STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056082	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Springs Post-Acute	180 North Jackson Avenue San Jose, CA 95116

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 10918 Based on interview and record review the facility failed to notify a responsible party (RP, person who makes healthcare decisions on behalf of a resident) regarding change in condition (clinically important change of a person's health status) when a resident sustained an injury to his left elbow for one of three sampled residents (Resident 1). This failure resulted in the RP not being informed. Findings: Review of Resident 1's clinical record indicated a physician's order was obtained on 1/20/23 at 3 p.m. to treat the resident's left elbow injury. The clinical record lacked documentation the RP was notified of the wound. During an interview on 6/4/24 at 1:38 p.m., the director of nurses (DON) reviewed Resident 1's clinical record and stated the elbow wound was a change in condition (new wound). The DON stated could not find documentation of RP notification in Resident 1's clinical record. Review of the facility's Change in a Resident's Condition or Status policy, dated February 2021, indicated a nurse was to notify the resident's representative when there was a significant change in the resident's status.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10918 Based on interview and record review the facility failed to ensure staff provided treatment and care in accordance with professional standards of practice when Resident 1's: 1. physician's orders were obtained late for wound treatments, and these orders were then implemented late, 2. physician's order for the right third toe was not obtained, 3. change of condition (clinically important change of a person ' s health status) was not documented regarding a (3a.) a STAT (urgent) lab that was ordered and (3b.) elbow wound, 4. clinical record lacked documentation relevant to an elbow wound. These failures placed the resident's health at risk. Findings: Review of Resident 1's clinical record indicated he was admitted [DATE] with diagnoses including diabetes mellitus (chronic condition in which a person's body has trouble controlling blood sugar) and malnutrition. Resident 1 was at risk for dehydration. Resident 1 also tested positive for COVID-19 on 1/14/23. Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/26/22, indicated the resident had severe difficultly with daily decision-making skill and he was dependent on staff for activities of daily living, such as eating. 1. Review of Resident 1's Admission Assessment, dated 12/23/22 at 8:57 p.m., indicated he had a wound of his left lower leg that was infected with methicillin-resistant staphylococcus aureus (MRSA, bacterial infection resistant to an antibiotic). Review of Resident 1's Nurses Note by a wound nurse, dated 12/26/22 at 4:37 p.m., indicated he had two wounds infected with MRSA. A left medial (towards the middle or center) lower leg wound had a 12/26/22 MD order to apply MediHoney (an antibacterial agent used to hasten healing of wounds) once daily, but it was carried out three days after admission from 12/29/22. A left anterior (towards the front) lower leg wound had a 12/26/22 MD order to apply MediHoney (an antibacterial agent used to hasten healing of wounds) once daily, but it was carried out three days after admission from 12/29/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/24 at 11:40 a.m., the wound nurse (WN) reviewed the record and confirmed the two lower leg wounds had late assessments, late treatment orders, and late implementation of the orders. The WN stated a comprehensive assessment is performed by the wound nurse within a day of the resident's admission. She stated the wound nurse obtains physician's treatment orders for wound treatment around the time of initial wound assessment. 2. Review of Nurses Note, dated 12/26/22 at 4:37 p.m., indicated Resident 1 had an injury to his right third distal toe with 10% slough (dead tissue) and 90% granulation (healing). Review of Resident 1's record lacked a physician's order for the right third toe. There was no order obtained to treat the right third toe. The hospital's Wound Care Consult note, dated 1/26/23, indicated Resident 1 was admitted with a full-thickness wound (wound involving damage to the dermis or middle layer of skin, subcutaneous fat and sometimes bone) to the right third toe due to an over-grown toenail. During an interview on 5/28/24 at 1:30 p.m., the director of social services (SSD) who reviewed the record stated Resident 1 was not seen by a podiatrist. During an interview on 6/3/24 at 11:40 a.m., the wound nurse (WN) reviewed the record and stated a treatment order should have been obtained for the right third toe. 3a. Review of Resident 1's Nurses Notes, dated 1/24/23 at 3:26 p.m., indicated a licensed nurse placed STAT lab orders; however, the reason for it was not