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	07/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38335 Based on interview and record review, the facility failed to ensure one of six sampled resident's (Resident 3) medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information was provided to the resident and/or responsible parties and desire for physician orders for life sustaining treatment (POLST) were reviewed, signed and dated by a physician. This failure had the potential for the resident's wishes not to be honored during a medical emergency. Findings: A review of Resident 3's admission record indicated the resident was admitted on [DATE], with diagnoses that included Pyonephrosis (an infection of the kidney with pus in the upper collecting system which can progress to obstruction), Calculus of the Kidneys (kidney stones), Sepsis of unspecified organism Bacteria, Hypokalemia, and Dysphagia (difficulty swallowing). During a record review on 7/09/24, no indication an Advanced Directive (AD) or executed POLST was present or documented in the medical record for Resident 3. During an interview on 7/11/24 at 3:10 p.m., the Social Services Director (SSD), was asked how she completed the AD process with Residents and how the facility ensures Advanced Directive document was complete, she stated the ADs are collected upon admission or during a care conference. If an AD is not wanted by the resident upon admission, we ask again during the care conference. When asked how the SSD knows to follow-up she stated by word of mouth, or she checks the resident chart. When asked if there was an advanced directive for Resident 3, she stated she would have to check the chart. The SSD confirmed, no documentation was found that Resident 3 or a family member was provided written information regarding the resident`s right to formulate an advance directive. (continued on next page)

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
	555826	A. Building B. Wing	07/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 3:30 p.m. Licensed Staff Q was asked where the CODE status (focuses on emergent treatment options during a life-threatening event) for residents was located. Licensed Staff Q opened the electronic medical administrative record (MAR) and reviewed Resident 3's CODE status. She stated the CODE status was usually listed on the face page on the MAR. Licensed Staff Q verified that a CODE status for Resident 3 was not listed, nor was there any documentation in the electronic chart indicating a CODE status. Licensed Staff Q stated the CODE status is always listed on the face page, the manual chart was reviewed and showed a POLST that was not executed. A review of the facility's Policy and Procedure (P&P), titled Physician Order for Life Sustaining Treatment (POLST), dated 7/2024, the P&P indicated, Upon admission, the resident/representative will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. As part of the overall admissions process, community personnel shall make efforts to obtain a POLST, or other applicable documentation. A POLST/Do Not Resuscitate (DNR) order must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State Law) and placed in the front of the resident's medical record. A review of the facility`s policy and procedure, dated July 2024, titled Advance Directives, indicated that upon admission of a resident to the facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive.

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	07/12/2024

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 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** 39621 Based on observation, interview and record review, the facility failed to ensure the facility develop a resident-centered, comprehensive care plan for 1 of 14 sampled residents (Resident 18) with a stage 4 pressure ulcer (A pressure ulcer is a wound caused by prolonged pressure on an area of the skin. Stage 4 pressure ulcers are the most severe type of pressure ulcer, and can extend into muscle and/or tendons and bones). This had the potential to result in inability for the wound to heal, decline of Resident 18's medical condition, medical complications including the acquisition of serious infections and death. Findings: Record review indicated Resident 18 was admitted to the facility on [DATE] with medical diagnoses including Pressure Ulcer of Left Heel, and Repeated Falls (History of having suffered falls, which may indicate increased risk for future falls), according to the facility Face Sheet (Facility demographic). During an observation on 7/08/24 at 11:30 a.m., Resident 18 was observed in his wheelchair, in his room, using a special type of boot on the left lower leg. Record review of a facility document titled, Skin Only Evaluation, dated 7/10/24 at 10:11 p.m., indicated Resident 18 had a pressure ulcer to his left heel that measured 0.5 cm (Centimeters) in length, by 0.5 cm in width, but the depth was unable to be determined. This document indicated, Resident was seen and Evaluated by .PA [Physician Assistant] wound specialist. 1. Left heel wound Stage 4 Pressure wound . Continue with the current Treatment: Wash with NS (Normal Saline-a mixture of sodium chloride and water used for cleaning wounds), Pat Dry, Apply Medihoney (A gel made of medical-grade honey for the treatment of wounds) and Cover with Mepilex dressing (An absorbent dressing for the treatment of wounds) one time a day. Kept foam boots on @ all times while (Sic) and bed and while sitting in the wheelchair. During a concurrent interview and record review with the Director of Staff Development (DSD) on 7/12/24 at 8:32 a.m., the care plan for care of Resident 18's Stage 4 pressure wound, initiated on 3/20/24, was reviewed. The care plan contained eight interventions, including, treat per facility protocol, and notify MD (Medical Doctor), family .Encourage good nutrition and hydration in order to promote healthier skin .Identify potential causative factors and eliminate/resolve when possible .Inform/instruct staff of causative facts and measures to prevent worsening condition. None of the interventions in the care plan were resident-specific, or indicated the specific treatments ordered by the physician for Resident 18, such as the treatments written on the Skin Only Evaluation, dated 7/10/24 at 10:11 p.m. The interventions were all basic, generalized nursing interventions that were not measurable, or added specific information to care for Resident 18's left heel. This was confirmed by the DSD, who stated the care plans needed to be resident-centered and specific. (continued on next page)

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	07/12/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled, Care Plans and Care Planning Process, last revised on 7/2024, indicated, It is the policy of [Name of Facility] to develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet each resident's physical, psychosocial and functional needs.

