STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555835	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VI at Palo Alto	600 Sand Hill Road Palo Alto, CA 94304

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38087 Based on observation, interview, and policy review, the facility failed to protect the rights of residents to confidentiality of protected health information (PHI, any information in the medical record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service) when staff members left the computer screen open and unattended in the hallways of resident care areas. This deficient practice had the potential to compromise the rights of the residents to privacy and confidentiality. Findings: During an observation on 8/19/24 at 1:00 p.m., a rolling cart containing an open laptop computer was left unattended in the hallway outside of a resident's room. The laptop computer was on and the screen displayed information about multiple residents. On 8/19/24 at 1:08 p.m., certified nursing assistant A (CNA A) returned to the computer. When CNA A was asked about the resident information visible on the screen, CNA A stated she was working on that computer then left to answer a call light and did not close the laptop. CNA A stated she should have not leave the computer screen open and visible to visitors and residents. During an observation on 8/22/24 at 8:25 a.m., a rolling cart containing an open laptop computer was left unattended in the hallway outside of a resident's room. The laptop computer was on and the screen displayed multiple resident's pictures and information about multiple residents. On 8/22/24 at 8:35 a.m., CNA B returned to the computer. When asked about the laptop being open and the resident information visible to the public, CNA B stated he should have closed the laptop when he leaves the area. CNA B stated he had stepped away from his working on the laptop to answer a resident's call light. CNA B stated I should not leave the computer open with the resident information on the screen. Anyone passing by can see it During an interview with the director of nursing (DON) on 8/22/24 at 8:45 a.m., DON was asked what was the process for protecting resident's personal information when laptops are used in the resident care areas. The DON stated the laptop computers should have be put on a locked screen when staff need to step away from the computer. The DON further stated the patient information should have not visible to the public and left the computer unattended. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled HIPPA Security, revised June 2011, indicated Electronic Protected Health Information (ePHI) is any and all information about an individual's health care plan(s) that is stored or transmitted electronically. The Health Insurance Portability and Accountability Act (HIPPA) mandates that ePHI be safeguarded and protected and that employees comply with the act. The policy further indicated 1. Employees who, in the normal course of their job responsibilities, come in contact with ePHI are obligated to safeguard and keep such information secure . 2. Systems containing ePHI are kept secure by various means including .Logging off immediately when leaving a workstation.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview, and record review, the facility failed to follow their restraint protocol and ensure the proper use of side rails or bed canes (adjustable rigid bars attached to the side of a bed) for nine (Residents 1, 12, 22, 26, 32, 33, 191, 243, and 246) of 24 residents (residents who used side rails or bed canes) when: 1. Resident 1 there was no physician order, side rail assessment, consent, or care plan for the use of side rails; 2. For Resident 243 there was no physician order or care plan for the use of bed canes; 3. For Resident 246 there was no physician order for the use of bed canes; 4. For Resident 191 there was no physician order or care plan for the use of bed canes; 5. For Resident 12 there was no physician order or consent for the use of bed canes; 6. For Resident 22 there was no consent for the use of bed canes; 7. For Resident 33 there was no consent for the use of bed canes; 8. For Resident 32 there was no consent for the use of bed canes; and 9. For Resident 26 there was no physician order for the use of bed canes. These failures had the potential to compromise the residents' rights to be fully informed, and make decisions regarding their care and treatment, and result in the residents not receiving the care and services necessary to maintain their health, safety, and well-being. Findings: 1. During an observation on 8/19/24, at 11:25 a.m., Resident 1 was lying in her bed and had upper half-length side rails (cover a portion of the bed, typically half the length). The side rails were in the upright position bilaterally (on both sides). Review of Resident 1's clinical record indicated there was no physician order for Resident 1's use of the side rails. Further review of Resident 1's clinical record indicated there was no consent, no side rail assessment, or no care plan documented for Resident 1's use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the DON on 8/20/24, at 3:35 p.m., the DON reviewed Resident 1's clinical record and confirmed there was no physician order, no consent, no side rail assessment, or no care plan in place for Resident 1's use of the half- length side rails. The DON stated there should have a physician order, a signed consent, and a side rail assessment prior to the installation of the side rails. The DON further stated a care plan should have been developed and implemented for Resident 1's use of side rails. 