documented in Resident 1's clinical record. During an interview on 6/4/24 at 4:45 p.m., the registered nurse A (RN A), who placed Resident 1's STAT lab orders, stated he probably spoke to a physician, but did not remember why a STAT lab order was placed. He stated STAT labs were usually associated with a resident's change of condition. Review of Resident 1's Nurses Note, dated 1/25/23 at 11:21 a.m., indicated the facility received lab results drawn on 1/24/23 that critically high sodium value of 161 mEq/L (milliequivalents per liter, units of measure; normal range is 135 mEq/L to 145 mEq/L). Review of the hospital discharge summary, dated 2/25/23, indicated Resident 1 was transferred to the hospital on 1/25/23 and was diagnosed with severe dehydration. 3b. Review of Resident 1's record indicated a physician's order was obtained on 1/20/23 at 3 p.m. to cleanse a left elbow injury with saline, apply MediHoney and cover with dressing once daily. Review of the Wound Evaluation & Management Summary, dated 1/23/23, documented by a wound doctor, indicated Resident 1 had a non-pressure wound of the left elbow for at least seven days duration and a surgical excisional debridement procedure was performed on the infected wound to remove necrotic (dead) tissue. There was no corresponding change of condition note. During an interview on 6/3/23 at 11:40 a.m., the WN reviewed the record and stated a change of condition should have been documented for Resident 1's elbow wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure Change in a Resident's Condition or Status, revised February 2011, indicated the nurse was to notify the resident's physician when there was discovery of injuries of an unknown source and significant change in the resident's condition. The nurse was to record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. If a significant change in the resident's physical or mental condition occurred, a comprehensive assessment of the resident's condition was to be conducted. 4. During an interview and record review on 6/4/24 at 1:38 p.m., the DON reviewed the record and stated, aside from a physician's daily wound treatment order on 1/20/23 for Resident 1's elbow wound, a wound doctor's note on 1/23/24 was the only other documentation about Resident 1's elbow wound, though nurses were supposed to document resident skin status weekly and, when a change in condition occurred, to include development of a new wound. Review of the facility's policy and procedure Charting and Documentation, dated 2001, indicated all services provided to the resident was to be documented in the resident's medical record. The medical record was to facilitate communication between the IDT regarding the resident's condition and response to care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 10918 Based on interview and record review the pharmacist failed to report drug irregularities for one of four sampled residents (Resident 1), when Resident 1 received a diuretic (Lasix) with a black box warning (BBW, medications identified by the Food and Drug Administration (FDA) to have serious side effects to alert consumers) label; however, the consultant pharmacist (CP) did not address side effects monitoring for it. This failure left the potential side effects of Lasix to be unmonitored for Resident 1. Findings: Review of Resident 1's physician's medication orders, dated 12/23/22, indicated furosemide (Lasix) 40 milligrams (mg, a metric unit of measurement) twice daily. Resident 1's hospital discharge summary, dated 2/25/23, indicated he presented to the hospital on 1/25/23 with hypernatremia (high sodium in blood), confusion more than baseline. Lab results drawn on 1/24/23 indicated a critically high sodium value of 161 mEq/L (milliequivalents per liter, units of measure; normal range is 135 mEq/L to 145 mEq/L), and he was admitted with a diagnosis of severe dehydration. During an interview on 6/4/24 at 12:41 p.m., the consultant pharmacist (CP) stated he believed Lasix was a BBW medication; and that, nursing staff should monitor side effects for it, such as signs and symptoms of dehydration. The CP stated the potential side effects of medications should be indicated in the resident's [of which they are prescribed] clinical record. Review of Resident 1's clinical record (to include care plans, physician's orders, and monitoring forms) lacked indication the resident was monitored for potential side effects specific to Lasix. Resident 1's Medication Record Review (MRR), dated 12/26/22, indicated, based upon all information available, no recommendations were issued. During an interview on 6/4/24 at 3:45 p.m., the director of nurses (DON) reviewed the clinical record and stated she could not find documentation indicating the side effects for Lasix were to be monitored. The policy and/or guideline addressing medications with black box warnings was requested and not provided. Review of the Medication Regiment Review policy, dated May 2019, indicated the MRR involved a thorough review of the resident's clinical record to prevent, identify, report, and resolve medication related problems, and irregularities, such as: monitoring for adverse consequences and potentially significant medication-related adverse consequences or actual signs and symptoms. