

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 12/04/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087</p> <p>Based on interview and record review the facility failed to follow physician's orders for Resident 1 when Resident 1's physician's steroid tapering (process of slowly decreasing a steroid dosage over time) orders were not carried out correctly. This resulted in Resident 1 receiving a larger dosage than prescribed for six days, and Resident 1 missing one steroid dose entirely.</p> <p>These failures resulted in Resident 1 not receiving proper treatment, and had the potential to compromise Resident 1's health and well-being.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (irregular heart rate), chronic obstructive pulmonary disease (chronic lung disease that makes it difficult to breathe) with acute exacerbation (sudden worsening in airway function), pulmonary hypertension (high blood pressure in the lungs), bronchiectasis (damage to tubes that carry air in/out of the lungs), and bacterial pneumonia (infection in the lungs caused by bacteria).</p> <p>Review of Resident 1's physician order dated 8/15/24, indicated to administer, prednisone (steroid drug used to reduce inflammation) 10 mg (mg/unit of measure) Give 3 tablet by mouth in the morning for inflammation [30 mg].</p> <p>Review of Resident 1's physician order dated 9/3/24, indicated to decrease prednisone to 25 mg by mouth daily for seven days, indicating specific dates from 9/4 to 9/11 (9/4 to 9/11 is eight days). The physician order also indicated to decrease Prednisone to 20 mg by mouth daily for seven days, indicating specific dates from 9/12 to 9/19 (9/12 to 9/19 is eight days).</p> <p>Review of Resident 1's medication administration record (MAR), for the month of August and September, indicated Resident 1 received 30mg of prednisone from 8/16/24 until 9/9/24.</p> <p>Review of Resident 1's September MAR indicated two prednisone orders. One order for prednisone 30 mg to be given at 9:00 a.m. and a second order for prednisone 25 mg to be given at 10:00 a.m. Resident 1 received 55 mg of prednisone for 6 days, from 9/4/24 through 9/9/24. Resident 1's September MAR also indicated no prednisone was administered to Resident 1 on 9/11/24.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and concurrent record review with licensed vocational nurse A (LVN A) on 9/4/24 at 1:30 p.m., she reviewed Resident 1's September MAR and stated she administered medications to Resident 1 on 9/6/24. When asked what dosage of prednisone was administered to Resident 1 on 9/6/24, LVN A stated she initialed 30 mg of prednisone administered at 9:00 a.m. and 25 mg of prednisone administered at 10:00 a.m. LVN further stated she does not recall administering 55 mg of prednisone to Resident 1 on 9/6/24 and stated she should have questioned the physician orders for two different prednisone dosages. When LVN A was asked what dosage of prednisone was administered to Resident 1 on 9/11/24, she stated there was no evidence of prednisone being administered on 9/11/24 on Resident 1's MAR.</p> <p>During an interview and concurrent record review with the director of nursing (DON) on 9/4/24 at 3:25 p.m., she reviewed Resident 1's physician orders for prednisone. The DON stated the physician orders on 9/3/24 indicated a gradual tapering of the prednisone dosage by 5 mg each week. The DON stated the physician wrote an order to decrease the prednisone from 30 mg to 25 mg on 9/3/24. She further stated the order for 30 mg of prednisone should have been discontinued, but licensed nurses administered both dosages, from 9/4/24 through 9/9/24. The DON confirmed Resident 1's September MAR indicated licensed nurses administered 55 mg of prednisone to Resident 1 for six days, from 9/4/24 through 9/9/24. The DON confirmed that Resident 1 did not receive prednisone on 9/11/24. The DON confirmed the physician orders for prednisone indicated for seven days but she stated the specific dates identified by the physician in the order totaled eight days. The DON stated the licensed nurses should have clarified the orders with Resident 1's physician.</p> <p>Review of the facility's undated facility's policy, Physician Orders, indicated the purpose of the policy is to establish standardized guidelines for receiving, documenting, verifying, and executing physician orders to ensure safe and effective patient care. Orders must be clear, complete, and include all necessary information (e.g., name, date, time, and specific instructions). The policy further indicated, Any ambiguities or concerns must be clarified with the ordering physician before execution.</p>		