2. During an observation on 8/19/24, at 12:05 p.m., Resident 243 was lying in her bed and had bed canes in the upright position bilaterally, attached at the head position of her bed frame. During a concurrent interview and record review with the DON on 8/20/24, at 3:35 p.m., the DON reviewed Resident 243's clinical record and confirmed there was no physician order or care plan in place for Resident 243's use of the bed canes. The DON stated there should have been a physician order prior to the installation of the bed canes. The DON stated residents who had bed canes in used should have a care plan in placed. The DON further stated care plans were important for nurses to know the proper implementation and interventions related to bed cane use. 3. During an observation on 8/19/24, at 1:05 p.m., Resident 246 was lying in her bed and had bed canes in the upright position bilaterally, attached at the head position of her bed frame. During a concurrent interview and record review with the DON on 8/20/24, at 3:35 p.m., the DON reviewed Resident 246's clinical record and confirmed there was no physician order in place for Resident 246's use of the bed canes. The DON stated there should have been a physician order prior to the installation of the bed canes. 42819 4. During an observation of Resident 191's room on 8/19/24 at 2:09 p.m., Resident 191's bed had bilateral partial bed canes up. Review of Resident 191's face sheet (summary page of patients' important information), indicated that resident was admitted to the facility on [DATE]. Review of Resident 191's active physician orders and care plans indicated that there was no order or care plan for the use of bed canes. During an interview with the DON on 8/21/24, at 2:10 p.m., the DON stated that there should have been a physician order and care plan for the use of bed canes. During a concurrent interview and record review on 8/23/24, at 1:30 p.m. with the DON. The DON reviewed Resident 191's restraint/adaptive equipment use assessment, physician orders, and care plans, and confirmed that there was no physician order or care plan in place for the bed canes. 48935 5. Review of Resident 12's facesheet indicated she was admitted to the facility on [DATE] with a diagnosis of aftercare following joint replacement surgery, placement of left artificial knee joint and urinary tract infection. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's minimum data set (MDS, a resident clinical and functional assessment tool) assessment, dated 8/2/24, indicated Resident 12 had a brief interview for mental status (BIMS, an assessment used in nursing homes to monitor cognition) score of 13 (a score of 13-15 indicates minimal cognitive impairment). Review of Resident 12's record indicated there was no physician order for the use of bed canes or an informed consent for the use of bed canes signed by either the Resident or Responsible Party. Review of Resident 12's record indicated a care plan was in place for the use of bed canes, to enable with transfers. During an observation on 8/19/24 at 9:28 a.m., Resident 12 was observed in bed, with two bed canes in a fixed position. 6. Review of Resident 22's facesheet indicated he was admitted to the facility on [DATE] with a diagnosis of atrial flutter (an irregular heart rhythm), vascular parkinsonism (a disease of the brain and motor function), and insomnia. Review of Resident 22's MDS, dated [DATE], indicated Resident 22 had a BIMS score of 7 (a score of 0-7 indicates severe cognitive impairment). Review of Resident 22's record indicated a physician order May use bilateral bed canes as enabler for assistance with transfers, bed mobility and aid in positioning while at SNF, dated 2/24/21. Review of Resident 22's record indicated there was no informed consent on file for the use of bed canes signed by either the Resident or Responsible Party. Review of Resident 22's record indicated a care plan was in place for the use of bed canes, to enable with transfers. During an observation on 8/19/24 at 11:45 AM, Resident 22 was observed in bed, with two bed canes in a fixed position. 