

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  02/10/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000</b></p> <p>Based on interview and record review, the facility failed to ensure practices that met professional standards of quality and facility policy and procedures (P&amp;P) for one of 3 sampled residents (Resident 1) when:</p> <p>1. Resident 1 received two insulin (an injectable medication for the treatment of high blood glucose/sugar) orders and was diagnosed with diabetes (disease that impairs the body's ability to regulate blood sugar [BS]) by Physician B without documented evidence of laboratory results and/or symptoms that met the diagnostic criteria for diabetes according to the American Diabetes Association (ADA).</p> <p>The failure resulted in the resident being diagnosed with diabetes and receiving insulin orders without supporting evidence for the diagnosis and the medications, and had the potential for adverse effects, such as severely low BS that could lead to confusion, blurred vision, fall, tremors, loss of consciousness, etc.</p> <p>2. Resident 1 received new orders for treatment without staff informing his responsible party (RP, person designated to make decisions on behalf of the resident) of the changes in treatment.</p> <p>The failure resulted in the resident/RP not being informed and participated in the resident's care.</p> <p>Findings:</p> <p>1. On 1/10/25, the California Department of Public Health received an anonymous complaint indicating Resident 1 was receiving insulin treatment while he was not diabetic, and he was noticed to be really sleepy and lethargic.</p> <p>A review of the American Diabetes Association's (ADA) online publication titled Understanding Diabetes Diagnosis, accessed 2/10/25, indicated:</p> <p>There are several ways to diagnose diabetes. Each way usually needs to be repeated on a second day to diagnose diabetes. when:</p> <p>a. A1c (hemoglobin A1c, average blood glucose for the past two to three months) level of 6.5% or higher (normal value is &lt;5.7%);</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>b. Fasting Plasma Glucose (FPG) Test: a fasting blood sugar level of 126 milligrams/deciliter (mg/dL, unit of measurement) or higher;</p> <p>c. Oral Glucose Tolerance Test (OGTT): A 2-hour plasma glucose level of 200 mg/dL or higher during an OGTT after consuming a sugary drink;</p> <p>d. Random Plasma Glucose Test: random blood sugar level of 200 mg/dL or higher, along with symptoms of diabetes (such as excessive thirst, urination, or weight loss).</p> <p>On 1/24/25, a review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including aphasia (disorder that affects a person's ability to communicate) following a cerebral infarction (stroke) and urinary tract infection. The list of admitting diagnoses did not include diabetes.</p> <p>A review of Resident 1's Minimum Data Set (MDS, an assessment and screening tool), dated 8/24/24, indicated he had a BIMS score of 9 [(Brief Interview for Mental Status, a test given by medical professionals to determine a patient's cognitive understanding that can be scored from 1 to 15, a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact) ], which indicated his cognitive condition was moderately impaired. The medical record indicated a family member was the resident's RP.</p> <p>A review of the prior-to-admission records indicated the resident was hospitalized from 8/8/24 until 8/22/24. The records indicated Resident 1 did not have a diagnosis of diabetes nor did he receive any insulin administration during the hospitalization or prior to hospitalization .</p> <p>A review of Physician A's progress notes, dated 8/22/24 (day of admission to the facility), indicated no diagnosis of diabetes in the physician's assessment.</p> <p>A review of the physician's orders indicated Resident 1 received two insulin orders, made by phone, by Physician A. They were entered into the computer system by Registered Nurse C (RN C) on 8/28/24 at 22:28 (10:28 p.m.), as follows:</p> <ul style="list-style-type: none"> <li>- Humalog solution (a short-acting insulin), inject 3 units subcutaneously (under the skin) three times a day before meals for diabetes; and</li> <li>- Humulin N (insulin NPH, a long-acting insulin), inject 5 units subcutaneously two times a day before breakfast and dinner.</li> </ul> <p>A review of Resident 1's August and September 2024 Medication Administration Records (MAR) indicated Resident 1 received these two medications from 8/29/24 to 9/2/24 (total of 5 days).</p> <p>Resident 1's clinical record indicated the nursing staff obtained the resident's BS three times a day starting on 8/29/24 at 7:35 a.m., at around the first dose of insulin was administered. There was no documented evidence of BS being obtained prior to 8/29/24.</p> <p>Further review of Resident 1's clinical record indicated it did not contain documented evidence Resident 1 exhibited symptoms consistent with diabetes such as excessive thirst, frequent urination, or weight loss.</p> <p>(continued on next page)</p>		

