

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Broadway Villa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1250 Broadway 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091</p> <p>Based on observation, interview and record review, the facility failed to ensure a safe environment for three of seventeen sampled residents when three residents (Resident 7, 8 and 9) were left unsupervised while smoking cigarettes.</p> <p>This failure had the potential to cause resident burn injuries and a facility fire hazard.</p> <p>Findings:</p> <p>During a review of Resident 7's Admission Record , printed 4/21/25, it indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular and often rapid heart rhythm that can lead to serious complications like stroke and heart failure), aphasia (a language disorder that makes it difficult to express thoughts or understand spoken or written language), depression, muscle weakness, abnormalities of gait and mobility (deviations from normal walking patterns and movement abilities), nicotine dependence (a highly addictive chemical compound naturally found in tobacco plants, responsible for the addictive nature of tobacco products like cigarettes, cigars, and smokeless tobacco), dyspnea (shortness of breath) and ataxia (a neurological disorder characterized by the loss of coordination of voluntary movements, often affecting balance, walking, and speech).</p> <p>A review of Resident 7's MDS-C (Minimum Data Set Section C-focuses on cognitive patterns. It assesses a resident's mental status, including short-term and long-term memory, recall abilities, and their capacity to make daily decisions. The section also evaluates for signs of delirium) , dated 4/14/25, indicated Resident 7 has a BIMS (Brief Interview for Mental Status, a standardized tool used to screen for cognitive impairment, especially in long-term care facilities. BIMS scores range from 0 to 15, with higher scores indicating better cognitive function) of 7, indicating moderate cognitive impairment.</p> <p>A review of Resident 7's Care Plan Report , undated, indicated observe smoking while in designated area .</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8's Admission Record , printed 4/21/25, it indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (Hemiparesis is a condition of partial muscle weakness on one side of the body, while hemiplegia is the complete paralysis of one side of the body), vascular dementia (a type of dementia caused by damage to the brain's blood vessels, leading to impaired blood flow and oxygen deprivation to brain cells), emphysema (a chronic lung disease, part of Chronic Obstructive Pulmonary Disease (COPD), characterized by damage to the air sacs (alveoli) in the lungs), nicotine dependence, depression, history of falling, bilateral open-angle glaucoma (a progressive optic neuropathy that affects both eyes, causing damage to the optic nerve and leading to vision loss), and history of transient ischemic attack (a temporary disruption of blood flow to the brain, causing symptoms similar to a stroke but that resolve completely within 24 hours).</p> <p>A review of Resident 8's MDS-C , dated 3/18/25, it indicated Resident 8 had a BIMS of 9, indicated moderate cognitive impairment.</p> <p>A review of Resident 8's Care Plan Report , undated, indicated monitor to assess compliance with facility smoking policy/individual plan , and observe smoking while in designated area .</p> <p>During a review of Resident 9's Admission Record , printed 4/21/25, it indicated Resident 9 was initially admitted to the facility on [DATE], with diagnoses including hemiplegia, personal history of transient ischemic attack, dysarthria and anarthria (anarthria is a severe form of dysarthria, a motor speech disorder. While dysarthria causes impaired speech, anarthria results in the complete inability to articulate words), nicotine dependence, psychosis, muscle weakness and abnormalities of gait and mobility (deviations from normal walking patterns and movement abilities).</p> <p>A review of Resident 9's MDS-C , dated 2/6/25, indicated Resident 9 has a BIMS of 15, indicating intact cognition.</p> <p>A review of Resident 9's Care Plan Report , undated, indicated provide 1:1 observation while smoking .</p> <p>During a concurrent observation and interview on 4/21/25 at 10:20 a.m., a staff member and a resident were observed entering the building from the outside smoking patio. There were three residents remaining outside on the patio (Resident 7, Resident 8, and Resident 9), smoking cigarettes. Resident 8 stated, we come out here and smoke whenever we feel like it, sometimes without staff . No staff was seen returning to the smoking area for 15 minutes.