7. Review of Resident 33's facesheet indicated she was admitted to the facility on [DATE] with a diagnosis of atrial fibrillation (an irregular heart rhythm), previous stroke (a brain attack), and type 2 diabetes mellitus (a disorder that affects insulin and blood sugar levels). Review of Resident 33's MDS , dated 8/9/24, indicated Resident 33 had a BIMS score of 14. Review of Resident 33's record indicated a physician order May use bilateral bed canes as enabler for assistance with transfers, bed mobility and aid in positioning while at SNF, dated 5/26/24. Review of Resident 33's record indicated there was no informed consent on file for the use of bed canes signed by either the Resident or Responsible Party. Review of Resident 33's record indicated a care plan was in place for the use of bed canes, to enable with transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/19/24 at 11:17 AM, Resident 33 was observed in bed, with two bed canes in a fixed position. 8. Review of Resident 32's facesheet indicated he was admitted to the facility on [DATE] with a diagnosis of paroxysmal atrial fibrillation (an irregular heart rhythm), type 2 diabetes mellitus and unsteadiness on feet. Review of Resident 32's MDS, dated [DATE], indicated Resident 32 had a BIMS score of 15. Review of Resident 32's record indicated a physician order May use bilateral bed canes as enabler for assistance with transfers, bed mobility and aid in positioning while at SNF, dated 4/4/24. Review of Resident 32's record indicated there was no informed consent on file for the use of bed canes signed by either the Resident or Responsible Party. Review of Resident 32's record indicated a care plan was in place for the use of bed canes, to enable with transfers. During an observation on 8/19/24 at 11:17 AM, Resident 32 was observed in bed, with two bed canes in a fixed position. 9. Review of Resident 26's facesheet indicated she was admitted to the facility on [DATE] with a diagnosis of fracture of lower end of right femur (right thigh bone), status post ORIF (open reduction internal fixation, a surgery to repair the bone) right femur, and hypertension (high blood pressure). Review of Resident 26's MDS, dated [DATE], indicated Resident 26 had a BIMS score of 15. Review of Resident 26's record indicated there was no physician order for the use of bed canes. Review of Resident 26's record indicated there was a signed informed consent on file for the use of bed canes, dated 7/31/24 Review of Resident 26's record indicated a care plan was in place for the use of bed canes, to enable with transfers. During an observation on 8/19/24 at 10:01 a.m., Resident 26 was observed in bed, with two bed canes in a fixed position. During an interview with the director of nursing (DON) on 8/21/24 at 1:57 p.m., the DON stated there should have a physician order for Resident 12 and 26. DON also stated there should have informed consent for Resident 12, 22, 33, and 32. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Restraint Protocol, revised October 2023, indicated . 3. If side rails are used as enablers, the Side Rail(s) Use Assessment in Matrix is completed. 4. The following items are also documented if side rails as enablers are going to be used: .Resident/responsible agent signed the Physical Restraint/Adaptive Equipment consent permitting the use of side rails as enabler; and Receipt of order authorizing the use of side rails. 5. Residents are assessed at least quarterly for continued need of side rails as enablers.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48935 Based on observation, interview and record review, the facility failed to provide appropriate pharmaceutical services when there were discrepancies between the controlled drug (those with high potential for abuse and addiction) record (CDR, an inventory/accountability sheet) and the medication administration record (MAR) for two out of two residents (Residents 140 and 26). This failure resulted in the facility not having accountability of controlled medications, which had the potential for misuse or diversion. Findings: During the survey, two random CDRs for two residents (Residents 140 and 26) were requested for review. On 8/22/24 at 11:00 AM, a review of the residents' physician orders, the CDRs and MARs indicated the following: 1. Resident 140 had a physician order, dated 8/5/24 for oxycodone (pain medication) 5 milligrams one tablet ever 4 hours PRN (as needed) for mild to moderate pain. Resident 140 had two instances initially noted to be in the CDR but not documented as given in the MAR: On 8/19/24 at 12:40 a.m., 8/19/24 at 8:40 a.m. and 8/20/24 at 8:40 p.m. 2. Resident 26 had a physician order, dated 7/31/24 for oxycodone 5 milligrams 1-2 tablet every 4 hours PRN for mild to moderate pain. Resident 26 had one instance which was recorded in the CDR but not in the MAR dated on 8/17/24 at 11:12 a.m. During a concurrent record review and interview with the director of nursing (DON), another instance was noted to be in the CDR for Resident 140 but not in the MAR dated on 8/19/24 at 8:40 PM. The DON confirmed the missing documentation for Resident 140, and Resident 26 on the MAR. The DON stated administration of controlled substances must be recorded in the controlled drug record and the MAR. The DON also stated We would have to provide education to the staff about documenting in both the MAR and CDR. Review of facility policy titled Medication/Treatment Management Protocol, last revised October 2023, indicated .Controlled substances are signed-off on the medication/treatment record in EMAR as well as on the Controlled Substance Record/signature page, if not automated .