STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555826	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods, A Community of Seniors	40 Camino Alto Mill Valley, CA 94941

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment was accurate for one resident (Resident 1), when Resident 1's Physician Orders for Life-Sustaining Treatment (POLST, a set of medical orders, based on a patient's preferences, that guide medical care for individuals with serious illnesses) form information was different from the information documented on Resident 1's MDS assessment.This failure could result in inappropriate care and treatment.Findings:A review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of April2025 and she was her own responsible party (RP, a person who is designated in making decisions about health care and financial matters).A review of Resident 1s MDS assessment, dated [DATE], indicated Resident 1 was admitted to the facility with a medically complex condition (a broad category of illnesses, diseases, or impairments that require extensive and ongoing medical care, often involving multiple body systems and comorbidities). Section S California POLST indicated Resident 1 had chosen for staff to attempt resuscitation/ cardiopulmonary resuscitation (CPR, an emergency treatment that's done when someone's breathing or heartbeat has stopped), full treatment (indicating the patient wishes to receive all medically appropriate and available treatments to prolong life, including interventions like mechanical ventilation, intensive care, and other life-sustaining measures), and opted for a trial period of artificial nutrition which can include the use of a feeding tube (FT, a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation).A review of Resident 1's signed POLST form, dated [DATE], indicated Resident 1 chose Do not Resuscitate (DNR, a medical order instructing healthcare provider not to perform CPR if a patient's breathing or heartbeat stops), selective treatment (indicating the patient wants medical conditions treated while avoiding burdensome measures. This option prioritizes treating the immediate medical issue but avoids measures like prolonged life support, intensive care, or invasive procedures such as intubation or mechanical ventilation), and no artificial means of nutrition including feeding tubes.During a concurrent interview and record review on [DATE] at 11:04 a.m. with the Minimum Data Set coordinator (MDSC), Resident 1's MDS assessment section S, dated [DATE], was reviewed. The MDSC verified Resident 1's MDS section S indicated Resident 1 had chosen attempt resuscitation/ cardiopulmonary resuscitation, full treatment, and trial period of artificial nutrition including feeding tubes. The MDSC stated MDS assessments should be accurate and the POLST accuracy in MDS section S was important because it provided direction of care in case of a medical emergency. During an interview on [DATE] at 11:50 a.m., the Director of Nursing (DON) stated the MDS section S information should be filled in from the POLST form signed by Resident 1 and the physician. The DON stated if the information did not match, it meant the MDS assessment was inaccurate. The DON stated inaccurate MDS could result in ineffective care and treatment. During a telephone interview on [DATE] at 2:58 p.m. the DON verified the information on Resident 1s POLS, dated [DATE], and the MDS assessment section S, dated [DATE], did not match. The DON confirmed Resident 1's MDS assessment section S dated [DATE] was inaccurate. The DON stated the facility did not have a policy and procedure on MDS assessment. A review of the American Association of Post Acute Care Nursing article titled understand the MDS trickle-down effect dated [DATE], it indicated, . well maintained and accurate source of documentation . are essential for MDS accuracy.

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure one resident (Resident 1) received treatment and care in accordance with the facility's Infection Control policy for influenza (flu- an illness caused by a virus [a germ] that is spread from person to person) when: Licensed Nurses (LNs) did not notify Resident 1's doctor (MD) that Resident 1 had symptoms of the flu and a report of Resident 1had been exposed to a family member who tested positive for flu; LNs did not notify the MD the facility ran out of flu tests; LNs did not place Resident 1 on droplet precautions (measures implemented to prevent the spread of infection when a person who is infected with a pathogen [germs that cause disease] coughs, sneezes, or talks);These failures resulted in Resident 1's hospitalization from 4/27/25 up to 5/6/25 where she was diagnosed with Influenza A and Acute Hypoxemic Respiratory Failure (AHRF, a serious condition where the respiratory system can't maintain adequate oxygen levels in the blood, potentially leading to organ dysfunction), received a new order for supplemental oxygen (additional oxygen to a person who is not receiving enough oxygen from the air they breathe), and decreased the facility's potential to prevent the spread of flu among other residents, visitors, and staff.Findings:A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] at the age of [AGE] years old.A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/27/25, indicated the primary reason for Resident 1's admission was due to a medically complex condition (a broad category of illnesses, diseases, or impairments that require extensive and ongoing medical care, often involving multiple body systems and comorbidities [simultaneous presence of two or more medical conditions in a patient]) including a diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing),.A review of Resident 1's admission Summary progress note, dated 4/24/25, indicated Resident 1 presented to the facility with stable (within normal limits [WNL] or acceptable ranges) vital signs (measurements of the body's most basic functions) including pulse (number of times the heart beats within a minute) at 94 beats per minute (bpm), and oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) at 94% without the use of supplemental oxygen.A review of Resident 1's nurse health status note, dated 4/24/25 at 4:06 p.m., indicated Resident 1's daughter notified Licensed Nurse (LN) A that Resident 1 had been exposed to a family member who tested positive for flu. The note also indicated Resident 1 had complained of sore throat and earache earlier that day.A review of Resident 1's nurse health status notes, for dates 4/24/25 and 4/25/25 did not indicate Resident 1's physician was notified that Resident 1 had been exposed to flu, had a reported symptom consistent with flu, and had not been tested for flu due to the facility not having flu testing supplies.A review of Resident 1's health status note, dated 4/26/25 at 9:56 p.m., indicated, [Resident 1's] daughter expressed concern regarding her mother's respiratory status. She requested that MD be notified regarding her concern that [Resident 1] may have flu.[with] [temperature] 98.7 [Fahrenheit, a unit of measure] ([Resident 1's] daughter notes that this is a high temp [temperature] for her mother.A review of Resident 1's health status note, dated 4/27/25 at 2:59 p.m., indicated, .[Resident 1] with elevated temp noted 99.1 [Fahrenheit].with episode of cough noted.family requesting to see MD; MD will be in on 4-28.A review of Resident 1's incident note, dated 4/27/25 at 11:30 p.m. indicated, .[Resident 1's] daughter called [facility] at approximately [4:30 p.m.] to report her concern that [Resident 1] had loose stools x2 [two times]. next call from [Resident 1's daughter] came after approximately one hour.that [Resident 1] had another loose stool.that [Resident 1] needed to be transferred to ‘the hospital' because ‘you are not doing anything for her'. [Resident 1] left [facility] with EMS [emergency medical services] staff at approximately [7 p.m.].[Resident 1] had resisted having vitals taken.A review of Resident 1's incident note, dated 5/11/25, indicated, late entry /addendum for 4/27/25: assessment of time.Timing of [Resident 1's] discharge from [facility] with EMS Paramedic staff is now estimated to be between [9:15 p.m.] and [9:30 p.m.] .A review of the emergency department (ED, provides unscheduled outpatient services to patients whose condition requires immediate care) provider note, signed 4/28/25, indicated on 4/27/25 Resident 1 was, . [brought in by ambulance] from [skilled nursing facility] for concerns of flu.HR [heart rate, the number of times the heart beats per minute] 140s, [O2 sat] 92% . placed on [supplemental oxygen].Triage vital signs Temp 99 [Fahrenheit], Heart rate 153, [Respiratory Rate] 35, [O2 sat] 97% [on supplemental oxygen].presenting with shortness of breath. wheezing [a high-pitched sound made when breathing is restricted/obstructed in the lungs] and rhonchi [low-pitched, continuous, snoring or gurgling sounds heard in the lungs, resulting from