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	07/02/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) received nursing care that was resident-centered and in accordance with professional nursing standards and his goals of care, as indicated in his Nursing Care Plan (a document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) when:1. Nursing staff did not inform him when changes were made to his medication regimen, and;2. Nursing staff did not medicate him for pain per physician orders.These failures: 1. Caused Resident 1 to feel out of control and horrible, 2. Caused his pain to go untreated for over twelve hours, contributing to his pain severity being an eight on the pain scale (The Pain Scale is a pain assessment tool; pain is described as 1-10 out of a possible ten. Zero is no pain and 10/10 is the worst pain imaginable), and; 3. Potentially prevented him from attaining his highest possible level of functioning and well-being, thereby negatively impacting his quality of life. A review of Resident 1's admission Record (front page of the medical record that contains a summary of basic information about the resident) indicated he was a seventy-eight-year-old male who was admitted to the facility on [DATE] with diagnoses including seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), diabetes mellitus (DM, disorder characterized by difficulty in blood sugar control and poor wound healing), and parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/28/26, indicated he had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14, indicating he was cognitively intact. The MDS indicated his Active Diagnoses included, .Seizure Disorder or Epilepsy.A review of the facility's order summary report, dated 4/18/26, indicated Resident 1's physician ordered the following anti-seizure medication: levetiracetam [Keppra] oral tablet 500 milligrams [mg] . give 1 tablet by mouth two times a day for. seizure for 30 days.A review of Resident 1's Medication Administration Records (MARs; a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/26 - 5/31/26, indicated Resident received his last dose of Keppra on 5/18/26 at 8 a.m.A review of the facility's order summary report, dated 5/30/26, indicated Resident 1's physician ordered the following anti-seizure medication: .LevETIRAcetam [Keppra] . 500 mg. Give 1 tablet by mouth two times a day. for 30 Days. The order date was 5/29/26.A review of Resident 1's MAR, dated 6/1/26 - 6/30/26, indicated Resident 1 received his last dose of Keppra on 6/28/26 at 4 p.m. The MAR indicated Resident 1 did not receive Keppra on 6/29/26 - 6/30/26.A review of Resident 1's MAR, dated 7/1/26 - 7/31/26 indicated, indicated Resident 1's Keppra was reordered on 7/01/26.A review of Resident 1's MAR, dated 6/01/26 - 6/30/26, indicated the following physician order, dated 5/29/2-26: Hydrocodone-Acetaminophen [Norco; a narcotic pain medication] oral tablet 5-325 mg. Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain (4-10/10) [on the pain scale] . The MAR indicated Resident 1 took Norco approximately two to four times a day during June 2026. His (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain was documented as four to eight out of ten. A review of Resident 1's MAR, dated 7/1/26 - 7/31/26, indicated he received Norco on 7/02/26 at 1:52 a.m. No other Norco administration was documented prior to 7/02/26 at 2:35 p.m. (over twelve-hours).A review of Resident 1's nursing care plan, revised 2/17/26, indicated, [Resident 1] is currently prescribed an Opioid [narcotic] for pain management. (Hydrocodone-Acetaminophen) . Care plan interventions indicated, Administer opioid as prescribed.A review of Resident 1's nursing care plan, revised 5/29/26, indicated, [Resident 1] has acute/chronic pain. The care plan goals indicated, . Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain.During an interview on 6/30/26 at 1 p.m., the Director of Nursing (DON) stated if changes were made to a resident's medication, the IDT team (interdisciplinary group of healthcare professionals including nursing, social workers, pharmacy, and dietary staff) discussed it at the daily Stand-Up meeting (meetings where healthcare teams connect at the start of the day to share relevant and time-sensitive information). The Charge Nurse (nurse caring for the resident) or Unit Manager (Nurse manager) would then speak to the resident about the changes.During an interview on 6/30/26 at 1:25 p.m., Licensed Nurse A (LN A) stated she was the Quality Assurance nurse (nurse who evaluates clinical practices, audits patient charts, and enforces regulatory compliance to improve patient safety). She stated if changes were made to a resident's Plan of Care, the Unit Manager would discuss the changes with the resident; the changes and discussion with the resident would be documented in the nurse's progress notes (nurse documentation of care and treatments).During an interview on 6/30/26 at 3 p.m., LN E stated she was the Unit Manager that evening and her duties included educating residents. She stated if a resident had a new physician order for a medication, she would talk to the charge nurse to inform them and she normally talked to the resident about it as well. She stated