

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER Canyon Springs Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to ensure care and treatment was provided in accordance with professional standards of practice for one of three residents (Resident 1), when a medication was ordered with no indication for use identified. This failure had the potential to compromise Resident 1's health and well-being. Findings: Review of Resident 1's physician order dated 6/24/25 indicated Ivermectin (medication that treats infections caused by roundworms, threadworms, and other parasites [an organism that lives on or in a host organism]) 3 milligrams (mg, a unit of measure) 4 tablets daily for 3 days. The physician order did not identify the indication for the use of the Ivermectin. Review of Resident 1's medication administration record (MAR) indicated Ivermectin Oral Tablet 3 mg. Directions indicated to give 4 tablets by mouth in the evening for parasite infection for 3 days. During an interview and concurrent record review with Licensed Vocational Nurse A on 7/18/25 at 3:15 p.m., she stated she received Resident 1's medication order for Ivermectin from the Nurse Practitioner (NP) on 6/24/25. LVN A stated there was no indication for the use of Ivermectin identified in the NP's order. LVN A further stated, I did not know what Ivermectin was used for, so I googled it. LVN A stated she carried out the Ivermectin order in the MAR and stated she added the words for parasite infection. When asked if Resident 1 had a parasitic infection, LVN stated she did not know. LVN A stated, I am sorry, I should not have done that. During an interview and concurrent record review with the Assistant Director of Nursing on 7/22/25 at 9:15 a.m., she reviewed Resident 1's nurse practitioner's order for Ivermectin dated 6/4/24. The ADON confirmed there was no indication for the use of the Ivermectin. When asked what the process is when a medication order does not have an indication for use, the ADON stated the licensed nurse should clarify the order with the author of the physician order. The DON further stated a medication order needs to have a specific diagnosis or indication for the use of the medication. When asked if a licensed vocational nurse could assign a diagnosis or identify the indication for the use of a medication, she stated diagnosing is not in the scope of practice for licensed vocational nurses. The ADON confirmed LVN A should not have added for parasite infection to Resident 1's medication order on the MAR. Review of the facility policy titled Medication and Treatment Orders, dated 2001, indicated orders for medications must include the clinical condition or symptoms for which the medication is prescribed.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056082
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