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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055798	A. BUILDING ______ B. WING ______	07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASONA CREEK HEALTHCARE CENTER	16412 LOS GATOS BOULEVARD LOS GATOS, CA 95030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 7/2/12 through 7/9/12. The facility was licensed for 148 beds. The census was 141 at the time of entrance. There were 24 sampled residents. Complaint CA00316578 regarding Quality of Care/Treatment/Resident Rights was investigated during the survey and was unsubstantiated. Representing the California Department of Public Health were 10918, Health Facilities Evaluator Nurse; 25460, Health Facilities Evaluator Nurse; 28150, Health Facilities Evaluator Nurse; 29260, Health Facilities Evaluator Nurse, and 31388, Health Facilities Evaluator Nurse.	F 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 20 2012 L & C DIVISION SAN JOSE	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced [redacted]	F 328		

LABO[redacted]

(X6) DATE 08-01-2012

Any [redacted] oviding it is determined that other [redacted] ve 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.

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F 328	Continued From page 1 Based on observation, interview and record review, the facility failed to ensure two of 24 sampled residents (6 and 17) received proper care and treatment for their gastrostomy tubes (a tube inserted through the abdominal wall into the stomach to provide liquid nutrition. Residents 6 and 17 did not receive gastrostomy tube feedings (nutrition administered through a tube into the stomach) according to the physicians order. Failure to give the tube feedings as ordered placed the residents at risk for inadequate nutrition intake. Findings: 1. Resident 6 was admitted with a diagnoses of bone infection. Resident 6's clinical record was reviewed on 7/2/12. Resident 6's minimum data set (MDS, an assessment tool) dated 4/23/12, indicated he was severely cognitively impaired and totally dependent on staff for feeding and all activities of daily living. A physician's order dated 4/10/12 indicated Resident 6 was to receive a tube feeding of Fibersource HN to run at a rate of 85 cubic centimeters (cc) per hour over 18 hours for a total of 1530 cc in twenty-four hours. During an interview and observation on 7/3/12 at 9 a.m., licensed nurse A (LN A) stated Resident 6's tube feeding ran from 2 p.m. on 7/2/12 to 8 a.m. on 7/3/12. LN A turned on Resident 6's feeding pump and stated the volume delivered by 8 a.m. on 7/3/12 was 1154 cc as indicated by the "Volume Delivered Display." LN A further stated Resident 6 did not receive the full amount of formula for 24 hours and was short 376 cc of tube	F 328	Teaching and Training were immediately provided for Nurse A and D on the time of survey to ensure Resident 6 and 7 received gastrostomy tube feeding according to physician order. There's no negative outcome related to the deficiency. A review of the remaining resident at [redacted] demonstrated that residents on tube feeding received gastrostomy tube feeding according to physician order and receiving adequate nutrition intake. An in service will be conducted by the DON for the License staff, emphasizing following physician order. To delivered the full volume of the enteral feeding as ordered by MD, regardless of any interruption of feeding. The inservice also stressed the importance of consistent and accurate documentation and measurement of the resident intake and output. Audits will be conducted by the medical records designee s 3x a week to determine the presence of documentation as required on the I &O flow records. Findings of the audits are submitted to the DON for further review. The DON will intervene with staff members in the event an absence of the information on the I & O flow record is noted The QAC will review audits findings quarterly x 1 year that are submitted to the DON for any additional recommendation.	07/10/12 07/27/12 08/08/12

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F 328	Continued From page 2 feeding. During an interview on 7/3/12 at 4:15 p.m. the director of nurses (DON) stated LN A should have continued Resident 6's feeding to complete the full dose of formula instead of turning the pump off at 8 a.m. During an interview on 7/3/12 at 4:10 p.m. the DON reviewed the "Total Intake and Output Record" (I&O) and stated there was no documentation indicating how much nutrient Resident 6 received on 7/2/12 during the 11 p.m. to 7 a.m. shift. During record review on the above date and time, of Resident 6's I&O sheet dated 6/27/12 - 7/3/12, it indicated no 24 hour totals were documented for intake. During an interview and observation of Resident 6's feeding pump on 7/6/12 at 7:05 a.m., LN B confirmed the "Volume Delivered" Display indicated 807 ml (milliliters) of nutrient was delivered by 7:05 a.m., and 891 ml's was delivered by 8:05 a.m., instead of the 1530 ml Resident 6 should have received over the 18 hours. The feeding was stopped by LN C at 8:15 a.m. LN B stated she was unsure Resident 6 consumed the correct amount of nutrient ordered. During an interview on 7/6/12 at 7:05 a.m., LN B reviewed Resident 6's I&O for 7/5/12 on the 3 p.m. to 11 p.m. shift and stated it was left blank by licensed nurse D (LN D). LN B stated any resident having a feeding tube should have intake and output documented on the I&O sheet. LN B further stated she was unsure Resident 6	F 328		

