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	01/26/2026

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.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review the facility failed to ensure Kitchen Staff F (KS F) used proper technique when testing sanitizer concentration for cleaning food contact surfaces. This failure had the potential to increase the risk of contamination and exposure to food borne illness for 37 residents in the facility.Findings: During a kitchen observation on 1/22/26, at 10:10 a.m., KS F was observed checking the sanitizer bucket used for cleaning food contact surfaces. KS F dipped the sanitizer test strip into the sanitizer solution and immediately removed the test strip. KS F did not allow the test strip to remain in the solution for the required contact time. According to the manufacturer's instructions on the Hydrion QT-40 sanitizer test strips indicated: Immerse for 10 seconds During an interview and concurrent review on 1/22/26 at 2:40 p.m., the Registered Dietitian (RD) was informed of the observation related to improper testing of the sanitizer bucket. The RD confirmed that the manufacturer's instructions on the Hydrion test strips require 10 second immersion time. The RD stated that staff should immerse the sanitizer test strip in the solution for 10 seconds and stated the facility would provide an in-service to kitchen staff.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were developed and revised timely for two of 12 sampled residents (Residents 30 and 7) when: 1.Resident 30's Care Plan indicated Full Code and the physician's order indicated DNR;2a.Resident 7's Care Plan indicated Full Code and the POLST indicated DNR; and2b.Resident 7's Care Plan did not indicate self-administration of medication. These failures had the potential to affect the provision of care. Findings: Review of Resident 30's Physician Order Report, dated [DATE] to [DATE], indicated Resident 30's code status was Do Not Resuscitate/Do Not Intubate (DNR, no CPR/chest compressions if the heart stops; DNI means no breathing tube or ventilator if breathing stops). Review of Resident 30's Care Plan, date [DATE], indicated the resident's code status was Full Code (all possible life-saving measures, including cardiopulmonary resuscitation (CPR) and other medical interventions, should be used in the event of a medical emergency). During a concurrent interview and record review on [DATE] at 4:00 p.m., the Director of Nursing (DON) confirmed that the care plan should have been revised to reflect the physician's order for DNR/DNI and acknowledged that the care plan was not revised. Review of facility's policy titled Care Plan Protocol revised 11/2011, indicated Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient . 2a. Review of Resident 7's Face Sheet (summary page of a patient's important information) indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including central cord syndrome (an incomplete traumatic injury to the portion of the spinal cord that runs through the bones of the neck) at C4 level of cervical spinal cord (area located in the mid-neck and critical segment for neck mobility, shoulder function and nerves that control breathing), type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) with diabetic neuropathy (nerve damage caused by long-term high blood sugar), long term use of insulin (medication used to lower blood sugar levels), chronic kidney disease (gradual loss of kidney function), hypertension (a condition in which the force of the blood in the blood vessels is too high), glaucoma (damage to the nerve in the eye cause by fluid buildup or increased pressure), rosacea (skin condition causing facial redness, visible blood vessels and bumps on face, chest, or back), and long term use of antibiotics (medications used to treat and prevent bacterial infections). Review of Resident 7's Quarterly review minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated a brief interview for mental status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Review of Resident 7's Physician Order Report dated [DATE], indicated Code Status: DNR/DNI. Review of Resident 7's POLST (Physician Orders for Life-Sustaining Treatment- a written medical (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order that assists people in making decisions about medical treatment and life saving measures during end-of-life care or a medical crisis) dated and signed by Resident 7 on [DATE] indicated, Do Not Attempt Resuscitation/DNR (Allow Natural Death). Review of Resident's 7's Care Plan dated [DATE] indicated Advance Directives (a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions): Resident's code status is: Full Code. During an interview on [DATE] at 3:32 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, A resident's care plan should be updated whenever there is a change. During an interview on [DATE] at 3:00 p.m., with the DON, the DON stated the POLST, Advanced Directives and care plan should match. Review of the facility's policy and procedure titled, Advanced Directives Protocol, revised [DATE], indicated, Determination of Advance Directives Upon Admission- Upon admission, the resident and/or responsible agent and/or Durable Power of Attorney for Healthcare (DPAH) are asked if the resident has executed an advance directive (AD). 