

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 08/09/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 38068</p> <p>Based on interview and record review, the facility failed to provide care and services for one of three residents (Resident 1) when:</p> <ol style="list-style-type: none"> 1. Resident 1's physician was not notified regarding her multiple refusal in participating in the Restorative Nursing Assistant program (RNA, a program that helps residents to gain an improved quality of life by increasing their level of strength and mobility) in a timely manner. 2. Resident 1's frequent refusal of RNA programs was not care planned. <p>These failures had the potential to result in resident's decline in range of motion and mobility.</p> <p>Findings:</p> <p>Review of Resident 1's medical record indicated she was admitted on [DATE] with diagnoses that included peripheral vascular disease (PVD, narrowing of blood vessels that cause poor blood flow to the legs and feet), osteoarthritis (a disorder due to aging that caused wear and tear on a joint) of bilateral knee, muscle weakness and abnormalities of gait and mobility.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a comprehensive resident assessment tool) dated 1/6/24 and 4/4/24 indicated her cognition was moderately impaired. There was no impairment in her upper and lower extremities. She required mostly partial and moderate assistance in activity of daily living (ADLs).</p> <p>Review of Resident 1's Care Plan dated 2/2/24 indicated, RNA program for ambulation three times per week as tolerated to maintain gait function with assistance and RNA program with the use of omni cycle (a therapeutic exercise system that helps patients improve their range of motion, strength, endurance and muscle control) three times per week as tolerated to maintain strength of all extremities.</p> <p>Review of Resident 1's RNA Treatment Administration Record (TAR) for the month of May 2024 it indicated, Resident 1 refused RNA ambulation program 12 out of 17 sessions and refused RNA omni cycle program 11 out of 18 sessions. Resident 1 refused RNA ambulation program on May 1, 5, 7, 8, 11, 17, 19, 23, 24, 26, 30 & 31. Resident 1 refused RNA omni cycle program on May 1, 5, 7, 8, 11, 17, 19, 23, 24, 26, & 30.</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 - Some</p>	<p>During an interview with Restorative Nursing Assistant G (RNA G) on 7/19/24 at 11:52 a.m. she confirmed Resident 1 had refused RNA program on the above dates. RNA G further stated Resident 1 was sometimes sleepy and complained about her lower leg wounds and swelling discomfort. RNA G stated she reported Resident 1's frequent RNA program refusals to Licensed Vocational Nurse H (LVN H).</p> <p>During a concurrent interview and record review with LVN H on 7/19/24 at 2:04 p.m., she confirmed RNA G reported to her that Resident 1 had refused RNA programs multiple times in May 2024. LVN H acknowledged there was no documentation Resident 1's physician was notified regarding her refusal of RNA programs in May 2024. LVN H added, notification to the physician should be documented. LVN H further stated there was no nursing care plan (NCP, a plan that provides direction on the type of nursing care that the patient may need) initiated for Resident 1's frequent refusal of RNA program last May 2024.</p> <p>During an interview with the Director of Nursing (DON) on 7/19/24 at 2:25 p.m., she confirmed there was no documentation that Resident 1's physician was notified regarding the RNA refusal in May 2024. The DON further confirmed Resident 1's physician was notified on June 2024. The DON acknowledged there was no NCP initiated regarding Resident 1's refusal. The DON further stated the license nurses (LNs) should have notified Resident 1's physician regarding the frequent refusals within seven days and the LNs should have initiated the NCP.</p> <p>Review of the facility's undated policy and procedures titled Requesting, Refusing, and/or Discontinuing Care or Treatment indicated, Documentation pertaining to a Resident's , discontinuation or refusal of treatment shall include at least the following: . The date and time the practitioner was notified as well as the practitioner's response .The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the by resident condition and potential serious consequences of the request .</p> <p>Review of the facility's undated policy and procedures titled Job: Description: Licensed Vocational Nurse indicated, Notifies the RN or Healthcare provider for any significant changes or concerns .</p> <p>Review of the facility's undated policy and procedures titled Job: Description: Charge Nurse indicated, Periodically assess the total needs of the resident and develops nursing care plans to meet these needs which includes .implementation of restorative nursing care measures.