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	12/05/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 51680 Based on record review, interview, and review of the Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate for 1 (Resident #125) of 24 sampled residents. Specifically, the facility failed to ensure Resident #125's discharge MDS accurately reflected the resident's discharge status. Findings included: The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, dated October 2024, Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0, Section A2105: Discharge Status revealed, Code 12, Home under care of organized home health service organization: if the resident was discharged home under care of an organized home health service organization. This includes only skilled services provided by a home health agency. An Admission Record indicated the facility admitted Resident #125 on 08/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a humerus fracture of the left arm, history of falling, and muscle weakness. According to the Admission Record, Resident #125 was discharged from the facility on 09/09/2024. Resident #125's Interdisciplinary Discharge Summary, dated 09/09/2024, indicated the resident went home as planned, with family, and with a home health agency referral. A Nurses Note, dated 09/09/2024, indicated all discharge instructions were reviewed with Resident #125's family member, and the resident was discharged in stable condition. A discharge-return not anticipated MDS, with an Assessment Reference Date (ARD) of 09/09/2024, revealed the MDS was coded to reflect that Resident #125 was discharged to a short-term general hospital. During an interview on 12/05/2024 at 10:15 AM, MDS Coordinator #8 stated Resident #125's discharge MDS was incorrectly coded. MDS Coordinator #8 said Resident #125 was discharged home with a family member, not to a hospital. During an interview on 12/05/2024 at 10:20 AM, the Director of Nursing (DON) stated Resident #125 discharged home with a family member. She stated she expected correct MDS coding. (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
	055884	A. Building B. Wing	12/05/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 10:25 AM, the Administrator stated he expected accurate MDS coding.

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	12/05/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37935 Based on record review, interview, and facility policy review, the facility failed to ensure Level I Preadmission Screening and Resident Reviews (PASRRs) were submitted when required and failed to complete them accurately for 2 (Resident #41 and Resident #70) of 3 residents reviewed for PASRR requirements. Specifically, the facility failed to ensure Resident #41's Level I PASRR screening reflected the presence of a serious diagnosed mental disorder and failed to submit a Level I PASRR screening after Resident #70 remained in the facility longer than 30 days. Findings included: A facility policy titled, Admission Criteria, revised in 03/2019, indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) [another acronym for PASRR] process. The policy revealed, z. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. 1. Resident #41's Admission Record indicated the facility admitted Resident #41 on 07/22/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of paranoid schizophrenia (onset 07/22/2024). Resident #41's Medicine Discharge Summary from the hospital that transferred the resident to the facility, dated 07/22/2024, revealed a Discharge Diagnosis of paranoid schizophrenia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated that the resident had an active diagnosis of schizophrenia. Per the MDS, the resident received antipsychotic medication during the assessment timeframe. Resident #41's care plan revealed a focus area, initiated 08/01/2024, that indicated the resident received psychotropic medications related to their diagnosis of paranoid schizophrenia. Resident #41's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 07/19/2024, completed by a hospital, indicated the resident did not have a diagnosis of a serious mental disorder. The screening also indicated the resident did not have a suspected mental illness and was not prescribed psychotropic medication. The screening indicated that a Level II evaluation was not required. A letter to Resident #41 from the California Department of Health Care Services, dated 07/19/2024, indicated, Your Level I Screening indicates that a Level II Mental Health Evaluation is not required. (continued on next page)

