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	08/07/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on observation, interview and record review, the facility did not provide Advanced Beneficiary Notice (ABN, a document informing residents Medicare will no longer pay for services and allows residents to make informed decisions on whether to continue certain services, which may incur out of pocket costs) to one (Resident 22) of three residents, when Resident 22 was discharged from Medicare Part A (temporary insurance which covers hospital and skilled nursing services) to long term care.This failure could have resulted in Resident 22 not given a chance to make informed decisions regarding his care or for his right to appeal.During a concurrent interview and record review on 8/6/2025 at 9:15 AM, with Social Worker (SW), Resident 22's Notice of Medicare Non-Coverage (NOMNOC, a document informing residents Medicare will no longer cover certain services and outlines appeals rights) was reviewed. Resident 22's NOMNOC indicated the notice was issued and signed by Resident 22's family member on 4/4/25. SW stated Resident 22 stayed in the facility under custodial care (long term care). SW stated the Skilled Nursing Facility Beneficiary Notice of Non-Coverage (SNFABN) was not used and one was not completed for Resident 22. SW further stated, I was reading about it and [the SNFABN] is required for long term residents.Review of the Guidance of Appendix PP, revised on 7/23/25, from Centers of Medicare and Medicaid Services (CMS) indicated, Inform each resident of services available in the facility and the charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate. As soon as reasonably possible when a change in coverage occurs; .

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to review and revise plan of care for Resident 32, one of 12 sampled residents, after 10 incidents of falls, to prevent further falls. This failure could result in resident's harm .Review of Resident 32's Facesheet, dated 8/5/24, indicated, Resident 32 was admitted on [DATE] with diagnoses including: Peripheral Vascular Disease (a condition that blood vessels are narrowed causing less blood flow to the limbs), Pain left leg , Cognitive Communication Deficit, Generalized Anxiety Disorder. During a concurrent observation and interview on 8/4/25 at 10:50 AM, in Resident 32's room, Resident 32 was observed in bed and had a caregiver(CG) from a private agency. CG stated she has been with patient for four years now, since last year doing 12 hour shift, was 24 hours before. CG stated Resident 32 was total care, could get agitated and confused, was able to stand up with small steps during transfer to wheelchair but cannot walk. CG stated Resident 32 had fallen but not on her shift and stated She gets scared when CG leaves for the day.Review of facility document, Fall Risk Assessment on admission. dated 8/21/23, indicated a score of 12 indicates high risk for fall.Review of facility document, Post Fall Assessment, dated 7/2/25, indicated a score of 24, high risk for falls with history of 3 or more falls.Review of facility document, Baseline and Comprehensive Care Plan for Falls, started 12/8/23. Resident then had 10 times unwitnessed fall, the latest was 8/6/25. Resident has a private caregiver during the day, has floor mats on both sides. Care plan did not indicate patient's representative's input on the goal and care of this resident. Review of MDS Section C, Cognitive Patterns, dated 6/5/25, not completed. No BIMS Summary Score. Review of Progress Notes by [NAME] ,Can MD (Geriatric Medicine), dated 7/30/25, indicated, Cognitive impairment diagnosis: No formal diagnosis of cognitive impairment but clearly has moderate to advanced dementia, likely AD. During an interview on 8/5/25 at 2:40 PM, with Occupational Therapist (OT), OT stated, Resident 32 had been falling and resident was on rehab for caregiver training to provide safest care. OT stated nurses did the fall risk assessment and approaches .During an interview on 8/6/25 at 10:05 AM, with Licensed Vocational Nurse (LVN), LVN stated she knew Resident 32, and worked for 4 years at facility. OT stated she was aware of resident's frequent falls at night, We check [Resident 32] frequently and when she's humming that means she is awake. OT stated Resident 32's family member was aware of the falls, [Resident 32] had 24/7 caregiver before and always had floor pads. During an interview on 8/6/25 at 10:30 AM, with Director of Nursing (DON), DON stated, It's a day to day basis, we cannot plan the day for her. She is falling even when caregiver is there. She has a private caregiver, she has floor pads. Nurses updates the care plan interventions and MDS to complete.During an interview on 8/6/25 at 11:00 AM, with Certified Nursing Assistant (CNA), CNA stated Resident 32 fell on her shift one time, patient was dreaming she wanted to go to school and was late already. CNA stated Resident 32 was getting anxious and needed to be calmed down. Review of facility Policy and Procedure, Fall Prevention Program-SNF., dated 4/24. Purpose: To prevent accidents and injuries by providing an environment that is free from hazards over which the facility has control. Policy: All resident's environment shall remain as free of hazards as is possible, and residents shall receive adequate supervision and assistive devices to prevent accidents. Procedure: Fall Prevention :b. If a resident triggers a risk for falls, the IDT shall further assess the fall risk factors and shall, if indicated, further update the care plan to minimize the risk of falls utilizing the Falling Star program criteria if appropriate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure controlled medications (narcotics that have high abuse potential) were fully accounted for when a random controlled medication use audit for two out of four sampled residents (Residents 4, 24) did not reconcile. The residents' medications were signed out of the Controlled Drugs Records (CDR, inventory record of controlled drugs) but not documented on the Electronic Medication Administration Record (eMAR, record of medications administered to a resident) to indicate they were administered to the residents. This failure resulted in inaccurate accountability of controlled medications and had the potential for abuse and narcotic diversion (unlawful distribution or use) of controlled medications. Findings: During the survey, the CDRs for four random residents receiving as-needed (PRN) controlled medications were selected for review. On 8/5/25 at 1:40 p.m., a concurrent interview and record review with the Director of Nursing (DON), the DON stated any time a PRN controlled medication was requested from the resident, the Licensed Nurse will administer the controlled medication after reviewing the medication orders, checking the time of administration, and documenting on the CDR and on the eMAR. A. A review of Resident 4's physician orders indicated an order for Oxycodone (a potent narcotic for pain) 5 milligrams (mg, unit of measurement), take 0.5 tablet to 1 tablet (2.5 mg to 5 mg total) by mouth every 6 hours as needed for moderate pain, start date 7/7/25. On 8/5/25 at 2: 25 p.m., a review of Resident 4's CDR for Oxycodone 5 mg and July 2025 medication administration record eMAR with a Licensed Nurse 1 (LVN1) indicated the nursing staff signed 1 tablet out of the CDR, but did not document the administration on the eMAR on two occasions: on 7/27/25 at 9 p.m. and 7/30/25 at 8:22 p.m. After reviewing the resident's clinical records including the eMAR and the nursing progress notes, LVN1 verified no documentation of administration was present, stating No, I don't see it. When asked about the process for controlled medication administration, LVN1 stated the nurse Put it on the eMAR first, then go to the resident (to administer), then sign out of narcotic (CDR) book. After medication is given, then click (document) on eMAR. B. A review of Resident 24's clinical record indicated she had a physician's order for Tramadol (Brand name: Ultram, a strong painkiller to treat pain) 25 mg, give 1 tablet by mouth every 4 hours as needed for moderate pain, start date 7/17/25. On 8/5/25 at 2:08 p.m., a review of resident 24's CDR for Tramadol 25 mg and the July 2025 MAR with LN1 indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the eMAR on three occasions: on 7/20/25 at 6 a.m., 7/23/25 at 2:38 p.m. and 9:00 p.m. In addition to the above medication order, Resident 24 also had a medication order for Tramadol 50 mg, give 1 tablet by mouth every 4 hours as needed for severe pain, start date 7/16/25. A review of resident 24's CDR for Tramadol 50 mg and the July 2025 MAR with LN1 indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR: on 7/20/25 at 12:30 p.m. LVN1 verified the findings and stated the medication administration should have been documented on the MAR During a concurrent interview and record review on 8/5/25 at 2:35 p.m. with LVN1 and DON, LVN1 reported the findings to the DON and stated after reviewing Resident 4 and Resident 24's clinical records, controlled medications were not documented on the MAR for two residents. The DON stated the CDR is a count sheet and verified the MAR should have also been signed when the controlled medications were given. Review of the facility's policy and procedure titled Medication Administration, reviewed/revised on 4/2024, indicated The licensed nurse shall chart the date and time of each administered medication.If the medication is given on a per need (PRN) basis, the time shall be noted on the eMAR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety, when a carton of orange juice and 4 cartons of apple juice and a paper cup wrapped in plastic, inside the refrigerator in the pantry, has no expiration date, has no use by date, cup has no label. This failure has the potential to put residents at risk for foodborne illnesses.During a concurrent observation and interview on 8/4/25 at 10:30 AM, with Registered Dietitian (RD), in the refrigerator in the pantry, found one orange juice carton, and four apple juice cartons, with no expiration date and no use by date, and one paper cup wrapped in plastic no