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	10/25/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on interview and record review, the facility failed to provide services to promote healing of pressure ulcers (damage to the skin and underlying tissue as a result of prolonged pressure) for one of 3 residents (Resident 1) when the licensed nurse did not obtain pressure ulcer measurements and no treatment order was obtained for 6 days for Resident 1's pressure ulcer. These failures had the potential to delay treatment and potentially lead to new or worsening pressure ulcers. Failure to obtain measurements had the potential to compromise the facility's ability to determine whether Resident 1's pressure ulcer was increasing or decreasing in size. Findings: Review of Resident 1's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including fracture of second and third lumbar vertebrae (small bones forming the backbone in the lower back), hemiplegia and hemiparesis (paralysis and weakness) affecting left side, obesity (too much body fat), type 2 diabetes (a condition which affects blood sugar), history of diabetic foot ulcer (open sore or wound), congestive heart failure (heart cannot pump enough blood to meet the body's needs), anemia (low levels of healthy red blood cells, hypertension (increase in blood pressure),muscle weakness, abnormalities of gait and mobility, and need for assistance with personal care. Review of Resident 1's Braden scale assessment (tool used in wound assessment) dated 6/18/24 indicated she had a score of 16 (a score of 15-18 represents a risk for developing pressure ulcers). Review of Resident 1's pressure injury skin assessment dated [DATE], indicated a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure wound to Resident 1's bilateral buttocks. There were no measurements of Resident 1's bilateral buttocks pressure injury on the skin assessment form. Review of Resident 1's Order Summary Report indicated there was no physician order for treatment to the pressure ulcer on Resident 1's bilateral buttocks until 6/24/24, and six days after the facility identified the pressure ulcer on admission on 6/18/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the treatment nurse (TN) on 9/5/24 at 1:15 p.m., she stated she performs treatments and wound assessments every week for residents in the facility, and stated she first assessed Resident 1's skin and wounds on 6/18/24. The TN reviewed Resident 1's Pressure Injury Skin Assessment document from 6/18/24 and confirmed there were no measurements of Resident 1's wounds. The TN stated she completed the form and identified the wounds but did not measure anything. The TN confirmed the measurements should be there and further stated all wounds should be measured during the weekly skin review to assess if treatments are effective. The TN reviewed Resident 1's physician orders and confirmed there was no treatment order for Resident 1's pressure ulcer until 6/24/24, 6 days after admission, when she first identified the Stage II pressure ulcer. The TN stated there should be a treatment order obtained from the physician when the pressure ulcer is first identified. During an interview and concurrent record review with the director of nursing (DON) on 9/5/24 at 1:45 p.m., she reviewed Resident 1's pressure injury skin assessment dated [DATE] and confirmed there were no measurements documented for Resident 1's stage II pressure ulcer. The DON stated all wounds should have been measured on admission, or when first identified, and recorded on the skin assessment document. The DON reviewed Resident 1's physician orders and confirmed there was no treatment order obtained until 6/24/24 to treat Resident 1's pressure ulcer. The DON stated the MD should have been notified and a treatment order obtained when a pressure ulcer was first identified. A review of the facility's undated policy, Pressure Injury Risk Assessment indicated to Conduct a structured pressure injury risk assessment using a facility-approved tool. The risk assessment should be conducted as soon as possible after admission. In addition, the policy indicated Documentation . The following information should be recorded in the resident's medical record utilizing facility forms .5. The condition of the resident's skin (i.e., the size and location of any red or tender areas) if identified.