STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods Post-Acute	1267 Meridian Avenue San Jose, CA 95125

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to provide written notice prior to multiple room changes for one of four sampled residents (Resident 1). This failure had the potential to compromise Resident 1's rights. Also, there was no documentation that the facility monitored Resident 1 after one room change. This failure had the potential to compromise the facility's ability to identify complications related to the room change and implement interventions accordingly. Findings: Review of Resident 1's clinical record indicated he was admitted on [DATE]. Further review of the clinical record indicated the facility implemented room changes for Resident 1 on 11/15/23, 11/17/23, and 1/2/24. During a telephone interview and concurrent record review with social services staff C (SS C) on 6/25/24, at 1:13 p.m., SS C reviewed Resident 1's clinical record remotely (from a location outside of the facility) and confirmed Resident 1 had room changes on the dates mentioned above. SS C explained when the facility implements room changes, they should complete a Room Transfer form (document that explains the reason for the room change and that must be signed by the resident), complete a consent form, and do behavior/psychosocial monitoring for 72 hours. SS C confirmed for Resident 1's room changes on 11/15/23, 11/17/23, and 1/2/24, there was no documentation that indicated the facility completed a Room Transfer form or a consent form prior to the room changes. SS C also confirmed for Resident 1's room change on 1/2/24, there was no documentation that indicated the facility did behavior/psychosocial monitoring for 72 hours. Since SS C was reviewing Resident 1's clinical record remotely, licensed nurse D (LN D) was also asked to review the record. During an interview and concurrent record review with LN D on 6/25/24, at 1:43 p.m., LN D reviewed Resident 1's medical record and confirmed for the room changes on 11/15/23, 11/17/23, and 1/2/24, there was no documentation that indicted the facility completed a Room Transfer form or a consent form prior to the room changes. LN D also confirmed for Resident 1's room change on 1/2/24, there was no documentation that indicated the facility did behavior/psychosocial monitoring for 72 hours. The facility's policy titled Room Change/Roommate Assignment, revised 3/2021, indicates the resident is given advanced written notice prior to a room change.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 37686 Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS, an assessment tool) for one of four sampled residents (Resident 1). The failure to accurately assess had the potential to compromise the facility's ability to develop and implement interventions to meet the resident's needs. Findings: Review of Resident 1's clinical record indicated he was admitted on [DATE] and had diagnoses including congestive heart failure (a condition in which the heart does not pump blood as well as it should), ascites (fluid in the abdominal cavity that causes swelling), muscle weakness, and abnormalities of gait (walking) and mobility (ability to move freely). Review of Resident 1's situation, background, assessment, recommendation (SBAR, a communication form), dated 12/21/23, indicated Resident 1 was seen on the floor. During an interview and concurrent record review with MDS nurse A (MDSN A) on 6/25/24, at 10:46 a.m., MDSN A reviewed Resident 1's clinical record and confirmed the resident fell on [DATE]. MDSN A stated this fall should have been coded on Resident 1's MDS, dated [DATE]. MDSN A reviewed Resident 1's MDS, dated [DATE], and confirmed section J1800 was coded No, indicating Resident 1 did not fall during the specified time frame. MDSN A confirmed section J1800 should have been coded Yes, to indicated Resident 1 fell during the specified time frame. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2023, indicated for section J1800, Code 1, yes if the resident has fallen during the specified time frame.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards for one of four residents (Resident 1) when: 1. There were multiple days for which there was no documentation that the facility obtained Resident 1's daily weight as ordered by the physician, and 2. There were multiple days for which there was no documentation that the facility notified Resident 1's physician of an abdominal girth (measurement of distance around the abdomen) increase of more than three centimeters (cm, unit of measurement). These failures had the potential to negatively affect the resident's health and well-being. Findings: 1. Review of Resident 1's clinical record indicated he was admitted on [DATE] and had diagnoses including congestive heart failure (a condition in which the heart does not pump blood as well as it should) and ascites (fluid in the abdominal cavity that causes swelling). Review of Resident 1's Order Summary Report indicated he had a physician's order, dated 10/30/23, for daily weights and to inform the physician if Resident 1 gained two pounds or more in a day. Further review of the clinical record indicated the facility was documenting Resident 1's daily weights on the medication administration record (MAR). Resident 1's MAR was reviewed. From 11/1/23 to 2/29/24, there were 29 days for which the section designated to document Resident 1's daily weight was left blank. Further review of Resident 1's electronic and paper clinical record (aside from the MAR) indicated there was no documentation that the facility obtained Resident 1's daily weight on those 29 days. There was also no documentation that indicated Resident 1 refused to be weighed on those days. During an interview and concurrent record review with licensed nurse B (LN B) on 6/25/24, at 12:03 p.m., LN B reviewed Resident 1's clinical record and confirmed there were several days on the MAR for which the section designated to document Resident 1's daily weight was left blank. LN B stated if the resident refused to be weighed, this should be documented either on the MAR or a nurse's note. LN B further reviewed Resident 1's clinical record and confirmed there was no documentation that the facility obtained Resident 1's daily weight on the days for which the designated section on the MAR was left blank. LN B also confirmed there was no documentation that indicated Resident 1 refused to be weighed on those days. The facility's policy titled Charting and Documentation, revised 7/2017, indicated all services provided to the resident shall be documented in the resident's clinical record. The policy further indicated that documentation will include whether the resident refused a procedure or treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 1's clinical record indicated he had a physician's order, dated 1/17/24, to measure abdominal girth every day and notify the physician of an increase of more than three cm. Further review of the clinical record indicated the facility was documenting Resident 1's abdominal girth measurements on the MAR. Resident 1's MAR was reviewed. On 3/2/24, 3/7/24, 3/14/24, 3/25/24, and 4/7/24, the documentation on the MAR indicated Resident 1's abdominal girth increased by more than three cm compared to the previous day. There was no documentation in the clinical record that indicated the facility notified Resident 1's physician of the increase in abdominal girth on the above dates. During an interview and concurrent record review with LN B on 6/25/24, at 12:03 p.m., LN B reviewed Resident 1's clinical record and confirmed there was a physician's order to measure abdominal girth every day and notify the physician of an increase of more than three centimeters. LN B confirmed that the documentation on the MAR indicated Resident 1's abdominal girth increased by more than three cm compared to the previous day on the dates mentioned above. LN B confirmed there was no documentation in the clinical record that indicated the facility notified Resident 1's physician of the increase in abdominal girth on those dates.