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure two of fourteen sampled residents (Resident 34 and Resident 190) at risk for falls, were provided with supervision (visual checks) by direct care staff and had effective revisions and implementation of their nursing care plans to prevent further falls to keep them safe. Facility policies on safety and management of falls were not followed. As a result, Resident 190 suffered two falls with major injuries, consisting of hip fractures, at the facility, and one fall with no injuries. This caused severe pain to Resident 190 and may have contributed to her death, just 7 days after her last fall with major injury. Resident 34 fell 7 times in 4 months due to lack of supervision, revision, and implementation of care plans to prevent falls. This had the potential to result in falls with major injuries for Resident 34. Findings: Resident 190 Record review of the facility Face Sheet (Facility Demographic) indicated Resident 190 was admitted to the facility on [DATE] with medical diagnoses including History of Falling (History of having suffered falls, which may indicate increased risk for future falls), Alzheimer's Disease (A progressive brain disorder that slowly destroys memory and thinking skills), Restlessness and Agitation. Record review of Resident 190's MDS (Minimum Data Set-An assessment tool) dated 1/14/24 indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 3, which indicated her cognition was severely impaired (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). This document also indicated under section GG (Section of the MDS that evaluates the amount of assistance a patient needs) dated 1/14/24, that Resident 190 required partial to moderate assistance with toileting and personal hygiene. Record review of an undated facility document titled, POST FALL INVESTIGATION, provided by the Director of Nursing (DON) on 7/12/24 at 9:30 a.m., in response to a request for a policy on neurological checks (A healthcare provider's evaluation of a person's nervous system after a fall to help determine the extent of damage from head trauma), indicated that after a resident fall, the following tasks were required to be completed, Complete Post Fall investigation Report .Complete Risk Management in [Electronic documentation system] .Update care plan on falls .Initiate Q30 (Every thirty minutes) checks for the next 72 hours .Complete neuro (neurological)-check (paper form). Neurological checks, as indicated in this form titled, POST FALL INVESTIGATION, were required to be performed every thirty minutes for 72 hours after the fall. Record review of a facility document titled, Falls Risk Assessment, dated 10/16/23, indicated Resident 190 was at medium (Moderate) risk for falls. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review with the DON on 7/11/24 at 9:38 a.m., Resident 190's care plans for falls were reviewed. There were no care plans created prior to the first fall on 1/01/24. The DON stated she would look to see if she could find one but did not provide this care plan. 1st Fall Record review of a progress note dated 1/01/24 at 2:45 p.m., indicated, Resident [Resident 190] called help, help from her room. Entered room with CNA (Certified Nursing Assistant). Resident is on the floor on her L (Left) side next to her bood (Sic, possibly meant bed). Resident unable to explain what happened .L hip is tender to touch. Pain intensifies with movement and attempt to reposition .911 called for transport to [General Acute Care Hospital (GACH)] .Resident left for hospital 15.20 (3:20 p.m.). Record review of a progress note dated 1/01/24 at 10:47 p.m., indicated, Received a phone call .on resident [Resident 190] status, resident has a left hip fracture with possible surgery. Record review of a facility physician progress note dated 1/13/24 at 7:35 a.m., indicated, [Resident 190] is a [AGE] year old female who was living in the healthcare center of [Name of facility] and sustained a fall resulting in left hip fracture. Patient was subsequently transferred to [name of GACH]. Patient underwent successful left hip hemiarthroplasty (A surgery to repair half of a hip joint after a traumatic injury in which the femoral head (Upper joint of the thigh bone) is fractured. Record review of a facility document titled, Fall Risk Assessment, dated 1/02/24 at 11:35 a.m., indicated Resident 190 was at low risk for falls, although she had just fallen the day before, on 1/01/24 and suffered a hip fracture. During a concurrent interview and record review with the DON on 7/11/24 at 9:38 a.m., the document, Falls Risk Assessment, dated 1/02/24 at 11:35 a.m., was reviewed. The DON stated this document was completed inaccurately, since it indicated Resident 190 had no history of falls within the last three months, was ambulatory and continent, and was taking only two medications increasing her risk of falls, when she was taking eight medications. The DON stated Resident 190 did have a history of falls within the last three months, since she had fallen on 1/01/24, required supervision with ambulation, and was incontinent (Inability to control the bowels and bladder) at times. The DON confirmed this assessment indicated Resident 190 was at low risk for falls due to the inaccurate responses submitted. Record review of a care plan for falls initiated on 1/08/24 (no time documented) for Resident 190, listed the following interventions to prevent further falls, Keep call light in reach at all times .Keep personal items and frequently used items within reach .Anticipate needs and meet on timely basis. There were no interventions in the care plan aimed at increasing supervision for Resident 190. During a concurrent interview and record review with the DON on 7/11/24 at 9:38 a.m., the care plan for falls initiated on 1/08/24 (no time documented), was reviewed. The DON confirmed there were no interventions to increase supervision for Resident 190 in the care plan, but supervision was increased through rounds completed every two hours by staff, which were initiated on 1/17/24 (17 days after the first fall with major injury) and provided the documents titled, RESIDENTS ON TOILETING SCHEDULE, dated 1/17/24 through 2/27/24. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the documentation for staff rounding titled, RESIDENTS ON TOILETING SCHEDULE, from 1/17/24 to 2/27/24 indicated there were several shifts and hours of the day, when Resident 190 was not checked, as the boxes were left empty. For example, on 2/25/24, Resident 190 was required to be checked at 7:00 a.m., 9:00 a.m., 11:00 a.m., and 1:00 p.m., but the documentation indicated she was not checked at all throughout morning shift. This was repeated on multiple occasions, such as on 2/15/24 for morning shift, 2/17/24 for night shift, 2/26/24 for evening shift, 2/27/24 for night and evening shifts, etc. Record review of interdisciplinary team (IDT) meetings titled, [Name of Facility], a Community of Seniors Clinical Sign in Sheet, dated 1/10/24 at 10:25 a.m.,1/16/24 at 10:35 a.m., 1/17/24 at 10:25 a.m., and 1/19/24 at 10:30 a.m., indicated Resident 190 returned from the GACH to the facility on [DATE], and was admitted to hospice (Palliative services aimed at keeping resident comfortable at the end of life) on 1/19/24. There was no documentation in these IDT meeting reports that Resident 190 suffered a fall with major injury at the facility. This was confirmed by the DON during an interview on 7/11/24 at 9:38 a.m. 2nd Fall Record review of a progress note dated 1/30/24 at 9:25 a.m., indicated, Resident [Resident 190] is OOB (Our of bed) for meals eating breakfast in the dining area. @0925 (At 9:25 a.m.) resident fall (Sic) in the wheelchair at dining area .no skin tear, denies hitting head and no discoloration. During a concurrent interview and record review with the DON on 7/11/24 at 9:38 a.m., the care plan for falls revised on 2/02/24 (3 days after the fall) for Resident 190 was reviewed. This care plan for falls included only two new written interventions. One of the newly written interventions indicated, Toiletted (Sic. Assisted to use the restroom) QAC (Before meals), PC (After meals), HS (Before bedtime) and PRN (As needed). The DON confirmed this new intervention was already in place before the fall on 1/30/24, although it had not been formally written before in the care plan. The second intervention indicated, Close monitoring for safety. The DON confirmed the resident continued the same rounding schedule by staff every two hours (Since 1/17/24), therefore, there was no increased supervision for Resident 190. The DON stated they did increase visual checks for Resident 190 but did not have any documentation of it. Record review of the documentation for staff rounding titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 1/17/24 indicated Resident 190 continued to be checked every two hours, despite the fall on 1/30/24. 3rd Fall Record review of a progress note dated 2/20/24 at 8:36 a.m., indicated, Rd [Resident 190] was found on the floor .She was on the floor on her right side at the base of the floor mat next to her bed .she was not complaining of pain at the time .She was lifted back to her bed and she started to complain of right inner thigh pain. Record review of a progress note dated 2/21/24 at 11:40 a.m., indicated, Resident is on S/p (Status post) unwitnessed fall Day 2 .Right hip fracture .Administrator, DON .was notified with the result of the Right Hip X-ray. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a facility document titled, NEUROLOGICAL ASSESSMENT FLOW SHEET, indicated staff documented neurological checks only from 2/20/24 at 12:15 a.m., to 2/20/24 for, NOC (Night shift, no specific hours documented). This was less than the 72 hours required in the document titled, POST FALL INVESTIGATION (Above). This was confirmed by the DON during an interview on 7/11/24 at 9:38 a.m. Record review of a, Falls Risk Assessment, for Resident 190 dated 2/20/24 at 6:37 p.m., indicated Resident 190 was at high risk for falls. During a concurrent interview and record review with the DON on 7/11/24 at 9:38 a.m., Resident 190's care plan for falls, updated on 2/20/24 (No time documented) was reviewed. The care plan only had one intervention aimed at preventing further falls. This intervention indicated, Remind resident not to get up by herself. Frequent checks. The DON confirmed this was the only intervention to prevent further falls, as other interventions had the intention of keeping the resident comfortable. The DON confirmed reminding the resident not to get up by herself was not appropriate as the resident's cognition was severely impaired. The DON stated she had no documented evidence supervision was increased after this fall, as they continued with the same rounding by staff every two hours. Record review of the documentation for staff rounding titled, RESIDENTS ON TOILETING SCHEDULE, from 1/17/24 through 2/27/24 indicated staff continued to check on Resident 190 every two hours, despite the fall on 2/20/24 which resulted in a fracture. During an interview on 7/11/24 at 9:38 a.m., the DON was asked to provide care plans for the two hip fractures caused by Resident 190's falls at the facility. During an interview on 7/11/24 at 1:44 p.m., the DON confirmed there were no care plans found specifically for the care of Resident 190's hip fractures. Record review of nursing progress notes (see below for dates and times) indicated Resident 190 experienced moderate to severe pain levels during her last days at the facility related to her right hip fracture, before passing away on 2/27/24 at 4:10 p.m., as follows: a) Progress note dated 2/21/21 at 11:40 a.m., indicated, Resident c/o (Complained of) 7/10 (Pain scale where 0 indicates no pain, and 10 is the worst pain experienced in a person's lifetime. A pain level of 0-2 = mild, 3-5 = moderate, and 6-10 = severe) r/t (Related to) Right hip fracture. b) Progress note dated 2/22/24 at 8:21 a.m., indicated, resident able to verbalize pain to rt (Right) hip . c) Progress note dated 2/22/24 at 11:40 a.m., indicated, Resident c/o pain 8/10 during turning and repositioning r/t right hip fracture. d) Progress note dated 2/22/24 at 3:51 p.m., indicated, Resident c/o pain when she moved . e) Progress note dated 2/23/24 at 9:34 a.m., indicated, received resident in bed .able to vocalize pain to right upper leg . f) Progress note dated 2/23/24 at 6:21 p.m., indicated, resident verbalized pain with mobility. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a progress note dated 2/27/24 at 5:49 p.m., indicated, resident's dtr (Daughter) present at bedside, notified passed away around 410 pm (4:10 p.m.). During an interview with the DON on 7/11/24 at 9:38 a.m., she stated the facility needed improvement in several areas of managing falls, such as completing the fall risk assessments accurately, care planning after every fall, and documentation of the visual checks. Resident 34 Record review of the facility Face Sheet indicated Resident 34 was admitted to the facility on [DATE] with medical diagnoses including Hemiplegia (Complete or severe loss of strength on one side of the body), & Hemiparesis (One-sided muscle weakness), Aphasia (Inability to speak or understand, or both), and Anxiety Disorder (Intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident 34's MDS dated [DATE] indicated she was completely dependent on staff for toileting, personal hygiene and bed-to-chair transfer. Record review of a facility document titled, Falls Risk Assessment, dated 1/26/24 at 6:33 p.m., indicated Resident 34 was at high risk for falls. Record review of a care plan for prevention of falls for Resident 34 initiated on 1/23/24, indicated, [Resident 34] is at High risk for falling R/T (Related to) recent hospitalization .Keep call light in reach at all times .Keep personal items and frequently used items within reach .anticipate needs. During an interview with the Director of Staff Development (DSD) on 7/11/24 at 3:30 p.m., the DSD was asked in writing and verbally to provide the following documents: a) All documentation of Resident 34's falls since 1/01/24 to the present. b) All care plans updated or revised after every fall since 1/01/24 to the present. c) All neurological checks performed after every fall since 1/01/24 to the present. d) All fall risk assessments performed after every fall since 1/01/24 to the present. During an interview with the DSD on 7/12/24 at 9:51 a.m., she provided some of the documents requested on 7/11/24 at 3:30 p.m., but stated she could not find them all. The DSD stated she was providing what she was able to find regarding the above request. The documents not provided by the DSD are written below. 1st Fall Record review of a progress note dated 2/07/24 at 7:55 a.m. indicated, Incident Date: 02/07/2024, Incident Time: 05:00 .resident found with bedding on the floor on right side of bed lying on her weak/right side at 5am (5:00 a.m.) when this nurse went to check on her. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a Falls Risk Assessment, dated 2/08/24 at 6:57 p.m., indicated Resident 34 was at high risk for falls. During concurrent record review and interview with the DSD on 7/12/24 at 7:50 a.m., the care plan for falls initiated on 2/07/24 was reviewed. This care plan indicated, frequent checks per facility protocol (The care plan did not indicate how often, or how this was going to be monitored) .request cradle mattress from hospice. This was confirmed by the DSD. During an interview with the DSD on 7/12/24 at 9:51 a.m., she provided some of the documents requested on 7/11/24 at 3:30 p.m., but the neurological checks after the fall on 2/07/24, was not included. The DSD stated she was providing what she could find. 2nd Fall Record review of a progress note dated 2/18/24 at 3:52 p.m., indicated, Resident had an unwitnessed fall at around 0900 (9:00 a.m.) in the morning (The morning of 2/18/24). Resident was seen sitting on the right side of her bed in a sitting position with her back leaning on her bed. During a concurrent interview and record review with the DSD on 7/12/24 at 7:50 a.m., the care plan for falls initiated on 2/18/24 was reviewed. The care plan did not contain any new interventions to prevent falls, or increased supervision. The interventions included, Neurochecks (Neurological assessments) as per facility protocol .VS (Vital Signs-Clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) .Monitor for pain. This was confirmed by the DSD. During an interview with the DSD on 7/12/24 at 9:51 a.m., she provided some of the documents requested on 7/11/24 at 3:30 p.m., but the neurological checks and fall risk assessment after the fall on 2/18/24, were not included. The DSD stated she was providing what she could find. 3rd Fall Record review of a care plan for falls initiated on 3/13/24 indicated, Fall-3/5/24-no injury (No time of the fall documented). During an interview with the DSD on 7/12/24 at 9:51 a.m., she provided some of the documents requested on 7/11/24 at 3:30 p.m., but specific documentation on the fall that occurred on 3/05/24, was not included. The DSD stated she was providing what she could find. Record review of a facility document titled, MORSE FALL-Senior Living (Fall risk assessment), dated 3/05/24 at 6:41 p.m., indicated Resident 34 was at high risk for falls. Record review of the care plan for falls initiated on 3/13/24 (8 days after the fall on 3/05/24) indicated, Activity staff will provide 1:1 (One staff to one resident) visit for socialization .Call light is present and within reach . Staff to anticipate needs .The resident is mostly bedbound r/t personal preference, physical impairment. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a facility document titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 3/05/24 and active through 7/11/24, indicated Resident 34 was placed on a schedule for staff checks every two hours. This document indicated there were several shifts and hours of the day, when Resident 34 was not checked, as the boxes were left empty. On 3/05/24, Resident 34 was required to be checked for evening shift at 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m., according to the form. This document indicated Resident 34 was not checked at all throughout evening shift on 3/05/24. Record review of neurological checks initiated on 3/05/24 at 8:30 a.m., indicated they were not conducted every 30 minutes as required (The POST FALL INVESTIGATION, provided by the Director of Nursing (DON) on 7/12/24 at 9:30 a.m., above, indicated neurological checks were to be conducted every 30 minutes for 72 hours after a resident fall). On 3/05/24, the documentation indicated neurological checks were completed at 4:15 p.m., and again at 8:15 p.m. (4 hours later), and again at 12:15 a.m., (4 hours later). The next time neurological checks were documented for Resident 34 was on 3/06/24 for AM (Morning shift, which started at 7:00 a.m.). 4th Fall Record review of a care plan for falls initiated on 3/13/24 indicated, Fall-3/15/24-no injury (No time of the fall documented). Record review of the care plan for falls initiated on 3/13/24 indicated the care plan was not revised or updated after the fall on 3/15/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. Record review of a facility document titled, Fall Risk Evaluation, dated 3/05/24 at 4:03 p.m., indicated Resident 34 was at risk for falls. Record review of a facility document titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 3/05/24 and active through 7/11/24, indicated Resident 34's supervision was not increased from the original checks conducted every two hours by staff despite the fall on 3/15/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. 5th Fall Record review of a progress note dated 4/13/24 at 9:10 p.m., indicated, PT (Patient [Resident 34]) found on the floor during routine check around 445pm (4:45 p.m. on 4/13/24). Staff assisted back to bed, no visible injuries. Record review of a facility document titled, MORSE FALL-Senior Living (Fall risk assessment), dated 4/13/24 at 10:43 p.m., indicated Resident 34 was at high risk for falls. Record review of the care plan for falls initiated on 3/13/24 indicated the care plan was not revised or updated after the fall on 3/15/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a facility document titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 3/05/24 and active through 7/11/24, indicated Resident 34's supervision was not increased from the original checks conducted every two hours by staff, despite the fall on 4/13/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. 6th Fall Record review of a progress note dated 4/15/24 at 9:55 p.m., indicated, During morning rounds right after am report at 7:30 am (On 4/15/24), resident found on the floor mat next to bed. Record review of a facility document titled, MORSE FALL-Senior Living, dated 4/15/24 at 10:44 p.m., indicated Resident 34 was at high risk for falls. Record review of the care plan for falls initiated on 3/13/24 indicated only two new interventions were added to the care plan after the fall on 4/15/24. These two new interventions were added on 4/19/24, four days after the fall, and indicated, Continue with the plan of care to frequently check the resident .Request [Hospice] scheduled visit to offset private caregiver time when possible. The care plan did not specify what frequently check the resident, meant, or how it was monitored. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. Record review of a facility document titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 3/05/24 and active through 7/11/24, indicated Resident 34's supervision was not increased from the original checks conducted every two hours by staff, despite the fall on 4/15/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 p.m. Record review of neurological checks initiated on 4/15/24 at 7:30 a.m., indicated they were only conducted from 4/15/24 at 7:30 a.m. to 4/16/24 for PM, which was approximately 40 hours, and not the 72 hours required in this form (The form, POST FALL INVESTIGATION (above), provided by the Director of Nursing (DON) on 7/12/24 at 9:30 a.m., indicated neurological checks were to be conducted every thirty minutes for 72 hours after a resident fall). 7th Fall Record review of a progress note dated 4/24/24 at 6:13 p.m., indicated, Resident noted to be on floor laying on R (Right) side. Assessed-No apparent injuries. Record review of a facility document titled, MORSE FALL-Senior Living, dated 4/24/24 at 10:44 p.m., indicated Resident 34 was at high risk for falls. Record review of the care plan for falls initiated on 3/13/24 indicated it was revised after the fall on 4/24/24, but only one new intervention was added. The new intervention was added on 7/11/24 (more than 2 months after the fall on 4/24/24) and indicated, Follow facility fall protocol. The care plan did not indicate to increase supervision. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a facility document titled, RESIDENTS ON TOILETING SCHEDULE, initiated on 3/05/24 and active through the 7/11/24, indicated Resident 34's supervision was not increased from the original checks conducted every two hours by staff, despite the fall on 4/24/24. This was confirmed by the DSD during an interview on 7/12/24 at 7:50 a.m. Record review of neurological checks initiated on 4/24/24 at 4:45 p.m., indicated they were not conducted every 30 minutes as required (The form, POST FALL INVESTIGATION (above), provided by the Director of Nursing (DON) on 7/12/24 at 9:30 a.m., indicated neurological checks were to be conducted every thirty minutes for 72 hours after a resident fall). On 4/25/24, the documentation indicated neurological checks were completed at 12:30 a.m., and again at 4:30 a.m. (4 hours later), and again at 8:30 a.m., (4 hours later). The next time neurological checks were documented for Resident 34 was on 4/25/24 for PM (Evening shift, which started at 2:30 p.m.). During a concurrent observation and interview with Unlicensed Staff S, assigned to Resident 34, on 7/08/24 at 3:14 p.m., he was asked if Resident 34 was able to speak. Unlicensed Staff S stated he did not know, as he was unfamiliar with Resident 34. Resident 34 was observed awake in bed, with the bed in the lowest position, right next to another bed, and a mat on the floor. Unlicensed Staff S stated he was from a registry company. Unlicensed Staff S was asked the reason Resident 34 had a mat right next to her bed, and another empty bed to the right of her bed. Unlicensed Staff S stated not knowing the reason. Unlicensed Staff S was asked if Resident 34 was at risk for falls. Again, Unlicensed Staff S stated not knowing the answer to the question. During an interview on 7/09/24 at 11:45 a.m., Unlicensed Staff E stated she was a private caregiver for Resident 34, hired by Resident 34's family. Unlicensed Staff E stated she worked with Resident 34 from Monday through Friday from 9:00 a.m., to 2:00 p.m. Unlicensed Staff E stated that if she did not notify facility staff Resident 34 needed to have her brief changed, they did not come to check on her every two hours, and even when notified, they had still left her up to thirty minutes with a soiled brief. Unlicensed Staff E also stated that most of the time, when she came to the facility at 9:00 a.m., Resident 34's breakfast tray was observed sitting on her bedside table, untouched and cold, waiting for her to assist Resident 34 with the meal. Unlicensed Staff E also stated the facility often assigned unfamiliar staff to Resident 34, including registry staff. During a concurrent interview and record review with the DSD on 7/12/24 at 7:50 a.m., after reviewing the care plans for falls, supervision documentation, fall risk assessments and other documents related to falls (Dates and specific titles of each document mentioned above, in falls 1 through 7), the DSD stated Resident 34's fall management process needed improvement. During a phone interview on 7/12/24 at 8:31 a.m., Anonymous Witness G stated being very dissatisfied with Resident 34's care at the facility. Anonymous Witness G stated she had hired a private caregiver to care for Resident 34 from 9:00 a.m. to 2:00 p.m., because she felt Resident 34 was not receiving the care she needed. Anonymous Witness G stated she made arrangements to transfer Resident 34 out of the facility on 7/11/24. Anonymous Witness G stated she had brought up resident care issues with the DON, but the DON never followed up on them. Anonymous Witness G stated being aware Resident 34 had fallen multiple times at the facility. (continued on next page)

