STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555813	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Oaks Nursing Center	3635 Jefferson Avenue Redwood City, CA 94062

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50147 Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission for two of two new admissions: Residents 18 and 36. This failure had the potential to negatively affect continuity of care and communication for nursing staff, decreasing resident safety, and an inability to monitor the resident's progress based on their changing needs and preferences. Findings: During a concurrent interview and record review on 1/14/25 at 3:55 p.m., with the Minimum Data Set (MDS- a standardized assessment tool used to comprehensively evaluate the health status of each resident) Coordinator, the facility's policy and procedure (P&P) titled, Preliminary Care Plans, dated August 2006 was reviewed. The P&P indicated a preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty- four (24) hours of admission . to assure that the resident's immediate care needs are met and maintained. Resident 18 was admitted on [DATE]. In review of Resident 18's electronic medical record in the three care areas of pain management, position/mobility, and anticoagulant (AC- is commonly known as a blood thinner, is a chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time), the MDS Coordinator was unable to find any baseline care plan, and stated there is none. During a concurrent interview and record review on 1/17/25 at 9:15 a.m., with the MDS Coordinator in his office, Resident 36's baseline care plan was reviewed. Resident's 36's care plan indicated there was no care plan for Activities of Daily Living (ADL- the basic tasks people perform every day to care for themselves like bathing, dressing, eating, etc.) and position/mobility. MDS Coordinator acknowledged there was no care plan.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48700 Based on observation, interview, and record review the facility failed to complete a comprehensive care plan for one of three sampled resident (Resident 4) when there was no evidence of documentation of a completed comprehensive care plan for foley catheter for Resident 4 This deficient practice had the potential to result in inadequate care and services rendered to Resident 4. Findings: Review of the Admission Record, dated 1/15/2025, indicated, Resident 4 was readmitted to the facility on [DATE], original admitted [DATE]. Review of the Admission History and Physical, dated 12/5/2024 indicated, the diagnoses that included, Hemiplegia and Hemiparesis (both are terms to describe weakness or inability to move muscles on one side of the body) following a cerebrovascular disease (disrupt blood flow to the brain leadin to lack of oxygen and nutrients) affecting left non dominant side, retention of urine, unspecified. During an interview on 1/16/2025 at 11:26 a.m., with Social Services (SS), SS stated, we still didn't do Interdisciplinary Team (IDT) meeting for resident 4 because we don't have time yet, but I already communicate with the family about it. During an observation on 1/16/2025 at 3:09 p.m., at room [ROOM NUMBER]B, Certified Nursing Assistant 1 (CNA1) entered the room and went directly to bed B then started searching for something on the sides of the bed, CNA1 found the urinary bag beside the left hip of resident 4. In concurrent record review and interview dated 01/16/2025 at 3:20 p.m., Director of Nursing (DON) stated there was no comprehensive care plan regarding urinary catheter, sorry i missed it, and acknowledged that there was no evidence of documentation of a completed comprehensive care plan for Resident 4. A review of the Policy and Procedure titled, Care Plans, Comprehensive revised 10/2010, the policy statement indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's care planning/Interdisciplinary Team, in coordination with the resident, his family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 3. Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas b. Incorporate risk factors associated with identified problems, f. Identify the professional services that are responsible for each element of care .

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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** 43913 Based on observation, interview, and record review, the facility failed to assess and review resident's status after an identified change of condition on one resident (Resident 12), when resident 12 had a change of condition on 1/5/25, no care plan and no interdisciplinary documentation and monitoring of change of status. This failure has potential for resident's needs not being met. Findings: Review of Resident 12' s, Admission record, dated 1/16/25, indicated, admitted on [DATE] with diagnoses including: Dementia (progressive decline in cognitive abilities such as memory, thinking, reasoning, and problem-solving) without behavioral disturbance, Other Seizures (uncontrolled movements, behaviors, sensations or states of awareness), Diabetes Mellitus (increased blood sugar requiring medication), Down Syndrome (a genetic disorder that causes distinct facial appearance and developmental delays). Review of facility progress notes, dated 1/5/25 at 11:58 p.m., indicated, around 6:48 p.m., the resident has an episode of seizure lasted 15 seconds and episode of desaturation (decrease of oxygen in the blood) around 88% RA (room air), BP 154/78, PR-98, Temp 98.3 RR-19. Blood sugar 273 md/dl. Gave oxygen at 2Lpm o2 sat increased to 95% via nasal cannula. No sob (shortness of breath - difficulty breathing) noted, not in distress. Informed MD via tigerconnect with order of STAT (immediate) CBC (blood work), CMP (blood work to check certain proteins, electrolytes, and minerals in the body) , stat Chest x-ray and follow up with neurologist (a medical doctor specializing in diagnosing, treating, and