

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  06/10/2025
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure they had communicated throughout the facility for one of three sampled residents (Resident 1)'s code status and documented in the medical record Resident 1's wishes and preference immediately, so that staff would know what action to take or not take when an emergency arises when:</p> <ol style="list-style-type: none"> <li>1. The case manager (CM) did not communicate to staff immediately regarding the changes in Resident 1's code status of DNR Do Not Resuscitate (DNR, is a medical order to instruct providers not to do cardiopulmonary resuscitation (CPR, is an emergency lifesaving procedure performed when the heart stops beating) order in her electronic medical record (EMR)when Resident 1's daughter submitted to the facility a copy of the POLST signed by Resident 1 and her attending physician while she was in the acute hospital dated [DATE].</li> <li>2. Facility staff did not remove from Resident 1's EMR the Physician Orders for Life Sustaining Treatment (POLST, is a medical order that helps give people with serious illness more control over their care during a medical emergency) signed by Resident 1 upon her admission to the facility on [DATE] that indicated she wanted to be Full code- refers to prolonging life by all medically effective means when patient is found with no pulse and/or not breathing).</li> <li>3. The case manager (CM) did not document immediately into Resident 1's (EMR) regarding the confirmed change in resident's status Full code to DNR after verifying it with Resident 1 and her daughter on [DATE].</li> </ol> <p>These failures created confusion as to the correct code status for Resident 1 and resulted in the provision of CPR by the 911 paramedics to the Resident 1 who had a DNR status.</p> <p>Findings:</p> <p>During a review of Resident 1's admission record indicated she was admitted to the facility on [DATE] with the primary diagnosis of acute on chronic systolic congestive heart failure (is a situation where a person with pre-existing chronic systolic heart failure (is a long-term condition where the heart's left ventricle weakens and cannot pump blood effectively, leading to a build-up of fluid in the lungs and other parts of the body) experiences a sudden worsening of their symptoms.</p> <p>Review of Resident 1's admission Record indicated she was self-responsible. Her POLST dated and signed [DATE] and [DATE] indicated she was the legally recognized decision maker.</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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review Resident 1's Skilled Nursing Facility admission Orders from the acute hospital upon discharge date d [DATE], indicated the code status as, DNR and Patient has capacity for medical decision making.</p> <p>Review of Resident 1's SNF admission History and Physical, dated [DATE], indicated, Her cognitive function appears intact as she correctly identified the date and spelled lunch both forward and backwards . Patient's code status and POLST status: DNR; limited additional interventions: Use medical treatment, antibiotics, and IV (intravenous, the administration of medications and fluids by vein) fluids as indicated. Do not intubate (is a medical order that specifies a patient does not want a breathing tube (intubation) placed in their airway, even if they stop breathing or experience respiratory distress). May use non-invasive positive airway pressure (is the use of breathing support administered through a face mask, nasal mask, or a helmet by pushing air at a higher pressure into your airway). Generally, avoid intensive care (critical care is a specialized medical setting within a hospital that provides round-the-clock care and treatment for patients with life-threatening illnesses or injuries).</p> <p>Review of Resident 1's POLST form, dated [DATE] (from the acute hospital), indicated, she chose Do Not Attempt Resuscitation/DNR with selective treatment, and the photocopy of this POLST included only the front page which was not clear.</p> <p>Review of Resident 1's another POLST form, dated [DATE] signed by the resident and her attending physician, indicated she chose Attempt Resuscitation /CPR and with selective treatment.</p> <p>During a review of Resident 1's active orders, dated [DATE], indicated, Follow code status per POLST instructions.</p> <p>Review of Resident 1's case manager progress notes, dated [DATE], indicated, 4/11- palliative consult done. Initially they wanted Full Code, but they decided to do DNR / Selective Treatment, no Vents (ventilator, a device for maintaining artificial respiration machines to keep her alive. The daughter sent a pic (picture) of the POLST done at Acute, printed it and put it in the chart. She stated if she continues to decline might consider Hospice Care. Daughter &amp; resident understand underlying cardiac &amp; pulmonary function, overall prognosis is poor. A further review of Resident 1's case manager progress notes, dated [DATE] at 5:20 p.m., indicated, Received a call from daughter that she is in the facility . confirmed POLST she is DNR/Selective Tx. Daughter &amp; resident wants to disregard what was filled out here upon her admission on 4.19. 25 where it says Full Code/Selective. Resident stated the one they did at hospital on 4.11.25 should be followed where she is DNR/Selective.