

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 01/28/2025
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)		
F 0678 Level of Harm - Actual harm Residents Affected - Few	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel, subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41283</p> <p>Based on interviews and record reviews, the facility failed to provide resident-centered care to one resident (Resident 1) of four sampled residents when Licensed Nurses administered Cardiopulmonary Resuscitation (CPR, an emergency procedure consisting of chest compressions combined with artificial breathing in an effort to manually preserve brain function to restore blood circulation and breathing in a person whose heart unexpectedly stops beating) against Resident 1's decision not to be resuscitated (rescued). This failure resulted in physical, psychosocial (involving both psychological and social aspects), and financial harm to Resident 1 after she had survived the medical emergency.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated an initial admission to the facility on [DATE]. The admission record also indicated Resident 1 was her own responsible party (a person in charge of making healthcare decisions).</p> <p>A review of Resident 1's Physician Orders for Life Sustaining Treatment (POLST, a portable medical order that documents a person's decisions regarding end-of-life care), prepared on [DATE] indicated, "First follow these orders, then contact Physician. A copy of the signed POLST form is a legally valid physician order. Cardiopulmonary Resuscitation (CPR): If patient has no pulse and is not breathing. [check marked as choice] Do Not Attempt Resuscitation/DNR (Allow for Natural Death). Medical Interventions: If patient is found with a pulse and/or is breathing. [check marked as choice] Comfort-Focused Treatment- primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. Information and Signatures: Discussed with. [check marked as choice] Patient (Patient has Capacity). [check marked as choice] No Advanced Directive. Signature of Physician. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences [signed by Physician on] XXX[DATE]. Signature of Patient. I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of this form. [signed by Resident 1] on XXX[DATE].</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 01/28/2025
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 0678</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15 which meant her cognition was intact.</p> <p>A review of Resident 1 ' s Care Plan initiated on [DATE] indicated, [Resident 1] has a POLST for DNR Status [with] the goal [that Resident 1 ' s] POLST/DNR status will be followed through [the] target date [of [DATE]] or till change of order .[interventions staff were expected to implement included] DNR POLST form will be in the medical records at all times .Staff will recognize [Resident 1 ' s] wishes and follow as indicated.</p> <p>A review or Resident 1 ' s Order Summary Report which indicated active orders as of [DATE] at 3:50 p.m. indicated, DNR Code .Active [order as of] [DATE] .Pt [Patient] has capacity to make healthcare decisions: Yes .Active [order as of] [DATE] .I have approved these orders for [Resident 1 ' s] .[Orders signed by Physician on] [DATE].</p> <p>A review of Resident 1 ' s Progress Note dated [DATE] at 12:28 p.m. documented by Licensed Nurse A indicated, Called to patients [sic] room by CNA [Certified Nursing Assistant]. [Resident 1] noted to be slumped over in wheelchair and unresponsive. Pallor [abnormal paleness of the skin] noted, sternal rub [the most common painful stimulus practiced in the field by Emergency Medical Technicians and paramedics] attempted without response, carotid pulse [a wave of blood pressure felt on either side of the neck] absent. Initiated CPR after transfer to bed .Another nurse [Licensed Nurse B] took over CPR. Chart checked and noted to be DNR. [Resident 1] began crying out in pain. Paramedics responded and transferred to ED [Emergency Department] .</p> <p>A review of Resident 1 ' s Hospital Discharge Summary dated [DATE] indicated, Principle Diagnosis: Syncope [a temporary loss of consciousness that occurs when the brain does not receive enough blood flow] .NSTEMI (non-ST elevated myocardial infarction) [a type of heart attack where involving a partial blockage of one of the coronary arteries, causing reduced flow of oxygen to the heart muscle] .[Resident 1] had a CPR for few minutes at the [facility] when they did not find a pulse over there. [Resident 1] woke up after 5 minutes .</p> <p>During an interview on [DATE] at 12:32 p.m. Resident 1 stated could not recall going to the hospital. Resident 1 stated she was told her heart stopped beating and was resuscitated by Licensed Nurse A. Resident 1 stated when she came back to the facility, Licensed Nurse A apologized to her for performing CPR when her code was DNR. Resident 1 stated she now must live in an assisted living facility where she has had to pay \$6,000 per month just to sit in a wheelchair, unable to do things independently. Resident 1 stated, I did not wish to live in this situation.</p> <p>During an interview on [DATE] at 1:35 p. m. with the Director of Nursing (DON), she stated it was her expectation for nurses to verify the resident ' s code status before initiating CPR. The DON stated Licensed Nurse A became aware of Resident 1 ' s DNR code status after she had already provided CPR.</p> <p>During an interview on [DATE] at 1:42 p.m. Licensed Nurse B confirmed she went to Resident 1 ' s room and saw Licensed Nurse A performing CPR on Resident 1. Licensed Nurse B stated she assisted Licensed Nurse A with the CPR and took over the chest compressions. Licensed Nurse B stated while she was performing chest compressions on Resident 1, another nurse informed her Resident 1 ' s code status was DNR, so she stopped performing the chest compressions.</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 01/28/2025
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)		
F 0678 Level of Harm - Actual harm Residents Affected - Few	<p>During an interview on [DATE] at 9:58 a.m., Resident 1 stated because she was resuscitated, she is now experiencing a financial burden because she is having to spend her money for people to take care of her since she is physically unable to care for herself. Resident 1 stated she is anxious because she is running out of money, and she is unsure of where she will go when her money runs out. Resident 1 also stated she is depressed and, would not wish her current situation on anybody.</p> <p>A review of the facility ' s policy and procedure titled Resident Rights, dated 2001, indicated, Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident ' s right to .self-determination .be supported by the facility in exercising his or her rights .participate in, his or her care planning and treatment .</p> <p>A review of the facility ' s policy and procedure titled Do Not Resuscitate Order, dated 2001, indicated, Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect .Do not resuscitate (DNR) orders will remain in effect until the resident .provides the facility with a signed and dated request to end the DNR order .</p>		