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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 a concurrent interview and record review with RN C on 1/24/25 at 3:28 p.m., she stated she received the above orders as endorsed by the morning nurse and entered them into the computer system. She said she recalled the resident had a BS reading of moderately high and that was the reason why the physician prescribed the two insulin orders. RN C reviewed Resident 1's clinical record and could not find the BS reading she was talking about, as there was no BS reading prior to 8/29/24 at 7:35 a.m. She reviewed the resident's lab results (which were not available in Resident 1's clinical record) via the contracted laboratory website and stated he had the A1c of 5.4% on 8/27/24, and 5.5% on 8/28/24. She acknowledged those A1c levels were normal (as defined by the ADA above, a value of less than 5.7%).</p> <p>During a concurrent telephone interview and record review with Assistant Director of Nursing (ADON) A on 1/24/25 on 4:02 p.m., she stated she received an order from Physician A to discontinue the insulin orders on 9/2/24 after Resident 1's RP insisting on them being discontinued because the resident was not diabetic. When asked if she could find any BS readings prior to 8/29/24 (the day the insulin was started), ADON C stated, I don't see any.</p> <p>During an interview with Physician A on 1/24/25 at 4:32 p.m., he stated he was the attending physician for Resident 1 when he was first admitted, but he did not prescribe the insulin orders. He explained he was on leave during that time, and the covering physician (Physician B) prescribed the insulin orders. He stated he recalled the resident's family member getting really upset when she found out Resident 1 was receiving insulin injections, so he ordered to discontinue them on 9/2/24. Physician A stated he recalled looking into this and I did not know why insulin was ordered; the thought was that maybe the patient was on steroid use or had high blood sugar, but there was no record of blood sugar checks. He reviewed the physician's progress notes (his and those of Physician B's) and stated he could not see any notes regarding the reason for diabetes or insulin. He stated, When this insulin happened, I looked at hospital record; A1c was normal. Physician A confirmed the resident was not receiving any steroid medications.</p> <p>A review of the laboratory reports indicated Resident 1 had an A1c reading of 5.4% on 8/27/24; and 5.5% on 8/28/24, the day the insulin orders were made.</p> <p>During a concurrent interview and record review with Licensed Vocational Nurse (LVN F) on 1/30/25 at 11:16 a.m., he stated he worked the morning shift on 8/28/24 and received the insulin orders for Resident 1 over the phone from Physician B towards the end of his shift. He endorsed the orders to the oncoming nurse, RN C, who carried out the orders. He stated Physician B explained to him the reason for the orders, that the blood sugar was too high. LVN F reviewed the resident's clinical record and stated he could not locate the said BS.</p> <p>During another interview with LVN F on 1/30/25 at 11:37 a.m., when asked whether he obtained the BS for Resident 1 the day the insulin orders were made, he stated, I don't recall.</p> <p>A concurrent interview and record review was conducted with ADON B on 1/30/25 at 11:48 a.m. A review of Physician B's progress notes, written on 8/28/24 at 16:31 (4:31 p.m.), indicated no diagnosis of diabetes nor a BS reading or any notation about insulin orders.</p> <p>(continued on next page)</p>		

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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 a telephone interview with Physician B on 2/10/25 at 11:25 a.m., in the presence of ADON A and the Administrator, he stated he examined the resident on 8/18/24, the day he made the orders for insulin. He explained, I reacted to the fasting blood sugar of about 160. I was given that information even though they didn't have the diagnosis of diabetes. When pointed out that his progress notes did not have any notation of diabetes diagnosis or of high BS reading, Physician B stated, I didn't document on the note; it's just the timing.</p> <p>A concurrent interview and record review was conducted with ADON A on 2/10/25 at 11:45 a.m. She reviewed Resident 1's clinical record and confirmed there was no documentation of Resident 1 having a high BS reading prior to the insulin orders being made; and his A1c levels were 5.4 and 5.5% on 8/27 and 8/28, respectively. There was no documented evidence to support the diagnosis of diabetes and the necessity for the insulin orders.</p> <p>A review of the facility's P&amp;P titled Physician Visits, revised 4/2013, indicated, The attending physician must perform relevant tasks at the time of each visit, including review of the resident's total program of care and appropriate documentation.</p> <p>2. A review of Resident 1's clinical record indicated it had no evidence the facility staff informing the resident's RP of the new insulin orders.