had diagnoses including sepsis (a condition in which the body responds improperly to an infection), diabetes (a disease that affects the body's ability to control blood sugar), respiratory failure (a condition in which the body does not have enough oxygen or has too much carbon dioxide), muscle weakness, and difficulty in walking. <p>Review of Resident 1's situation, background, assessment, recommendation (SBAR, a communication form), dated 4/16/23, indicated Resident 1 had a Wound or ulcer. The SBAR indicated Resident 1 had, Dry skin condition with light brown/yellow, flaky keratinous [bumps on the skin] substance on bilateral [both] feet, lower extremities, hands and under nails. The SBAR further indicated Resident 1's doctor gave an order to apply Clotrimazole Cream (medication used to treat fungal infections) to the affected areas two times a day.</p> <p>Review of Resident 1's medication administration record (MAR), dated 4/2023 and 5/2023, indicated Resident 1 received Clotrimazole Cream twice a day as ordered for the above skin condition until she was discharged from the facility on 5/1/24.</p> <p>Further review of Resident 1's clinical record indicated the facility completed a Skin & Wound Evaluation for the above skin condition on 4/16/23. There was no documentation that indicated the facility completed any Skin & Wound Evaluations for Resident 1 after 4/16/23.</p> <p>During an interview and concurrent record review with licensed nurse B (LN B) on 6/18/24, at 10:39 a.m., LN B stated for residents with skin conditions, Skin & Wound Evaluations should be completed weekly. LN B reviewed Resident 1's clinical record and acknowledged the resident was noted with the above skin condition on 4/16/23. LN B confirmed there was no documentation that indicated the facility completed any Skin & Wound Evaluations for Resident 1 after 4/16/23.</p> <p>The facility's policy titled Wound Care, revised 10/2010, indicated all assessment data obtained should be recorded in the resident's clinical record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident 1's clinical record indicated she was admitted on [DATE] and discharged on [DATE].</p> <p>Resident 1's Nursing Weekly Summary, dated 4/16/23, was reviewed. The form had sections designated to document assessment information for multiple areas, including but not limited to activities of daily living, mobility, skin, nutritional status, safety, hearing, vision, communication, and activities. There was no documentation that indicated the facility completed any Nursing Weekly Summaries for Resident 1 after 4/16/23.</p> <p>Review of Resident 2's clinical record indicated he was admitted on [DATE] and was still in the facility.</p> <p>Resident 2's Nursing Weekly Summary, dated 12/27/23, was reviewed. The form had sections designated to document assessment information for multiple areas, including but not limited to activities of daily living, mobility, skin, nutritional status, safety, hearing, vision, communication, and activities. There was no documentation that indicated the facility completed any Nursing Weekly Summaries for Resident 2 after 12/27/23.</p> <p>During an interview and concurrent record review with LN B on 6/18/24, at 10:39 a.m., LN B explained that the Nursing Weekly Summary is an assessment form that covers multiple areas of the resident's condition. LN B confirmed this should be completed weekly. LN B reviewed the clinical records of Resident 1 and Resident 2 and confirmed there was no documentation that indicated the facility completed any Nursing Weekly Summaries after 4/16/23 (for Resident 1) and 12/27/23 (for Resident 2).</p> <p>The facility's undated document titled Policy for Weekly Summary indicated weekly summaries should include information regarding ambulation (walking) status, activities, bowel and bladder continence, care plans, communication, exercise/range of motion, impairments, behavior, use of PRN (as needed) medications, mental status, nutritional status, hygiene, personal care, toileting habits, unusual occurrences, doctor visits, and vital signs (heart rate, temperature, respiration rate, blood pressure).</p>		