

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER The Sequoias		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Portola Road Portola Valley, CA 94028	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>31922</p> <p>Based on interviews and record review the facility failed to ensure an intervention recommended by a physician was communicated in a timely fashion for Resident 1, one of 12 sampled residents. Resident 1 had a fracture of unknown origin, and his physician recommended no Hoyer lift (a transfer device). This recommendation was not communicated in a timely manner to all direct caregivers. Failure to communicate physician's recommendations to direct caregivers had the potential to inflict and/or worsen an injury. Additionally, the facility failed to provide their policy regarding shift-to-shift endorsement.</p> <p>Findings:</p> <p>Review of Resident 1's medical records titled Progress Notes, Dated 5/19/2024 10:27 AM, indicated the physician assessed Resident 1 and charted .(leg) fracture .He is in his bed, I recommended that staff no longer use the Hoyer lift to get him up because that is what probably caused this fracture, .</p> <p>The facility has an endorsement report book that nurses write down what they want to pass onto the next shift regarding residents under their care. Review of the endorsement report book indicated the No Hoyer lift recommendation was not documented until 5/21/24 (almost 48 hours later).</p> <p>CNA 1 was assigned to care for Resident 1. During an interview on 5/22/24 at 10:04 AM, CNA 1 stated Resident 1 was on bedrest. When asked if the nurses said not to use a Hoyer lift on Resident 1, CNA 1 stated They just told me he was on bedrest.</p> <p>On 5/23/24, the facility was asked to provide their policy regarding endorsement to the next shift. Review of the policy sent by the facility found no such policy. The policy sent by the facility was titled FALL PREVENTION PROGRAM-SNF, revised 8/17. A search of the policy provided found no language about reading the physician's notes and passing on recommendations to the next shift.</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
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