1. If the resident has executed an AD, a copy of the document is requested. 6.1. Document the status of the advance directive in the care plan or service plan. 2b. During a concurrent observation and interview on [DATE], at 11:27 a.m., with Resident 7, one opened container and one unopened container of anti-fungal powder was observed on the over bed table in Resident 7's room. Resident 7 stated she used the anti-fungal powder on the irritated area on her abdomen during her stay in the facility. During an interview on 1/21/ 26 at 12:04 p.m. with LVN B, LVN B confirmed the two containers of anti-fungal powder were on the over bed table in Resident 7's room. LVN B stated not knowing the anti-fungal powder containers were at the resident's bedside and didn't know if the containers should be in the resident's room. During an interview and concurrent review of Resident 7's Physician Orders and Care Plan on [DATE] at 3:00 p.m., the DON stated Resident 7 had not been assessed for self-administration of medication and did not have an order or a care plan for self-administration of any medication. During a review of the facility's policy and procedure title, Medications-Bedside Storage and Self-Administration, revised [DATE], indicated Prescription and nonprescription over the counter (OTC) medications, except narcotic analgesics and other Class II drugs, may be stored at the bedside in a secure, locked drawer when ordered by a healthcare provider with prescriptive authority, and after the assessment and approval by the interdisciplinary team of the resident's ability to self-administer medication. 1. The order received for the medication to be used/stored at the bedside includes directions for use and specifies that the medication is to be stored at the bedside. All bedside medications are labeled as such and stored securely under lock and key. 3. Any resident who has bedside medications is instructed on the proper use and storage of the medication. 4. Items documented in the resident's plan of care include but are not limited to the following: Assessment confirmation of ability to self-administer; Authorization from the healthcare provider with prescriptive authority; and Relevant safety issues.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act upon the pharmacy consultant's medication regimen review recommendation for one of 12 sampled residents (Resident 1). This failure had the potential to affect the safety and management of the resident's medication regimen. Findings: Review of Resident 1's clinical record indicated diagnoses including benign prostatic hyperplasia (BPH, enlargement of the prostate gland). Review of Resident 1's Physician Orders, dated 12/23/25 through 1/23/26, indicated an order for Tamsulosin (medication that helps relax prostate and bladder) 0.4 milligrams (mg, unit of weight) one capsule by mouth twice a day for BPH. Review of Resident 1's admission Medication Regimen Review, dated 12/26/25, indicated the consultant pharmacist recommended updating the instructions to Tamsulosin 0.4 mg, take two capsules (0.8 mg) by mouth once daily, to be administered 30 minutes after the evening meal, and that the capsules should not be crushed, chewed, or opened. During a concurrent interview and record review on 1/23/26 at 3:30 p.m., the Director of Nursing (DON) stated the physician had been notified. Further review, of Resident 1's medical record did not show documentation of physician notification or documentation of physician's response to the pharmacist's recommendation. The DON acknowledged that documentation of physician's response to pharmacist recommendations and rationale if the physician agreed or disagreed, should be documented in the medical record. During a phone interview on 1/26/26 at 10:40 a.m., the Consultant Pharmacist (CP) stated she completes monthly drug regimen reviews. The CP further stated that she reviewed Resident 1's physician orders and confirmed that the Tamsulosin recommendation was not carried out. Review of facility's policy titled Drug Regimen Review, revised 10/2023, indicated, .The Pharmacist will make a written report of any irregularities to the resident's attending physician, the Community's Medical Director, and the Director of Nursing on the Drug Regimen Review Irregularity Report or comparable pharmacy Drug Regimen Review Report .The resident's attending physician will document in the clinical record that the Drug Regimen Review Irregularity Report was reviewed. The physician will also document any action that must be taken to address the irregularity. If no change to the resident's medication is made, the physician will document his or her rationale in the clinical record. Should any potential or actual clinically significant medication issues be identified, throughout the resident's stay, the clinician will contact the physician and complete the prescribed/recommended actions by midnight of the next calendar day. This will be documented in the electronic health record in a Drug Regimen Review progress note or in an Event report if related to a medication error .