label. RD stated, every food stored in the refrigerator should have expiration dates or use by dates and should be labeled. Review of facility Policy and Procedure: Food and Supply Storage, dated 1/24, indicated, Policies: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain safety an wholesomeness of the food for human consumption. Procedures : . Most, but not all, products contain an expiration date.Foods past the use by , sell by, best by date should be discarded. Cover, label and date unused portions and open packages.Review of the Guidance of Appendix PP, revised on 7/23/25, from Centers of Medicare and Medicaid Services (CMS) indicated, When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and coverage, labeling and dating all stored foods in the refrigerator or freezer as indicated.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use was implemented when: 1. The Infection Preventionist (IP, a licensed nurse that has specialized training in infection prevention) did not communicate or provide notification to the primary medical doctor when the residents' presenting symptoms did not meet criteria for antibiotic use based on McGeer criteria (Standardized criteria to help consistently identify and classify infections treated with antibiotics) for 2 out of 6 residents (Residents 22 and 17).2. The IP did not track the antibiotic use for 1 out of 6 residents (Resident 26).This failure resulted in antibiotics being prescribed without the qualified indication (use) or monitoring and had the potential for adverse outcomes and the development of antibiotic- resistant organisms. Findings:During an interview on 8/7/25 at 9:31 AM with the Infection Preventionist (IP), the IP stated when antibiotic medication is administered, he utilizes the McGeer Criteria for qualification of antibiotic use based on the resident's presenting symptoms, communicates the determination with the physician, and updates a tracking spreadsheet for monitoring all residents receiving antibiotics. The IP further stated if the antibiotic use qualifications are not met based on McGeer Criteria he would communicate with physician and would ask for what to do next. During a concurrent interview and record review on 8/7/25 at 10:05 AM with the IP, Resident 26's Physician's Orders were reviewed. Resident 26's Physician's Orders indicated, Methenamine (an antibiotic used to treat or prevent urinary tract infection [UTI]) 1 gram (a unit of measurement) 1 tablet by mouth twice daily UTI prevention, was dated 7/15/25. The IP stated he did communicate antibiotic order with the physician, but did not add Resident 26 to the tracking spreadsheet for antibiotic use monitoring. The IP stated, It should have been included because it is an antibiotic. During a concurrent interview and record review on 8/7/25 at 10:07 AM with the IP, facility document titled, Safety Meeting - Infection Control was reviewed. Safety Meeting - Infection Control, dated 7/30/25, indicated Resident 17 had an antibiotic order for Cephalexin (Brand name: Keflex, an antibiotic used to treat infections) 500 milligrams (mg, unit of measurement) 1 tablet by mouth twice daily for seven days for UTI. The IP stated Resident 17 did not have any presenting UTI symptoms and therefore did not meet McGeer criteria for antibiotic use. The IP was unable to provide documentation of physician notification for further guidance. The IP stated Resident 17 completed a full dose of antibiotic therapy. During a concurrent interview and record review on 8/7/25 at 10:13 AM, with the IP, facility document Safety Meeting - Infection Control was reviewed. Safety Meeting - Infection Control, dated 7/30/25, indicated Resident 22 had physician orders on 6/16/25 for Azithromycin (an antibiotic to treat infections) 500mg 1 tablet by mouth daily for 5 days and Ceftriaxone (an injectable antibiotic for infections) 1 gram solution for injection intramuscularly daily for three days for pneumonia. The IP stated Resident 22 did not have any presenting respiratory symptoms, but was weak, lethargic, and had a change in level of consciousness. The IP stated Resident 22 did not meet McGeer criteria for use of the two antibiotics. After reviewing his notes, the IP stated he had no documentation of physician notification about this. He confirmed Resident 22 completed all antibiotic therapies. During a phone interview on 8/7/25 at 11:11 a.m., with the consultant pharmacist (CP, a contracted pharmacist that provides consultation for medication program), the CP stated she meets with the IP quarterly to review infection control and vaccination status for all residents. The CP further stated, If not met McGeer criteria, the nurse would notify the doctor, and she (the physician) will decide whether the resident will continue the antibiotic. Review of the facility policy and procedure titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes reviewed/revised on 8/2022, indicated The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent wit the appropriate use of antibiotics.At the conclusion of the review, the provider will be notified of the review findings.