STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055466	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Sequoias	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31922 Based on observation, interviews, and record review the facility failed to ensure there was a clean comfortable homelike environment when these two issues were found: 1. Two window screens had gaps. 2. Washbasins in four different rooms were found stored on the bathroom floor. Failure to ensure window screens were properly maintained had the potential to allow flying pests into residents' living spaces. Failure to store Resident's washbasins in a sanitary manner had the potential for residents to be exposed to dirty personal care equipment or infectious agents. Findings: Washbasins During observation on 5/20/24 at 9:43 AM, a washbasin was found stored on the bathroom floor in room [ROOM NUMBER]. During observation on 5/20/24 at 10:27 AM, a washbasin was found stored on the bathroom floor in room [ROOM NUMBER]. During observation on 5/21/24 at 10:37 AM , a washbasin was found stored on the bathroom floor in room [ROOM NUMBER]. During observation on 5/21/24 at 10:38 AM , a washbasin was found stored on the bathroom floor in room [ROOM NUMBER]. During an interview on 5/23/24 at 9:44 AM, the Staff Development (SD) Nurse stated staff were trained to use these washbasins sometimes to clean the patient's body including their private areas. The SD Nurse was shown three pictures of washbasins stored on the floor in three different bathrooms. The SD Nurse stated No they should not be storing .(these washbasins) like that. I'll in-service to correct that. (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was asked to provide their policy regarding storage of washbasins on 5/23/24. On 5/24/24, the facility provided a policy titled Cleaning and Disinfecting Non-Critical Resident-Care Items, revised on June 2011. Review of the policy found no mention of washbasins and no information about proper storage of wash basins after use. Window Screens During observation on 5/22/24 at 12:00 PM, room [ROOM NUMBER] and 10's window screens were noted to have gaps between the window opening and the outer frame of the window screens. These observations were confirmed with LVN 2. Review of the facility's policy titled SCHEDULED MAINTENANCE, not dated, indicated .The Director of Plant Operations will also conduct a grounds inspection (externally) once a week and identify any areas of concern such as: dead foliage, weeds, pot holes in pavement, trees/lawn issues, etc. (see attached external grounds checklist) . The attached external grounds checklist indicated .Window/Screens . should be checked during these weekly inspections.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 31922 Based on interview and record review the facility failed to transmit one of 12 sample residents' MDS (Resident 22) in a timely manner and failed to complete and transmit one of 12 sample residents' MDS (Resident 26). Failure to transmit required assessments violated the facility's contractual agreement with the State and CMS. Additionally, the facility failed to provide a policy governing the tracking and timely transmission of MDSs. Findings: During a concurrent interview and record review on 5/23/24 at 11:08 AM, the MDS Nurse was invited to review MDS for Resident 22 and Resident 26. The MDS Nurse acknowledged Resident 22's MDS was transmitted late and Resident 26's MDS was incomplete. The facility was asked to provide their policy regarding timely completion and transmission of MDS. The document submitted by the facility appears to be pages out of a Resident Assessment (RAI) manual published by CMS, dated October 2023. The document did not contain critical elements of a policy (such as General Information, Purpose, Policy, Procedure) and did not address how the facility should have a system in place to track when MDS are due and when they should be submitted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31922 Based on interviews and record reviews the facility failed to accurately code Resident 10's Minimum Data Set (MDS) assessment, one of 12 sample residents. Failure to accurately code Resident 10's assessment regarding restraints did not ensure health care providers could make safe and individualized health care decisions/recommendations based on Resident 10's MDS. Additionally, the facility failed to provide a policy regarding accurately coding a resident's MDS assessment. Findings: Review of Resident 10's MDS assessments dated 11/14/23 and 2/14/24 indicated the MDS nurse coded him as having a restraint. On 5/22/24 at 12:00 PM during an observation and concurrent interview, Resident 10 stated he was never restrained. Observation indicated there no signs of restraints in his room and Resident 10's wheelchair had no restraints nor were there any restraints on his bed. During an interview on 5/22/24 at 10:29 AM, the MDS Nurse stated I don't know why .