STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055987	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Villa Post Acute	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's nursing staff failed to implement care plan interventions for three residents (Resident 1, Resident 2, Resident 3) out of three sampled residents when fall risk interventions were not executed following an actual fall. These failures decreased the facility's potential to effectively implement their fall prevention program, thereby placing Residents 1,2 and 3 at risk for recurrent falls and further injury.Findings:A review of Resident 1's admission record indicated admission to the facility on 1/19/26 with a diagnosis of muscle weakness, repeated falls, and Diastolic Heart Failure (a condition where the heart cannot fill up with enough blood due to stiffness, making the heart unable to meet the body's needs).A review of Resident 1's fall risk assessment dated [DATE] indicated Resident 1 had a history of three or more falls in the past three months and was hospitalized within the last 30 days. The remainder of the assessment tool was blank and made it unclear whether Resident 1 was considered a fall risk upon admission.A review of Resident 1's fall risk care plan, dated 1/20/26, indicated Resident 1 was at risk for falls. In order to prevent injury from falling, staff were required to place fall mats by Resident 1's bed.A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), dated 1/26/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 1's cognition (related to processes of reasoning and thinking) was fully intact.A review of Resident 1's progress note dated 1/22/26 at 7:22 p.m., indicated Resident 1 experienced an unwitnessed fall while transferring himself from the bedside commode to his bed. Resident 1 was found with his upper torso on the bed, while his lower extremities were on the floor. Resident 1 reported to the staff that he slipped while I tried to get up. Resident 1 sustained a skin tear which measured 1-centimeter (cm-a unit of measure) by 1 cm to his right forearm.A review of Resident 1's progress note dated 2/13/26 at 3:12 p.m., indicated Resident 1 fell while attempting to stand and use his urinal at bedside. This fall resulted in Resident 1 hitting his head and sustaining injuries to the bridge of his nose and head along with multiple skin tears to both knees and shin areas on his legs. Resident 1 was transported to the local hospital for evaluation. A progress note, dated 2/13/26, at 6:24 p.m., indicated Resident 1 was being treated for a nasal fracture, orbital fractures (eye sockets) and a brain bleed.A review of Resident 1's care plan, dated 2/13/26, indicated Resident 1 had an actual fall with injuries. To maintain a goal of healing injuries without complications, staff were expected to place fall mats by Resident 1's bed and begin a toileting schedule.A review of Resident 1's progress note, dated 2/16/26, at 2:40 p.m., indicated the Interdisciplinary Team (IDT-a collaborative group of healthcare professionals from different fields who work together toward shared, resident-centered goals) met to discuss Resident 1's fall on 2/13/26. The note indicated neither Resident 1 nor his partner, who was in the room at the time of the fall, pushed (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the call bell for help. Resident 1's partner reported to the IDT that Resident 1 frequently fell at home and Emergency Medical Services needed to be called to assist in getting Resident 1 off the floor. The IDT recommended placing floor mats on both sides of Resident 1's bed.During a concurrent observation and interview in Resident 1's room on 2/27/26 at 12:34 p.m., Resident 1 was sitting upright in bed with a cervical collar (a medical device worn around the neck to support the head and neck portion of the spine) in place. Resident 1 had multiple healing wounds to his face, arms and legs. Resident 1 stated he believed he fell because he passed out while attempting to stand to urinate. Resident 1's girlfriend (GF) was present during the interview and stated Resident 1 fell at home prior to admission to the facility and required hospitalization due to hitting his head during the fall. During our conversation, Resident 1 had intermittent spasms that caused his left leg to contract to a near full contraction. The GF stated Resident 1 has had these contractions for some time, but they were more pronounced since the recent fall. Resident 1 confirmed GF's statement. Fall mats were not observed by Resident 1's bed, however, it was noted fall mats were present by his roommate's bed. The GF stated she asked staff about fall mats to protect Resident 1 if he fell again and was told As long as [Resident 1] asks for help, they [floor mats] are not needed.A review of Resident 2's admission record indicated admission to the facility on 7/25/24 with a diagnosis of muscle weakness, a history of falling, and Transient Cerebral Ischemic Attack (a brief period of stroke-like symptoms caused by a temporary interruption of blood flow to a part of the brain).A review of Resident 2's progress note, dated 2/7/26, indicated Resident 2 experienced an unwitnessed fall. Resident 2 was found lying on her side in the bathroom next to the toilet. The note indicated Resident 2 fell while she was sitting on the toilet and she sustained a cut to the left side of her forehead. A review of Resident 2's care plans included:A care plan initiated on 7/25/24 for her fall risk, was revised on 2/10/26 following her fall on 2/7/26. The intervention required staff to provide a bedside commode to assist Resident 2 with safe toileting and achieve her goal of remaining fall free.A subsequent care plan dated 2/9/26 indicated an actual fall and directed staff to ensure Resident 2 wore non-skid footwear during all activities that involved walking to prevent further incidents.During a concurrent interview and observation in Resident 2's room on 2/27/26 at 12:25 p.m., a bedside commode was not observed at Resident 2's bedside. Resident 2 confirmed a commode had not been placed in her room previously. A pair of household slippers were observed to be positioned near Resident 2's bed. The slippers were well worn with very slippery soles and no grip. Resident 2 stated she wore those slippers when she got out of bed and when she walked. A review of Resident 3's admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of Atherosclerosis of the Aorta (a condition where fatty deposits, calcium, cholesterol and other substances-collectively known as plaque-build up along the inner walls of the body's largest blood vessel carrying oxygen away from the heart to other organs) and Age related Osteoporosis (a condition where bones become increasingly porous, thin and brittle due to the natural aging process).A review of Resident 3's progress notes, dated 2/10/26, indicated Resident 3 was found on the floor next to her bed and sustained a skin tear to her right cheek and multiple abrasions (scratches) to her upper back.A review of Resident 3's care plan, dated 5/16/25, indicated Resident 3 was at risk for falls. To meet the established goals of being free from falls and will not sustain serious injury, nursing staff were expected to keep Resident 3's call bell within her reach. A revision to this care plan on 2/12/26 indicated staff were to place fall mats on the left side of Resident 3's bed.During a concurrent interview and observation in Resident 3's room on 2/27/26 at 12:12 p.m., Resident 3 was lying in her bed. Resident 3's call light was not observed to be within her reach. This surveyor asked Resident 3 where her call light was located and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 could not find it. This surveyor then requested Certified Nursing Assistant 1 (CNA 1) to assist in locating Resident 3's call light. The call light was found tucked under the blanket and pillow on Resident 3's right hand side. In addition, there were no fall mats on either side of Resident 3's bed as per her care plan.During an interview on 2/27/26, at 2:21 p.m., CNA 2 stated fall risk status was communicated during shift change report. CNA 2 stated he took special care to ensure residents who were identified to be at risk for falls had their bed in a low position, their call lights within reach and fall mats were in place. During an interview at the nurse's medication cart on 2/27/26, at 2:32 p.m., Licensed Nurse 1 (LN 1) stated fall risk status was communicated during shift change report, and it was also printed on a report that was reviewed and carried throughout the shift. LN 1 stated fall risk interventions should include a low bed and the placement of fall mats. LN 1 was not sure if any fall risk identifiers are placed outside the resident's room.During a concurrent interview and record review of Resident 1, Resident 2, and Resident 3's medical records in the physician's lounge with the Assistant Director of Nursing (ADON) and the Administrator (ADM) on 2/27/26 at 2:40 p.m., the following were discussed:Resident 1's fall risk assessment was reviewed. Although the form was blank, the ADM stated Resident 1's fall risk score was 10, which placed Resident 1 at a moderate risk to fall prior to his fall on 2/13/26. Neither the ADON nor the ADM were able to provide documentation of Resident 3 having been placed on a toileting schedule as per Resident 1's revised 2/13/26 care plan. Furthermore, this surveyor notified the ADM and the ADON there were no fall mats in Resident 1's room as per revised 2/13/26 fall care plan. The ADM and ADON reviewed Resident 2's interventions listed in her care plan regarding her fall risk. The ADM and ADON were then shown a picture of Resident 2's slippers found at her bedside which had no grip on the soles which she stated she used. The ADM and ADON were also notified that a bedside commode was not observed at bedside or in Resident 2's bathroom as indicated in her care plan. The ADM and ADON reviewed Resident 3's interventions listed in her care plan regarding her fall risk. The ADM and ADON were notified no fall mats were observed on either side of Resident 3's bed and Resident 3's call light was difficult to find. The ADM stated nursing staff were encouraged to use resident care plans but added he cannot say how often they are used.A review of the facility's policy and procedure titled Falls and Accidents Prevention revised November 2022 indicated, Purpose.To investigate the circumstances surrounding each resident fall.and implement actions to reduce/prevent the incidence of additional falls.and minimize potential for injury.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility's licensed nurses (LNs) failed to provide pain management to one resident (Resident 4) out of six residents when Resident 4 was experiencing severe pain from a displaced, comminuted fracture (a severe break where the bone is broken in three or more pieces that are significantly shifted from their normal alignment) of the shaft (the long cylindrical section) of the left humerus (long bone of the upper arm).This failure resulted in Resident4 enduring unnecessary suffering and experience prolonged physical distress.Findings: A review of Resident 4's admission record indicated admission to the facility on 2/4/26 with a diagnosis of a displaced, comminuted fracture of shaft of humerus.A review of Resident 4's progress notes, dated 2/4/26, indicated Resident 4 arrived at the facility at 6:20 p.m. The note further indicated Resident 4 opted for non-surgical intervention for her fracture, which included wearing a sling around the neck 24 hours per day, strict non-weight bearing to her left arm, and pain medication administration. A review of Resident 4's physician orders, dated 2/4/26 at 3:58 p.m., indicated LNs were to administer Oxycodone HCl [pain medication used to treat severe pain] 5 mg [milligram-a unit of measure]. Give 1 tablet by mouth every 6 hours as needed for severe pain 7-10/10 [refers to a pain level of 7-10 on a 10-point scale where 10 is the most severe]. Use [acetaminophen (an over-the-counter pain relief medication)] as first line agent and oxycodone as 2nd line agent .A review of Resident 4's pain management care plan, dated 2/4/26, indicated Resident 4 had a goal to verbalize adequate pain relief or ability to cope with incompletely [sic] relieved pain. To meet this goal, LNs were required to Administer medication as per orders. Monitor for effectiveness.Anticipate need for pain relief and respond immediately to any complaint of pain.Follow pain scale to medicate as ordered.A review of Resident 4's Medication Administration Record (MAR), dated February 2026, indicated Resident 4 reported a pain level of 10 and was medicated with Oxycodone HCl 5 mg on 2/4/26 at 7:50 p.m. The MAR further indicated no additional oxycodone was administered to Resident 4 on 2/4/26. On 2/5/26, Resident 4 was administered oxycodone three times only with noted pain scale levels of 9, 8 and 9 respectively.A review of Resident 4's oxycodone administration history and effectiveness, dated 2/4-2/16/26 indicated Resident 4 experienced temporary relief of pain after being given oxycodone as evidenced by Resident 4 reporting recurring levels of severe pain (8-9). LNs did not identify that Resident 4 was reporting a pattern of recurring severe pain which consistently returned prior to the next scheduled dose throughout the day on 2/5/26 and into the morning of 2/6/26. By allowing the medication to wear off completely before the next six-hour window, LNs staff forced Resident 4 to experience a state of unnecessary physical distress instead of advocating to the physician for a more frequent dosing schedule to maintain a steady therapeutic level.A review of Resident 4's progress note, dated 2/5/26, at 8:05 a.m., indicated Resident 4 requested additional oxycodone on 2/4/26 at approximately 11:30 p.m. The note indicated a licensed nurse notified Resident 4 that the oxycodone was unavailable at that time but might arrive at midnight or at the 3 a.m. pharmacy delivery. Resident 4 was offered alternative pain relief, which included an ice pack and scheduled acetaminophen. Resident 4 refused the acetaminophen, stating she did not use those medications, but agreed to attempt to rest and notify the nurse if the pain persisted. Despite Resident 4's refusal of the first line agent (acetaminophen) and the unavailability of the second line agent (oxycodone), the LN failed to attempt access to the Emergency Medication Kit (E-Kit: a secure electronic system provided by a pharmacy which contains a small supply of medications for immediate therapeutic needs when the regular pharmacy is unavailable) at that time. The note further indicated Resident 4's pain persisted, and Resident 4 requested oxycodone again on 2/5/26 at approximately 4:30 a.m.; however, the oxycodone had not been delivered at midnight or 3 a.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the LN updated Resident 4 on the continued delay, Resident 4 became upset and frustrated, stating the situation was unacceptable. Only at this time, five hours after the initial request, did the LN attempt to access the E-Kit. The LN was instructed to call a mobile number for a code, but a second call at 5:15 a.m. revealed a system outage and gave instructions to call back in one hour. The LN finally obtained the code and administered the oxycodone at 7:16 a.m., resulting in Resident 4 experiencing unmanaged, severe pain for nearly eight hours.During a phone interview on 2/27/26, at 8 a.m., Resident 4 stated when she arrived at the facility on 2/4/26 and her pain level was a 15 (on a 1-10 pain scale) that never really went away. Resident 4 stated her pain level was consistently elevated during her first two days at the facility, I never really got relief from the pain. I would rather have ten 10-pound babies than experience pain like that again. Resident 4 stated she has never cared to take acetaminophen pain relief medication, as she felt it never worked for her. Resident 4 did accept the ice pack as ordered but stated it really did not have any effect on her pain level. Resident 4 stated, The experience was physically and mentally detrimental to my healing.During an interview at the nursing station on 2/27/26 at 10:46 a.m., LN 2 stated if pain medication was ordered but not received at the facility, he would get a code from the pharmacy to open the E-kit. LN 2 further stated if he were unable to obtain the medication, he would notify the Director of Nursing (DON), the Assistant DON (ADON), or the Unit Manager. LN 2 stated the LN should notify the physician that the resident was unable to receive the ordered medication especially if the resident's pain could not be relieved.During an interview on 2/27/26 at 10:55 a.m., LN 3 stated narcotics were kept in the electronic E-kit. LN 3 stated if ordered medications did not arrive with the next medication delivery, LN 3 would call the pharmacy to find out why medication was not delivered, notify the physician of the situation and obtain different orders.During an interview with the DON, ADON, and the Administrator (ADM) on 2/27/26 at 2:40 p.m., the DON and the ADON confirmed they had not been notified that Resident 4 had been experiencing unrelieved pain on the evening of 2/4/26, nor the early morning of 2/5/26. Both the DON and ADON acknowledged staff failed to escalate the clinical situation or seek assistance with pharmacy delays when Resident 4 continued to report severe pain. The ADM stated he would have offered to send Resident 4 back to the hospital due to her uncontrolled pain.During a phone interview on 2/27/26 at 3:52 a.m., the physician (MD) stated he did not want any of his residents in pain. If staff are unable to obtain pain medication for a resident, I would want them to call me. The MD stated it was not good physically or mentally for a resident to have unrelieved pain.A review of the facility's policy titled Recognition and Management of Pain, dated January 2020, indicated, It is the policy of this facility that pain management is provided to residents that require such services, consistent with professional standards of practice.and the resident's goals and preferences.If the pain management program is not effective, the licensed nurse will contact the resident's physician.Consult physician for additional interventions if pain is not relieved by current orders.A review of the facility's policy titled E-Kit, dated November 2023, indicated, It is the policy of this facility to maintain an Emergency Kit (E-KIT) containing essential medication and supplies to ensure timely and appropriate care for residents when medications are urgently needed and cannot be obtained from the pharmacy in a reasonable timeframe. The E-KIT may be used for.Situations where a delay in medication therapy could cause harm to the resident.Purpose.To support timely intervention, reduce risk of complications and maintain continuity of care.