

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Apple Valley Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 Gravenstein Hwy South Sebastopol, CA 95472	

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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682</p> <p>Based on record review, interview, and facility policy review, the facility failed to issue a written notice of bed hold when a resident transferred to a local hospital for 1 (Resident # 78) of 2 sampled residents reviewed for hospitalization .</p> <p>This failure resulted in a bed not being available upon discharge of the resident from the acute care hospital.</p> <p>Findings included:</p> <p>Review of a facility policy titled; Bed Hold Acknowledgement/Notification, revised 03/29/2018, indicated 1. facility will issue two notices related to bed-hold: a The first notice will be given upon admission to the facility. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were changed; b Second notice will be given at the time of transfer of a resident for hospitalization or therapeutic leave which specifies the duration of the bed-hold policy.</p> <p>An Admission Record indicated the facility admitted Resident #78 on 09/19/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type I diabetes mellitus and personal history of transient ischemic attack (TIA) and cerebral infarction without residual effects. Per the Admission Record, Resident #78 discharged (transferred) to an acute care hospital on 10/09/2024.</p> <p>A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident #78 had an unplanned discharge to a short-term general hospital on 10/09/2024.</p> <p>Resident #78's Progress Notes, dated 10/09/2024 at 2:55 PM, revealed the physician visited the resident related to ongoing complaints of nausea and uncontrolled pain. Per the Progress Note, there was a physician's order given to transfer the resident to an acute care hospital for further evaluation and treatment.</p> <p>Resident #78's medical record revealed no evidence to indicate the resident was provided a bed hold notice on transfer from the facility to the hospital on 10/09/2024.</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: 055919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Apple Valley Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 Gravenstein Hwy South Sebastopol, CA 95472	
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/2024 at 9:01 AM, the Director of Admissions stated she was not responsible for the issuance of a second written bed hold notice to Resident #78 or the resident's responsible party on transfer from the facility and was not aware that was included in the facility policy. The Director of Admissions stated she was responsible for checking with the hospital discharge planner to determine if the resident would readmit to the facility. Per the Director of Admissions, after the resident transferred to the hospital, she spoke with resident's spouse and informed the spouse that the facility was at capacity and therefore did not have a bed available for the resident. The Director of Admissions stated she referred the resident's spouse to other local skilled nursing facilities. The Director of Admissions stated during the resident's hospitalization, the hospital staff reached out to her and she informed the hospital staff that the facility did not have any beds available for the resident.</p> <p>During an interview on 11/07/2024 at 9:40 AM, the Director of Social [NAME] stated the admissions team was responsible for the issuance of all bed hold notices during transfer from the facility.</p> <p>During an interview on 11/08/2024 at 8:23 AM, the Director of Nursing (DON) stated a member of the admission teams would provide the bed hold documentation to the resident and/or the resident's responsible party during the admission process. Per the DON, if the resident had a change of condition that required a transfer to the hospital, staff would ask the resident and/or the resident's responsible party, if they wished to have a bed hold, and that request and/or denial would be documented in the resident's medical record.</p> <p>During an interview on 11/08/2024 at 1:02 PM, the Administrator stated he expected the staff to follow the facility policy and procedures related to bed hold notification.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Apple Valley Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 Gravenstein Hwy South Sebastopol, CA 95472	
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>51682</p> <p>Based on record review, interview, and facility policy review, the facility failed to resubmit a Level I screening for 1 (Resident #6) of 4 sampled residents reviewed for preadmission screening and resident review (PASARR, a tool to ensure residents are not inappropriately placed in nursing homes for long term care).</p> <p>This failure had the potential to affect the care the resident received.</p> <p>Findings included:</p> <p>An undated facility policy titled, Preadmission Screening and Resident Review, indicated 1. The facility will obtain/complete a Preadmission Screening and Resident Review timely.