(the MDS dated [DATE] and 2/14/24 were) coded as a restraint. I'll do a correction and re-submit. The facility was asked to provide their policy regarding accurate coding of MDS data. The document sent by the facility was not a policy but what appears to be pages out of a Resident Assessment (RAI) manual published by CMS, dated October 2023. The document did not contain critical elements of a policy (such as General Information, Purpose, Policy, Procedure) and did not address how the MDS nurse should gather and verify data (either through observation, record reviews or staff/resident interviews) prior to coding a resident's MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31922 Based on observation, interviews, and record review the facility failed to develop an individualized care plan for one of 12 sample residents (Resident 11). The facility failed to address Resident 11's behavior of refusing footrests for her wheelchair. Failure to develop an individualized care plan did not ensure the facility was providing care tailored to Resident 11's personal needs. Findings: During observation on 5/21/24 at 1:30 PM, Resident 11 was seen in her wheelchair. The bottom half of her left leg and foot was bent under the seat of her wheelchair. Resident 11 was seen dragging her left leg under her wheelchair as she wheeled herself down the hallway. During an interview on 5/21/24 at 1:31 PM, LVN 2 stated Resident 11 has a history of refusing footrests for her wheelchair. A follow up interview with Resident 11 indicated she does not want a footrest as she believes that the footrest would tip her wheelchair. LVN 2 was asked to search Resident 11's medical record for evidence that this behavior was care planned. LVN 2 stated the behavior was not care planned. Review of the facility's policy titled CARE PLANNING/ INTERDISCIPLINARY TEAM CARE PLANNING CONFERENCE, effective 3/24, indicated To assure that all residents care needs are identified through continuous assessments and that those needs are care planned with corresponding measurable objectives and adequate interventions. All residents will have a comprehensive care plan to meet their individual needs that is . periodically reviewed and revised after subsequent assessments.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on interview, and record review, the facility failed to ensure there was monitoring for adverse side effect (harmful effects suspected to be caused by a medicine) or behavioral monitoring for Ambien (same as Zolpidem, a drug used to treat insomnia) for one of 3 sampled residents (Resident 136). This failure could result in Resident 136 receiving unnecessary use of, ineffective, and/or lack of monitoring for psychotropic medications (any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic [a type of psychiatric medication which are available on prescription to treat psychosis]; (ii) Anti-depressant [prescription medicines to treat depression]; (iii) Anti-anxiety [drugs used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress]; and (iv) Hypnotic [a class of drugs that induce or prolong sleep in people with sleep disorders and are intended to improve the overall quality of sleep]) that could negatively affect the resident's highest practicable mental, physical and psychosocial well-being. Findings: Review of Resident 136's document titled, Profile Face Sheet indicated, she was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a common lung disease that blocks airflow and makes it difficult to breathe), generalized muscle weakness (a decrease in muscle strength), and insomnia (inability to sleep). Review of the document titled, MATRIX FOR PROVIDERS (a form used by the facility to list all current residents and to note pertinent care categories), dated 5/20/24 indicated, Resident 136 was on hypnotic. During a concurrent interview and record review on 5/24/24 at 11:17 AM with Licensed Vocational Nurse (LVN) 3, Resident 136's physician's orders (PO) dated 5/19/24 were reviewed. The PO indicated, Ambien 5mg (milligram) tablet [Zolpidem] -Give 2.5 mg by mouth at HS (Latin: [NAME] somni, at bedtime) For Insomnia AT BEDTIME . LVN 3 stated, I don't see any monitoring when asked if there was behavioral monitoring for Ambien. During a concurrent interview and record review on 5/24/24 at 11:55 AM with Infection Preventionist (IP), Resident 136's document titled, Baseline & Comp (comprehensive) Care Plan was reviewed. The care plan indicated, XXXXX (Resident 136's name) has medication concerns related to . Hypnotic . (A) Monitor . adverse side effects of medication . (A) Every shift recording of presence/absence of untoward mood/behaviors . related to psychotropic medications . IP stated, the care plan was initiated on 5/19/24, but there was no evidence of monitoring for adverse side effects or behaviors for Ambien. She stated, monitoring adverse side effects or behaviors was a part of the care plan, but it was not ordered for nurses to do the interventions when asked. She stated, There is no monitoring since 5/19 when asked. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/24/24 at 12:27 PM with LVN 3, Resident 136's documents were reviewed. LVN 3 stated, I don't see any sleeping hours when asked if there was monitoring sleeping patterns, sleeping hours, or anything regarding sleeping. She stated, I don't see anything. There's none. Review of the facility's policy and procedure (P&P) titled, Psychotherapeutic (a variety of treatments that aim to help a person identify and change troubling emotions, thoughts, and behaviors) Medication Management Program revised in June 2017 and reviewed in April 2024 indicated, . The focus of this policy is to ensure that all residents who receive psychotherapeutic mediations do so only when necessary to improve their wellbeing and that those medications are consistently monitored for effectiveness, the present of adverse consequences . This facility shall monitor all psychotherapeutic medications for effectiveness and adverse consequences .