

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 01/23/2025
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45849 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 2 (Resident #64 and Resident #79) of 26 sampled residents. Findings included: A facility policy titled, Accuracy of Minimum Data Set (MDS) Assessments, revised 04/2024, indicated, [Facility name] is committed to completing accurate and timely MDS assessments for all residents in compliance with the Resident Assessment Instrument (RAI) User Manual, Federal Regulations under the Code of Federal Regulations (CFR), Title 42 S483.20, and California Department of Public Health (CDPH) guidelines. The policy further indicated, Each assessment must accurately reflect the resident's current clinical status, functional abilities, and care needs. 1. An Admission Record indicated the facility admitted Resident #64 on 03/11/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of nicotine dependence. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/23/2024, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #64 did not use tobacco. Resident #64's care plan, included a focus area initiated 08/08/2022, that indicated the resident was at risk for injury related to smoking. The care plan indicated Resident #64 refused smoking cessation interventions. During an observation on 01/22/2025 at 2:03 PM, Resident #64 was noted outside smoking. During an interview on 01/20/2025 at 10:51 AM, Resident #64 stated they smoked. During an interview on 01/23/2025 at 9:00 AM, the Infection Prevention Nurse / MDS Coordinator stated Resident #64 smoked and acknowledged it was not coded on the resident's MDS assessment, but that it should have been since the resident smoked since their admission to the facility. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055987	Facility ID: 055987 If continuation sheet Page 1 of 10

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/2025 at 10:00 AM, the Director of Nursing (DON) stated he and the MDS Coordinator were responsible to ensure the accuracy of the MDS assessment. The DON confirmed that Resident #64 smoked, and it should have been captured on the MDS assessment. During an interview on 01/23/2025 at 10:23 AM, the Administrator stated the MDS assessment should be accurate for billing purposes, and it should reflect the care that the facility provided. The Administrator stated Resident #64 had been a long-term smoker and should have been coded for tobacco use on the MDS assessment. 45555 2. An Admission Record indicated the facility admitted Resident #79 on 05/11/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right non-dominant side. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/09/2025, revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident did not receive a restorative nursing program. Resident #79's care plan, included a focus area revised 10/19/2023, that indicated the resident had a potential for a decline in range of motion (ROM) and strength. Interventions directed staff to provide restorative nursing three times a week for bilateral upper and right lower extremity bike to maintain strength and tolerance to functional activities, Resident #79's Order Summary Report for active orders as of 01/22/2025, revealed an order dated 08/25/2022, for restorative nursing aide (RNA) three times a week for bilateral upper extremity and right lower extremity bike to maintain strength and tolerance to functional activities, and an order dated 11/11/2024, for RNA three times a week for sound leg bridge; residual leg bridge against a towel roll; residual limp/hip adduction/abduction in side lying; prone quad set with hip flexion, and prone hip adduction using towel roll; and sit to stand at the hallway hand rail with bilateral upper extremity support wearing prosthetic limb. Resident #79's Restorative Nursing administration record for the timeframe 01/01/2025 - 01/31/2025, revealed the resident received restorative nursing services on 01/02/2025, 01/04/2025, 01/07/2025 01/09/2025, 01/11/2025, 01/14/2025, 01/16/2025, 01/18/2025, and 01/21/2025 for a minimum of 15 minutes each day. Resident #79's RNA Weekly Summary dated 01/09/2025 revealed the resident received active range of motion exercise three times a week for 15 minutes. During an interview on 01/23/2025 at 9:01 AM, MDS Licensed Vocational Nurse (LVN) #1 stated the accuracy of the MDS was important because it reflected the resident and the MDS person was responsible for the accuracy of the MDS. MDS LVN #1 stated Resident #79 did receive restorative services. After review of the resident's MDS with an ARD of 01/09/2025, MDS LVN #1 confirmed he completed the resident's MDS, and restorative services was not coded on Resident #79's MDS. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/2025 at 9:35 AM, the Assistant Director of Nursing (ADON) stated the MDS needed to be accurate for billing purposes and for resident care. The ADON stated the accuracy of the MDS was the responsibility of the MDS Coordinator. The ADON stated the facility did not for restorative services, so they did not code it on the MDS. During an interview on 01/23/2025 at 10:00 AM the Director of Nursing (DON) stated it was best practice for the MDS to be accurate. The DON stated he and the MDS Coordinator were responsible to ensure the accuracy of the MDS. The DON stated Resident #79 received restorative services and confirmed that it was not captured on the most recent MDS. During an interview on 01/23/2025 at 10:23 AM, the Administrator stated the MDS assessment should be accurate for billing purposes, and it should reflect the care that the facility provided. The Administrator stated he unsure about restorative services being coded on the MDS, the facility did not bill for restorative services, so they did not code it on the MDS.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45555 Based on interview, record review, and facility policy review, the facility failed to hold insulin as ordered by the physician when the resident's blood sugar was out of parameters for 1 (Resident #57) of 5 sampled residents reviewed for unnecessary medications. Findings included: A facility policy titled, Medication Pass Observation, revised 09/2024, specified, D. Vital signs and blood sugar need to be monitored according to facility policy and/or the physician's order with medication given based on results. An Admission Record indicated the facility readmitted Resident #57 on 11/24/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/08/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received insulin seven of seven days of the assessment period. Resident #57's care plan included a focus area revised 05/11/2023 that indicated the resident had type 2 diabetes mellitus. Interventions directed staff to administer diabetes medication as ordered by the doctor and monitor for side effects and effectiveness. Resident #57's Order Summary Report for active orders as of 01/22/2025, included an order dated 11/16/2024, for insulin glargine 100 units per milliliter with instructions to inject 35 units subcutaneously every morning and at bedtime with instructions to hold if the resident's blood sugar was less than 180 milligrams per deciliter (mg/dL). Resident #57's Medication Administration Record [MAR] for 12/01/2024 - 12/31/2024, revealed insulin glargine was administered to the resident when the resident's blood sugar was less than 180 mg/dL on the following days for the 8:00 AM dose: -12/04/2024 - blood sugar 167 mg/dL, -12/05/2024 - blood sugar 178 mg/dL, -12/08/2024 - blood sugar 165 mg/dL, -12/11/2024 - blood sugar 178 mg/dL, -12/14/2024 - blood sugar 152 mg/dL, -12/16/2024 - blood sugar 149 mg/dL, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/17/2024 - blood sugar 145 mg/dL, and -12/30/2024 - blood sugar 177 mg/dL. Resident #57's MAR for 01/01/2025 - 01/31/2025, revealed insulin glargine was administered to the resident when the resident's blood sugar was less than 180 mg/dL on the following day for the 8:00 AM dose: -01/11/2025 - blood sugar 167 mg/dL, -01/12/2025 - blood sugar 179 mg/dL, and -01/17/2025 - blood sugar 145 mg/dL. During an interview on 01/22/2025 at 1:21 PM, Licensed Vocational Nurse (LVN) #2 stated that when giving a medication with parameters, she would get the needed vital, such as a blood pressure, pulse, or blood sugar, and verify it with the order. LVN #2 stated if the results were out of the parameters, then she would hold the medication and document it on the MAR. LVN #2 stated Resident #57 had parameters for their insulin glargine to hold it if the blood sugar was less than 180 mg/dL. After review of Resident #57's MAR for 12/2024 and 01/2024, LVN #2 confirmed that she signed that she administered the insulin when it should have been held on 12/04/2024, 12/05/2024, 12/11/2024, 12/16/2024, 12/17/2024, 12/30/2024, 01/11/2025, 01/12/2025, and 01/17/2025. During an interview on 01/22/2025 at 1:53 PM, the Assistant Director of Nursing (ADON) reviewed Resident #57's MAR and confirmed that the resident's insulin should have been held. During a follow-up interview on 01/23/2025 at 9:35 AM, the ADON stated that when administering medications with parameters, the nurse should review the parameters and hold the medication if out of parameters. The ADON stated giving a medication when it should have been held could cause an adverse reaction later. The ADON stated the nurse should have followed the order and held the resident's when their blood sugar was below 180 mg/dL. During an interview on 01/23/2025 at 10:00 AM, the Director of Nursing (DON) stated that when administering medications, the nurse should follow the ordered parameters, and they would either hold the medication or give it depending on the parameters. The DON stated that in general it could have adverse effects when given when it should not be. The DON stated the nurse should have held the insulin when the resident's blood sugar was below 180 mg/dL. During an interview on 01/23/2025 at 10:23 AM, the Administrator stated medications should be administered according to the physician order, and staff should get clarification if needed.