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	07/12/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Licensed Staff D on 7/12/24 at 12:00 p.m., she was asked how often Resident 34 was required to be checked by staff when she was still residing at the facility. Licensed Staff D stated Resident 34 was required to be checked every two hours, which corroborated that supervision requirements were never changed for Resident 34 despite multiple falls at the facility. Record review of the facility policy titled, Accident Prevention/Mitigation and Response, last reviewed in November of 2023, indicated, Avoidable Accident: means than an accident occurred because the facility failed to: Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk .Monitor the effectiveness of the interventions and modify the care plan as necessary .Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment.

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	07/12/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility did not have a system to track staff compliance in required trainings, when: 1. Two of four sampled employees had mandatory trainings that were overdue (Licensed Staff K and Unlicensed Staff L). This finding had the potential to result in inadequate staff competency to care for the residents within professional standards or practice, poor quality of care, and harm to the residents of the facility. 2. The facility failed to provide a competent DSD to enforce training and verify competencies for Nursing staff when Unlicensed Staff F's (BLS) Basic Life Support Certification (CPR Cardiopulmonary Resuscitation the act of performing chest compressions and artificial respirations) was expired for 4.5 months while working in the facility. This failure had the potential to result in 30 out of 36 sampled residents needing CPR but not having access to a Certified CPR staff member to perform CPR. Findings: 1. During an interview on [DATE] at 11:00 a.m., with the Director of Staff Development (DSD), she was asked to provide the list of annual mandatory trainings for Licensed Nurses and Certified Nursing Assistants (CNAs) and another list of all direct care personnel working at the facility. The DSD provided these lists on [DATE] at 2:10 p.m. From the list of employees, the Surveyor chose two Licensed Nurses and two CNAs and asked the DSD to provide evidence by [DATE] at 10:00 a.m., that these employees had completed their mandatory trainings. The DSD explained the mandatory trainings were taken using an online training platform. During a concurrent interview and record review with the DSD on [DATE] at 10:00 a.m., the transcripts of the annual mandatory trainings were reviewed for both Licensed Nurses and CNAs. Of these four sampled employees, one Licensed Nurse (Licensed Staff K) and one CNA (Unlicensed Staff L) had annual mandatory trainings that were overdue. For example, for the Licensed Staff K, the mandatory annual training on infection control and prevention was last taken on [DATE], according to the transcript. The rest of the annual mandatory trainings were also taken in May of 2023. For Unlicensed Staff L, the mandatory annual trainings were over a year overdue. For example, the training on abuse and neglect in the elder care setting was last taken on [DATE] according to the provided transcript. This was confirmed by the DSD. The DSD was asked if she tracked mandatory trainings to ensure staff were taking them annually as required. The DSD stated she did not have a tracking system to ensure these trainings were taking annually. Record review of the facility document titled, Employee Benefits, dated 2023, indicated, Attendance at new hire, annual training an in-service training is mandatory and attendance time is paid .Training for the job requirements and for compliance is mandatory and must be completed on time every year or as necessary. (continued on next page)

