Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055854	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Post Acute	4650 Hoen Avenue Santa Rosa, CA 95405

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview and record review, the facility failed to provide adequate nutrition and weight monitoring for (Resident 1) when (Resident 1) lost 7.8 pounds (5.3%) within the first week of the Resident's admission. This failure had the potential for Resident 1 to be at risk for malnutrition, dehydration, and electrolyte imbalance. Findings: During a record review of Resident 1's medical record, face sheet revealed Resident 1 is a [AGE] year old with multiple diagnoses with some being; Spastic Quadriplegic Cerebral Palsy, (impaired movements, due to brain damage at a very young age characterized by paralysis of both arms and both legs, with muscle stiffness in face and trunk of body), Epilepsy (seizure disorder), Dysphagia, (difficulty swallowing), and cognitive communication deficit (difficulty communicating). During a record review of Resident 1's medical record, Brief Interview for mental status (BIMS Score) (indicates thinking and reasoning capabilities. A score of 15 out of 15 is the highest score.) Resident 1's score was 4 out of 15. During a record review of Resident 1's medical record, Speech Therapy Evaluation and Plan of Treatment dated, 4/27/24, signed by SLP1, indicated, skilled SLP (Speech Language Pathologist), Skilled SLP services for dysphagia are warranted to assess/evaluate least restrictive oral intake and design and implement strategies in order to enhance patient's quality of life by improving ability to safely consume least restrictive diet, decrease signs and symptoms of oral dysphagia, decrease risk of aspiration, decrease risk of malnutrition and weight loss. During a record review of Resident 1's medical record, Nutritional Risk Assessment, signed by Registered Dietician (RD1), dated 5/1/24, indicated, an admission weight on 4/27/24 was 146.8 pounds / 67 kg (kilograms). Resident 1 was dependent at meals with 1:1 feeding assistance required. Weight Goal: maintain weight. Estimated Energy Needs: 1750 calories and 1650-2000 milliliters (25-30 / kg) per day. During a record review of Resident 1's medical record, Dietary Progress Note, dated 5/1/24, signed by RD1, indicated, Resident 1 at risk for malnutrition. Maintain oral intake greater than 75% for most meals and maintain positive hydration status. Recommend 1:1 feeding assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4650 Hoen Avenue Santa Rosa, CA 95405	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's medical record, Medication Administration Record, dated 5/2/24 - 5/14/24, indicated, Resident 1 needed 1:1 Feeding assistance every shift. Unlicensed Staff 1 documented Resident 1 was a maximum assist. During a review of Resident 1's medical record, Care plan dated 4/29/24, indicated Resident 1 has swallowing problem related to coughing or choking during meals and loss of food/fluids from mouth while eating. Interventions: Monitor for shortness of breath, choking, dysphagia, pocketing and holding food in mouth and drooling. Meals/fluids 1:1 feeding assistance. Monitor weight per protocol. During an interview with Licensed Vocational Nurse (LVN 1) on 8/7/24 at 3:30 p.m., LVN 1 stated, she remembers Resident 1 to be a maximum assist because he could not do much for himself. He could not feed himself due to his arms being contracted no matter what position you repositioned him in he kept his hands clenched due to his muscle spasms. During a review of Resident 1's medical record, Intervention / Task Summary for meals, dated 5/1/24 - 5/11/24, Resident 1 was documented 15 times as eating independently. During a review of Resident 1's medical record, Intervention / Task Summary for Amount Eaten, dated 4/27/24 - 5/14/24, indicated Resident 1 had eaten less than 50% of his meals while at the facility. During a record review of Resident 1's medical record, IDT Note, (interdisciplinary note) dated 5/10/24, signed by RD1, indicated, weight loss 7.8 pounds in 7 days. Resident at risk for malnutrition. Resident dependent at meals. During an interview with Anonymous 1 on 8/5/24 at 4:00 p.m., Anonymous 1 stated, he observed multiple times while at the facility, Resident 1's meal tray was placed on his bed side table. Anonymous 1 informed staff that the tray was in the room getting cold and no staff came to feed Resident 1. Anonymous 1 stated, he asked why they did not feed the resident and staff responded Resident 1 refused. Anonymous 1 observed no one asked Resident 1 if he wanted to eat. Staff just took the tray away. During a record review of Resident 1's medical record, MD Order Summary Sheet, signed by MD1, dated, 4/26/24, indicated, weekly weights times 4 weeks. Discontinue if stable, then do monthly in the morning every Sat for 4 Weeks. During an interview with the Director of Nursing (DON) on 7/25/24 at 12:00 p.m. in conference room, queried DON for Resident 1's weekly weights. DON responded, we only did monthly weights on Resident 1, not weekly weights. Requested documentation of the monthly weights for Resident 1. Received Facility's Monthly Weight Report with only 2 weights documented. First weight was documented on 4/27/24, indicated 146.8 pounds. Last weight was documented on 5/2/24 which indicated 139 pounds. DON queried for any further weights completed on Resident 1. DON responded we only did those 2 weights. Both weights were done in 1 week and 7 days apart. Resident 1 lost 7.8 pounds in 7 days. Both weights were completed on the same lift mechanical scale. DON queried what the risks are for Resident 1 who is at risk for malnutrition and dehydration was not weighed. DON Responded he could be losing weight, and we wouldn't know it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RD2 on 8/6/24 at 1:04 p.m. RD2 queried for further documentation listing dietary interventions for Resident 1's Nutritional and fluid maintenance. RD2 stated she was a contractor and was new to the facility. RD2 stated RD1 recently resigned from the facility, and RD2 is not familiar with Resident 1 but RD2 would check the computer for further documentation from RD1. RD2 had produced RD1's progress note, and IDT note which surveyor already had. No new documentation was received for Resident 1 dietary goals. During a review of Resident 1's medical record, MD order, signed by MD1, dated 5/13/24 at 3:00 p.m., indicated, Start Sodium Chloride intravenous IV at 100 cc / hour for total 500cc's. (Salt fluid given through the vein for hydration). During a review of Resident 1's medical record, Nurses Note, dated 5/13/24 at 7:06 p.m., signed by RN2, indicated Normal Saline 0.9 flowing at rate of 100ml/hr., total 500ml for hydration. During a review of Resident 1's medical record, Social Service Director (SSD) note, dated 5/14/24, indicated, resident discharged back to group home transported by van. During an interview with Anonymous 2 on 8/8/24 at 10:00, Anonymous 2 stated, she remembers on 5/14/24 when Facility 1 transferred Resident 1 back to Facility 2 Resident 1 had to be sent to the Emergency Department for dehydration. During a review of Resident 1's medical record from Facility 2, Resident 1's Lab work dated 5/14/24, indicated, Resident 1's Blood Urea Nitrogen Level (BUN) (Blood test that determines if a Resident is dehydrated if the test result is high) was 27. Normal BUN result is 0-18 mg per deciliter. During a review of the facility's policy and procedure titled, Weight Assessment and Intervention, dated 2001, indicated, any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. Evaluation: Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evolution includes: the resident's calorie, protein, and other nutrient needs compared with the resident's current intake, chewing or swallowing abnormalities, increased need for calories and/or protein, fluid and nutrient loss, and inadequate availability of food or fluids. Care Planning: Care planning for weight loss or impaired nutrition is a multidisciplinary effort an includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident legal surrogate. Individualized care plans shall address: the identified causes of weight loss, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment. Interventions: for undesirable weight loss are based on careful consideration of the following: Nutrition and hydration needs of the resident, Chewing and swallowing abnormalities and the need for diet modifications, the use of supplementation and/or feeding tubes.