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	01/27/2025

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 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 maintain a complete medical record for one of three sampled residents (Resident 1) when: 1. The facility treated a wound to Resident 1's coccyx (tailbone) that was present upon admission, but did not document that they obtained a physician's order for wound treatment until eight days after admission; 2. The facility did not document treatments of Resident 1's coccyx wound until eight days after admission; and, 3. There was one week during which the facility did not document the assessment of Resident 1's coccyx wound. These failures had the potential to compromise the facility's ability to ensure Resident 1's wound was treated and monitored. Findings: Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including overactive bladder (a condition that causes the sudden urge to urinate) and enterocolitis due to clostridium difficile (inflammation of the intestines that causes watery stools). Review of Resident 1's nursing admission assessment, dated 10/3/24, indicated Resident 1 had non blanchable redness (redness that does not turn white when pressed) with open skin on the coccyx. During an interview with Resident 1's family member (FM) on 1/24/25 at 3:10 p.m., the FM confirmed Resident 1's coccyx wound was present upon admission. The FM explained that once the facility saw the wound was present, they implemented routine wound treatments. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During an interview and concurrent record review with the wound treatment nurse (WTN) on 1/27/25 at 9:55 a.m., the WTN explained that if a resident has a wound upon admission, the admitting nurse should obtain a physician's order for wound treatment, and the wound treatments should be documented on the treatment administration record (TAR). The WTN further explained that for residents with wounds, there should be wound assessments documented in the medical record weekly. The WTN reviewed Resident 1's medical record and confirmed the resident had a coccyx wound upon admission. The WTN confirmed there was no documentation that the facility obtained a wound treatment order, and no documentation that wound treatments were performed until 10/11/25. The WTN also confirmed there was no documentation of weekly wound assessments in Resident 1's electronic health record, but stated he would check with the assistant director of nursing (ADON) to see if she had the assessments. During an interview and concurrent record review with the ADON on 1/27/25 at 2:12 p.m., the ADON presented weekly wound assessments for Resident 1's coccyx wound. The wound assessments indicated Resident 1's wound was classified as moisture-associated skin damage (caused by prolonged exposure to various sources of moisture, including urine or stool). There was no weekly wound assessment for the week after Resident 1's admission to the facility. The ADON confirmed there were no weekly wound assessments for Resident 1 until 10/17/24 (two weeks after the resident was admitted to the facility). The facility's policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 2001, indicated the physician will authorize pertinent orders related to wound treatments. The facility's policy titled Charting and Documentation, revised 12/2019, indicated the services provided to the resident should be documented in the resident's medical record. The policy further indicated documentation of procedures and treatments includes details such as the date and time the procedure/treatment was provided, the name and title of the individual who provided the care, assessment data, and physician notification.