managing disorders of the brain, spinal cord, and nerves) . Also left voicemail to Responsible Party (RP) regarding the resident's condition Review of Physician Order, dated 1/7/25, indicated, Dextrose Intravenous Solution 5% (Dextrose) (a type of sterile water with sugar). Use 50 cc intravenously every shift for supplement x 2 liters. Ceftriaxone (a medication to treat infections) Sodium Solution Reconstituted 1 GM use 1 gram intravenously (given through a vein) every 24 hours for infection until 1/15/25. During a concurrent interview and record review on 1/14/25 at 12:00 p.m., with Director of Nursing (DON), DON stated resident had a change of condition on 1/5/25, resident is non verbally responsive, but alert. DON stated, there should be a care plan for UTI (urinary tract infection), she is on IV antibiotic, urine C&S (culture and sensitivity - bacteria are grown and identified to make treatment more specific) was collected and waiting for result. DON stated resident is on IV hydration due to kidney failure. DON acknowledged no care plan for UTI and for dehydration. During an interview on 1/16/25 at 10:00 a.m., with MDS(Minimum Data Set) Nurse, per MDS, there should be a care plan and IDT (interdisciplinary Team meeting - a team of individuals with different expertise coming together to achieve a common goal) after a change of condition. We are in the 14-day assessment period if new MDS will be completed for the significant change of condition. MDS acknowledged there is no care plan and no IDT meetings documented at the start of the change of condition on 1/5/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50147 Based on interview and record review, the facility failed to ensure controlled medications (medications that can be easily abused and are under strict government control) without witness signatures for two residents, Resident 1 and Resident 2. This failure had the potential for controlled drug abuse or diversion (when the transfer of any legally prescribed substance from the individual for whom it was prescribed to another person for any illicit use). Findings: During a concurrent interview and record review on [DATE] at 3:31 p.m., with Director of Nursing (DON) in the med room, the Polaris Rx Narcotic (a drug or other substance that affects mood or behavior and is consumed for nonmedical purposes, especially one sold illegally) Destruction Log dated [DATE] was reviewed. The Polaris Rx Narcotic Destruction Log indicated there were no signatures or dates of destruction witnessing the waste (drugs that can no longer be used because of being expired, unused, spilled, withdrawn, recalled, damaged, contaminated, or for any other reason) of: lorazepam (a medication prescribed for anxiety and sleep) 0.5 mg, 26 tabs, for Resident 1 morphine sulfate (an oral liquid medication prescribed for severe pain) 20 mg/ml sol, 30 ml for Resident 1 morphine sulfate 20 mg/ml sol, 30 ml for Resident 1 lorazepam 0.5 mg, 5 tabs, for Resident 1 oxycodone (a medication prescribed for severe pain) 5 mg, 16 tabs, for Resident 2 During a concurrent interview and record review on [DATE] at 9:40 a.m., with the Licensed Nursing Home Administrator (LNHA) and Business Office Associate, in the LNHA's office, the Polaris Rx Narcotic Destruction Log dated [DATE] was shown to them and reviewed. The LNHA stated, Everyone knows that two signatures are required by a registered pharmacist and licensed nurse, especially for controlled substances. During a concurrent phone interview and record review on [DATE] at 2:00 pm with the Consulting Pharmacist (CP), the Polaris Rx Narcotic Destruction Log dated [DATE] was reviewed. CP confirmed he signed/witnessed the same March Narcotic Destruction Log for three other medications on [DATE]; however, did not recall Residents 1 and 2, had no recall of the disposition of the five unwitnessed, undated narcotics. Additionally, he states that the next monthly narcotic destruction log is dated [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, dated [DATE] was reviewed. The P&P indicated, D. Scheduled II-V controlled substances remaining in the facility after a resident has been discharged , or the order discontinued, are disposed of in the facility by the director of nursing or designated facility registered nurse in conjunction with the pharmacist . F. The nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability record/book: 1. Date of destruction 2. Resident's name 3. Name and strength of medication 4. Prescription number 5. Amount of medication destroyed 6. Signatures of witnesses

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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. 26875 Based on interview and record review, the facility failed to 1. offer snacks to every resident who did not have contraindications. Total residents' census on 1/13/2025 was 29 residents. 2. Unpasteurized eggs were provided to residents who wanted fried eggs for breakfast on 1/14/2025. 3. The temperature of the water at the handwashing sink in the kitchen did not reach a level warm enough for washing hands. This failure resulted in possible contaminated food to residents, residents who did not receive a snack, and insufficient warm water for kitchen staff to wash their hands with. Findings: 1.) During an interview on 1/15/2025, at 10:20 a.m., the Dietary Manager stated, Residents have to ask for snacks because a lot of it gets thrown away and wasted . Residents who can't ask for snacks need a recommendation by the dietician, nurse or doctor. Review of Nourishment Policy, dated 2023, indicated, Policy: Nourishments or between meal snacks shall be provided when required by the diet prescription. Bedtime snacks of a nourishing quality will be offered routinely to all residents unless contraindicated . It is the Nursing department's responsibility to see that each resident receives the nourishments, as ordered . 