</p> <p>During an interview on 4/21/25 at 1:00 p.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the ADON stated some smoking residents do not comply with smoking policy or care plan, and this is a concern due to burning risks. ADON stated if competent residents want to smoke during unscheduled times, they are supposed to sign-out of the facility. The ADON stated the three residents smoking earlier with no supervision had not signed out of the facility.</p> <p>During a review of facility policy and procedure (P & P) titled Smoking and Safety Measures , revised 12/2023, it indicated, designated smoking times are 10:00, 14:00, 16:00 .smoking sessions will be 15 minutes in length , and smoking may only occur with facility staff present .</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091</p> <p>Based on observation, interview and record review, the facility failed to ensure immediate resident assistance when call light system was inoperable or inaccessible for six (6) residents (Residents 1, 2, 3, 4, 5, and 6) of 17 residents.</p> <p>This failure had the potential for delayed resident care and emergency response times.</p> <p>Findings:</p> <p>A record review of Resident 1's Admission Record , printed 4/18/25, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including monoplegia (paralysis in which only one limb, an arm or a leg, has lost complete voluntary muscle movement) of lower limb affecting left side, muscle weakness, obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing normally), and benign prostatic hyperplasia (a condition where the prostate gland grows larger than normal due to a non-cancerous increase in cell growth). Resident 1 was discharged from the facility on 4/10/25.</p> <p>A review of Resident 1's MDS-C (Minimum Data Set-a standardized tool that all nursing homes participating in Medicare or Medicaid use to assess residents) , dated 2/18/25, indicated Resident 1 had a BIMS (Brief Interview of Mental Status) provides a quick assessment of a resident's cognitive function, particularly in skilled nursing facilities (SNFs) and long-term care facilities) score of 15, indicating intact cognition.</p> <p>A review of Resident 2's Admission Record , printed 4/21/25, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (a term for lung diseases that cause airflow obstruction and make it difficult to breathe), muscle weakness, need for assistance with personal care, and shortness of breath.</p> <p>A review of Resident 2's MDS-C , dated 4/18/25, it indicated Resident 2 had a BIMS score of 14, indicating intact cognition.</p> <p>A review of Resident 3's Admission Record , printed 4/21/25, indicated Resident 3 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, muscle weakness, dementia (general term for the progressive decline in mental ability, including memory, language, and reasoning, that interferes with daily life), and anxiety disorder.</p> <p>A review of Resident 3's MDS-C , dated 4/7/25, indicated Resident 3 had a BIMS score of 3, indicating severely impaired cognition.</p> <p>A review of Resident 4's Admission Record , printed on 4/21/25, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia, muscle weakness, and other abnormalities of gait and mobility (gait refers to the pattern of walking, while mobility is the ability to move freely).</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 4's MDS-C , dated 2/12/25, indicated Resident 4 had a BIMS score of 3, indicating severely impaired cognition.</p> <p>A review of Resident 5's Admission Record , printed 4/21/25, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including dementia, osteoporosis (a bone disease that causes bones to become weak and brittle, increasing the risk of fractures(broken bones)), and fracture of the right femur (thigh bone).</p> <p>A review of Resident 5's MDS-C , dated 3/4/25, indicated Resident 5 had a BIMS score of 5, indicating severe cognitive impairment.</p> <p>A review of Resident 6's Admission Record , printed 4/21/25, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis (a chronic neurological disorder where the body's immune system mistakenly attacks the protective sheath (myelin) covering nerves in the brain and spinal cord, disrupting communication between the brain and body), neuromuscular dysfunction of the bladder (a condition where bladder control is lost due to damage to the nerves and muscles that regulate bladder function), paralytic syndromes (conditions characterized by paralysis, or the loss of muscle function), anxiety disorder, and chronic pain syndrome.</p> <p>A review of Resident 6's MDS-C , dated 4/14/25, indicated Resident 6 had a BIMS score of 3, indicating severe cognitive impairment.