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F 328	Continued From page 3 received the full amount of nutrient ordered. During an interview on the above date at 8:05 a.m., LN B stated 850 ml's should have been infused by 11 p.m. on 7/5/12, the beginning of her shift, instead of the 100 ml's the feeding pump display indicated. During an interview on 7/6/12 at 8:30 a.m., LN C stated she had telephoned LN D to determine if Resident 6 had received the correct amount of nutrition for the 7/5/12 evening shift. LN C reported per LN D's telephone conversation, she may have accidentally hit the pump reset button. LN C then documented 680 ml intake on the I&O sheet for the 3 p.m. to 11 p.m. shift on 7/5/12. During record review on 7/5/12 at 11:40 a.m., Resident 6's nutritional care plan dated 7/20/11 indicated NG/GT feeding should be administered as ordered. During review on 7/6/12 at 9:30 a.m. of Resident 6's I&O sheet dated 7/4/12 - 7/6/12, it indicated no 24 hour totals were documented in the intake column. The facility's policy, "Enteral Nutrition" revised December 2008, indicated, "The following information will be included to ensure that the full volume will be infused, regardless of any interruption of feeding . . . total daily volume to be infused (number of ml per day)." It further included, "Document the following in the resident's medical record every shift . . .intake and output totals . . ." 2. Resident 17 had a physician order dated	F 328		

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F 328	Continued From page 4 6/22/12 for Diabetic resource through gastronomy tube at 80 cubic centimeter (cc) to run for 20 hours a total of 1800 cc for twenty four hours. During interview and record review on 7/9/12 at 10:00 a.m., the intake and output record indicated Resident 17 did not receive a total intake of 1800 cc formula for twenty hours. The record showed on 6/23/12 a twenty hour total intake of 1620 cc and on 6/24/12 a total intake of 1760 cc. Licensed nurse F (LN F) stated she had no explanation why the resident did not get the right amount of formula at that time. LN F stated the licensed nurse "probably" copied the resident's total intake data from the previous shift. The facility's policy, "Enteral Nutrition", revised December 2008 indicated, "The following information will be included to ensure that the full volume will be infused, regardless of any interruption of feeding . . . total daily volume to be infused (number of ml per day)." It further included, "Document the following in the resident's medical record every shift . . .intake and output totals . . ."	F 328		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368		

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F 368	Continued From page 5 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 24 sampled residents (10) received his meal at a regular time. On 7/2/12 Resident 10 received his breakfast tray three hours past the scheduled breakfast time and there was more than a fourteen hour span between the evening meal and breakfast. Findings: Resident 10's Minimum Data Set dated 6/30/12 indicated he was alert and able to verbalize his needs. He required assistance with meals. During the initial tour on 7/2/12 at 8:30 a.m., with licensed nurse G (LN G) Resident 10 complained he was hungry and had not eaten breakfast. When asked by LN G, Resident 10 stated the staff took his tray because the food was too tough to eat and he could not chew the toast due to his mouth pain. Resident 10 also stated he had mouth abscess and a recent tooth extraction. At 8:45 a.m., LN G sent a certified nurses assistant (CNA) to the kitchen to request a soft diet for the resident. At 9:45 a.m., Resident 10 stated he was still waiting for his breakfast tray. The surveyor informed LN G of the concern. LN G stated the dietary staff sent the wrong diet	F 368	Resident G received a breakfast tray upon identification of tray delivery, at time of survey. The CNA received immediate 1:1 in service by the licensed nurse, emphasizing the importance of checking for any room changes, to determine appropriate delivery of resident's meal trays, at time of survey. Remaining residents at [redacted] all received their meals within the specified timeframe of no more than 14 hours elapsing between nourishing meals. Dietary orders have been checked by the DON and Dietary Food service and resident's diets correspond with the physician's orders. Diets have been checked by the DON and the Dietary food services and dietary order accuracy was noted.	07/04/12