</p> <p>During a concurrent interview and record review with LVN F on 1/24/25 at 3:28 p.m., she stated the resident's RP is here most of the time during the PM shift. If she was here, she would be notified. When asked to provide documented evidence the RP was notified, LVN F reviewed Resident 1's clinical record and stated, I don't see it. I think she was notified in person but it was not translated in progress notes.</p> <p>During a telephone interview with ADON A on 1/24/25 at 4:02 p.m., ADON A was asked to review Resident 1's clinical record remotely. After a few moments, she stated, I didn't see any progress notes the [RP] was informed. They should be notified.</p> <p>During a concurrent interview and record review with ADON B on 1/30/25 at 11:48 a.m., ADON B reviewed Resident 1's clinical record and stated, I don't see anything that family was informed. Family should have been informed.</p> <p>A review of Physician A's progress notes, written on 9/3/24 at 2012 (8:12 p.m.), indicated Physician A Discussed with family in hallway they were upset that insulin was given.</p> <p>During a telephone interview with Resident 1's RP on 1/30/25 at 3:50 p.m., when asked if she was informed about the resident's insulin orders, the RP stated, No, they never called and let me know about the insulin. She explained she found out accidentally from a staff after Resident 1 kept asking her Why am I so sick? She stated, I asked the staff; they said it's because the blood sugar was too low.</p> <p>A review of the facility's P&amp;P titled Resident Rights, revised 2/2021, indicated, Federal and stated laws guarantee certain basic rights to all residents of their facility. These rights include the resident's right to . be notified of his or her medical condition and of any changes in his or her condition.</p> <p>(continued on next page)</p>		

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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>A review of the facility's P&amp;P titled Change in a Resident's Condition or Status, revised 2/2021, indicated the facility promptly notifies the resident . and the resident representative of changes in the resident's medical condition and/or status .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>27000</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored in 3 of 6 medication carts when: 1. Discontinued medications for 3 residents (Residents 2, 3, and 4) were not removed from active stock; and 2. An insulin pen (a pre-filled pen containing multiple doses of insulin for the treatment of high blood sugar) was not labeled with patient-specific information and not dated with an open date.</p> <p>These failures had the potential for medication errors; spread of infection due to being mixed up with another resident's insulin pen; and insulin given past its effective date.</p> <p>Findings:</p> <p>a. On 1/24/25 at 10:15 a.m., at Medication Cart 3A with Licensed Vocational Nurse (LVN) D, a multi-dose vial of insulin lispro (a short-acting insulin), with the expiration date of 1/11/25, was identified in the medication cart. LVN D stated it belonged to Resident 2 who was no longer residing in the facility.</p> <p>A review of Resident 2's clinical record indicated she was discharged from the facility on 12/18/24, more than a month ago.</p> <p>b. On 1/24/25 at 10:20 a.m., at Medication Cart 1A with LVN E, a Humulin N (a long-acting insulin) belonging to Resident 3 and a Lantus (a long-acting insulin) vial for Resident 4, were identified in the cart. LVN E stated both residents were not here. She acknowledged they should have been removed from the cart.</p> <p>A review of Resident 3's clinical record indicated she was discharged from the facility on 1/11/25, or 13 days ago.</p> <p>A review of Resident 4's clinical record indicated the resident was discharged from the facility on 12/19/24, more than a month ago.</p> <p>c. On 1/24/25 at 10:32 a.m., at Station 4 Medication Cart with LVN F, an insulin glargine-yfqn pen (a pre-filled pen containing long-acting type of insulin that works slowly, over about 24 hours) was identified without any patient-specific labeling and without an open date. LVN F stated he did not know whom the pen belonged to and when it was opened.</p> <p>A review of the manufacturer's Prescribing Information (detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for insulin glargine-yfqn, dated 7/2021, indicated to discard the pen 28 days after opening.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on 1/24/25 at 5:02 p.m., she stated medications belonging to discharged residents are to be removed from the medication carts when they are discharged , to prevent them from being given in error; and insulin pens need to have resident name on it and an open date.</p> <p>A review of the facility's undated policy and procedures titled, Medication Labeling and Storage indicated, The nursing staff is responsible for maintaining medication storage .in a .safe .manner . If the facility has discontinued .medications . the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial If the medication containers have missing, incomplete, improper .labels, contact the dispensing pharmacy for instructions .</p>		