</p> <p>During a phone interview on 4/18/25 at 10:08 a.m., Resident 1's family member stated Resident 1 called on multiple occasions because facility staff had not answered call light after an hour or more. Resident 1 said he was left in urine-soaked clothing and bedding at these times, and Resident 1's family had to call the facility to prompt staff to attend to Resident 1.</p> <p>During an interview on 4/18/25 at 10:17 a.m. with Resident 2, Resident 2 indicated he had problems with his call button since his arrival in the facility, and when he pressed his call button it made noise , but no light would come on at the hallway door to alert staff. Resident 2 stated on multiple occasions he waited over an hour for assistance, including when he needed pain medications.</p> <p>A review of document titled, Broadway Villa Daily Census , dated 4/20/25, indicated Resident 2 now occupied the same bed as Resident 1 had before his discharge on 4/10/25.</p> <p>During a concurrent observation and interview on 4/21/25 at 10:06 a.m. with Certified Nursing Assistant 1 (CNA 1), a resident bedroom was observed. The beds occupied by Resident 3 and Resident 4 were seen with call buttons on the floor behind the right side of each bed. CNA 1 stated they must have fallen off the bed and acknowledged neither of these call lights were accessible to the residents. When CNA 1 asked the residents if they needed anything, Resident 3 stated I didn't know where my call light was .</p> <p>During a concurrent observation and interview on 4/21/25 at 10:10 a.m. with Licensed Vocational Nurse 1 (LVN 1) in a bedroom occupied by Resident 5, LVN 1 observed Resident 5's call button was not on the bed but laying on the right side of the bed on the floor. LVN 1 gave the call button back to Resident 5, who yelled give me my call light!</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 4/21/25 at 10:25 a.m. with Licensed Vocational Nurse 2 (LVN 2) in a resident bedroom, Resident 6's bed was seen with no call button or cord attached to the wall. LVN 2 stated it had been removed a couple of days prior, and that Resident 6 now had a manual metal call bell. LVN 2 could not locate the metal call bell anywhere within reach of Resident 6's bed. LVN 2 didn't know why Resident 6's regular call light was removed and could not say how Resident 6 would alert staff if he needed help.</p> <p>During an interview on 4/21/25 at 10:30 with Resident 2, Resident 2 stated he heard his roommate (Resident 6) calling out for help quietly, and Resident 2 reminded Resident 6 to use his call light. Resident 2 stated he was not aware Resident 6 no longer had a call light.</p> <p>During a concurrent interview and record review on 4/21/25 at 11:45 a.m., the facility Maintenance Assistant ([NAME]) reviewed the Weekly Nurse Call System Testing , dated 3/3/25, which indicated the facility changed out the call light cord at the bed formerly occupied by Resident 1 (now occupied by Resident 2) on 3/17/25. The [NAME] stated that call light system repair and maintenance was communicated by floor staff to maintenance department via radio, and the work completed was not always recorded in any maintenance log.</p> <p>During a phone interview on 4/21/25 at 12:30 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 6's call button was missing for two days, and she didn't know why. CNA 2 stated she forgot to mention it to maintenance at the end of her shift.</p> <p>During an interview with the Director of Nursing and the Assistant Director of Nursing on 4/21/25, the ADON stated Resident 6's call bell was found underneath his bed and was replaced to the bedside table. The DON stated Resident 6's call button and cord had been removed from the wall because Resident 6 had expressed suicidal ideation (the thought process of having ideas about the possibility of dying by suicide), and it was a safety intervention. The ADON or DON could not say how Resident 6's call bell got underneath the bed, and acknowledged Resident 6 had no means to get staff attention without it.</p> <p>During a review of facility policy and procedure (P & P) titled Call Light/Bell , revised 2/2023, it indicates It is the policy of this facility to provide the resident with a means of communication with nursing staff .answer the light/bell within a reasonable time .place the call device within the resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.</p> <p>During a review of untitled, undated facility P & P regarding nursing rounds, it indicated CNA's are expected to round on all assigned residents at least every two hours during waking hours and every hour during night shifts. Each round should include visual safety checks (bedrails, call lights within reach, floor clear of hazards) .</p>		