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	12/05/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 9:36 AM, MDS Coordinator #8 stated she was responsible for ensuring the accuracy of PASRR submissions. She stated that Resident #41's Level I screening did not list a serious mental illness diagnosis. She confirmed that the resident's admission MDS revealed that the resident had schizophrenia. She stated Resident #41's diagnosis of paranoid schizophrenia should have been listed on the Level I screening. MDS Coordinator #8 stated the Level I screening for Resident #41 was completed by the hospital staff before admission. She stated she should have reviewed the Level I screening to ensure it was completed accurately by the hospital staff. She stated if she had identified the error, she would have resubmitted a new Level I screening to the state. During an interview on 12/05/2024 at 9:48 AM, the Director of Nursing (DON) stated that when a resident was admitted , she ensured the hospital submitted a Level I screening. She stated she looked at the Level I Screening to make sure it was submitted accurately by the hospital. She stated that Resident #41's Level I Screening did not list a serious mental illness diagnosis. She stated Resident #41 had a diagnosis of paranoid schizophrenia and it should have been listed on the Level I screening. She stated she did not notice that schizophrenia was not included on Resident #41's Level I screening. The DON stated that she expected each section of the Level I screening to be reviewed for accuracy. 29358 2. An Admission Record indicated the facility admitted Resident #70 on 12/03/2022. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder (onset 12/03/2022) and major depressive disorder (onset 12/03/2022). Resident #70's care plan included a focus area, initiated 12/09/2022, that indicated the resident was at risk for altered mood and behavior due to diagnoses of depression and schizoaffective disorder. Resident #70's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 12/04/2022, indicated that the resident had a serious diagnosed mental disorder. The screening indicated that the resident had diagnoses of schizoaffective disorder and major depressive disorder. Per the Level I screening, the resident had been prescribed psychotropic medications for a serious mental illness. The screening indicated that the screening result was Negative, with a Reason Code that revealed 30-Day Exempted Hospital Discharge. During an interview on 12/03/2024 at 9:17 AM, MDS Coordinator #8 stated that Resident #70 was discharged from a hospital and was not expected to stay longer than 30 days and was considered exempt from the PASRR process. She stated the facility did not submit a Level I screening after the resident remained in the facility longer than 30 days but should have. MDS Coordinator #8 stated that they were educated the previous year on the PASRR process and learned that if a resident was discharged from the hospital and stayed longer than 30 days, they had to submit a Level I screening to the state. She stated that after their training, they did not review the previous Level I screenings of residents who may have stayed longer than 30 days. During an interview on 12/05/2024 at 9:47 AM, the Director of Nursing (DON) stated that Resident #70's Level I screening should have been resubmitted after the resident remained in the facility longer than 30 days. (continued on next page)

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	12/05/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 9:59 AM, the Administrator stated that he was not involved in the PASRR process. He stated that his expectation was for the PASRRs to be completed and submitted within the guidelines.

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	12/05/2024

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. 46194 Based on observation, interview, record review, and facility policy review, the facility failed to provide supervision to prevent a fall for 1 (Resident #68) of 2 residents reviewed for falls and failed to ensure the environment remained free of accident hazards for 1 (Resident #45) of 1 resident reviewed for accident hazards. Findings included: 1. An Admission Record, indicated the facility admitted Resident #68 on 10/04/2021. According to the Admission Record, the resident had a medical history that included diagnoses of muscle weakness, difficulty in walking, spinal stenosis, and muscle spasms. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/10/2024, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the resident required partial/moderate assistance with bathing and supervision or touching assistance with tub/shower transfers. A Morse Fall Assessment, dated 09/10/2024, indicated Resident #68 was at moderate risk for falling. Resident #68's care plan, initiated 10/01/2024, indicated the resident was at risk for injuries related to sudden body movements. An intervention initiated on 10/01/2024 directed staff to provide a safe environment. A document titled, SBAR [Situation, Background, Assessment, and Recommendation]-Falls, dated 11/22/2024, indicated Resident #68 had an unwitnessed fall without injury in the shower room. The document indicated that at 10:00 AM on 11/22/2024, a nurse heard yelling from the shower room, and upon entry, the nurse found the resident sitting on the floor of the shower room, alone. Per the document, a certified nursing assistant (CNA) left the resident alone in the shower room to obtain linens. On 12/04/2024 at 8:15 AM, Resident #68 stated they were in a shower chair and slid out of the shower chair onto the floor. The resident stated they fell out of the chair during the shower and the water was running over them. The resident stated they told staff not to leave them there and they left anyway. On 12/04/2024 at 10:56 AM, CNA #2 stated Resident #68 was in a shower chair, and the CNA had turned on the water. She stated she dropped the towels on the floor, and they got wet. CNA #2 stated she left the room to get a new towel. She stated she was aware the resident needed to be supervised and should not be left alone. However, she stated because of the inconvenience of the resident's shower towels getting wet, she left the room and left the resident unattended for less than two minutes. (continued on next page)