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR, is a communication tool used to structure conversations, especially in healthcare, to ensure clear and concise information transfer), dated [DATE], indicated, At 11 p.m., staff member asked nurse to assess resident because resident appears unresponsive. Licensed nurse (LN) performed bedside assessment. Resident noted with weak pulse, but unresponsive to verbal and tactile stimuli. Oxygen (O2, is a colorless and odorless gas. It is needed for animal and plant life ) saturation at 94% on O2 2 L/min via nasal cannula. Obtained physical copy of POLST from medical chart- DNR/selective treatment. At 11:05 p.m., called 911. At 11:10 emergency medical services (EMS) arrived at the scene. Determined that resident had no pulse. At 11:15 p.m., paramedics asked if there is another copy of the POLST because the current POLST is missing from the back side . updated copy of POLST was retrieved from resident's electronic file on PCC- full code/ attempt CPR. At 11:18 p.m., paramedics started CPR because of updated copy of POLST. At 11:40 p.m., resident was pronounced death by paramedics.</p> <p>During an interview on [DATE], at 11:10 a.m. and 3:30 p.m., the CM stated Resident 1 had a change in her code status after palliative care in the hospital, from being Full code to DNR with selective treatment on [DATE] before her admission to the facility. The CM also stated upon Resident 1's admission on [DATE] Resident 1 completed another POLST that indicated she wanted full code with selective treatment. The CM clarified with Resident 1's daughter on [DATE] around 5:20 p.m. regarding Resident 1's code status. The CM stated, Resident 1's daughter told him that the code status was supposed to be DNR, so he marked VOID on the [DATE]'s POLST form, then he removed this POLST form from the hard copy of Resident 1's medical record.</p> <p>Further interview and record review with the CM also indicated, the [DATE]'s POLST signed by the physician on [DATE] was uploaded into Resident 1's EMR by medical record staff in the morning of [DATE]. The CM also stated that he verified Resident 1 regarding the correct code status which was DNR with selective treatment because she did not want full treatment. The CM stated that the POLST form dated [DATE] should have been removed from the EMR to avoid confusion, and he should have documented immediately in Resident 1's EMR when DNR code status was confirmed on [DATE].</p> <p>During an interview on [DATE], at 3:40 p.m., with registered nurse A (RN A), RN A stated he was notified by the night shift certified nursing assistant (CNA) C at 11 p.m. regarding Resident 1's altered mental status. RN A checked Resident 1's chart for her POLST which was DNR with selective treatment, then RN A called since Resident 1 still had breathing with weak pulse. When the paramedics arrived at the facility, they did not want to take the photocopy of the [DATE]'s POLST without back side page. RN A also stated, the paramedics questioned the validity of the POLST provided because it has no back page. RN A further stated his supervisor (LVN B, licensed vocational nurse B) went to check their Resident 1's EMR to look for additional information as requested by the paramedics and she found the [DATE]'s POLST that indicated Resident 1 was full code. LVN B showed Resident 1's EMR indicating the full code status, so the paramedics started to perform CPR to Resident 1.</p> <p>During an interview on [DATE], at 11:50 a.m., with the director of nursing (DON), she stated, they forgot to update in their EMR to upload Resident 1's POLST dated [DATE].</p> <p>During an interview on [DATE], at 5:15 p.m., with licensed vocational nurse B (LVN B), LVN B stated she was not aware the [DATE]'s POLST was voided, and no one endorsed to her. LVN also stated, when the paramedics questioned the validity of the picture of Resident 1's POLST placed at the chart, she could not provide any response and could not also validate the correct code status.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE], at 12:15 p.m., the CM provided the original copy of [DATE]'s POLST that she obtained from the acute hospital on [DATE] (a day after Resident 1 passed away on [DATE]) and filed in Resident 1's chart.</p> <p>During an interview on [DATE], at 12:17 p.m., the administrator (ADM) stated, on [DATE] the facility (he did not mention the specific staff) should have followed up and obtained the original copy of signed POLST dated [DATE] from the hospital and filed it in Resident 1's chart.</p> <p>Review of the facility's performance improvement project (PIP) guide, dated [DATE], it indicated, conflicting POLST documentation caused emergency personnel to initiate interventions inconsistent with known resident wishes. Actual POLST on file not consistent with POLST uploaded on electronic medical record (EMR). Root causes identified: Dual POLST forms present without clear policy guidance on version validation. Incomplete scan of POLST form (missing back side). Lack of clear workflow for verifying POLST accuracy during emergency events.</p> <p>Review of the facility's undated policy and procedure (P&amp;P) titled, Do Not Resuscitate Order, the P&amp;P indicated, Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. In addition to the advance directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include Physician Orders for Life-Sustaining Treatment (POLST) Do not resuscitate (DNR) orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes.</p>