

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  10/31/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47914</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure staff immediately reported an incident of suspected abuse to the Administrator for 1 (Resident #32) of 1 resident reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Reporting Abuse to Facility Management, revised in 12/2013, indicated, It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc. [et cetera] to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy specified, 4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. 5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator, Director of Nursing Services, or Charge Nurse.</p> <p>An Admission Record revealed the facility admitted Resident #32 on 10/20/2019. According to the Admission Record, the resident had a medical history that included diagnoses of dysphasia (impaired ability to understand or use spoken language) following cerebral infarction (stroke), schizophrenia, parkinsonism, major depressive disorder, and anxiety disorder.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment.</p> <p>Resident #32's Care Plan included a focus area, initiated on 06/24/2024, that indicated the resident had a need for activities that were consistent with their abilities and interests. According to the focus area, enjoyable, meaningful activities to the resident included, but were not limited to, visiting with their spouse and talking to their spouse on the cell phone.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #32's Progress Notes revealed a Nurse's Note, documented by Licensed Vocational Nurse (LVN) #6 on 10/27/2024 at 7:45 AM, that indicated when LVN #6 entered Resident #32's room to administer medication, the resident was yelling for help. Per the note, when LVN #6 entered the room, LVN #6 heard Resident #32's spouse on the phone very loudly and aggressively telling the resident to shut the [expletive] up. The progress note indicated LVN #6 asked the spouse not to speak to the resident like that under any circumstances, and Resident #32 whispered, thank you as LVN #6 was administering their medications. The note did not indicate whether LVN #6 notified anyone of suspected abuse.</p> <p>During an attempt to contact LVN #6 on 10/31/2024 at 8:52 AM, an automatic recording was received that indicated the wireless customer was unable to be reached.</p> <p>During an interview on 10/30/2024 at 3:53 PM, both the Administrator and Director of Nursing (DON) #16 stated they were not aware of the incident documented in Resident #32's progress notes.</p> <p>During an interview on 10/31/2024 at 11:50 AM, DON #16 said if staff suspected abuse, she expected them to notify the abuse coordinator and the DON, so they could notify the state agency and start an investigation.</p> <p>During an interview on 10/31/2024 at 2:38 PM, the Administrator stated he expected staff to report all suspected abuse to himself or the DON.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>47914</p> <p>Based on interview, record review, facility document review, and facility policy review, the facility failed to resubmit a new Level I Preadmission Screening and Resident Review (PASARR) for 1 (Resident #74) of 4 residents reviewed for PASARR and failed to ensure a PASARR was accurately completed for 1 (Resident #110) of 4 residents reviewed for PASARR.</p> <p>Findings included:</p> <p>An undated facility policy titled, Admission Criteria, revealed, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The policy also indicated, 11. The state may choose not to apply the preadmission screening requirement if: a. the individual is admitted directly to the facility from a hospital where he or she received acute inpatient care; b. the individual requires facility services for the condition for which he or she received care in the hospital, and c. the attending physician has certified (prior to admission) that the individual will likely need less than 30 days of care at the facility.</p> <p>1. An Admission Record revealed the facility admitted Resident #74 on 05/14/2024. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/16/2024, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had active diagnoses that included anxiety disorder, depression, and bipolar disorder.</p> <p>Resident #74's care plan, included a focus area initiated on 05/15/2024, that indicated the resident was at risk for psychosocial well-being due to concerns related to anxiety, bipolar disorder, and diagnosis of depression. Interventions directed staff to allow the resident to voice feelings and frustrations; encourage family and friends to visit; to listen attentively; and observe the resident for tearfulness, increased agitation, and decreased participation in care.</p> <p>A State of California - Health and Human Services Agency, Department of Health Care Services letter dated 05/16/2024, revealed the resident had a negative Level I Screening, and the reason was for an exempted hospital discharge. The Department of Health Care Services letter also indicated, If the individual remains in the NF [nursing facility] longer than 30 days, the facility should resubmit a new Level I Screening as a Resident Review on the 31st day.</p> <p>During an interview on 10/31/2024 at 11:54 AM, Director of Nursing (DON) #16 stated a new Level I Screening should have been completed for Resident #74 after 30 days.