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48935 Based on observation, interview and record review, the facility had a facility medication error rate of 7.59% when two medication errors occurred out of 26 opportunities during medication administration for two out of 5 residents (Resident 21 and Resident 32). This failure resulted in medication not given in accordance with the prescriber's orders which resulted in residents not receiving the full therapeutic effects of the medications. Findings: 1. During a concurrent medication pass observation and interview on 8/19/24 at 11:00 AM with registered nurse (RN) C , RN C administered Timolol (an eye drop medication) to Resident 21, one eye drop in each eye. RN C then administered Simbrinza (another eye drop medication) one eye drop in Resident 21's left eye without waiting 5 minutes after giving the Timolol. RN C stated I should have wait 5 minutes before giving the other eye drop. During an interview with the director of nursing (DON) on 8/22/24 at 11:45 a.m., the DON stated she expects staff to wait 5 minutes between eye drops if residents get more than one eye drop. A review of Resident 21's physician order, dated 12/17/2022 indicated Resident 21 was to receive Timolol , one eye drop in both eyes, once a day at 9:00 a.m. for indication of glaucoma (a disorder of the eyes caused by high eye pressure). Special instructions indicated Wait at least 5 minutes before any other eye drops. A review of Resident 21's physician order, dated 12/17/2022 indicated Resident 21 was to receive Simbrinza one eye drop in the left eye, three times a day at 9:00 a.m., 5:00 p.m., and 9:00 p.m., for indication of glaucoma. Special instructions indicated Wait at least 5 minutes before any other eye drops. Review of facility policy titled Specific Medication Administration Procedures-IIB5: Eye Drop Administration, last revised 5/16/2018, indicated .If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, (or the amount of time specified by the manufacturer) then repeat procedure above. 2. During a concurrent medication pass observation and interview on 8/20/24 at 4:29 PM with LVN E, LVN E administered 3 units of novolog (a type of insulin injection) to Resident 32 with a pen injector (an injector that uses a dial to administer the correct medication dosage). Prior to administering the 3 units, LVN E did not prime the pen injector needle with 2 units of novolog. LVN E stated I did not know about it when asked about priming a pen injector needle prior to giving a dosage of novolog. A review of Resident 32's physician order, dated 8/10/24 indicated Resident 32 was to receive insulin aspart U-100 (novolog, medication for blood sugar) per sliding scale, before meals at 6:30 a.m., 11:30 a.m., and 4:30 p.m. The order also indicated If blood sugar was between 201-250, give 3 units. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Lexidrug UpToDate indicated for insulin aspart administration .For prefilled pen injectors, prime the needle before each injection with 2 units .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38087 Based on observation, interview and record review, the facility failed to ensure food was stored in accordance with professional standards for food safety when: 1. There was an opened undated food item in the pantry freezer; 2. There were open and undated food items, and unopened food items with no expiration dates in the dry storage area of the main kitchen. These failures had the potential to cause food contamination and food-borne illness to 37 of 37 residents who received their food from the kitchen. 1. During an initial kitchen tour on 8/19/24 at 9:20 a.m., accompanied by the Executive Chef (EC), inside the reach-in freezer there was an opened, undated container of mango sorbet. The EC confirmed the sorbet was opened and not dated and he stated all items should have been dated when opened. The EC stated the mango sorbet must be discarded. 