she would document the medication change and subsequent conversations with the nurse and resident in the progress notes. During an interview on 6/30/26 at 2:10 p.m., Resident 1 stated he wanted to be informed by staff about his care and changes to his medications. He stated if he was not informed about his medications, he had no control and had no way of knowing if the nurse was making a mistake. He stated he felt frustrated and horrible when he was not informed about his medications. When asked if any nurse had explained that some of his medications had been changed, Resident 1 stated, no.During an interview on 7/2/26 at 1:45 p.m., Resident 1 stated he had not gotten his Norco (pain medication) since the previous day. He stated the nurse told him, they ran out of Norco and she would reorder some. He stated he had requested Norco that day at 9 a.m. and again at 2 p.m. and his pain was currently at a level of eight (out of ten).During an interview on 7/2/26 at 2:10 p.m., LN B stated Resident 1's Norco had run out the previous day; she stated she had reordered it at that time but it had not yet arrived. She stated Resident 1 requested the Norco but none was given on her shift (day shift: approximately 7 a.m. through 3 p.m.) as she was awaiting its delivery from the pharmacy. When asked if she could have administered Norco from the Emergency supply (Emergency Kit; supply of medication designed to prevent treatment delays when regular pharmacy services are unavailable), she stated, yes, and stated she had not done so.During a follow-up interview on 7/02/26 at 2:35 p.m., Resident 1 stated he was not informed Norco was available in the emergency supply. He stated he usually took Norco every four hours and his pain level remained at eight. He stated after he received Norco, his pain usually decreased to about four, which he stated was, better than eight.During an interview with the Administrator and DON on 7/02/26 at 4 p.m., the DON confirmed the nursing progress notes did not contain documentation that he had been educated about medication changes. The Administrator stated he expected nursing staff to inform Resident 1 if medication changes were made.During the same interview on 7/02/26 at 4 p.m. the DON confirmed Resident 1's Norco was on order (from the pharmacy) since the previous day. She confirmed Resident 1 had not been given Norco since approximately 1:52 a.m., when it was administered form the Emergency Kit.A review of the facility policy titled, Resident Rights, revised 12/2016, indicated, 1. Federal and state laws guarantee certain basic rights to all residents. These rights include the resident's right to: . e. self-determination. o. be notified of his or her medical (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition and of any changes in his or her condition. p. be informed of, and participate in, his or her care planning and treatment.A review of facility policy titled, Comprehensive Person-Centered Care Planning, subtitled, Policy, revised 12/2023, indicated the, . IDT shall develop a comprehensive person-centered care plan for each resident. to meet a resident's medical. and psychosocial needs that. provide effective and person-centered care that meet professional standards of quality care. Under subtitle, Definitions, the policy indicated, . Person-centered care - means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.A review of the nurse job description titled, Registered Nurse., subtitled, Essential Duties and Responsibilities, dated 12/17/2021, indicated, . Prepare and administer medications as ordered by the physician.A review of the nurse job description titled, License Vocational Nurse., subtitled, Essential Duties and Responsibilities, dated 12/17/2021, indicated, . Prepare and administer medications as ordered by the physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) received nursing care that was resident-centered and in accordance with nursing professional standards of practice when he experienced seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) in April 2026 (his second seizure) and in May 2026, both requiring transfer to the hospital and:1. His anti-seizure medication, Keppra, was completed (reached the 30-day stop date; date medication administration ends) on 5/18/26; Keppra was not reordered and nursing staff did not call his physician to ensure this was intentional, and not an error,2. Nursing staff discontinued one of two Keppra orders (a duplicate), both ordered on 5/29/26; nursing staff discontinued the continuous Keppra order, maintaining the Keppra order with a 30-day stop date, and;3. Keppra was stopped on 6/29/26; nursing staff did not contact the physician until 7/1/26 to ensure this was intentional, and not an error.These failures:1. Prevented Resident 1 from receiving antiseizure medication from 5/19/26 through 5/23/26, when he experienced another seizure, necessitating transfer to the hospital,2. Prevented Resident 1 from receiving anti-seizure medication for approximately three days, beginning on 6/29/26, placing him at increased risk of additional seizures; and3. Potentially prevented Resident 1's physician the opportunity to review his medications and reorder the Keppra timely. A review of