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F 368	Continued From page 6 for the resident. LN G stated she would send a pureed diet slip order to the kitchen. At 10:15 a.m., Resident 10 received his breakfast tray which was a pureed consistency. Resident 10 stated he did not know why it took too so long for the staff to bring back his tray. During interview on 7/2/12 at 10:20 a.m., LN G stated Resident 10 was on a pureed diet. LN G stated she did not know why the dietary staff kept sending the wrong diet. LN G further stated the CNA had difficulty dealing with the dietary staff because they were too busy. During interview on 7/5/12 at 10:30 a.m., the dietary supervisor (DS) stated breakfast trays went out at 7:20 a.m. and dinner trays went out at 5:30 p.m. DS stated Resident 10 moved to another room and the CNA could not find the tray. Review of the facility's 2009 policy on "frequency of meals" indicated: The facility will serve at least (3) meals or their equivalent daily at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast.	F 368	An inservice is scheduled for the licensed staff and CNAs, to be given by the DON, stressing the importance of notification of CNAs and dietary of room changes. In service is scheduled for the dietary staff by Director of food services stressing the importance of providing meal trays to CNA in timely manner. Dietary checks to be conducted by the licensed staff every meal once a week for assurance of following physician's orders related to specific diets for residents as well as checking for appropriate times of tray deliveries. Meals will be served at breakfast, lunch and dinner within a reasonable time frame but no more than 14 hours between meals. The licensed nurses /and Director of Staff Development will do random check of tray delivery times at meals weekly and their findings will be submitted to the DON for any possible further staff actions and the Quality Assurance Committee will review the findings quarterly x 1 year for further potential recommendations.	08/08/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the consultant pharmacist (CP) reported a lack of laboratory monitoring for one of 24 sampled residents (12). Resident 12 received digoxin, a heart medication requiring periodic laboratory tests for possible signs of toxicity. Findings: Resident 12's record was reviewed on 7/3/12. Resident 12 was admitted to the facility with diagnoses including atrial fibrillation (AF, irregular heart beat). The resident had a physician's order dated 10/1/09 for digoxin 0.125 milligram (mg) daily to treat AF. There was no physician's order for a BMP test. Lexi-Comp (a nationally recognized drug information resource), has outlined monitoring parameters to assess for signs of toxicity from digoxin use included obtaining laboratory results of periodic serum creatinine, potassium, magnesium, and calcium. During an interview on 7/3/12 at 6:15 p.m., CP who reviewed the record, stated a BMP (basic metabolic panel, a laboratory test that included serum creatinine, potassium, magnesium and calcium levels) for Resident 12 was not obtained within a year. CP stated a BMP test should be obtained every six months for residents taking Digoxin. She stated she did not address it in her medication review for Resident 12.	F 428	Resident's 12 had Digoxin level done at time of survey. The pharmacy consultant was notified at time of survey that Digoxin level was not obtained within a year. Audits were conducted by the medical records designees at the time of survey and Digoxin level was done to all residents on Digoxin. An in service will be conducted for the licensed staff and pharmacy consultant , given by the DON, teaching the importance of monitoring parameters to assess for the signs of toxicity from Digoxin use which include obtaining the lab results . The Pharmacy consultant will address the necessary lab test needed to monitor toxicity from Digoxin on monthly drug regimen review. Audits will be conducted for every patients with Digoxin by medical records designee every quarter to determine the presence of the lab result as required. Findings of the audits are submitted to the DON for further review. The QAC will review audit findings quarterly x 1 year that are submitted to the DON for any additional recommendation.	07/04/12 08/08/12