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when inspection of two of three medication carts identified an insulin pen without a visible resident's name on it. This failure had the potential for the unlabeled insulin to be administered to the wrong resident. Findings:Findings: During an inspection of Medication Cart #3 on 1/26/26 at 10:59 a.m. with Registered Nurse (RN) C, an insulin pen (a pre-filled pen containing insulin to lower blood sugar) was identified opened and did not have resident specific labeling on it. RN C verified this finding and acknowledged it should have a label to indicate the name of the resident. During an interview on 1/26/26 at 3:26 p.m. with the Director of Nursing (DON), the DON confirmed the insulin pen did not have a resident specific label. The DON stated the resident specific label is only placed on the box of insulin pens when delivered from the pharmacy and stored in the refrigerator in the Medication Room. The DON confirmed one pen would be removed from the refrigerator, placed in a cellophane bag labeled with the resident's name and left in the medication cart for multiple administrations for the resident. A review of the 2017 Institute for Safe Medication Practices (ISMP, a nonprofit patient safety organization with recognized national expertise in medication error prevention) Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults, indicated, If an institution chooses to use insulin pen devices, each should contain a patient-specific label and be stored in a patient-specific bin/drawer . to prevent contamination from inadvertent misuse on another patient. A review of the facility's Policy and Procedure titled Medication Management Protocol, revised June 2011 indicated: Storage of Medications 1. Resident medications are packaged by a pharmacy and labeled accordingly with the: Name of the prescribing healthcare provider; Resident's name; Date dispensed; Name and strength of medication; Directions for usage; Time to be taken; and Other directions and restrictions (e.g., with food, 1 hour after eating). The prescription number, name and address of the issuing pharmacy. 1.1. Medications packages having soiled, damaged, incomplete, illegible or makeshift labels are returned to the issuing pharmacy for disposal or re-labeling.

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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. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when the shared glucometer was not sanitized and disinfected for one out of two sampled residents. This failure could result in cross-contamination and the spread of infection throughout the facility.Findings: During a medication pass observation on 1/22/26 at 11:27 a.m., Licensed Vocational Nurse (LVN) A was observed returning the glucometer to the medication cart drawer after obtaining the blood sugar reading for Resident 1 without disinfecting it. During an interview on 1/22/26 at 11:20 a.m., LVN A stated she was supposed to use the Sani-Cloth (a germicidal disinfectant) wipes to disinfect the glucometer to prevent the spread of infection between residents. LVN A stated, It's usually sanitized after every resident but I forgot. During an interview on 1/26/26 at 11:41 p.m. with the Infection Preventionist (IP), the IP stated the nurses should sanitize before and after use of the glucometer with the Sani-Cloth wipes. The IP explained the disinfection process, dwell time two minutes, the glucometer wet for two minutes. The IP stated online and in person Infection Prevention and Control in-services are conducted on a regular basis for all staff. A review of the facility's policy and procedures titled, Glucometer Quality Control Testing and Cleaning, revised October 2017 indicated, .5. The glucometer and fingerstick device is disinfected after each use using the PDI Super Sani Cloth or Sani cloth Plus or other approved cleaner noted in the manufacturer's guidelines. 5.1 Follow manufacturer's guidelines for the cleanser, which include thoroughly wetting the surface. The treated surface must remain visibly wet for a full 2 minutes and to use additional wipes as needed to assure continuous 2 minute wet contact time and let air dry.