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49264 Based on observation, interview and record review, the facility failed to ensure that all medications were properly labeled in one out of one sampled medication carts when Resident 132's Prednisone (a medication used to decrease swelling in the body) label was not consistent with the physician order written in the electronic medical record (EMR). This failure has the potential to result in a medication error that could over dose a resident or under dose them. Findings: During a concurrent observation and interview on 05/21/24 at 9:30 AM with Licensed Vocational Nurse (LVN) 4, outside of Resident 132's room, LVN 4 was observed dispensing (taking out medication from its package) two tablets of Prednisone 1 milligram (mg) and one tablet of Prednisone 5mg. LVN 4 stated that they are administering a total of 7mg of Prednisone to Resident 132. A review of Resident 132's medication order for Prednisone, dated to start 05/28/24, indicated that Resident 132 should receive 7 mg (5mg+ 1mg + 1mg = 7mg Total) By Mouth Once daily (For Month of May give 7mg and starting June 1st 6mg daily) During a concurrent interview and record review on 05/21/24 at 11:50 AM with LVN 4, Resident 132's Prednisone medication labels, dated 05/18/24, were reviewed. The Prednisone 5mg tablet label indicated that Resident 132 should get 1 TAB [tablet] WITH 5MG (6MG) BY MOUTH ONCE DAILY. The Prednisone 1mg tablet label indicated that Resident 132 should get 1 TAB WITH 1MG (6MG) BY MOUTH ONCE DAILY. LVN 4 stated that the label did not match what was written in the EMR. LVN 4 stated that if the physician's medication order is different from the label on the medication, the medication should also have a sticker indicating a dosage change. LVN 4 verified that Resident 132's Prednisone did not have a sticker indicating a dosage change and stated, it should have that sticker. During an interview on 05/21/24 at 12:11 PM with the Director of Nursing (DON), the DON stated that medication labels should typically match the physician's written medication order. In instances that an order is changed but the medication can still be used, the DON stated that the LVN should place a dosage changed sticked on the medication label. The DON further stated that her expectation is that the licensed nurses always defer to the EMR for the most accurate written order. During an interview on 05/22/24 at 11:58 AM with Pharmacist 1, Pharmacist 1 stated that if a medication's ordered directions are changed but the facility would like to use the existing medication, she expects that a change of direction sticker be placed on the medication label to ensure that nurses follow the new order in the EMR. Pharmacist 1 further stated it is possible for a medication error to occur if a medication's label and the order in the EMR are not consistent and there is no sticker indicating a change in the direction of administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44477 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were met for food storage in the kitchen when there was a garlic oil container beyond its use-by date in the refrigerator. This failure had the potential to put residents at risk for foodborne illnesses. Findings: During a concurrent observation and interview on [DATE] at 11:05 AM with Director of Dining Services (DoDS), and Executive Chef (EC) in the kitchen, there was one peeled garlic oil container in the refrigerator with a use-by date of [DATE]. DoDS stated, the garlic oil was expired when asked. He acknowledged that it should have been tossed out. EC also acknowledged it was expired. EC stated, Yes when asked if it should have been tossed out. Review of the facility's policy and procedure P&P titled, PRODUCTION, PURCHASING, STORAGE revised in [DATE], indicated, . All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption . Foods past the use by, sellby, best-by, or enjoy by date should be discarded . Date and rotate items; first in, first out . Discard food past the use-by or expiration date . Review of the Guidance of Appendix PP, revised on [DATE], from Centers for Medicare and Medicaid Services (CMS) indicated, the facility should follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Appendix PP also indicated, unsafe food handling practices represent a potential source of pathogen (any organism, such as viruses or bacteria, that causes disease) exposure for residents. Review of U.S. Food and Drug Administration (FDA)'s 2022 Food Code indicated, . The Food Code states the person in charge of a food establishment is accountable for developing, carrying out, and enforcing procedures aimed at preventing food-borne illness .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 31922 Based on interview and record review, the facility failed to transmit their Payroll Based Journal (PBJ) data to Center for Medicare Services (CMS) in a timely manner. Failure to transmit staffing data did not ensure the facility was fulfilling their contract agreement with the State and CMS. Additionally, the facility provided an incomplete PBJ data transmission policy which lacked certain key policy elements. Findings: Review of CMS data base indicated the facility failed to transmit their Payroll Based Journal (PBJ, direct caregiver staffing data) data to Center for Medicare Services (CMS). During an interview on 5/20/24 at 3:42 PM, the Minimum Data Set Nurse (MDS Nurse) stated she was responsible for transmitting PBJ data to CMS. The MDS Nurse stated she did not have access to the CMS website, and she had to call IT (Information Technology) at CMS to get access. It was 48 hours before she was granted access. By that time, the deadline for PBJ data submission had passed. On 5/23/24 at 11:50 AM, the Director of Nursing was asked to provide a copy of their policy regarding PBJ data submission. The undated document provided by the facility was titled PBJ Reporting Export & conversion Process Guide. Review of the document indicated it was a process guide and was missing key elements of a standard policy such as: 1.Clearly states the policy's objectives and the expected behavior or actions. 2.Responsibilities: Outlines the roles and duties of individuals or departments involved. 3.Purpose.