Resident 1's admission Records (front page of the medical record that contains a summary of basic information about the resident) indicated he was a seventy-eight-year-old male who was admitted to the facility on [DATE] with diagnoses including seizures, epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), Diabetes mellitus (DM- disorder characterized by difficulty in blood sugar control and poor wound healing), and Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).A review of Resident 1's Minimum Data Set (MDS; a resident assessment tool), dated 5/28/26, indicated he had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14, indicating he was cognitively intact. The MDS indicated his Active Diagnoses included, .Seizure Disorder or Epilepsy.A review of Resident 1's electronic medical record (EMR) revealed a nurses' note for a Change of Condition Assessment, dated 4/14/26 at 9;38 p.m., that indicated, . Mental Status Evaluation: Altered level of consciousness. Nursing observations. Not able to answer questions, not able to state his name. He only stairs (sic). He is noted clammy [skin moist with sweat] . gurgly [wet sounding] sound on exhalation [breathing out] .A review of hospital discharge note [physician synopsis of the hospital course] subtitled, Problem-Based Discharge Summary dated 4/18/26 at 12:08 p.m. indicated, [Resident 1] .had a witnessed. seizure in the ED [emergency department] . Neurology consultation [medical doctor who specializes in diagnosing/treating disorders of the brain and nervous system] . recommended initiation of maintenance (ongoing) antiepileptic [antiseizure] therapy [medication]. Given this represents his second seizure, chronic prophylaxis [preventative care] is indicated. He was started on levETIRAcetam (Keppra) 500 mg. Plan: Continue levETIRAcetam 500 mg twice daily indefinitely [for an unlimited period of time] . A review of the hospital discharge instruction to Resident 1 subtitled, Home Care, dated 4/18/26 at 12:36 p.m., indicated, Follow these tips when caring for yourself at home. If medicine was prescribed to prevent seizures, take it exactly as directed. Missing doses will increase your risk of having another seizure.A review of the facility's order summary report, dated 4/18/26, indicated Resident 1's physician ordered, levetiracetam [Keppra] oral tablet 500 milligrams [mg] . give 1 tablet by mouth two times a day for. seizure for 30 days. The physician order was started on 4/18/26 and contained an end date of 5/18/26.A review of Resident 1's nurse progress notes (nurse documentation of care and treatments), dated 5/16/26 at 1:39 p.m. indicated the IDT (interdisciplinary team of healthcare professionals including nursing, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	social workers, pharmacy, and dietary staff) team met to discuss Resident 1's self-care and mobility issues, but did not document the impending discontinuation of his antiseizure medication, Keppra. A review of Resident 1's Medication Administration Records (MARs; a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/26 - 5/31/26, indicated Resident received his last dose of Keppra on 5/18/26 at 8 a.m.A review of Resident 1's EMR revealed a nursing assessment titled, .Skilled Evaluation, subtitled, Comments, dated 5/18/26 at 9:33 p.m., indicated, . No seizure activity noted this shift. The evaluation did not contain documentation that Resident 1 was no longer receiving antiseizure medication.A review of Resident 1's medical record revealed a nurses' note for a Change of Condition Assessment, dated 5/23/26 at 5: 35 p.m., that indicated, . At around 1650 [4:50 p.m.] he [Resident 1] was found seizing [having a seizure] that lasted more than 30sec [seconds]. remained unresponsive until 1705 [5:05 p.m.]. MD was notified and patient sent out to ED.A review of hospital discharge note subtitled, Hospital Course, dated 5/29/26 at 2:35 p.m., indicated, The patient presented with status epilepticus [medical emergency characterized by prolonged seizure activity] requiring IV [intravenous] Lorazepam [a benzodiazepine medication] and loading [administration of an initial, larger dose of medication at the start of a treatment] with LevETIRAcetam (Keppra). Under subtitle, Problem-Based Discharge Summary, the physician documented, .Treated with levETIRAcetam (Keppra) with resolution of seizures and no recurrence during hospitalization. discharge on maintenance (ongoing) therapy [antiseizure medication] .A review of the facility's order summary report, dated 5/30/26, indicated Resident 1 had two orders for Keppra: Keppra. 500 mg. Give 1 tablet by mouth two times a day related to. seizures. The order date was 5/29/26 and had no end date (indefinite order). The second Keppra order indicated, .LevETIRAcetam [Keppra] . 500 mg. Give 1 tablet by mouth two times a day. for 30 Days. The order date was 5/29/26 and the end date was 6/29/26.A review of Resident 1's MAR, dated 6/01/26 - 6/30/26, indicated one of the duplicate Keppra orders was discontinued: Keppra. 500 mg. give 1 tablet . two times a day. The order was dated 5/29/26 and had a discontinuation date of 6/02/26 (four days later). The MAR indicated Resident 1 received two doses of Keppra on 6/01/26 under that order.A continued review of Resident 1's MAR, dated 6/01/26 - 6/30/26, indicated the following Keppra order was maintained (not discontinued): levETIRAcetam oral tablet 500 mg. give 1 tablet by mouth two times a day for. seizure for 30 days. The MAR indicated Resident 1 received his last dose of Keppra on 6/28/26 at 4 p.m. The MAR indicated Resident 1 did not receive Keppra on 6/29/26 - 6/30/26.A review of Resident 1's MAR, dated 7/01/26 - 7/31/26 indicated he did not receive Keppra on 7/01/26.A review of Resident 1's nursing care plan, dated 4/19/26, indicated, [Resident 1] has. Seizures. Care plan interventions indicated, Give seizure medication as ordered. The care plan did not address the discontinuation of Resident 1's Keppra. During an interview on 6/30/26 at 2:10 p.m., Resident 1 stated staff did not inform him about changes to his medications. He stated his antiseizure medications had been decreased and he wondered if that caused his recent seizures.During a concurrent interview and record review on 7/01/26 at 4 p.m., the Director of Nursing (DON) reviewed Resident 1's electronic medical record. The DON stated Resident 1 was sent to the hospital after having a seizure on 4/14/26. She stated he returned from the hospital 4/18/26 and was ordered to receive Keppra 500 mg twice a day for 30 days. The DON confirmed that after Resident 1 received his last dose of Keppra at the end of May 2026, he suffered another seizure four to five days later. The DON stated Resident 1 was transferred to the hospital and when he returned on 5/29/26, he was restarted on Keppra for 30 days. She confirmed he received his last dose of Keppra at the end of June 2026.During a concurrent telephone interview and record review on 7/02/26 at 3:28 p.m., Pharmacist C and Pharmacist D reviewed Resident 1's electronic medical record. Pharmacist C stated it was unusual to order Keppra with a discontinuation timeframe of 30 days; she stated Keppra did not usually have a stop order. She stated Keppra was usually not taken for a short period of time. The Pharmacist stated it was possible the discontinuation of Keppra contributed to his seizure activity. She stated stopping Keppra placed him at risk of further (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	seizures.During an interview on 7/02/26 at 4 p.m. with the DON and Administrator, the DON confirmed Resident 1's healthcare team did not document addressing the discontinuation of his antiseizure medication at the IDT meeting, dated 5/16/26. The DON confirmed the nurse's Skilled Evaluation, dated 5/18/26 did not contain documentation that Resident 1's Keppra had been discontinued or that his physician was notified and questioned about it. When asked if any nurse progress notes contained information that nursing staff notified the physician that Resident 1's Keppra had been stopped, she confirmed that physician notification was not located in the notes.During an interview on 7/02/26 at 4:15 p.m. with the Administrator and DON, the Administrator stated Keppra had been discontinued mistakenly during a medication recap (recapitulation; review of physician orders and MARS to ensure accuracy). He stated the nurse discontinued the duplicate Keppra order that did not have a stop date, which lead to Keppra being stopped and doses being missed .A review of the nurse job description titled, Registered Nurse., subtitled, Essential Duties and Responsibilities, dated 12/17/21, indicated, Confer with the Medical Director and the attending physician regarding specific residents assigned to you. Consult with the physician concerning resident evaluation.Examine the resident and his/her records and charts to distinguish between normal and abnormal findings in order to recognize early stages of serious physical. problems.A review of the nurse job description titled, License Vocational Nurse., subtitled, Essential Duties and Responsibilities, dated 12/17/21, indicated, Confer with the Medical Director and the attending physician regarding specific residents assigned to you. Consult with the physician concerning resident evaluation.Examine the resident and his/her records and charts to distinguish between normal and abnormal findings in order to recognize early stages of serious physical. problems.A review of facility policy titled, Comprehensive Person-Centered Care Planning, subtitled, Policy, revised 12/2023, indicated the, . IDT shall develop a comprehensive person-centered care plan for each resident. to meet a resident's medical. needs. provide . care that meet professional standards of quality care. Under subtitle, Procedure, the policy indicated, . 6. plan of care will be reviewed and/or revised by the IDT. 7. The facility IDT includes. A. Resident Physician or Non-Physician Practitioner. B. Registered Nurse with responsibility for the resident. E.resident.An online review of the Federal Drug Administration's (FDA) product information titled, Highlights of Prescribing Information, subtitled, Warnings and Precautions, revised 3/2024, indicated abrupt discontinuation of Keppra could cause, .Withdrawal Seizures: KEPPRA must be gradually withdrawn. (https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/021035s115,021505s053lbl.pdf#page=32)