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068</p> <p>Based on interview and record review, the facility failed to ensure the safety of one of three residents (Resident 1) when the facility did not investigate thoroughly the root causes of the incidents of skin tears during transfers from bed to wheelchair and transfer to wheelchair after using the bathroom. This failure led to four recurrent incidents that resulted to lower legs skin tears for Resident 1. Resident 1 had skin tear incidents on 2/24/24, 4/2/24, 5/17/24, and 6/10/24.</p> <p>Findings:</p> <p>Review of Resident 1's medical record indicated she was admitted on [DATE] with diagnoses that included peripheral vascular disease (PVD, narrowing of blood vessels that cause poor blood flow to the legs and feet), osteoarthritis (a disorder due to aging that caused wear and tear on a joint) of bilateral knee, muscle weakness and abnormalities of gait and mobility.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a comprehensive resident assessment tool) dated 1/6/24, 4/4/24 and 7/2/24 indicated her Brief Interview for Mental Status (BIMS, a mental status test that measures orientation, learning and memory) was 12, a score of 8-12 indicates her cognition (mental process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired.</p> <p>Further review of Resident 1's MDS dated [DATE], 4/4/24 and 7/2/24 indicated she had no impairment on both sides of her upper and lower extremities. She required partial/moderate assistance (helper does less than half of the effort) during chair/bed to chair transfer and toilet transfer.</p> <p>During an interview with Resident 1 on 7/19/24 at 8:22 am, she stated sometime in February 2024 her right leg was caught in the wheelchair when CNA transferred her from bed to wheelchair.</p> <p>During an interview with Certified Nursing Assistant A (CNA A) on 7/19/24 at 9:02 a.m., she stated Resident 1 was alert and oriented to time, person, and place and was able to verbalize her needs.</p> <p>During an interview with Licensed Vocational Nurse B (LVN B) on 7/19/24 at 10:58 a.m., she stated Resident 1 was alert and oriented to time, person, and place.</p> <p>Review of Resident 1's Nursing Care Plan (NCP, a plan that provides direction on the type of nursing care the patient may need) for at risk of skin breakdown dated 1/1/24 indicated, to assess for any skin breakdown during activities of daily living (ADLs). Notify nurse immediately for any new areas of skin breakdown.</p> <p>Review of Resident 1's NCP for Fall/Injury Risk dated 1/1/24 indicated, Provide with equipment/wheelchairs brakes that are intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps healthcare teams share information about patients) dated 2/24/24 indicated, sometime after 5:30 p.m. after dinner, Resident 1 was observed with active bleeding to the right lateral side of the leg measuring 4.5 centimeter (cm, unit of measurement) by 0.5 cm. Pressure was applied to the affected site and first aid rendered. Resident 1's physician and Resident 1's friend was notified of the incident.</p> <p>During an interview with LVN C on 7/19/24 at 11:13 a.m., she stated Resident 1 informed her that her right lateral side of her leg was hit at something. LVN C stated she did not know the exact cause of Resident 1's right leg skin tear on 2/24/24.</p> <p>Review of Resident 1's NCP dated 2/24/24 indicated, skin tear on lateral side of right leg will resolve without complications. Monitor for signs and symptoms of infection and notify the physician if symptoms present. Treatment as ordered.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on 8/9/24 at 11 a.m., she confirmed there was no documentation in Resident 1's medical record regarding a follow-up investigation on how and what was the exact cause of Resident 1's right leg lateral skin tear on 2/24/24 incident. The DON acknowledged it should have been investigated and followed-up on what was the reason and exact cause of Resident 1's skin tear on her right leg.</p> <p>Review of Resident 1's SBAR dated 4/2/24 indicated, Resident 1 was noted with skin tear on the right lower leg. Resident 1 verbalized it got caught on the wheelchair from transferring from bed to wheelchair. Pressure and steri-strip (a thin and sticky bandages that are used to close small wounds and cuts) applied then covered with xeroform (non-adherent dressing that maintain a moist wound environment) and dry dressing. Resident 1's physician and friend were notified.</p> <p>During an interview with CNA D on 7/29/24 at 2:43 p.m., she stated she was the assigned CNA for Resident 1 on 4/2/24 morning shift. CNA D stated she could not remember how Resident 1 sustained the skin tear on her right leg.