STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055798	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vasona Creek Healthcare Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to notify the responsible party (RP, person designated to make decisions on behalf of the resident) of a change of condition and new medication order for one of three sampled residents (Resident 1). This failure had the potential to compromise the RP's right to be fully informed of the resident's health condition and treatment. Findings: Review of Resident 1's clinical record indicated she was admitted on [DATE]. The clinical record further indicated Resident 1 had a designated RP. Review of Resident 1's situation, background, assessment, recommendation (SBAR, a communication tool), dated 5/29/24, indicated Resident 1's blood pressure was elevated. The SBAR further indicated Resident 1's physician gave an order for hydralazine (medication used to lower blood pressure) 10 milligrams (mg, unit of dose measurement) twice a day. Further review of Resident 1's clinical record indicated there was no documentation that the facility notified Resident 1's RP of the elevated blood pressure and new order for hydralazine on 5/29/24. During an interview and concurrent record review with licensed nurse A (LN A) on 7/19/24, at 12:02 p.m., LN A confirmed the facility must notify the RP of any changes of condition and new medication orders. LN A reviewed Resident 1's clinical record and confirmed there was no documentation that indicated the facility notified Resident 1's RP of the elevated blood pressure and new order for hydralazine on 5/29/24. The facility's policy titled Change in a Resident's Condition or Status, revised 2/2020 indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The facility's policy titled Health, Medical Condition and Treatment Options, Informing Residents of, revised 2/2021 indicated, Each resident is informed of his/her total health status and medical condition, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also informed.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 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 to compromise the facility's ability to develop and implement interventions to meet the resident's needs. Findings: Review of Resident 1's clinical record indicated she was admitted on [DATE] and had diagnoses including abnormal posture and difficulty in walking. Review of Resident 1's situation, background, assessment, recommendation (SBAR, a communication tool), dated 5/30/24, indicated Resident 1 had an unwitnessed fall in the facility. During an interview and concurrent record review with licensed nurse B (LN B) on 7/18/24, at 1:26 p.m., LN B reviewed Resident 1's clinical record and confirmed the resident fell on [DATE]. LN B stated this fall should have been coded on Resident 1's MDS dated [DATE]. LN B 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. LN B confirmed section J1800 should have been coded Yes, to indicate Resident 1 fell during the specified time frame. 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.

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(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** 37686 Based on interview and record review, the facility failed to accurately document in the clinical record for one of three sampled residents (Resident 1) when Resident 1's clinical record contained progress notes pertaining to a different, unknown resident. This failure had the potential to compromise the facility's ability to monitor and implement interventions for the correct resident. Findings: Review of Resident 1's clinical record indicated she was admitted on [DATE] and had diagnoses including abnormal posture and difficulty in walking. Review of Resident 1's Progress Notes, dated 5/30/24 at 7:15 a.m., indicated Resident 1 had an unwitnessed fall in the facility. The Progress Notes indicated the facility called 911 and emergency medical services (EMS) transported Resident 1 to the acute hospital five minutes after the fall. Resident 1's clinical record indicated she never returned to the facility after being transported to the acute hospital on the morning of 5/30/24. Further review of Resident 1's clinical record indicated there were multiple Progress Notes created as late entries (documentation that pertains to events that occurred in the past). The clinical record indicated these late entries were created by licensed nurse C (LN C) on 7/18/24 (seven weeks after Resident 1 was transferred to the acute hospital). The clinical record indicated the late entries were for the dates of 5/31/24, 6/1/24, and 6/2/24. The late entries for these dates indicated, S/P [status post] Fall - Resident is alert and verbally responsive. No pain/distress reported. No s/sx [signs and symptoms] of SOB [shortness of breath]. VS [vital signs] within normal range. No change in LOC [level of consciousness], can move all extremities [arms and legs]. Continuing to monitor neuro[logical] check on my shift. Patient consumed meal and appeared to have a good appetite. Took prescribed medications. No new skin issues. All needs have been met. Call light is within reach. Bed in the lowest position. Reinforced and explained for the use of call light when assistance is required. Plan of care ongoing. During an interview and concurrent record review with LN A on 7/19/24, at 12:02 p.m., LN A reviewed Resident 1's clinical record and acknowledged there were multiple late entries, created by LN C on 7/18/24, for the dates of 5/31/24, 6/1/24, and 6/2/24. LN A acknowledged these late entries were not accurate, as Resident 1 was transferred to the acute hospital on 5/30/24 and never returned to the facility. During an interview and concurrent record review with LN C on 7/19/24, at 12:40 p.m., LN C acknowledged the late entries she created in Resident 1's clinical record for the dates of 5/31/24, 6/1/24, and 6/2/24. LN C confirmed Resident 1 was no longer in the facility on these dates. LN C explained that she documented the late entries in the wrong resident's clinical record and the notes were supposed to be for another resident, not Resident 1. When asked which resident the late entries were supposed to be for, LN C stated she had a list of residents for whom she had to do late entries, so she was not able to provide the resident's name. LN C stated she would locate the list and provide the resident's name. LN C never provided the resident's name. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated document titled Clinical Records Policy Statement indicated the facility must maintain clinical records on each resident that are complete and accurately documented.