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	07/12/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated job description for Director of Staff Development, indicated, Oversees the [Computerized training] training for all HCC (Healthcare Center) .Tracks participation and follows up to ensure all team members are compliant with the policies of [Name of Facility]. 40402 2. During an observation on [DATE] at 9:00 a.m., outside of room [ROOM NUMBER], observed an Enhanced Barrier Isolation Cart (a cart that contains gloves, alcohol, masks, and gowns for staff to wear while providing high contact (Hygiene and bathing) activities for residents. Unlicensed Staff F was also observed in room [ROOM NUMBER] without a gown on providing hygiene for Resident 31 when he was incontinent of stool. Observed Unlicensed Staff F exiting Resident 31's room without washing his hands or using hand sanitizer after caring for Resident 31. During an interview on [DATE] at 9:20 a.m., in the hallway outside room [ROOM NUMBER], Unlicensed Staff F queried as to what care he was providing in room [ROOM NUMBER]. Unlicensed Staff F stated, he had to change and wash Resident 31 due to Resident 31 being incontinent of Stool. Unlicensed Staff F queried why he did not wear a gown while providing high activities care with Resident 31. Unlicensed Staff F stated, he forgot. Unlicensed Staff F queried why he did not wash his hands or use hand sanitizer after he finished with high activities with Resident 31. Unlicensed Staff F stated, he forgot. Requested Human Resource File from NHA on Unlicensed Staff F. Observed in file, Registry Staff Orientation Form dated [DATE], signed by DSD. The area on the form for CPR card verification with expiration date was left blank. Observed CPR BLS Certification Card in file to be expired [DATE]. During an interview with the DSD on [DATE] at 8:20 a.m., DSD queried if she was aware that Unlicensed Staff F's CPR card was expired. DSD stated, she was not aware that Unlicensed Staff F's BLS card was expired. DSD queried as to who is responsible to verify the current competencies and current certifications of the nursing staff. DSD stated, the ADP which is our Payroll Department. Queried DSD as to why a Payroll Department would be checking for current competencies and certifications. DSD stated, well, it's actually, my job as Director of Staff Development to keep track of the current competencies and current certifications. DSD queried if Unlicensed Staff F had a current BLS certification card. DSD stated, after she notified Unlicensed Staff F, he produced a BLS card with today's date [DATE]. DSD queried if she verified the company named on Unlicensed Staff F's BLS Certification Card to be sure it is accredited by the (AHA) American Heart Association. DSD stated, she did not verify that the company was approved by AHA. DSD queried what the risks are to resident safety if the facility does not have CPR certified staff. DSD stated, she thinks the residents would not receive the correct CPR. During a review of DSD's job description, signed by DSD, dated [DATE], Job Description indicated, DSD is responsible for Staff Development. DSD Prepares required paperwork for CNA (certified nursing assistants) re-certifications. Submits all required training plans to CDPH. Assists in survey preparation, maintains all training and in-service records. (continued on next page)

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	07/12/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Sufficient and Competent Staffing, Revised , d+[DATE], indicated, Applicable Redwoods personnel will develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. We determine the amount and types of training necessary based on their facility assessment. The Facility will hire only qualified licensed or registered personnel and/ or consultants and outside contract services, as specified within the laws, rules and regulations by which the facility shall abide, including Evaluation where applicable shall have their license and required reviews conducted annually or as required thereafter, including where applicable their competency training requirements as well as required training for the position. Certified Nursing Assistants (CNA) shall be hired as qualified CNA and meets all the facility, state, federal personnel licensing and certification requirements and facility personnel requirements. During a review of the facility's Facility Assessment, dated [DATE], signed by NHA, DON, Licensed Staff B, and the Governing Body representative, indicated, on page 21 Contracted Providers, The Facility does maintain relationship with contracted providers to perform certain services on behalf of the Facility. Each Provider is expected to meet certain requirements depending on the nature of services that they are providing. In general, each contracted provider is expected to: Ensure that its staff members performing the services in the facility are appropriately trained/certified/licensed to perform the service. Comply with all applicable rules, regulations, standard of practice, facility policies and procedures. Adhere to standards of professional conduct. Promptly respond to any reported/identified concerns. Abide by any clauses/rules/expectations set forth in the applicable contract.

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	07/12/2024

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 39621 Based on observation, interview and record review, the facility failed to ensure the daily nursing staffing information was posted in a conspicuous place, during one of five days (7/08/24). This finding had the potential to result in inability for residents, visitors, and staff to review the staffing information, advocate for the residents' care, and identify issues with staffing numbers, which could have contributed to decreased quality of care. Findings: During a concurrent observation and interview with the Director of Staff Development (DSD) on 7/08/24 at 9:20 a.m., the posting that included the nursing staffing information, posted on the wall across the nursing station of the facility, had staffing posting information from the previous Friday, 7/05/24. At the time of the observation, there was a lot of activity going on at the facility. More than 10 residents were observed in the dining area involved in recreational activities, and staff were busy with their morning work routines. The DSD confirmed the finding and stated the unit clerk was responsible for posting the nursing staffing information, and this was usually done daily at around 10:00 a.m. During an interview on 7/08/24 at 11:01 a.m., the Staffing Coordinator stated she was the staff member responsible for creating and posting the daily nursing staffing information. The Staffing Coordinator stated she usually posted this document at around 8:30 a.m., Monday through Friday, as she did not work on the weekends. The Staffing Coordinator stated that on the weekends, this assignment was delegated to one of the charge nurses, but if the charge nurses were busy, they did not post the nursing staffing information. The Staffing Coordinator confirmed the posting in place the morning of 7/08/24 was from 7/05/24, which indicated the daily staffing information was not posted on 7/06/24 or 7/07/24 (Saturday and Sunday). Record review of the facility policy titled, Sufficient and Competent Nurse Staffing, dated July of 2024, indicated, Within three (3) hours of the beginning of each shift, the number of Licensed Nurses .and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. This policy contradicted Federal regulation S483.35(g)(2) which indicated, The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

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	07/12/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38335 Based on interview and record review, the facility failed to ensure the Pharmacist's Drug Regimen Review (DRR/Medication Regimen Reviews- a monthly summary report of each resident's medication irregularities) report was acted upon with timely responses from Physicians and Medical Director. This failed practice had the potential to affect all residents currently receiving medications (36 of 36 residents) and placed them at risk for negative clinical outcomes due to a potential urgent action not being communicated in a timely fashion. Findings: During a review of the monthly Drug Regimen Review binder on 7/11/24, it was observed that monthly medication reviews conducted by the Consulting Pharmacist for the months of May and June showed no follow-up responses to recommendations made by the Consulting Pharmacist, and no documentation was present in the binder. Previous months (February, March, and April) Pharmacist recommendations for several residents was incomplete and did not show Physician responses or that follow-through was conducted. During an interview on 7/12/24 at 9:30 a.m., the Consulting Pharmacist (CP) was asked how often she conducts medication reviews at the facility. The CP stated she comes to the facility monthly reviews all resident charts and makes her recommendations. When asked who was present at the monthly meetings she stated the DON, DSD, and sometimes the Medical Director. When asked if the recommendations are followed through with timely responses from the physicians' she stated No, I had to hunt down physicians to receive responses, it has improved since we have a new Medical Director, he is more responsive and involved with the other physicians to ensure more timely responses to medication recommendations. When asked what her expectation was for a response to her recommendations, she stated a reasonable response time would be 30-days. During an interview with the Director of Nursing (DON) on 7/12/24 at 11:30 a.m., the DON could not show any paper or electronic documentation indicating the prescribing physicians had addressed the pharmacist's requests or that Nursing had contacted the physicians and Medical Director for responses to the pharmacist's recommendations. The DON was asked who had oversight to ensure the pharmacist's medication recommendations were followed-up and responses from physicians were documented. The DON stated she had oversight and acknowledged that she had not followed through with recommendations from the pharmacist. Further discussion with the DON, regarding lack of follow-through and documentation of recommendations did not ensure residents were medicated appropriately and safely. The DON stated she understood and would follow-up with the medical director and the pharmacist's recommendations. A request of the facility's Policy and Procedures for Medication Regimen Review was requested but not provided. (continued on next page)