</p> <p>During an interview with Treatment Nurse E (TN E) on 7/29/24 at 3 p.m., she stated the CNA called her and reported that CNA was helping Resident 1 to transfer from bed to wheelchair then the right leg was caught in the wheelchair. TN E stated she did not know how and what was the exact reason Resident 1's leg was caught in the wheelchair on 4/2/24.</p> <p>Review of Resident 1's NCP on skin tear on right lower leg dated 4/2/24 indicated, Check wheelchair for any sharp edges. Identified potential causative factors and eliminate/resolve them when possible. Treatment as ordered.</p> <p>Review of the SBAR dated 5/17/24 at 4 p.m. indicated, noted left lower leg skin tear 2.5 by 6 cm. Cleansed with normal saline, pat dry and applied steri-strip. Resident 1 claimed she sustained the skin tear when her left leg caught the wheelchair brake handle.</p> <p>During an interview with CNA F on 8/7/24 at 3:12 p.m., she stated on 5/17/24 she assisted Resident 1 in the bathroom and assisted her to sit on the wheelchair. The wheelchair was positioned behind Resident 1 and her left leg was caught in the wheelchair during the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 8/14/24 at 10:56 a.m., she stated on 5/17/24 Resident 1 hit her left leg on the wheelchair handle break. The DON confirmed there was no documentation in the Resident 1's medical record regarding how the incident happened.</p> <p>Review of Resident 1's NCP for skin tear on left lateral lower leg dated 5/17/24 indicated, wheelchair brake handle was padded with plumber tube and other areas of wheelchair to minimize recurrence.</p> <p>Review of the SBAR dated 6/10/24 at 10:30 a.m. indicated, the CNA was transferring Resident 1 from bed to wheelchair and Resident 1 right leg got caught on wheelchair and sustained skin tear on right lateral leg measuring 3 cm by 1.5 cm with minimal bleeding. Treatment was provided.</p> <p>During an interview with TN E on 7/29/24 at 3 p.m., she stated the CNA [no longer work at the facility] reported to her that CNA was assisting Resident 1 transferring from bed to wheelchair and Resident 1's right leg was caught in the wheelchair. TN E stated she did not know the exact cause and how Resident 1 sustained the skin tear on 6/10/24.</p> <p>Review of Resident 1's NCP for skin tear on the right lateral leg dated 6/10/24 indicated, to ensure Resident 1 was wearing pants and to handle Resident 1 gently. Treatment as ordered.</p> <p>During an interview with the DON on 8/14/24 at 10:56 a.m., she confirmed there was no documentation in the SBARs and Resident 1's medical record regarding a follow-up investigation on how and what was the exact cause of Resident 1's right leg lateral skin tear on 2/24/24, 4/2/24 and 6/10/24. She also acknowledged the initial investigation on how Resident 1 sustained left lower leg skin tear on 5/17/24 should have been documented in Resident 1's medical record. The DON further stated Resident 1's incident of sustaining skin tears on 2/24/24, 4/2/24 and 6/10/24 should have been investigated and followed-up.</p> <p>Resident 1 sustained skin tear on 2/24/24, 4/2/24, 5/17/24 and 6/10/24, however there was no documentation the facility discussed the incidents on how or what was the cause of the skin tear/incidents.</p> <p>During a concurrent interview and record review with the DON on 8/9/24 at 11 a.m., she reviewed the facility's Interdisciplinary Team (IDT, a group of healthcare professionals from different disciplines who work together to provide person-centered care to patients) record signed and dated 4/11/24, 5/15/24 and 6/11/24. The DON confirmed there was no detailed discussions of Resident 1's four repeated incidents where she sustained skin tear during transfers from bed to wheelchair and after using the toilet.</p> <p>Review of the facility's revised policy and procedures dated 09/2013 titled Skin Tears-Abrasions and Minor Breaks, Care of: Documentation indicated, Record the following information in the resident's medical record: 1. Complete in-house investigation of causation.</p> <p>Review of the facility's undated policy and procedures titled Investigating Resident Injuries indicated, All resident injuries are investigated. The Director of Nursing services or a Designee assesses all resident injuries and document findings in the medical records.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's undated policy and procedures titled Registered Nurse (RN) Job Description indicated, Initiate investigations of accidents and unusual occurrences and makes the necessary written report to the Director of Nursing Services (DNS).</p> <p>Review of the facility's revised policy and procedures dated 3/2022 titled Care Plans, Comprehensive Person-Centered indicated, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying sources (s) of the problem area(s) and not just the symptoms or triggers .12. The IDT team reviews and updates the care plan . when the desired outcome is not met.</p>		