STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055268	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonoma Post Acute	678 2nd Street West Sonoma, CA 95476

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and record review [AES1] the facility failed to provide pain medicine in the form of a cream (lidocaine) for one out of two sampled residents (Resident 1). This failure potentially caused Resident 1 pain and further suffering by missed medication administrations. Findings: During a review of Resident 1 ' s Admission Record, dated 1/23/2007, indicated Resident 1 had initially been admitted to the facility on [DATE] with a medical history of stroke (blockage of blood supply in parts of the brain), quadriplegia (as defined as the dysfunction or loss of motor and sensory function of the cervical area [AES3] of the spinal cord, leading to partial or total loss of function in the arms legs, trunk and pelvis) and high blood pressure. During an interview with Resident 1 on 6/13/24 at 10:38 a.m., Resident 1 stated the medication, Lidocaine (ointment type cream which when applied relieves pain) Ointment was to be administered two times a day and it had not been administered for days and the facility was giving excuses like it been refused (by resident) or it was back ordered. Resident 1 stated when the medication had not been applied, to the buttocks area and could be painful. During a concurrent review of Resident 1 ' s, Medication Administration Record and Physician orders, for the month of Jun, 2024 indicated Resident 1 was administered Lidocaine External Ointment 5%, two times a day (06:30 am, 9pm) on 6/1/24. The Medication Administration Record indicated on 6/2/24 both am and pm doses had a code of nine (indicating the medication was not administered), 6/3/24 the am dose documentation space was left blank, indicating the medication had not been given and at 9 pm, the same code of 9 was documented. On 6/4/24 at 06:30 am the same code of nine was documented but the 9 pm dose was documented to be given as ordered. During a concurrent observation and interview on 6/13/24 at 3:30 pm, at the medication cart , with Licensed Staff A, Licensed Staff A indicated by pulling out a drawer that Resident 1 had a tube of Lidocaine cream with Residents 1 ' s name and prescription information on the tube. The tube filled with medication appeared to be almost full and when Licensed Staff A was asked when would the medication be re-ordered, Licensed Staff A indicated by gesturing, using the thumb and index finger when the top was approximately 1/3 left of the medication and would be re-ordered so it would not run out. Licensed Staff A reviewed the Medication Administration Record, dated 6/1/24 to 6/4/24 and stated the code documented on 6/2/24, 6/3/24 and 6/4/24 meant the medication had not been administered. (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
	055268	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonoma Post Acute	678 2nd Street West Sonoma, CA 95476

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Staff A indicated on the Medication Administration Record, dated 6/1/24 to 6/4/24 was reviewed and stated the code documented on 6/2/24, 6/3/24 and 6/4/24, indicated the code meant the medication had been re-ordered but had not yet arrived at the facility. Licensed Staff A stated Resident 1 had received the medication on 6/4/24 at the 9 pm dose but had missed the 6:30 am dose. Licensed Staff A could not explain when the medication had been originally re-ordered but there was documentation to indicate the medication had to be re-ordered for a second time on 6/3/24 and was delivered after the 6:30 am dose and prior to the 9 pm. dose. During an interview on 6/13/24 at 3:35 pm. with Director of Nursing (DON), DON indicated the Lidocaine cream for Resident 1 had been ordered on 6/1/24 (when last dose administered) and then had to be re-ordered again, on 6/3/24 and was then delivered on 6/4/24 (this timeline explains why Resident 1 did not receive the doses of lidocaine cream). DON could not explain why the medication had not been re-ordered prior to the medication running out and would not explain the outcome of not having the medication. There was no documentation that indicated when did Resident 1 ran out of Lidocaine cream or when the Lidocaine cream was ordered to the pharmacy.