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Lexidrug (an online drug reference) monogram (drug description) for Lasix, dated 6/8/24, indicated, ALERT: US Boxed Warning . Fluid/electrolyte loss: Furosemide is a potent diuretic that, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule must be adjusted to the individual patient's needs . Monitoring Parameters . BP (blood pressure); serum electrolytes; kidney function; fluid intake and output.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 10918 Based on interview and record review the facility failed to ensure a STAT (urgent) laboratory result was obtained timely for one of three sampled residents (Resident 1). Resident 1's STAT laboratory order was not obtained until a day after it was ordered and one test result had a critical value (potentially life-threatening requiring immediate medical attention). This failure resulted in a delay in hospital transfer and placed the resident's health at risk. Findings: Review of Resident 1's care plan, dated 12/23/22, indicated the resident was at risk for dehydration. Review of Resident 1's physician order dated 1/24/23 at 9:44 a.m. indicated STAT lab tests including a comprehensive metabolic panel (CMP, blood test that measures different substances to provide information about a person's chemical balance and metabolism). Review of Resident 1's Nurses Note, dated 1/25/23 at 11:21 a.m., indicated the facility received lab results drawn on 1/24/23 that had a critical high sodium 161 mEq/L (milliequivalents per liter, units of measure; normal range is 135 mEq/L to 145 mEq/L) value for which the physician was notified, and Resident 1 was sent to the hospital. Review of the hospital discharge summary, dated 2/25/23, indicated Resident 1 presented to the hospital on 1/25/23 with a diagnosis of severe dehydration. During a telephone interview on 6/4/24 at 3:44 p.m., a staff from the lab company stated Resident 1's STAT lab was drawn on 1/24/23 at 4:30 p.m.; and when the results was known, a staff reported it to the facility via phone call on 1/25/23 at 10:09 a.m. During an interview on 6/4/24 at 4 p.m., the director of nurses stated it took about 9 hours for the lab specimen to reach the lab, that is too long, the purpose for ordering a STAT lab was for the result to come early instead of waiting a few days, and the facility has been having problems obtaining timely lab results. During an interview on 6/4/24 at 4:27 p.m., the administrator (ADM) stated we do STAT labs because it may take two days to obtain lab results. Review of the facility's undated Laboratory Services policy indicated all STAT order test results were to be released within 4 to 6 hours from the time of the blood draw.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10918 Based on interview and record review the facility failed to promptly notify an abnormal lab result to the physician/nurse practitioner (NP) for one of four sampled residents. This failure resulted in the delay of the resident's change in prescription. Findings: Review of Resident 1's clinical record indicated he was admitted on [DATE] with a diagnosis of diabetes mellitus (long term condition in which the body has trouble controlling blood sugar). Review of Resident 1's clinical record indicated he had a lab drawn on 12/29/22 at 6:25 a.m. with an elevated A1c (a test that measures the average amount of sugar in a person's blood over the past few months) level of 9.1% (desired range is below 5.7%). Review of a Nurse's Note, dated 1/5/23 at 2:33 p.m., indicated the NP made changes to Resident 1's diabetic medications and reordered lab tests. Review of a physician's order, dated 1/10/23, indicated Resident 1's dosage of a diabetic medication was increased and noted his A1c result was 9.1%. Review of Resident 1's clinical record lacked documentation indicating licensed nurses reviewed the result and the physician or NP was notified. There was also no licensed nurse documentation to indicate whether, or not, the A1c test result met the criteria for immediate notification. During an interview on 6/4/24 at 10:40 a.m., the director nurses reviewed Resident 1's clinical record and stated she did not find documentation indicating licensed nurses reviewed the A1c results or that the physician or NP were notified of it. Review of the facility's Lab and Diagnostic Test Results - Clinical Protocol policy, dated 2001, indicated if a test result did not meet the criteria for immediate notification, then the nursing staff was to review why the test was obtained, as well as to indicate resident's current clinical status including the presence of any signs and symptoms.