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F 457 SS=D	483.70(d)(1)(i) BEDROOMS ACCOMODATE NO MORE THAN 4 RESIDENTS Bedrooms must accommodate no more than four residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one resident room (509) accommodated no more than four residents. This failure could potentially compromise residents' quality of life and rendering of care. Findings: Room 509 was observed to house five residents on 5/2/12, 5/3/12 and 5/4/12. Multiple observations during the survey revealed there was sufficient room for the provision of care and the quality of life was not compromised by the number of residents exceeding the limit of four. The room size, closet and storage spaces met the particular needs of the residents. The residents were afforded privacy with sufficient space for the provision of nursing care, such as transferring residents from the bed to a wheelchair. None of the residents voiced concerns regarding the room size. Continuance of the room waiver is recommended.	F 457	Room variation were in accordance with the particular needs of the residents. The closet and storage spaces were reasonable and accommodated the needs of the residents in these rooms. The residents were afforded privacy with sufficient space for the provision of nursing care and accommodation of infection control principles. Thank you for your recommendation for continuance of the room variances. Continuance to be posted and incorporated into the facility QAAC process.	
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458		

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F 458	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide 80 square feet per resident in multiple resident rooms 304, 404, 406, 407, 408, 409, 410, 411, 412, 414, 415, 416, 500, 504, 506, and 511. These failures could potentially compromise the quality of life and the quality of care the residents received. Findings: Room 304 was occupied by three beds with a square footage of 74 feet per resident. Room 404 contained 2 beds with a square footage of 70 feet per resident. Rooms 406, 410, 412, 414, 416, 500, 504, and 506 had 2 beds each with a square footage of 72 feet per resident. Room 407 had 2 beds with a square footage of 70.94 feet per resident. Room 408 contained 2 beds with a square footage of 72.25 feet per resident. Room 409 had 2 beds with a square footage of 71.48 feet per resident. Room 411 had 2 beds with a square footage of 70.5 feet per resident. Room 415 had 2 beds with a square footage of 73.5 feet per resident. Room 511 had 3 beds with a square footage of 78.7 feet per resident. Although the room sizes were less than 80 square feet per resident in multiple rooms, staff met the needs of the residents. The closet and storage spaces also accommodated the needs of the residents in these rooms. No resident voiced concern of the room size. The residents were afforded privacy with sufficient space for the provision of care and activity. Continuance of the room variances is recommended.	F 458	Please refer to response for F457. Thank you for your recommendation for continuance to be posted and incorporated into facility QAAC process.	

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F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain complete and accurate documentation in accordance with accepted professional standards and practices for four of 24 sampled residents (5, 7, 8, and 18,) when side rail assessment forms were inaccurate and incomplete. Failure to provide an accurate assessment could result in misleading information and an inaccurate plan of care. Findings: 1. Resident 5's minimum data set (MDS, an assessment tool) dated 6/5/12 indicated he had moderate cognitive impairment and needed extensive assistance with activities of daily living. During an observation on 7/2/12 at 11:45 a.m., Resident 5 was in his bed with full-length side rails elevated on both sides of his bed.	F 514	Resident # 5 and #18 was reassessed for the use of side rails and side rails assessment form was completed at the time of survey. Resident #5 had their full side rails replaced with half side rail. Resident # 7 was reassessed for the use of side rails. Side rails were discontinued, order obtained & care plan updated. Responsible party was notified. Although Resident # 8 was discharge to home, audit will be conducted by medical records designee and in the event a SR assessment form was incomplete, patient will be reassessed to determine the resident's symptoms or reason for using the side rail and type of side rails. The risk and benefits will be explained to resident/family indicating the full name of the person to whom they were explained .	08/07/12