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	07/12/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Pharmacy policy and procedure titled, Medication Regimen Review and Reporting, dated 9/2018, indicated, Procedures - 6. Resident-specific MRR recommendations and findings are documented and acted up by the nursing care center and/or physician. 8. The nursing care center follows-up on the recommendations to verify that appropriate actions have been taken. Recommendations shall be acted upon within 30 calendar days.

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	07/12/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure one of fourteen sampled residents (Resident 16) was free of psychotropic drugs (Medications used to treat mental health disorders. These medications have many side and adverse effects) she did not need. This failure had the potential to result in adverse consequences such as medication interactions, depression, confusion, immobility, falls with fractures, and death. Findings: Record review indicated Resident 16 was admitted to the facility on [DATE] with medical diagnoses including Dementia (A condition that affects memory) without Behavioral Disturbance (When a person is presenting signs and symptoms of dementia and has a dementia diagnosis, but they lack any symptoms of behavioral disturbances), and Repeated Falls (History of having suffered falls, which may indicate increased risk for future falls), according to the facility Face Sheet (Facility demographic). Record review of Resident 16's MDS (Minimum Data Sheet-An assessment tool) dated 6/04/24 indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 6, which indicated her cognition was severely impaired (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). Record review of Resident 6's physician orders for July, 2024, indicated she was initiated on Seroquel (Brand name for the medication Quetiapine Fumarate, an antipsychotic medication that treats several kinds of mental health conditions) 12.5 mg tab daily beginning on 5/16/24. The order indicated, at bedtime for Aggression. These physician orders for July 2024 did not indicate Resident 16 was to be monitored for aggression, to track the effectiveness or need for the medication. This was confirmed by the Director of Staff Development (DSD) during an interview on 7/11/24 at 3:53 p.m. Record review of an article titled, Quetiapine Oral Route, last revised on 7/01/24 by the Mayo Clinic (A non-profit academic medical center that provides integrated health care, education, and research), indicated, Quetiapine is used alone or together with other medicines to treat bipolar disorder (A mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and schizophrenia (A serious mental health condition that affects how people think, feel and behave) .This medicine should not be used to treat behavioral problems in older adult patients who have dementia or Alzheimer disease (A progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out simple tasks). Record review of Resident 16's Medication Administration Record (MAR) for July 2024, indicated Resident 16 was being administered Seroquel 12.5 mg tab daily at 9:00 p.m., as prescribed. (continued on next page)

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	07/12/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of all active care plans for Resident 16 did not indicate she had aggression issues or was being monitored for aggression. Record review of Resident 16's Face Sheet did not indicate she had medical diagnoses related to or causing aggression. This was confirmed by the DSD during an interview on 7/11/24 at 3:53 a.m. The DSD was also asked to provide evidence the facility had attempted other interventions to control aggression prior to the administration of Seroquel. The DSD stated she was unable to find this evidence. During a dining observation on 7/08/24 at 12:30 p.m., Resident 16 was observed having lunch in the dining room of the facility. Resident 16 was noted to be a pleasant, polite and charming individual. No aggression was observed at all during interactions with other residents or staff. During an interview with the DSD on 7/11/24 at 2:25 p.m., the Surveyor asked the DSD to contact Physician R (The Physician that prescribed Seroquel for Resident 16) for an interview. The DSD contacted Physician R through text. Physician R texted the DSD back indicating, I am about to board my flight. She [Resident 16] has behavioral issues of aggressive behavior when she came. We can try to reduce dose and tapering it off if able. Please reach out to hospice [Agency that provides end of life services] staff and MD (Medical Director) they can help address too. You can address how the facility is monitoring. The Surveyor was unable to conduct an interview with Physician R to inquire about the Seroquel prescription. During a phone interview with Pharmacist J on 7/12/24 at 9:43 a.m., she stated Resident 16 was originally prescribed Seroquel on 12/05/23 at the facility. The Pharmacist stated she wrote a recommendation on 5/05/24 to the prescribing Physician to stop Seroquel, on the facility Medication Regimen Review (A thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication). Pharmacist J stated the pharmacy psychiatric team had met and noted that Resident 16 did not have issues with aggression, therefore, she felt this medication was not necessary. Pharmacist J stated she never received a response back from Physician R regarding this recommendation. Pharmacist J stated physicians were expected to respond to their recommendations within 30 days. Record review of the facility policy titled, Psychotropic Medications, last reviewed on 7/2024, indicated, Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective .The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications .The Physician shall respond appropriately to feedback from the staff by changing or stopping problematic doses or medications, or clearly documenting why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. 40402

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	07/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure the temperature of one of one medication refrigerators in the medication room of the facility (Medication Refrigerator A), was kept within normal parameters for several months, to store resident medications. The medication room where Medication Refrigerator A was stored, was observed propped open with a stool, unattended, prior to entering the room. In addition, one expired medication was found stored with active medications in one of the two medication carts (Medication Cart B, cart for the south hall), stored with other active medications. This failure had the potential to result in medications that were no longer effective, causing harm to the residents involved, and access to unauthorized personnel to the resident medications. Findings: During a concurrent observation and interview on [DATE] at 7:34 a.m., with the Director of Staff Development (DSD), the medication room door was observed propped open with a small stool, and no staff inside, unattended. The door had a sign that indicated, THIS DOOR TO BE LOCKED AT ALL TIMES. The DSD stated the door should not be propped open and night shift staff must have left it like that. During medication storage observation and interview with the DSD on [DATE] at 7:44 a.m., Medication Refrigerator A's temperature was noted to be 28 degrees Fahrenheit. Inside, the following medications were found: a)1 bottle of Lorazepam (A medication to treat seizures and relieve anxiety) oral liquid 30 ml (Milliliters) 2 mg (Milligram)/ml for Resident 34. This box indicated, Store at Cold Temperature (36 F (36 degrees Fahrenheit) to 46 F). b) 1 bottle of Lorazepam oral liquid 30ml, 2 mg/ml for Resident 16. This box indicated, Store at Cold Temperature (36 F to 46 F). c) An emergency medication kit containing several medications for the residents. This kit was not labeled for a specific resident. During the observation and interview on [DATE] at 7:44 a.m., the DSD confirmed findings and stated staff needed education on the correct refrigerator temperature. During concurrent interview and record review on [DATE] at 7:50 a.m., Medication Refrigerator A's temperature log for [DATE] was reviewed with the DSD. The log indicated that on most days, the temperature had been recorded by staff at, or around 28 degrees Fahrenheit. At the bottom of this log, a statement clearly indicated the temperature should be between 36 to 46 degrees Fahrenheit. This was confirmed by the DSD who also reviewed the logs. Prior temperature logs indicated the temperature of Medication Refrigerator A had been at, or around 28 degrees Fahrenheit since December of 2023. (continued on next page)

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	07/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Maintenance Technician H on [DATE] at 9:22 a.m., he was asked if he had been notified by staff that Medication Refrigerator A's temperature was outside of the normal ranges. Maintenance Technician H stated he had not been notified. During a concurrent medication storage observation and interview with Licensed Staff I on [DATE] at 8:15 a. m., a bottle of concentrated protein liquid was found in Medication Cart B with an expiration date of [DATE]. This medication was stored with other active medications in the medication cart. Licensed Staff I confirmed the finding, and stated this medication was for resident use, but was rarely used. During a phone interview on [DATE] at 9:43 a.m., Pharmacist J stated medications that were not stored within required temperature ranges, may not be viable (capable of working or functioning adequately). Record review of the facility policy titled, Medication Storage and Labeling, last reviewed on ,d+[DATE], indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .Medications requiring refrigeration are stored in a refrigerator located in the medication room at/near the nurses' station or other secured location .Only persons authorized to prepare and administer medications have access to locked medications.