2. During a continuation of the initial kitchen tour on 8/19/24 at 9:45 a.m., accompanied by the EC, an inspection of the main kitchen dry storage area was conducted. There was a box labeled [NAME] French Lentils which contained an opened bag of lentils. The open bag was undated. The EC stated the bag should have been dated when opened and he stated the lentils must be discarded. In addition, the dry storage area contained four 2- pound bags of chopped peanuts. The four bags were unopened but did not have an expiration date on the bags. The EC stated the bags had been removed from their original box for storage on the shelves and the expiration date would have been on the original box. The EC stated the four bags of peanuts must be discarded since their expiration date was unknown. Review of the facility's policy titled Sanitation and Safety, revised June 2011, indicated . 5. Labeling and dating food; Prepared and packaged food will be labeled and rotated to decrease the risk for food-borne illnesses, provide the highest quality product for the residents and minimize waste.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935 Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices for two out of two sampled residents when: 1) A Licensed Vocational Nurse E (LVN E) did not disinfect a glucometer after using it to test a resident's blood sugar (Resident 32). 2) A Registered Nurse C (RN C) did not scrub the hub (an endcap) at the end of a peripherally-inserted central catheter (PICC, a type of tube that goes directly to the heart) line for 15 seconds before flushing the PICC line with normal saline solution and before connecting the intravenous (IV) drug tubing to the PICC line (Resident 191). 3) RN D did not wear gloves when removing a medicated patch from a resident's chest, then did not wear gloves or perform hand hygiene when applying a new medicated patch to the resident's chest (Resident 15). These deficient practices had the potential to result in transmission of infection causing agents to the residents in the facility. Findings: 1. During a concurrent observation and interview with LVN E on 8/20/24 at 4:29 PM, LVN E used a glucometer (a device that checks blood sugar levels) but did not disinfect the glucometer after usage. LVN E stated I will do it . During an interview with the director of nursing (DON) on 8/22/24 at 11:45 AM, the DON stated I expect the staff to wipe the glucometer after using it. Review of facility policy titled Glucometer Quality Control Testing and Cleaning, last revised October 2017, indicated .The glucometer and fingerstick device was disinfected after each use using the PDI Super Sani Cloth or Sani Cloth Plus or other approved cleaner noted in the manufacturer's guidelines. 2. During a concurrent observation and interview with RN C on 8/20/24 at 10:50 AM, RN C scrubbed the end cap with a rubbing alcohol swab at the end of Resident 191's PICC line for less than 10 seconds, before connecting a syringe pre-filled with normal saline solution (a solution used to ensure the PICC line is unblocked from debris build up), and then between flushing the PICC line and between connecting the IV drug tubing to the PICC line. RN C stated I am supposed to scrub for 60 seconds, when asked how long the end cap must be wiped for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555835	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VI at Palo Alto	600 Sand Hill Road Palo Alto, CA 94304

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 - Few	Review of literature pertaining to the care of central venous catheters and PICC lines titled CLABSI Toolkit-Scrub the Hub! indicated .Use a scrubbing device with an alcohol product such as chlorhexidine with alcohol or 70% alcohol to disinfect catheter hub and stopcocks[.]Rub for 10 to 15 seconds (unless directed otherwise by the manufacturer's instructions), generating friction by scrubbing in a twisting motion as if you were juicing an orange (The Joint Commission. Preventing Central Line-Associated Bloodstream Infections: Useful Tools, An International Perspective. [DATE]. Accessed August 23rd, 2024) 3. During a concurrent observation and interview with RN D on 8/19/24 at 11:15 AM, RN D removed a medicated patch without performing hand hygiene or putting on gloves from Resident 15's upper chest. RN D also did not perform hand hygiene or put on gloves before applying a new medication patch to Resident 15's upper chest. RN D stated I don't use gloves because the patch gets stuck on my gloves, when asked about removing and applying the medicated patch without wearing gloves. During an interview with the DON on 8/22/24 at 11:45 am, the DON stated I expect staff to wear gloves when removing an old patch and putting on a new patch, and performing hand hygiene before donning gloves. Review of facility policy titled Specific Medication Administration Procedures-IIB13: Transdermal Drug Deliver System (Patch) Application, last revised 5/16/18, indicated before administration to .Wash hands or use facility-approved sanitizer . Put on examination gloves . Remove old patch from body by using gloved hands to peel off slowly .Using gloves unwrap the new patch .Apply new patch firmly against the skin .Wash hands thoroughly with antimicrobial soap and water or facility-approved hand sanitizer.