

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  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41175</b></p> <p>Based on observation, interview and record review, the facility failed to provide a reliable communication channel to one of three sampled residents (Resident 1), when phone calls to the facility were not picked up in a timely manner. These multiple unanswered phone calls resulted in difficulties in establishing communication between Resident 1 and her family, causing frustration and distrust.</p> <p>Findings:</p> <p>During an interview on 8/29/24 at 10 a.m., Family Member (FM) stated phone calls to the facility were not always answered. FM stated she did not live in the area, and calling the facility was the only way to contact her mother, Resident 1. FM stated she tried to call the facility in the evenings after her work, and added it was very frustrating when she was unable to get ahold of any staff for any updates or to answer questions. FM stated one phone call was even picked up by a very confused lady, most likely another resident there. FM stated it was pointless for the facility to post their phone number as their contact information, if no one would be answering the calls.</p> <p>An internet search of the facility indicated a publicly listed address and phone number. Calls were made to the facility on [DATE] at 6:30 a.m. and on 9/2/24 at 4:30 p.m. Neither of the calls were picked up.</p> <p>During an interview on 8/29/24 at 4:30 p.m., Confidential Staff stated the facility 's phone system was pretty bad. Confidential Staff because the phone system was not provided by traditional landline companies, phone service was dependent on the strength of the Internet signal, which affected the calls' reliability and consistency. Confidential Staff stated not only were there previous issues with Internet signal in the neighborhood, but there were also areas in the facility where there was poor Internet reception, making phone calls impossible.</p> <p>During an interview on 8/29/24 at 4:55 p.m., Licensed Staff B stated a receptionist sat by the front desk during the day and answered phone calls, and a cordless phone would be handed to the residents should a call come in for them. During the concurrent observation of the front desk, Licensed Staff B pointed to an empty phone charger on the desk and stated that was the usual location of the cordless phone used for the residents. Licensed Staff B stated he did not know where or who had the phone.</p> <p>(continued on next page)</p>

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  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/29/24 at 5:01 p.m., DON stated a receptionist worked during business hours (between 8 a.m. to 5 p.m.) during the weekdays (Monday to Friday), and part of her role was to answer the phones. DON stated the phones were answered by the staff afterhours. During a concurrent observation of the of the empty front desk, DON stated it was not unusual for the area to not be staffed at times, such as during meal service and med (medication) pass. DON stated the facility was aware of previous incidents where a resident with dementia picked up the front desk phone. DON proceeded to cross the front desk area, took a phone from the desk counter, and placed it behind the counter. DON stated expected the staff to keep the phones out of reach of the residents. DON stated she understood how frustrating unanswered phone calls could feel. DON stated the facility had no current policy on answering calls and/or assisting resident with calls.</p>		

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  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41175</b></p> <p>Based on interviews and record reviews, the facility failed provide pharmaceutical services that meet the needs of the residents when one of four sampled residents (Resident 1) did not receive Lyrica (a medication used to treat It is used to treat painful nerve diseases) twice, over a seven-day period, contrary to the physician ' s orders. This failure was not in alignment with facility policy and procedures and resulted in Resident 1 to experience unrelieved pain which prompted her subsequent transfer to the emergency room .</p> <p>Findings:</p> <p>During an interview on 8/29/24 at 10 a.m., FM (Family Member stated Resident 1 was not given several doses of Lyrica. FM stated Resident 1 had been on Lyrica for a long time to control her pain and her suddenly missing several doses would increase her risk for withdrawal. FM stated Resident 1 ' s pain got so severe that she requested to be sent out to the emergency room .</p> <p>Record review revealed Resident 1 was admitted to the facility with diagnoses including acute transverse myelitis (a neurological disorder that occurs when a section of the spinal cord is inflamed, causing pain, weakness, sensory problems, and dysfunction in the body) and an unspecified injury to the lumbar spinal cord (section of the spinal cord in the lower back).</p> <p>A review of Resident 1 ' s Medication Administration Records (MARs), dated [DATE], on 8/29/24 at 2:30 p.m. , indicated an order for Lyrica Capsule 75 MG Give 1 capsule by mouth two times a day for Chronic pain, with codes marked on the following scheduled doses: 8/2/24 0900 (9 a.m.) = 9, and 8/6/24 2100 (9 p.m.) = 9.</p> <p>Further review of the MARs revealed a Chart Codes/Follow Up Codes, indicating, [9] = Other/See Nurses Notes.</p> <p>During an interview on 8/29/24 at 4:11 p.m., Licensed Nurse A stated the pharmacy delivers medications daily to the facility three times a day. Licensed Nurse A stated in the event of a resident ' s medication supply running out, emergency kits could be accessed, but added, not all medications are there. Licensed Nurse A stated part of a nurse ' s role was to pay attention to the residents ' medications, making sure there were enough doses. Licensed Nurse A stated the physician, and the pharmacy should be notified if a medication is unavailable, and request for a stat (immediate) medication delivery.</p> <p>(continued on next page)</p>		

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  10/04/2024
NAME OF PROVIDER OR SUPPLIER  Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and concurrent review of Resident 1 ' s MARs on 8/29/24 at 4:16 p.m., Director of Nursing (DON) confirmed Resident 1 ' s Lyrica doses on the morning of 8/2/24 and the evening of 8/6/24 were marked 9. DON stated Resident 1 did not received her Lyrica doses on said dates. DON stated the morning shift nurse should have realized there were no more Lyrica left in Resident 1 ' s supply after giving the last unit that morning and should have notified the physician to review the order. DON confirmed there was no documentation showing any interventions done by the nurse to ensure the next Lyrica doses were available. DON stated had the nurse notified the physician and had the order reviewed, the pharmacy would have been able to deliver Patient 1 ' s Lyrica, in time for the next schedule. DON stated stopping Lyrica abruptly could potentially result in residents to feel pain and anxiety, among other withdrawal symptoms.</p> <p>A review of the facility policy titled, Administering Medications, dated April 2019, indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed .</p>