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F 514	Continued From page 11 During an interview on 7/3/12 at 9:50 a.m., licensed nurse E (LN E) stated side rail assessments are documented on the Admission Side Rail form. During review on 7/3/12 at 8:07 a.m. of the side rail assessment document, it indicated the physician's order for side rails dated 1/28/12 for Resident 5 required "Top Half" side rails on "Two Sides." The documentation did not include the full name of person(s) to whom(risks/benefits) were explained for use of side rails. Also, the side rail assessment had no documentation indicating medical symptoms requiring use of side rails. During review on 7/3/12 at 9:22 a.m. of Resident 5's side rail assessment, it indicated "Medical symptoms requiring use of side rails" was not completed. There was no documentation indicating risks and benefits were explained or to whom the risks were explained. 2. On 7/2/12 at 12:15 p.m., Resident 7 was observed in bed with four half side rails up. On 7/3/12 at 8:00 a.m., the side rails remained in the same condition with the resident in bed. On 7/2/12 at 12:15 p.m., the ADON stated the resident was unable to move and staff do not get him out of bed because he is non-responsive. According to ADON, Resident 7 opened his eyes halfway occasionally when staff talked to him. On 7/2/12 at 2:35 p.m., Resident 7's MDS indicated he was non-verbal, with no cognitive abilities. The bed mobility data indicated total dependence with two person assistance with bed	F 514	The DON has scheduled an in service that will be given to licensed nursing staff emphasizing the need of the side rail forms to be completed and accurate, documentation of risk and benefits explained to resident /family indicating the full name of the person to whom they explained, documentation of medical symptoms or reason for side rails usage and type of side rails. Audits will be conducted by medical records or design e to every new admit patient and quarterly to determine SR assessments forms are completed and accurate. Findings of the audit are submitted to the DON for further review. The DON will intervene with staff members in the event an absence of information on the side rails form is noted. The QA committee will review quarterly x 1 year all the findings that are submitted to DON for further review and recommendations`	08/08/12

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
AUG 20 2012
L & C DIVISION SAN JOSE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055798	A. BUILDING _____ B. WING _____	07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 12	F 514		

mobility. The side rail assessment document 5/23/12 indicated the reason for side rail usage is "assist with transfer and bed mobility" (assist with turning side-to-side). The type of side rails to be used was not documented but did document two side were required.

During observation on 7/6/12 at 3:30 p.m., Resident 7 was in bed with two upper half side rails only.

3. On 7/2/12 at 8:00 a.m., Resident 8 was in bed with four half side rails in the up position.

Clinical record review was conducted on 7/3/12 at 8:15 a.m. The MDS dated 6/3/12 indicated, Resident 8 required two person extensive assist for bed mobility and transfer. The side rail assessment dated 5/27/12 indicated side rail usage is, "assist with transfer and bed mobility" (assist with turning side-to-side). The type of side rails (half or full) to be used was not documented but did document two sides were required.

On 7/3/12 at 3:30 p.m., Resident 8 was observed in her bed with two upper half side rails in the up position.

On 7/5/12 at 9:55 a.m., Resident 8 was being transferred from her bed to her wheelchair with two person assist but no use of the two upper side rails by the resident. The side rail assessment dated 5/27/12 had no documentation the responsible party was informed or had risk vs. benefits explained about the use of side rails.

4. During clinical record review on 7/6/12 at 8:40

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F 514	Continued From page 13	F 514		

a.m., Resident 18's clinical record side rail assessment, dated 10/3/11, indicated medical symptoms requiring use of side rails as "bed mobility". Types of rails to be used; top half (one or two sides was blank).

The side rail assessment dated 11/17/11 indicated medical symptoms requiring the use of side rails was blank and had no documentation of how many side rails to be used. The section for risk and benefits explained to resident/family date was blank.

The side rail assessment dated 1/10/12 indicated the section under medical symptoms requiring use of side rails was blank. The section under the reason for side rail usage indicated "assist with transfer and bed mobility" (assist with turning side-to-side). The section to indicate the for risks and benefits were explained to resident/family and the date was blank.

The side rail assessment dated 4/11/12 was blank in the section for medical symptoms requiring use of side rails. The reason for side rail usage indicated "assist with transfer and bed mobility" (assist with turning side-to-side).

The side rail assessment dated 7/4/12, indicated the medical symptoms requiring the use of side rails was for "bed mobility".

During an interview with the DON on 7/6/12 at 2:25 p.m., DON stated bed rail assessments were incomplete.

The facility policy, "Proper Use of Side Rails" revised December, 2007, indicated, "An

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F 514	Continued From page 14 assessment will be made to determine the resident's symptoms or reason for using the side rails. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility; and ability to change positions, transfer to and from bed or chair, and to stand and toilet. "Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. The risks and benefits of side rails will be considered for each resident."	F 514		