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	12/05/2024

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	On 12/04/2024 at 11:08 AM, Licensed Vocational Nurse (LVN) #3 stated partial/moderate assistance meant there should always be someone with the resident, supervising and assisting the resident when needed. She stated none of the residents should be left alone in the shower for safety reasons. On the day of the incident, LVN #3 stated a CNA called her to the shower room because Resident #68 had fallen to the floor. She stated the CNA had stepped out to get a dry towel, because she dropped the towel on the floor and the towel got wet. On 12/05/2024 at 8:40 AM, the Director of Nursing (DON) stated if a resident required partial/moderate assistance during a shower, the resident should not be left alone. She stated Resident #68 had jerking movements, which created a concern with the resident being left alone in the shower. On 12/05/2024 at 8:55 AM, the Administrator stated if a resident required partial to moderate assistance, they needed to be assisted with their needs. He stated he would expect staff to be in the shower room assisting the resident unless the resident requested them to be out of the room. 2. A facility policy titled, Proper Use of Bed Rails, revised 12/2016, revealed The purposes of these guidelines are to ensure the safe use of bed rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's symptoms. The policy revealed, 11. The resident will be checked periodically for safety relative to bed rail use. An Admission Record, indicated the facility admitted Resident #45 on 01/17/2020. According to the Admission Record, the resident had a medical history that included diagnoses of orthopedic aftercare following surgical amputation, acquired absence of the right leg below the knee, muscle weakness, abnormal posture, Alzheimer's disease, and a history of falling. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/17/2024, revealed the resident had moderately impaired cognitive skills for daily decision-making and short-term and long-term memory problems, per a Staff Assessment for Mental Status (SAMS). The MDS revealed the resident was totally dependent on staff for rolling left and right in bed, moving from a sitting to lying or lying to sitting on the side of bed, and for chair/bed to chair transfers. Per the MDS, bed rails were not being utilized as a physical restraint. Resident #45's care plan revealed a focus area, initiated 08/23/2024, that indicated the resident was at risk for falls/injuries related to cognitive impairment, physical limitations, a history of falls, status post partial below the knee amputation, incontinence, and side effects of medication. An intervention initiated on 08/23/2024 directed staff to place bed rails in the upright position for mobility, repositioning, and transfers. On 12/02/2024 at 10:25 AM, an observation was made of Resident #45's bed rails. The resident had a bed rail on each side of the bed that began approximately six inches from the head of the bed and extended to the center of the bed. The right bed rail was not tight and was able to be moved. On 12/03/2024 at 11:13 AM, an observation revealed there was a two-to-three-inch gap between the bed and the bed rail. On 12/03/2024 at 11:59 AM, Certified Nursing Assistant (CNA) #6 stated she was not sure how long the bed rail had been loose and said the loose rail could cause the resident to fall. (continued on next page)

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	12/05/2024

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	On 12/04/2024 at 8:51 AM, CNA #4 stated she worked with Resident #45 on 12/02/2024. She stated she had not noticed anything wrong with the bed rails. CNA #4 stated when the resident began hospice services, they got a new bed. The CNA observed the rails during the interview and stated she had not noticed being able to move the bed rails in and out and up and down. She stated if she had noticed, she would have attempted to fix the bed rail. She stated if she could not fix it, she would have called the supervisor. On 12/04/2024 at 11:26 AM, Licensed Vocational Nurse (LVN) #5 stated she was also assigned to care for Resident #45 on 12/02/2024. She stated she had not noticed the bed rails being loose. LVN #5 observed Resident #45's bed rails during the interview and stated the bed rails should be secure, and they should not move. She stated if she had noticed the rails were not secure, she would have called maintenance right away. She stated the bed rail should be secure for the resident's safety. On 12/03/2024 at 12:17 PM, LVN #3 stated everyone should be checking the bed rails for safety. LVN #3 observed Resident #45's bed rail and stated the bed rail was loose and it could come off. She stated she was not aware that the bed rail was loose. On 12/03/2024 at 12:33 PM, Environmental Services (EVS) Staff #9 stated the facility installed Resident #45's bed rails approximately two weeks prior. He stated they checked bed rails every month, but did not document the installation or the monthly checks. He stated they made sure the bed rails were bolted to the bed frame. EVS Staff #9 observed Resident #45's bed rail and stated the bed rail should not be loose or rotate. According to EVS Staff #9, the resident could fall if the bed rail came loose. He stated he was not aware of any issues with Resident #45's bed rail. He stated the CNA staff should have reported the loose bed rail to him. On 12/05/2024 at 8:34 AM, the Director of Nursing (DON) stated staff should identify hazards and ensure any issues were taken care of. Per the DON, staff should have identified the loose bed rail. On 12/05/2024 at 9:01 AM, the Administrator stated staff should identify and report any bed rail concern. He stated anything that would jeopardize the safety of the resident should be reported. He stated he was not sure how long Resident #45's bed rail had been loose, and the loose bed rail was not brought to their attention. He stated a bed rail should not be loose or moving.