2.) During a concurrent observation and interview on 1/15/2025 at 10:20 a.m., the Dietary Manager, 12 dozen unpasteurized eggs were in the refrigerator. Dietary Manager stated, the resident's were given unpasteurized eggs for breakfast on 1/14/2025. The pasteurized eggs are hard to get, they don't have any. Dietary Manager stated he orders pasteurized eggs but he receives unpasteurized eggs because the company doesn't have pasteurized eggs. Review of the facility Menu for the period January 13 - 19, 2025 indicated for Tuesday, January 14, 2025 breakfast consisted of: Fried Egg, Buttered Wheat Toast, Raisin Bran, Pineapple Juice. Review of the Dietary Manager's invoice egg order, dated 12/26/2024, showed an order for one case of 15 dozen shell eggs, pasteurized, not ordered. An order for 15-2 lb. cartons of liquid eggs, pasteurized, was ordered, on the same invoice. Review of the Dietary Manager's invoices for period covering 10/10/2024-12/26/2024, indicated shell eggs were either not ordered or ordered and pasteurized was not requested. 3.) The temperature of the water on 1/13/2025 at the kitchen hand washing sink was 96.6 degrees Fahrenheit, at its highest, and felt cold to the touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations of the water temperature to the touch on 1/14/2025, 1/15/2025, and 1/16/2025, the water was cold. During an interview on 1/17/2025, at 10:30 AM, Dietary Manager stated the water temperature is usually about 100 degrees Fahrenheit he agreed it felt cold.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on observation, interview and record review, the facility failed to develop a coordinated plan of care and communication process with the Hospice agency, when there was no care plan to address what services Hospice will provide and for facility and when to notify Hospice for two of two Hospice residents, (Resident 4 and Resident 28). This failure has the potential to place residents health and well -being at risk of harm. FINDINGS: 1. Review of Resident 28's Admission record dated [DATE], indicated admitted to SNF under Hospice Services ,d+[DATE] with diagnosis of End Stage of Alzheimer's Dementia (a terminal decline in cognition including memory, problem-solving., thinking, and reasoning). Review of untitled document, indicated, [DATE], admitted to (name of Hospice) Care, alert and verbally responsive, incontinent of bowel and bladder, fell yesterday at home. She is No CPR, comfort care measures only . During an interview on [DATE] at 11:00 a.m., with Resident 28's family member, family member stated she took off work for months to take care of (Resident 28) at home. It was getting very hard, cannot manage her at home, so we decided to bring her here for care. She is under Hospice care here. She is much better here. Family Member comes daily to see resident. Review of facility Order Summary Report, dated [DATE], indicated, admitted to (Hospice) on [DATE] with Terminal Dx of End Stage Alzheimer's Disease, order date is [DATE]. No Physician Order on admission. During an interview and record review on [DATE] at 10:00 a.m., with Registered Nurse (RN1), RN 1 stated she cannot find a Physician's order for Hospice Admission. No documentation on family meetings and Interdisciplinary meetings found in chart. RN 1 further stated there should have been an IDT meeting during admission assessments. Per RN, she does not know the Hospice schedule, maybe 2 to 3 times a week. During an interview on [DATE] at 10:30 a.m., with Social Services (SS), SS stated, Hospice is contracted with facility, Hospice comes weekly. Hospice schedule is in the binder at the nursing station. SS stated, I talk to Hospice staff when they come, asked about care plan collaboration with the agency, not charted, will do that calling them for funeral arrangements and do quarterly notes. During an interview and record review on [DATE] at 11:00 a.m., with Director of Nursing (DON), per DON looking at the care plans, reason for Hospice admission is End Stage Alzheimer's Dementia, care plan created [DATE], no baseline care plan. DON stated Hospice is mentioned in the care plan to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. DON did not find coordinated plan and directives to include managing pain and other comfortable measures in the care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48700 2. Review of the order summary report dated [DATE], resident 4 was admitted to (Hospice) on [DATE] with terminal diagnosis of Ileus (a condition where the intestines stop working properly, leading to a blockage), CerebroVascular Accident (CVA - stroke), [NAME] Syndrome (is the acute dilatation of the colon in the absence of any functional obstruction in severely ill patients) During a concurrent record review and interview on [DATE] at 12:33 p.m., with the Director of Nursing (DON), DON stated that Resident 4 was admitted straight from acute care hospital on hospice and additionally I admit that I can't see care plan which includes the communication between the facility and the hospice agency. During a concurrent record review and interview on [DATE] at 3:16 p.m. with Registered Nurse (RN1), the progress notes from the hospice chart dated [DATE] were reviewed and indicated redness on buttocks area, and has a 0.5x0.5cm open area on left buttocks, denies any pain . RN 1 stated , I didn't know about that nurse note from the hospice nurse, she didn't say anything when she came here at the facility, they only do it by themselves without asking us or communicating with us moreover I don't see a care plan for hospice, I know that if no documentation, it means no justification. Review of facility document, Hospice Program dated ,d+[DATE], indicated, Policy Statement: Our facility contracts for Hospice services for residents who wish to participate in such programs. Policy Interpretation and Implementation: 4. When a resident participates in the Hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status.