

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

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Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>055987                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Broadway Villa Post Acute                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1250 Broadway<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                 |
| F 0550<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51218</b></p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 3) was treated with dignity and respect when a Certified Nursing Assistant (CNA) made an inappropriate comment to Resident 3.</p> <p>This failure resulted in Resident 3 feeling uncomfortable and insulted.</p> <p>Findings:</p> <p>A review of Resident 3's admission record indicated she was admitted on [DATE] with the diagnoses of malignant neoplasm (a cancerous tumor [abnormal growth of tissue] that forms when cells grow and divide uncontrollably) of the left female breast.</p> <p>A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/27/24, indicated Resident 1 had no memory impairment.</p> <p>During an interview, on 1/14/25 at 2:50 p.m., Resident 3 stated that while providing care CNA 1 had made a comment regarding her tumors something like, Why is your boob so big? Resident 3 stated the comment was inappropriate and it was none of CNA 1's business.</p> <p>During a phone interview, on 1/14/25 at 3:17 p.m., CNA 1 stated while caring for Resident 3 she had made an inappropriate comment about Resident 3's breasts. CNA 1 acknowledged she needed to be more careful with her communication.</p> <p>During an interview, on 1/14/25 at 4:28 p.m., with the Assistant Director of Nursing (ADON), the ADON stated it was her expectation staff treated residents with dignity and respect. The ADON stated she had been made aware of the comment made by CNA 1 to Resident 3 and agreed it was inappropriate.</p> <p>During a review of a facility document titled, Resident Rights, it indicated, As a resident of this nursing facility . You have the right to be treated with respect and dignity .</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

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| F 0609<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>51218</p> <p>Based on interview and record review, the facility failed to ensure allegations of abuse were reported within the required timeframe for three of four sampled residents (Resident 1, Resident 2 and Resident 3) when initial reports of an allegation of abuse were not received by the Department.</p> <p>These failures of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety.</p> <p>Findings:</p> <p>A review of a facility document, dated 12/19/24 and received by the Department on 12/19/24, indicated it was a follow-up summary of a reported allegation of abuse related to an altercation between Resident 1 and Resident 2 which had occurred on 12/15/24.</p> <p>A review of a facility document, dated 1/6/25 and received by the Department on 1/6/25, indicated it was a follow-up summary of a reported allegation of abuse related to an incident involving staff and Resident 3 which had occurred on 12/30/24.</p> <p>During an interview, on 1/14/25 at 4:28 p.m., the Assistant Director of Nursing (ADON) stated it was the facility's policy to report an allegation of abuse to the Department within two hours. The ADON confirmed neither of the allegations of abuse had been reported to the Department within 2 hours.</p> <p>A review of a facility policy titled, Abuse Prevention, revised 6/23, stipulated, The allegation will be reported within two hours to the appropriate state agency, the Department of Health .</p> |                                                                                |                                                 |