</p> <p>An Admission Record indicated the facility admitted Resident #6 on 11/04/2019. According to the Admission Record, the resident had a medical history that included diagnoses of adjustment disorder (an excessive reaction to stress), bipolar disorder (disorder characterized by mood swings between depressive lows and manic highs), and dementia.</p> <p>An quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had active diagnoses to include dementia and manic depression (bipolar disease),</p> <p>A letter from the State of California Department of Health Care Services, dated 10/26/2021, indicated Resident #6 had a positive Level I screening and a Level II mental health evaluation was required.</p> <p>A letter from the State of California Department of Health Care Services, dated 12/14/2021, indicated the Level II mental health evaluation was unable to be completed as Resident #6 was in isolation as a health and safety precaution. Per the letter, a new Level I screening must be submitted.</p> <p>Resident #6's medical record revealed no evidence to indicate a new Level I screening was submitted.</p> <p>During an interview on 11/06/2024 at 8:40 AM, the Director of Nursing (DON) stated she was able to retrieve a document that indicated a level II was attempted; however, Resident #6 was under isolation at the time of the attempt. The DON stated the facility did not attempt to file a new Level I screening after Resident #6 was removed from isolation.</p> <p>During an interview on 11/06/2024 at 9:10 AM, Licensed Vocational Nurse #1 stated the facility did not resubmit a new Level I screening for Resident #6 when the resident came off isolation.</p> <p>During an interview on 11/08/2024 at 12:53 PM, the Administrator stated he expected the staff to follow the PASARR policy for the completion of Level I screenings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Apple Valley Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 Gravenstein Hwy South Sebastopol, CA 95472	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51682</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff performed hand hygiene when soiled gloves were removed and before a new pair of gloves were put on during the provision of wound care for 1 (Resident #4) 1 sampled resident reviewed for pressure ulcer/injury.</p> <p>This failure had the potential to cause the spread of infection between residents.</p> <p>Findings included:</p> <p>A facility policy titled, Handwashing/Hand Hygiene revised 08/2019, revealed This facility considers hand hygiene the primary means to prevent the spread of infections. The policy specified, 6. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device; f. Before donning (putting on) sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects in the immediate vicinity of the resident; m. After removing gloves; Per the policy, 8. The use of gloves does not replace hand washing/hand hygiene.</p> <p>An Transfer / Discharge Report indicated the facility admitted Resident #4 on 08/24/2021. According to the Transfer/Discharge Report, the resident had a medical history that included diagnoses of multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), quadriplegia (a form of paralysis that affects all four limbs), acquired absence of the right leg above the knee, and neuromuscular dysfunction of the bladder.</p> <p>A quarterly Minimum Data Set (MDS, an assessment tool), with an Assessment Reference Date (ARD) of 09/15/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS, a tool to assess cognition) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one Stage 3 pressure ulcer (a deep wound when skin loss extends through the entire thickness of the skin into the underlying tissue, but not to muscle, tendon, or bone).</p> <p>Resident #4's Order Summary Report, that contained active orders as of 11/05/2024, revealed an order dated 08/17/2024 that directed staff to cleanse the resident's left buttock with cleanser, pat dry, and apply a thin layer of paste to the periwound (an area of tissue around a wound), and calcium alginate to the wound bed and cover with a foam dressing daily and as needed.</p> <p>During an observation of wound care for Resident #4 on 11/05/2024 at 2:26 PM, Licensed Vocational Nurse (LVN) #3 did not perform hand hygiene after she removed a soiled pair of gloves and before she applied a new pair of gloves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Apple Valley Post-Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 Gravenstein Hwy South Sebastopol, CA 95472	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/05/2024 at 2:48 PM. LVN #3 stated she was educated to perform hand hygiene and put on clean gloves between each step of wound care to include the removal of the old dressing, cleansing the wound, and the application of the clean dressing. LVN #3 confirmed she did not perform hand hygiene with hand sanitizer and/ or soap and water with gloves changes.</p> <p>During an interview on 11/07/2024 at 9:25 AM, the Infection Preventionist (IP) stated staff had been educated to perform hand hygiene during wound care whenever gloves were removed and a new pair was put on. The IP stated it was never acceptable to not perform hand hygiene.</p> <p>During an interview on 11/08/2024 at 8:12 AM, the Director of Nursing stated hand hygiene should be performed before applying gloves, with each glove change, and at the completion of the care provided.</p>		