

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Creekside Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3580 Payne Avenue San Jose, CA 95117	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36044</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from unwanted touching of her perineal area when one staff (receptionist E) found Resident 2 was inside Resident 1's room with his hands seen to be inside Resident 1's diaper between her legs, and when the facility did not complete Resident 2 whereabouts monitoring to help prevent this incident of sexual allegation to happen. Failure to protect Resident 1's rights to be free from sexual abuse could result in psychological harm to her.</p> <p>Findings:</p> <p>Review of Resident 1's admission record indicated she was admitted to the facility on [DATE] with diagnoses including late onset Alzheimer's disease (a progressive disease that affects memory and other mental functions begins after age 65) and hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (is characterized by one-sided weakness, but without complete paralysis) following cerebral infarction(occurs as result of disrupted blood flow to the brain due to problems with blood vessels that supply it) affecting right dominant side.</p> <p>Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 5/22/24 indicated her Brief Interview for Mental Status (BIMS, a tool used to have a snapshot of a resident cognitive function) scoring was unable to complete the interview, and her cognitive skills for daily decision making were severely impaired.</p> <p>Review of Resident 2's admission record indicated he was admitted to the facility on [DATE] with diagnoses including cerebral infarction, aphasia (a language disorder that affects a person's ability to communicate), and age-related cognitive decline.</p> <p>Review of Resident 1's Situation Background Assessment Recommendation (SBAR, a verbal or written communication tool used by healthcare professional) date 5/27/24, indicated at approximately 3 p.m. (5/27/24), the receptionist found Resident 2 was at Resident 1's bedside with his hands under Resident 1's diaper and Resident 2 was stopped by receptionist then he (Resident 2) walked back to his room. The charge nurse confronted Resident 2's unacceptable behavior and started every one-hour monitoring for him.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/29/24, at 2:30 p.m., with Resident 2, he stated, I felt bad , because they told me I got in trouble for touching the other lady. However, when asked him the detail of incident, Resident 1 indicated he could not remember the details.</p> <p>During an observation on 5/29/24, at 2:38 p.m., in Resident 1's room, she was lying in bed while eyes opened with no eye contact or verbal response after several attempts by calling her name.</p> <p>During an interview on 5/29/24, at 2:46 p.m. and 5/31/24 10:10 a.m., with licensed vocational nurse A (LVN A), she stated, Resident 1 is now on hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) with total care. LVN A also stated, on 5/27/24 at around 3:00 pm, she received a report from receptionist E that while she was passing by Resident 1's room, she saw Resident was inside Resident 1's room and Resident 2's hands were inside the diaper of Resident 1. LVN A claimed she immediately assessed Resident 1's skin and noted no redness nor discoloration. LVN A further stated, after completing Resident 1's skin assessment, she went to Resident 2's room to check Resident 2's hands and asked him why he touched Resident 1 as reported by receptionist E (who found that his hands were inside Resident 1's diaper). LVN A further stated, he told me sorry, would not do it again. LVN A also claimed Resident 2 knew what he was doing at that time of the incident, she talked to Resident 2 herself aftvalidaer the incident and found Resident aare of what he did to Resident 1. LVN A confirmed this was the first time Resident 2 had the incident of touching a female resident although he had the behavior of wandering to other people's room taking food or belongings whenever no one was around.</p> <p>During an interview on 5/29/24, at 3:05 p.m., with receptionist E, she stated that when she was passing by Resident 1's room on 5/27/24 at around 3 p.m. she saw Resident 2 was sitting on the foot of Resident 1's bed with his hands in between Resident 1's legs at inside and beneath the diaper.</p> <p>During an interview on 5/31/24, at 9:30 a.m., with CNA C, she stated that she used to be Resident 2's regular CNA. CNA C also stated Resident 2 had a behavior of going around the facility during the afternoon and would grab other residents' food or belongings. CNA C stated, facility staff had to check Resident 2's room for hoarding food or other people's belongings but admitted they had not been monitoring Resident 2's whereabouts (location in the facility like residents' rooms where he goes to).</p> <p>During an interview on 5/31/24, at 11:50 a.m., with Resident 3, the roommate of Resident 1, she stated having seen Resident 2 walked inside their room three times in the past (could not recall the dates).</p> <p>Review of Resident 3's MDS dated [DATE] indicated her BIMS score was 15 (means intact cognitive).</p> <p>During an interview and record review on 5/31/24, at around 11 a.m., with the minimum data set coordinator) MDSC, the MDSC reviewed Resident 2's care plans, and she found no specific plan of care to address Resident 2's wandering behavior except a care plan to address his behavior of going to other people's room grabbing other resident's food or other residents' belongings. The MDSC confirmed there was no monitoring in place for Resident 2's whereabouts except his wander guard placement being checked each shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/31/24, at 12: 20 p.m., with CNA D, she stated, Receptionist E notified her first regarding the incident when Resident 2 was found inside Resident 1's room with his hands pretty much inside the diaper of Resident 1. CNA D claimed she immediately notified LVN A about it then both of them went to check Resident 1. Upon entering Resident 1's room, they saw Resident 1's blanket was already off (uncovered) Resident 1's body, and her top clothing was lifted up. CNA D also stated that before this incident on 5/27/24, she completed her resident's round at approximately 2:55 p.m., she tucked Resident 1 with a blanket to make sure she was comfortable before leaving her room. CNA D further stated, the strange thing is when the nurse was checking on her private area it's different than usual because I clean her every day. CNA D confirmed after this sexual incident involving Resident 2, Resident 2 was placed on every one-hour monitoring of his whereabouts.</p> <p>Review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, the P&P indicated, Resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This include but not limit to sexual or physical abuse</p>		