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were stored properly for 1 (Resident #37) of 6 sampled residents reviewed for accidents. Findings included: A facility policy titled, Self-Administration of Medications, revised 11/2023, specified, Storage and location of drug administration will comply with state and federal requirements for medication storage. An Admission Record indicated the facility readmitted Resident #37 on 06/28/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/27/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Observation on 01/20/2025 at 9:50 AM, 01/21/2025 at 11:40 AM, and 01/22/2025 at 11:25 AM revealed a container of Citrucel (an over-the-counter fiber laxative used to relieve constipation) on the nightstand in the corner of Resident #37's room with instructions written on the lid to put one spoonful in water. Resident #37's Order Summary Report for active orders as of 01/22/2025 revealed no order for the Citrucel. During an interview on 01/22/2025 at 11:25 AM, Certified Nursing Assistant #3 stated she did not realize the container of Citrucel was in the resident's room. During an interview on 01/22/2025 at 1:21 PM, Licensed Vocational Nurse (LVN) #2 stated Resident #37 should not have medications at their bedside. LVN #2 entered Resident #37's room and removed the Citrucel from the nightstand. LVN #2 stated the resident's family must have brought it in and did not tell them. According to LVN #2, she did not think the resident had an order for the Citrucel. During an interview on 01/23/2025 at 9:35 AM, the Assistant Director of Nursing (ADON) stated medication should not be left at the bedside unless the resident had an order to self-administer medications, and then the facility would refer to their policy. The ADON stated the resident's family should have told the facility that the Citrucel was brought in, but it should have been caught by the staff and followed up on. (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/2025 at 10:00 AM, the Director of Nursing (DON) stated medications should not be left at the bedside unless the resident had been assessed for self-administration. The DON stated the resident did not have an order for medications to be left at the bedside and did not have an order for the Citrucel. The DON stated it should not have been left in the room but should have been identified by the staff and an order received for its use if it was appropriate. During an interview on 01/23/2025 at 10:23 AM, the Administrator stated the Citrucel in Resident #37's room should have been identified and removed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to have a physician order for the use of a continuous positive air pressure (CPAP) and failed to properly clean and store CPAP and nebulizer equipment for 1 (Resident #57) of 3 sampled residents reviewed for respiratory care. Findings included: A facility policy titled, BiPap [bilevel positive airway pressure]/CPAP, revised 05/2024, specified, It is the policy of this facility that BiPap/CPAP be administered as ordered by the physician under the following procedures. Per the policy, Procedures: 1. Verify settings per MD [medical doctor] order and 4. BiPap/CPAP checks will be done before use. 5. BiPap/CPAP settings are preprogrammed by Pulmonologist and preset by company providing the equipment for the facility. An Admission Record indicated the facility readmitted Resident #57 on 11/24/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of obstructive sleep apnea. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/08/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #57's care plan, included a focus area revised 05/09/2024 that indicated the resident was at risk for altered respiratory status related to obstructive sleep apnea. Interventions directed staff to apply BiPAP at night as ordered. Resident #57's Order Summary Report for active orders as of 01/22/2025, revealed no order for the use of a BiPAP and/or CPAP machine. During a concurrent observation and interview on 01/20/2025 at 10:17 AM, the surveyor noted Resident #57 had a CPAP machine with the tubing connected to nasal pillows lying on top of the nightstand. There was a nebulizer machine next to the CPAP machine with the tubing and medication cannister connected lying on top of the over-the-bed table on top of books. There was no bag or container to store the CPAP nasal pillows or nebulizer equipment in. Resident #57 stated they used the CPAP every night and the nebulizer as needed when they were short of breath. According to Resident #57, the staff took care of the equipment. During an observation on 01/21/2025 at 2:10 PM, the surveyor noted Resident #57's CPAP nasal pillows and nebulizer equipment were in the same position as on 01/20/2025. During an observation on 01/22/2025 at 10:46 AM, the surveyor noted the CPAP head piece with the nasal pillows hanging on the left bed cane with the tubing attached. The nebulizer machine on the nightstand had the tubing and medication cannister attached lying on the over-the-bed table. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/2025 at 11:29 AM, Resident #57 stated they used the nebulizer machine about a week ago, and only got it when they requested. The resident stated they used the CPAP every night, and the staff put tap water in it but that it should be distilled water. During an observation and interview on 01/22/2025 at 1:21 PM, Licensed Vocational Nurse (LNV) #2 stated Resident #57 used the CPAP at night and sometimes during the day. LVN #2 stated she thought the resident had an order but after looking in the computer system, she confirmed that the resident did not have an order for the use of the CPAP. LVN #2 stated she was unsure how it was supposed to be cleaned or stored. LVN #2 stated she would have to find out what the facility policy was on the orders, storing, and cleaning. LVN #2 stated staff should put distilled water in the machine, and it was available in the medication room. LVN #2 stated Resident #57 used the nebulizer as needed and she did administer a treatment on 01/22/2025. LVN #2 stated the cannister and mouthpiece should be rinsed and stored in a plastic bag in between use. LVN #2 stated she did not rinse out the nebulizer equipment after use that afternoon and confirmed there was not a bag to store it in. During an interview on 01/23/2025 at 9:35 AM, the Assistant Director of Nursing (ADON) stated the facility needed an order for a resident to use a CPAP or BiPAP machine that included the settings from the hospital or home, but she would have to look at the policy to see how often the mask and tubing should be changed. The ADON stated it should be stored in a bag when not in use. The ADON stated she would also have to refer to the facility policy on cleaning the nebulizer equipment but stated it needed to be bagged. During an interview on 01/23/2025 at 10:00 AM, the Director of Nursing (DON) stated the facility needed to have orders for a resident to use a CPAP machine that included the cleaning and maintenance of it. The DON stated that when the resident was done using the CPAP or nebulizer, it should be rinsed out then weekly cleaned with soap and water. The DON stated it should be stored where it was accessible, as long as it was not on the floor. The DON stated nebulizer equipment should be stored in a cool dry place and not on the floor. The DON stated he expected the staff to rinse and store the CPAP and nebulizer equipment between each use. During an interview on 01/23/2025 at 10:23 AM, the Administrator stated the facility should have orders for the CPAP machine and the staff should clean and store the respiratory equipment appropriately.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 35314 Based on interview, document review, and facility policy review, the facility failed to ensure the daily staffing posted included the facility name and the actual hours worked by the licensed and unlicensed staff for 32 of 32 days reviewed. Findings included: A facility policy titled, Policy on Posting Nursing Hours Per Patient Day (NHPPD) Numbers, effective 04/2024, revealed, Purpose To ensure compliance with California state and federal regulations regarding the public posting of Nursing Hours Per Patient Day to maintain transparency and accountability in staffing levels. Per the policy, b. The posting must include: i. Total NHPPD. ii. Actual hours worked by RNs [registered nurses], LVNs/LPNs [licensed vocational nurses/licensed practical nurses], and CNAs [certified nursing assistants]. The facility daily staff posting for the timeframe 12/20/2024 to 01/20/2025, revealed the posting did not include the name of the facility or the actual hours worked by the staff. During an interview on 01/23/2025 at 8:41 AM, the Staffing Supervisor confirmed the daily staff posting did not include the facility's name or the actual worked by the staff. During an interview on 01/23/2025 at 8:53 AM, the Director of Nursing stated he was not aware the name of the facility was not posted on the daily staff posting and that he did not know the actual worked hours for the staff had to be included. Per the DON, the Staffing Supervisor was responsible for ensuring the posting included all the required information. During an interview on 01/23/2025 at 10:41 AM, the Administrator stated he expected the daily staffing posting to include the information required.		