Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Post-Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38068 Based on interview and record review, the facility failed to ensure the safety for one of two residents (Resident 1) when: 1. The Certified Nursing Assistant A (CNA A) did not position Resident 1 properly in wheelchair before doing another task, 2. CNA A did not notify the Licensed Nurse (LN) immediately to assess Resident 1 for possible injury after the fall prior to transferring back Resident 1 to wheelchair and 3. The facility failed to document the correct information on how the fall incident happened for Resident 1 on 8/5/24. These failures put Resident 1's safety at risk. Findings: Review of Resident 1's medical record indicated she was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD, an illness at its final stage where kidneys are permanently damage and can no longer function properly) and dependence on renal dialysis (a process that involve a machine that removes excess water, solutes and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Review of Resident 1's admission nursing assessment dated [DATE] indicated she had short term memory problem and was totally dependent with staff for transfers. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA A on 8/23/24 at 10:52 a.m., he stated on 8/5/24 at around 1:20 a.m., he assisted Resident 1 in transferring to the wheelchair after toileting using a gait belt. CNA A stated he helped Resident 1 sat in the wheelchair but Resident 1's buttock was halfway in the wheelchair, then CNA A stated he turned around from Resident 1 to fix the garbage and change his gloves, then when he turned back around he saw Resident 1 was already sitting on the bathroom floor with her legs in a straight position. CNA A stated Resident 1 told him she was okay when he asked her how she was doing. CNA A told Resident 1 to hold on to his both shoulders, and he lifted up and assisted Resident 1 back to her wheelchair then assisted her back to bed. CNA A admitted he did not notify the LN staff after the fall prior to him transferring back Resident 1 to the wheelchair. CNA A stated he reported the fall incident to Registered Nurse F (RN F) after he already put Resident 1 in bed after he lifted Resident 1 from the floor, transferred to wheelchair then to bed on 8/5/24. During an interview with the Licensed Vocational Nurse B (LVN B) on 8/27/24 at 1:25 p.m., she stated when transferring resident who needed assistance, the staff should make sure the buttocks is all way in the wheelchair to prevent resident sliding down on the floor. During an interview with CNA C on 8/27/24 at 1:47 p.m., she stated the resident's buttocks should be put all the way in when transferring resident to prevent sliding from wheelchair. During an interview with the Director of Staff Development (DSD) on 8/28/24 at 4:11 p.m., she stated CNA A should have made sure Resident 1's buttocks was positioned all the way in the wheelchair to prevent sliding down from wheelchair. During an interview with LVN D on 8/30/24 at 1:58 p.m., she stated facility staff should notify the Charge Nurse/Licensed Nurse (CN/LN) immediately after any resident's witnessed and unwitnessed fall to assess for possible injuries prior to transferring back the resident to wheelchair or bed. During an interview with CNA E on 8/30/24 at 3:40 p.m., she stated CNAs should have reported to the CN immediately and ask for help for any resident's witnessed and unwitnessed fall for assesment first for injury and follow the instruction from the CN if it is okay to assist resident to transfer back to wheelchair or bed or not. During an interview with the DSD on 9/4/24 at 10:28 a.m., she stated CNA A should have reported first to the Charge Nurse to assess the resident after any fall for possible injuries before transferring back Resident 1 to wheelchair and /or bed. During an interview with the Assistant Director of Nursing (ADON) on 10:35 a.m., she stated CNA A should have positioned Resident 1 all the way in the wheelchair, not halfway in to prevent sliding down and fall from wheelchair. The ADON further stated CNA A should have notified first the CN for assessment of possible injuries prior to transferring Resident 1 from floor to wheelchair and bed when Resident 1 fell on the floor on 8/5/24. During an interview with the DSD on 9/4/14 at 3:21 p.m., the DSD stated she was with the DON when the DON interviewed CNA A regarding the Resident 1's incident of fall on 8/5/24. The DSD stated CNA A narrated to the DON that he put Resident 1 in wheelchair after using the bathroom. CNA A stated he turned around to clean up the garbage and change his gloves, then when CNA A turned back around he saw Resident 1 already on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 9/5/24 at 11:19 a.m., she confirmed she did not find any documentation in Resident 1's medical records regarding the correct information about Resident 1's fall incident on 8/5/24 even after the DON and DSD have verified from CNA A on how the fall incident happened. During an interview with Administrator (ADM) with the presence of Health Facilities Evaluator Supervisor (HFES) on 9/6/24 at 12:03 p.m., the ADM confirmed there was no documentation in Resident 1's medical record indicating the correct statement provided by the CNA A (staff who has the first-hand information on the incident of fall happened on 8/5/24) from an interview conducted by the Surveyor and from the results of DON's and DSD's interview from CNA A about the fall incident happened on 8/5/24 for Resident 1. Review of the Facility's revised policy and procedure dated 03/2018 titled, Assessing Falls and Their Causes- Steps in the procedure: After a Fall indicated 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 11. Obtain and record vital signs as soon as it is safe to do so. 12. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 13. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. Review of the Facility's undated policy and procedure titled Job Description: Certified Nursing Assistance indicated, Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical. Report all accidents and incident observed as they occur . Monitor and always supervise resident to ensure resident safety. Review of the facility's revised policy and procedures dated 3/2018 titled Assessing Falls and Their Causes: Identifying Causes of a Fall or Fall Risk indicated Continue to collect and evaluate information until the cause of falling is identified . Review of the facility's revised policy and procedures dated 3/2018 titled Falls - Clinical Protocol: Assessment and Recognition indicated, In addition, the nurse shall assess and document/report the following: . h. Precipitating factors, details on how fall occurred. For Cause Identification it indicated: The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified .