STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056082	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate assessment and revise the plan of care to address foot care management of one of three sampled Residents. Resident 1 had condition that poses a risk to foot health. These failures could potentially put resident at risk for complications without appropriate interventions. Findings: Review of the Resident 1's clinical record indicated he was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident 1's Clinical admitted d [DATE], indicated Charcot (a condition affecting the bones, joints, and soft tissues of the foot and ankle, characterized by inflammation in the earliest phase) left great toe. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated [DATE], indicated Resident 1 did not have foot problem. Review of Resident 1's Diabetes Care Plan dated [DATE], did not address an updated care plan for Resident 1's foot care management. Review of Resident 1's Skin Care plan dated [DATE], indicated at risk for altered skin integrity related to impaired tissue perfusion due to diabetes with [MEDICAL CONDITION]. The approach included to do skin check in weekly summary. There was no revision of care plan to address the left foot condition. Review of Resident 1's Hospital Transfer Form dated [DATE], indicated he was transferred to the general acute care hospital (GACH) for suspected left foot infection. Nursing notes also indicated Resident had a temperature of 100.4. Review of Resident 1's GACH Discharge Summary dated [DATE], indicated Resident 1 expired on [DATE]. Resident 1's [DIAGNOSES REDACTED]. Review of Resident 1's Nurses Notes dated [DATE], indicated Resident 1 had noted poor circulation of left foot with gangrene (refers to the death of body tissue due to either a lack of blood flow or a serious bacterial infection) in color, complained of pain upon being touched, the first big toe really swollen and remaining toes were greenish to blackish in color. Resident 1 was sent to the GACH. On the same day, Resident 1 returned to the facility with [DIAGNOSES REDACTED]. Review of Resident 1's Nurses Notes on [DATE] at 9:24 a.m., indicated Resident 1's left foot with swelling, toes blackish in color. From [DATE], there were no further assessments of Resident 1's left foot on nursing notes. Morever, Resident 1's Weekly Summary Report under head to toe skin observation condition from [DATE] to [DATE], indicated there was no skin issues, and the Care Plan did not include an updated care plan to address the left foot condition. During an interview and concurrent record review with the director of nursing (DON) on [DATE] at 11:40 a.m., the DON acknowledged Resident 1's left foot should have a monitoring on nurses notes for at least three days, a revision of care plan to address the left foot, and the weekly summary to address any skin issues from [DATE]. The DON indicated Resident 1 had a podiatry referral after he returned to the facility on [DATE]. The DON stated a podiatrist saw Resident 1 as an outpatient on [DATE]. During an interview and concurrent record review with licensed vocational nurse A (LVN A) on [DATE] at 12:25 p.m., LVN A stated he saw Resident 1 on [DATE] and acknowledged the description of Resident 1's left foot as gangrene, greenish, poor circulation, and Resident 1 had pain. LVN A confirmed he did not create a care plan for his findings on Resident 1's left foot and he should have. Review of Podiatry Office Visit progress notes dated [DATE], indicated the following: Toenails description: Elongated, thick, yellow brown, pincer (nail deformity) shaped and ingrown. Comments : severe mycotic (become infected with fungus) and dry fibrotic (connective tissue deposition that occurs as part or normal healing) changes to the bilateral nail plates, left greater than right, left hallux is enlarged, concern for a neoplastic changes and/or chronic bone infection. Severe pain with attempted palliation. Plan: At this time, the staff who transported the patient was told that this could be borderline neglect, unable to do any outpatient palliation procedures .severe withdrawing pain on palpation .OR (operating room) will be required to do for all fluoroscopy (an imaging technique that uses X-rays to obtain real-time moving images of the interior of an object) surveillance to rule out bony changes . During an interview with the DON on [DATE] at 11:30 a.m., the DON stated she was not aware of the content of the visit notes from the podiatrist. The DON stated licensed nurses' were responsible to make sure to review notes from outpatient visits. During an interview with the Transport Person B (TP B) on [DATE] at 12:25 p.m., he stated Resident 1's left foot was wrapped with a white material. During an interview and concurrent record review with LVN C on [DATE] at 2:55 p.m., LVN C stated on [DATE], she did not remember receiving the visit notes from the podiatry appointment, but received a call for a planned surgery in few weeks. LVN C stated she did not remember if she checked Resident 1's left foot. LVN C nurses note dated [DATE], did not have the assessment of Resident 1's left foot and she acknowledged she should have check Resident 1's left foot. Review of Resident 1's Weekly Summary completed by LVN C, dated [DATE] at 11:26 p.m., indicated under head to toe skin observation conditions: skin intact, no new skin issue noted. During an interview and concurrent record review with the DON on [DATE] at 1:40 p.m., she confirmed Resident 1's nursing notes from [DATE] should have included the assessments on Resident 1's left foot and his care plan should have been updated to address his left foot. During an interview with the doctor of podiatry medicine (DPM) on [DATE] at 3:30 p.m., the DPM acknowledged seeing Resident 1 on [DATE] at his office. The DPM described Resident 1's left foot condition as severe left foot issues, all of left toe nails incurred long nails, gangrene looking, and concern of left leg becomes ischemic (reduced blood flow) in some areas, poor hygiene care on left foot than right. The DPM stated he was not able to treat Resident 1 because Resident 1 was screaming in pain and also stated it's the worst I've seen in a patient condition. Review of facility's ,[DATE] policy, Foot Care, indicated overall foot care would include the care and treatment of [REDACTED].g., diabetes .) Review of facility's ,[DATE] policy, Nursing Care of the Resident with Diabetes Mellitus, indicated foot complications: [MEDICAL CONDITION] , skin and foot care: skin should be kept as dry and clean as possible. Review of facility's ,[DATE]'s Charge Nurse Job Description, indicated based on observation of resident's condition, develop or revise the plan of care with interventions and time measurable objectives to assist each resident to attain or maintain highest practicable physical, mental, and psycho-social well being
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy of record was maintained for one of three sampled residents (Resident 1). Resident 1 was discharged from the facility on 6/26/2020 and the licensed nurse added notes to Resident 1's clinical record on 9/1/2020. This failure had the potential to have inaccurate record of the residents' care. Findings: Review of the Resident 1's clinical record indicated he was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident 1's Nurses Notes dated 6/3/2020, indicated Resident 1 had noted poor circulation of left foot with gangrene (refers to the death of body tissue due to either a lack of blood flow or a serious bacterial infection) in color, complained of pain upon being touched, the first big toe really swollen and remaining toes were greenish to blackish in color. Resident 1 was sent to the general acute care hospital (GACH). On the same day, Resident 1 returned to the facility with [DIAGNOSES REDACTED]. During record review on 9/1/2020 at 11:05 a.m., Resident 1's Weekly Summary Report dated 6/4/2020, indicated there were no skin issues. The report had an observation date of 6/4/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and completed date of 6/4/2020. During another record review on 9/17/2020 at 10:55 a.m., Resident 1's Weekly Summary Report dated 6/4/2020, indicated swelling and blackish toes in color. The report had an observation date of 6/4/2020 and completed date of 9/1/2020. During a follow-up interview with the director of nursing (DON) on 9/17/2020 at 10:55 a.m., the DON confirmed the above findings and stated the licensed nurse made notes on 9/1/2020, months passed the observation date on 6/4/2020, and that was not allowed. The DON stated Resident 1 did not return to the facility since 6/26/2020. During a telephone interview with licensed vocational nurse D (LVN D) on 9/17/2020 at 12:15 p.m., LVN D confirmed she added notes to Resident 1's Weekly Summary Report on 9/1/2020 to reflect what she wrote on her nurses notes regarding Resident 1's left toes. LVN D stated she knew she should not have made changes because Resident 1 was no longer in the facility. Review of the facility's Charge Nurse Job Description dated 3/2014, indicated Complete required documentation of care and services delivered during shift . Review of the facility's 7/2017 policy, Charting and Documentation, indicated documentation in the medical record will be objective, complete, and accurate.