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	07/12/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure resident records for 1 of 2 sampled residents that suffered multiple falls at the facility (Resident 190) were accurate. These documents consisted of the fall risk assessments for Resident 190, who suffered three falls at the facility, with two resulting in major injuries. As a result of the inaccurate responses in the fall risk assessments, one of these documents indicated Resident 190 was at low risk for falls, when that was not the case. This failure may have contributed to the lack of care planning and interventions to prevent further falls for Resident 190. It also had the potential to result in inability for staff to identify triggers and patterns necessary for fall prevention measures for Resident 190. Findings: Record review indicated Resident 190 was admitted to the facility on [DATE] with medical diagnoses including History of Falling (History of having suffered falls, which may indicate increased risk for future falls), Alzheimer's Disease (A progressive brain disorder that slowly destroys memory and thinking skills), Restlessness and Agitation, according to the facility Face Sheet (Facility Demographic). 1st Fall with Major Injury: Record review of a progress note dated 1/01/24 at 2:45 p.m., indicated, Resident [Resident 190] called help, help from her room. Entered room with CNA (Certified Nursing Assistant). Resident is on the floor on her L (Left) side next to her bood (Sic, possibly meant bed). Resident unable to explain what happened .L hip is tender to touch. Pain intensifies with movement and attempt to reposition .911 called for transport to [General Acute Care Hospital (GACH)] .Resident left for hospital 15.20 (3:20 p.m.). Record review of a progress note dated 1/01/24 at 10:47 p.m., indicated, Received a phone call .on resident [Resident 190] status, resident has a left hip fracture with possible surgery. Record review of a facility document titled, Fall Risk Assessment, dated 1/02/24 at 11:35 a.m., indicated Resident 190 was at low risk for falls, although she had just fallen the day before, on 1/01/24 and suffered a hip fracture. During a concurrent interview and record review with the Director of Nursing (DON) on 7/11/24 at 9:38 a.m., the document, Falls Risk Assessment, dated 1/02/24 at 11:35 a.m., and December 2023 Medication Administration Record (MAR) were reviewed. The DON stated the fall risk assessment was completed inaccurately, since it indicated Resident 190 had no history of falls within the last three months, was ambulatory and continent, and was taking only two medications that increased her risk for falls, when she was taking eight of these medications, according to her December 2023 MAR. The DON stated Resident 190 did have a history of falls within the last three months, since she had fallen on 1/01/24, required supervision with ambulation, and was incontinent (Inability to control the bowels and bladder) at times. The DON confirmed this assessment indicated Resident 190 was at low risk for falls due to the inaccurate responses submitted. (continued on next page)

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	07/12/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2nd Fall with Major Injury: Record review of a progress note dated 2/20/24 at 8:36 a.m., indicated, Rd [Resident 190] was found on the floor .She was on the floor on her right side at the base of the floor mat next to her bed .she was not complaining of pain at the time .She was lifted back to her bed and she started to complain of right inner thigh pain. Record review of a progress note dated 2/21/24 at 11:40 a.m., indicated, Resident is on S/p (Status post) unwitnessed fall Day 2 .Right hip fracture .Administrator, DON .was notified with the result of the Right Hip X-ray. Record review of a, Falls Risk Assessment, for Resident 190 dated 2/20/24 at 6:37 p.m., indicated Resident 190 was at high risk for falls. During a concurrent interview and record review with the Director of Nursing (DON) on 7/11/24 at 9:38 a.m., the document, Falls Risk Assessment, dated 2/20/24 at 6:37 p.m., and February 2024, MAR were reviewed. The DON confirmed that although the fall risk assessment indicated Resident 190 was at high risk for falls, it was completed inaccurately, since it indicated Resident 190 was taking only two medications that increased her risk for falls, when she was taking eight of these medications, according to her February 2024 MAR. Record review of the facility policy titled, Medical Record Documentation, last reviewed on 7/2024, indicated, All entries in the individual's record should be written objectively and without bias, personal opinion, or value judgment. Entries are to be factual, complete and accurate.

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	07/12/2024

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview, and record review the facility failed to follow their Infection Control policy and QAPI (Quality Assurance and Performance Improvement) policy for 36 out of 36 residents when the facility failed to track and surveil data for resident's chronic UTI (Urinary Tract Infections). This failure had the potential to result in residents developing MRDO (multidrug resistant organisms). Findings: During an interview with Licensed Staff A on 7/10/24 at 10:15 a.m., Licensed Staff A was queried for the QAPI documentation for tracking chronic UTI's in the facility. Licensed Staff A stated, I have not been tracking chronic UTI's. Licensed Staff A queried as to what the risks are to the resident population if the chronic UTI's in the building are not being tracked and surveilled. Licensed Staff A stated, the residents taking long term or frequent antibiotics could become resistant to antibiotics due to overuse. Licensed Staff A queried if she has tracked UTI data for QAPI and IDT conferences to develop a root cause analysis for the residents with chronic UTI's. Licensed Staff A stated, no, she has not. During an observation and record review with Licensed Staff A on 7/11/24 at 10:00 a.m., Licensed Staff A queried for a list of residents who had chronic UTI's since January 2024. Licensed Staff A printed out the monthly Summary of Infection Control and Surveillance Report Tool for the months of 1/2024, 2/2024, 3/2024, 4/2024, 5/2024. Licensed Staff A stated, she has not completed the Infection and Control Surveillance Report Tool for June 2024. Observed on the bottom of the Infection and Control Surveillance Report Tool from January 2024 to May 2024 the area labeled chronic infections was left blank. During an interview and record review with Licensed Staff A in the conference room on 7/12/24 at 9:20 a.m., this surveyor received a printout from Licensed Staff A. The printout had a list of residents who had Chronic UTI's since January 2024. Observed on the list of UTI's was a Resident who was in room [ROOM NUMBER] prior to discharged who had 3 UTI's in 3 months while a resident in the facility; the first UTI occurred 2/12/24, the second UTI occurred 2/22/24 and the third UTI occurred on 4/25/24. Also, on the list was Resident 89 had 2 UTI's in 2 months, the first UTI occurred 3/7/24 and the second UTI occurred on 5/7/24. Resident 4 had 2 UTI's in 2 weeks, the first UTI occurred on 6/18/24 and the second UTI occurred 7/2/24. During an interview with the NHA on 7/12/24 at 10:30 a.m., NHA queried if he had any data from the tracking and surveillance of chronic UTI infections in the facility. NHA responded, no. NHA queried if there has been any data captured to investigate root cause analysis for chronic UTI's in the facility. NHA, responded, not to my knowledge. (continued on next page)

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	07/12/2024

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Infection Control Plan, Revised 3/2024, indicated, Surveillance: The type of surveillance will be reviewed and approved by the Infection Control/QA Committee on an annual basis, or more often if needed. A systematic, active, and ongoing observation of the occurrence and distribution of disease or disease potential within a population group and the events or conditions that increase or decrease the risk of disease transmission shall be used. Identification of resident care problems associated with healthcare epidemiology/infection control is ongoing to prevent health care associated infections in the population at greatest risk. Current surveillance includes (but not limited to) UTI's. During a review of the facility's Facility assessment dated , 12/28/23, indicated, General Quality Assurance and Performance Improvement (QAPI) Program. Policy: It is the policy of the Facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on the outcomes of care and quality of life. This program shall make reasonable efforts to involve/engage staff at all levels of the organization. Page 5 Genitourinary System, urinary retention, Page 6 Urinary Tract Infections. Page 10 Infection prevention and control - identification and control, prevention of infections. During a review of the facility's policy and procedure titled, Quality Assurance and Performance Improvement (QAPI), revised 7/2024, indicated, all corrective actions shall be intended to address gaps in organizational systems. The QAPI committee is responsible for initiating, coordinating, monitoring, and evaluating all QAPI activities under the QAPI program.

