STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055884	A. Building B. Wing	04/15/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on interview and record review, the facility failed to provide care and services in accordance with professional standards of practice for one of three sampled residents (Resident 1) when: 1. The licensed nurse failed to notify the physician when Resident 1 experienced a change in condition. 2. The licensed nurse failed to transfer the wound care order from the hospital discharge instructions to the Skilled Nursing Facility (SNF) orders, resulting in no wound dressing change for Resident 1 for two days. These failures resulted in Resident 1 being sent to the hospital for further evaluation and treatment. Findings: 1. A review of Resident 1's clinical record indicated she was admitted from the acute hospital to the facility on [DATE] and had the diagnosis including encounter for orthopedic aftercare following surgical amputation (the loss or removal of a body part such as a finger, toe, hand, foot, arm or leg). A review of Resident 1's discharge instructions from the acute hospital, dated 1/24/2025, indicated notifying physician for change in conditions including acute change in mental status. A review of Resident 1 ' s nursing progress notes dated 1/26/2025 at 18:56 indicated that the resident was confused and had declined from being alert and oriented x3 on the admitted (1/24/2025) to alert and oriented x1. The nurse documented a message in the communication binder asking the physician whether the confusion could be related to narcotic medication administered in the hospital. During an current interview and record with the Director of Nursing (DON) on 4/15/2025 at 3:12 p.m., the DON reviewed the nursing progress notes and stated the nurse should have notified the physician regarding Resident 1 ' s condition change (change in mental status) instead of leaving a message on the facility's communication binder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 1's hospital discharge orders dated 1/24/2025 indicated a wound care order for a stockinet dressing and a loosely wrapped ACE wrap (Elastic Bandage with Hook Closure delivers comfortable support) to be changed daily while in the SNF. However, a review of Resident 1 ' s SNF physician orders and the Treatment Administration Record (TAR) for January 2025 indicated that no wound care order had been transcribed and carried out. During a current interview and record review with the Wound Care Nurse (WCN) on 4/15/2025 at 2:00 p.m., the WCN reviewed Resident 1's January 2025 SNF orders and TAR. She confirmed that there was no documented wound care order. She stated that she was not aware that a wound dressing change was required and she did not change Resident 1's wound dressing on 1/25 or 1/26/2025. During a concurrent interview and record review with the DON on 4/15/2025 at 3:15 p.m., the DON reviewed Resident 1's hospital discharge orders and SNF orders. She confirmed that there was no wound care order in the SNF orders. She further stated that the admission nurse should have transcribed the hospital wound care order to the SNF orders so that the wound care nurse could carry out the treatment. A review of the facility's policy and procedure titled Change in a Resident ' s Condition or Status, revised 2/2021, indicated .the nurse will notify the resident's attending physician or physician on call when there has been a(an): .significant change in the resident's physical, emotional, mental condition . A review of the facility's policy and procedure titled Timely Implementation of Treatment Orders Policy, indicated .to ensure that all treatment orders are implemented promptly and consistently, treatment orders must be initiated within 24 hours unless specified otherwise .