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/2024 at 1:42 PM, the Marketing Director stated that typically the hospital would send out the PASARR electronically and the facility would download it and that someone from the MDS or billing department would conduct a review. The Marketing Director said if there needed to be another review completed, it would be done to make sure it did not go past the 30 days. The Marketing Director said Resident #74 was never brought to his attention.</p> <p>During an interview on 10/31/2024 at 2:21 PM, the Administrator stated the admissions team usually did an audit to see if there was a PASARR and if there were any clinical changes that would warrant a Level II. The Administrator said the admissions team and medical records staff were responsible for catching any errors. For Resident #74, the Administrator said the expectation was that the Level I would be done on the 31st day.</p> <p>22445</p> <p>2. An Admission Record revealed the facility admitted Resident #110 on 03/15/2024. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified moderate dementia with other behavioral disturbances (03/15/2024), anxiety disorder (03/15/2024), and unspecified psychosis not due to a substance or known physiological condition (03/15/2024).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed the resident had modified independence in cognitive skills for daily decision-making and had short-term and long-term memory problems per the Staff Assessment of Mental Status (SAMS). The MDS indicated the resident had active diagnoses that included anxiety disorder and psychotic disorder.</p> <p>Resident #110's care plan, included a focus area initiated on 05/08/2024, that indicated the resident was at risk for psychosocial well-being concerns related to anxiety. Interventions directed staff to encourage visits from family and friends; listen attentively; and observe for tearfulness, increased agitation, and decreased participation in activities. Resident #110's care plan also included a focus area initiated on 05/17/2024, that indicated the resident was at risk for potential side effects, complications, or adverse reactions related to the ordered use of olanzapine (an antipsychotic medication) that was ordered for psychosis with behavioral disturbances. Interventions directed staff to give the medication as ordered, approach the resident in a calm manner, attempt a gradual dose reduction as indicated, monitor episodes of angry outbursts, observe and report signs of hallucinations, observe for adverse effects of the medications, and observe/record the effectiveness of the medication treatment.</p> <p>A Preadmission Screening and Resident Review (PASRR) [PASARR] Level 1 Screening, dated 03/15/2024 indicated Resident #110 had no serious diagnosed mental disorder that included anxiety disorder and symptoms of psychosis.</p> <p>A State of California- Health and Human Services Agency, Department of Health Care Services letter dated 03/15/2024 revealed the negative Level I Screening for Resident #110 indicated a Level II Mental Health Evaluation was not required. The Department of Health Care Services letter indicated the reason the Level I Screening was negative was due to no mental illness. According to the Department of Health Care Services, if mental illness was suspected, then a Level II Mental Health Evaluation could be conducted to determine if the individual could benefit from specialized mental health services.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social Services Director (SSD) #15 was interviewed on 10/31/2024 at 10:25 AM and stated that anyone could initiate a PASARR. She stated that when a resident was admitted the Director of Nursing (DON) or the nurses on the hall were responsible to make sure the PASARR was accurate.</p> <p>Director of Nursing (DON) #16 was interviewed on 10/31/2024 at 11:54 AM. DON #16 stated the admission team reviewed residents' PASSARs to make sure the PASSARs were accurate. DON #16 stated it was the responsibility of the nursing department to review the PASARR to make sure the diagnoses were accurate and stated that included both her and the MDS nurses. DON #16 reviewed the PASARR for Resident #110 and stated the PASARR was not accurate with the resident's diagnosis of psychosis omitted.</p> <p>The Marketing Director was interviewed on 10/31/2024 at 1:44 PM. The Marketing Director stated that when a resident was admitted , someone from the business office reviewed the PASARR but added he was unsure if that person checked for accuracy of the PASARR. The Marketing Director stated the absence of psychosis on Resident #110's PASARR should have been caught, especially with the psychiatric medications the resident took.</p> <p>The Administrator was interviewed on 10/31/2024 at 2:21 PM. The Administrator stated it was the responsibility of the admission team to review the PASARRs, and if there were inconsistencies, they involved the clinical team. The Administrator stated the medical records staff member audited the charts to make sure a PASARR was present and to make sure there were no clinical changes to warrant a Level II. The Administrator stated that on review by the facility someone should have captured Resident #110's antipsychotic medication and the psychiatric diagnosis.</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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to obtain treatment orders for a laceration for 1 (Resident #54) of 2 sampled residents reviewed for non-pressure related alteration in skin integrity.</p> <p>Findings included:</p> <p>A facility policy titled, Wound Care, dated 2001, indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The policy indicated, 1. Verify that there is a physician's order for this procedure. The policy also indicated, The following information should be recorded in the resident's medical record: 6. All assessment data (i.e. [id est, which was Latin for, that is], wound bed color, size, drainage, etc. [et cetera, and other similar things]) obtained when inspecting the wound.</p> <p>An Admission Record revealed the facility admitted Resident #54 on 12/17/2019. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia, difficulty in walking, generalized muscle weakness, and unspecified macular degeneration (an eye condition that limited the visual field).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2024, revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #54 used a walker for mobility and required setup assistance from staff for transferring from bed to chair or chair to bed, walking 10 feet, and walking 50 feet. The MDS revealed Resident #54 required supervision or touching assistance to walk 150 feet. The MDS indicated Resident #54 had one fall since the previous assessment that resulted in no injury.</p> <p>Resident #54's care plan included a focus area initiated 10/24/2024, that indicated the resident was at risk for falls with or without injury related to a history of falls. Interventions directed staff to encourage and assist with toileting at start of day, to keep call light within reach, keep bed in low position, to keep personal/frequently used items within reach, and to keep the resident within supervised view as much as possible.</p> <p>A nursing Progress Note dated 10/24/2024 at 10:00 PM, revealed that around 7:15 PM, a certified nursing assistant (CNA) notified the licensed vocational nurse (LVN) that Resident #54 was on the floor. The Progress Note indicated that the resident sustained an open cut with active bleeding. The Progress Note indicated the LVN cleaned the wound with normal saline, applied adhesive strips, and covered the wound with a dry dressing. The Progress Note indicated the physician was notified and gave an order to send the resident to the hospital and the resident was transported to the hospital for further treatment.</p> <p>A Progress Note, dated 10/25/2024 at 3:35 AM, revealed the resident returned to the facility at 2:38 AM with no new orders.</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>An interdisciplinary team (IDT) Progress Note dated 10/25/2024 at 7:35 PM, indicated the IDT met to discuss Resident #54's fall. The Progress Note indicated the resident was found on the floor by an LVN with active bleeding from the forehead. The Progress Note revealed the LVN cleaned the wound, applied adhesive strips, notified the physician and the resident's family, and sent the resident to the hospital for further evaluation. The Progress Note indicated the resident returned with no new orders. The Progress Note lacked any evidence of treatment orders for the wound.</p> <p>An Order Summary Report with orders active as of 10/29/2024, did not include orders for the assessment or treatment of the cut on Resident #54's forehead.</p> <p>An observation was made of Resident #54 on 10/28/2024 at 11:20 AM. The resident had a bandage on their left forehead.</p> <p>An observation was made on 10/30/2024 at 8:41 AM of Resident #54 sitting in the hallway in a wheelchair. Three adhesive strips were seen covering a laceration on the resident's left forehead. The area had no redness or drainage.</p> <p>LVN #7 was interviewed on 10/30/2024 at 8:44 AM. LVN #7 stated the area on Resident #54's forehead was due to a fall the resident sustained.</p> <p>LVN #5 was interviewed on 10/30/2024 at 1:15 PM. LVN #5 stated if a resident was sent to the hospital with a laceration and returned to the facility with no orders, she would notify the primary care provider (PCP) to obtain needed orders for treatment. LVN #5 reviewed the orders for Resident #54 and confirmed there were no treatment orders for the resident's adhesive strips or dressing that were observed in place on 10/28/2024 and there should have been. LVN #5 stated that without orders to treat the wound, the wound could become infected.</p> <p>Director of Nursing (DON) #16 was interviewed on 10/31/2024 at 11:01 AM. DON #16 stated that when a treatment was initiated after a fall, she expected the nurse to write an order for the treatment.</p> <p>The Administrator was interviewed on 10/31/2024 at 2:27 PM. The Administrator stated he expected the facility policy for wound care to be followed. The Administrator stated he expected orders to have been written for Resident #54's wound care.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28196</p> <p>Based on observation, interview, record review, and facility policy review the facility failed to follow enhanced barrier precautions (EBP) for 1 (Resident #124) of 5 residents reviewed for wounds. Specifically, during an observation of wound care treatment for a pressure ulcer for Resident #124 staff members failed to wear a gown as part of the appropriate personal protective equipment (PPE).</p> <p>Findings included:</p> <p>The facility undated policy titled, Enhanced Barrier Precautions, indicated, Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. The policy indicated, 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. The policy indicated, 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). The policy also indicated, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. a. wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. The policy also indicated, 11. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 12. PPE is available outside the resident rooms.</p> <p>An Admission Record revealed the facility admitted Resident #124 on 10/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure and need for assistance with personal care.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/05/2024, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had one stage I pressure injury and was receiving pressure ulcer/injury care and application of ointments/medications other than to feet.</p> <p>On 10/30/2024 at 9:32 AM, observation was conducted of wound care to Resident #124's pressure ulcer to their coccyx performed by Licensed Vocational Nurse (LVN) #12 and assisted by Infection Control Preventionist (ICP) #13. Both staff wore a surgical mask and gloves, but no gown.</p> <p>On 10/30/2024 at 10:30 AM, ICP #13 stated that based guidance and the facility's EBP policy and procedure, Resident #124 should be on EBP.</p> <p>On 10/30/2024 at 11:01 AM, MDS Nurse #14, who was the previous ICP nurse, said that EBP should be implemented with residents who had drainage ports, indwelling catheters, urostomies, and residents with chronic wounds that required in depth treatments.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/31/2024 at 11:55 AM, Director of Nursing #16 stated if a wound was chronic, she expected the ICP to place the resident on EBP. She also said the importance of them being on EBP was to decrease the risk of MDROs.</p>

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<p>F 0911</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22445</p> <p>Based on interview and document review, the facility failed to ensure 1 (room [ROOM NUMBER]) of 62 resident rooms accommodated no more than four residents per room.</p> <p>Findings included:</p> <p>A memorandum dated 11/15/2021, revealed room [ROOM NUMBER] had five beds.</p> <p>During the entrance conference on 10/28/2024 at 9:23 AM, Director of Nursing #16 stated there was one room in the facility, room [ROOM NUMBER], that housed more than four residents.</p> <p>The Maintenance Director was interviewed on 10/31/2024 at 1:18 PM. The Maintenance Director stated the facility had one room that housed more than four residents.</p> <p>The Administrator was interviewed on 10/31/2024 at 2:33 PM. The Administrator stated there had been discussion about the room with five beds. The Administrator stated that yearly the facility received a waiver for the room. The Administrator stated he received no concerns about the room having more than four residents.</p>		

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445</b></p> <p>Based on interview, and facility document review, the facility failed to provide the required 80 square (sq) feet (ft) of living space per resident in 16 of 62 resident rooms in the facility.</p> <p>Findings included:</p> <p>The Client Accommodations Analysis, dated 01/01/2023, indicated the following living space per resident:</p> <ul style="list-style-type: none"> <li>- In room [ROOM NUMBER], there was 74 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 71 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 70 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 71 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 73 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 71 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 73.5 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 74 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 73.5 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 72 sq ft per resident.</li> <li>- In room [ROOM NUMBER], there was 76 sq ft per resident.</li> </ul> <p>The Maintenance Director was interviewed on 10/31/2024 at 1:18 PM. The Maintenance Director stated the minimum square footage per resident in a room was 80 sq ft and added the facility had between 10 to 20 rooms that did not meet that minimum standard.</p> <p>(continued on next page)</p>

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  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Vasona Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  16412 Los Gatos Boulevard Los Gatos, CA 95032	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed Vocational Nurse (LVN) #3 was interviewed on 10/31/2024 at 11:45 AM. LVN #3 stated the size of the small rooms had no impact on her ability to provide care for the residents. LVN #3 stated she had received no complaints about small rooms from the residents.</p> <p>Certified Nursing Assistant (CNA) #4 was interviewed on 10/31/2024 at 12:05 PM. CNA #4 stated she had no issues providing care in small rooms.</p> <p>Director of Nursing (DON) #16 was interviewed on 10/31/2024 at 12:10 PM. DON #16 stated she did not think the size of the room impacted the care provided by the staff and stated residents received the same amount of care. DON #16 stated no residents, family members, or staff had verbalized difficulty getting residents from the bed to wheelchairs or stretchers.</p> <p>The Administrator was interviewed on 10/31/2024 at 2:33 PM. The Administrator stated that yearly the facility received a waiver for the rooms that had less than 80 square feet per resident, and he had received no complaints about the room size.</p>