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	07/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview and record review, the facility did not follow their Enhanced Barrier Precautions policy and their Hand Hygiene Policy's when 1 resident (Resident 31) out of 36 sampled residents had a staff member who did not practice hand hygiene or correct isolation techniques while administering hygiene care to a resident on Enhanced Barrier isolation. Findings: During an observation on 7/8/24 at 9:00 a.m., outside room [ROOM NUMBER], observed an Enhanced Barrier Isolation Cart (a cart that contains gloves, alcohol, masks, and gowns for staff to wear while providing high contact (Hygiene and bathing) activities to residents. Unlicensed Staff F was observed in room [ROOM NUMBER] without a isolation gown providing hygiene care for Resident 31 who was incontinent of stool. Observed Unlicensed Staff F exiting Resident 31's room also without washing his hands or using hand sanitizer after caring for Resident 31. During an interview on 7/8/24 at 9:20 a.m., in the hallway outside room [ROOM NUMBER], Unlicensed Staff F queried as to what care he was providing in room [ROOM NUMBER]. Unlicensed Staff F stated, he had to change and wash Resident 31 due to Resident 31 being incontinent of stool. Unlicensed Staff F queried why he did not wear a gown while providing high activities care with Resident 31. Unlicensed Staff F stated, he forgot. Unlicensed Staff F queried why he did not wash his hands or use hand sanitizer after he finished with high activities with Resident 31. Unlicensed Staff F stated, he forgot. During an interview with Licensed Staff A on 7/10/24 at 9:45 a.m., Licensed Staff A queried as to what her PPE expectations would be for Unlicensed Staff F caring for a resident on Enhanced Barrier Precautions who was incontinent of stool and being provided hygiene care by Unlicensed Staff F. Licensed Staff A stated, that would be considered High Activity in our Enhanced Barrier Precautions so I would expect the CNA to be wearing a gown and gloves as well as practicing hand hygiene before and after the resident's care. Licensed Staff A was Informed that Unlicensed Staff F was in room [ROOM NUMBER] without a gown, changing and providing hygiene to Resident 31 who was incontinent of stool. Licensed Staff A also informed that Unlicensed Staff F did not practice hand hygiene after he finished changing and providing hygiene to Resident 31. Licensed Staff A queried as to the risks involved to the residents in the facility if Unlicensed Staff F is not wearing an isolation gown or practicing appropriate hand hygiene. Licensed Staff A stated, we could get an outbreak of a serious infection throughout the facility. During a review of the Infection Preventionist's job description, Infection Preventionists Develops and ensures all team members follow infection control procedures including isolation precautions and transmissible disease such as COVID, PPE, flu, and other requirements. Ensure that all personnel wear and/or use safety equipment and supplies (PPE) when appropriate. Provides input and guidance on isolation and required types of precautions. (continued on next page)

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	07/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, revised 5/2023, indicated, the purpose of the Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRO (Multiple Drug Resistant Organisms) to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High Contact Resident Care Activities include Changing Briefs or assisting with toileting, Bathing, providing Hygiene, and dressing. Post clear signage on the door/wall outside resident room a. Type of precautions Enhanced Barrier. Personal Protective equipment is required for all staff providing high-contact resident care activities to include Gown and gloves with bathing, providing hygiene, changing linens, changing briefs, or assisting with toileting, isolation care with PPE is to be placed immediately outside resident room. Provide a trash receptacle inside the resident room at the exit of the room for discarding of PPE after removal and before exiting room or before providing care to another resident in the same room. During the review of the facility's policy and procedure titled, Hand Hygiene / Handwashing, Revised 3/2024, indicated, the facility will establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Standard precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. The facility's hand washing / hand hygiene the primary meant to prevent the spread of infections. In order to perform hand hygiene appropriately, soap, water, ABHR (alcohol), and sink should be readily accessible in an appropriate location including but not limited to resident care areas, and food and medication preparation areas. Staff must perform hand hygiene (even if gloves are used). All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing / hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene products supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Hand Hygiene should be practiced after removing personal protective equipment (e.g., gloves, gown, facemask), before and after entering isolation precaution settings, after contact with resident's intact skin, the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. During a review of the facility's policy and procedure titled, Resident Rights, Revised 4/2023, indicated, all residents shall be treated with respect, kindness, and dignity. Resident must be free from abuse and neglect. Staff Training: Methods of evaluating competency, such as a post test shall be utilized to ensure understanding of resident rights. All training and competency evaluations shall be documented in accordance with facility policy and applicable regulatory requirements. During a review of the facility's policy and procedure titled, Infection Control, Revised 3/2024, indicated, the facility's Infection Control Program has been established to ensure a realistic framework that contributes to the organizational effectiveness through the identification of risk and risk reduction methods. This support will influence and improve the quality of health care in the Facility through identification and reduction of risks from acquiring and transmitting infections among residents.

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	07/12/2024

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 39621 Based on interview and record review, the facility did not provide three of four Unlicensed Staff (Unlicensed Staff N, Unlicensed Staff O & Unlicensed Staff P) with 12 hours of abuse and dementia training annually. This failure had the potential to result in inadequate staff competency to care for the residents within professional standards or practice, poor quality of care, and harm to the residents of the facility. Findings: During an interview with the Director of Staff Development (DSD) on 7/11/24 at 10:00 a.m., she was asked to provide evidence of abuse and dementia training from 7/10/23 to the present for four sampled Certified Nursing Assistants (CNAs-Unlicensed Staff M, Unlicensed Staff N, Unlicensed Staff O & Unlicensed Staff P). During a concurrent interview and record review with the Director of Staff Development on 7/11/24 at 11:30 a.m., the DSD provided the requested documents. The documents provided indicated: 1) Unlicensed Staff M-She was still in orientation taking mandatory trainings. This was confirmed by the DSD during the interview on 7/11/24 at 11:30 a.m. 2) Unlicensed Staff N-Her abuse training was provided on 10/31/23, and the duration of the training was one hour. There were no trainings on dementia for her. This was confirmed by the DSD during the interview on 7/11/24 at 11:30 a.m. 3) Unlicensed Staff O-His last abuse training was provided on 10/31/23 and the duration of the training was one hour. His dementia training was provided on 12/18/23 and the duration of the training was one hour. This was confirmed by the DSD during the interview on 7/11/24 at 11:30 a.m. 4) Unlicensed Staff P-Her abuse training was provided on 11/07/23 and the duration of the training was one hour. Her dementia training was provided on 12/20/23 and the duration of the training was one hour. This was confirmed by the DSD during the interview on 7/11/24 at 11:30 a.m. During the interview and record review with the DSD on 7/11/23 at 11:30 a.m., she was asked how many hours of dementia and abuse trainings were provided to each CNA annually. The DSD stated they were provided with about 5 hours of dementia and abuse training per year. Record review of the facility document titled, Facility Assessment, dated 2023, indicated, The following are requirements for in-service training for nurse aides specifically: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training.