STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056259	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northvine Postacute Care	446 Arrowood Dr Santa Rosa, CA 95407

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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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to involve two out of two residents (Residents 1 and 2) in decision making regarding their choice of physician when the facility transferred their care to another physician without their consent. This failure violated residents ' rights to choose their own physician. Findings: A review of Resident 1s face sheet (demographics) indicated Resident 1 was admitted on [DATE] with a diagnoses of Muscle Weakness, Chronic Pain Syndrome (CPS, pain that lasts over 3 months) and Spinal Cord Disease (SCD, nerve damage that cause permanent severe problems, such as paralysis (loss of the ability to move (and sometimes to feel anything) in part or most of the body) or impaired bladder and bowel control). Resident 1s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents) dated 8/29/24 score was 15 out of 15 indicating intact cognition. Resident 1s face sheet also indicated he was self-responsible (able to make decision for himself). A review of Resident 2s face sheet indicated Resident 2 was readmitted on [DATE] with a diagnoses of Muscle Weakness and Dysphagia (difficulty swallowing). Resident 2s BIMS dated 9/20/24 score was 12 out of 15 indicating moderately impaired cognition. Resident 2s face sheet also indicated she was self-responsible. During an interview on 9/30/24 at 10:25 a.m., Licensed Nurse A stated it was a resident right to choose their own primary physician. LN A stated a residents ' right was not honored if their physician was changed into another physician without their knowledge or consent. (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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, progress note (PN, documents residents medical status, important details) note, Interdisciplinary note (IDT, team of professionals that plan, coordinate and deliver you personalized health care), Change of Condition (COC, documents change in resident medical status) note and Care Plan (CP, health document designed to facilitate communication among the members of your care team) for Residents 1 and 2 on 9/30/24 11:07 a.m., the Minimum Data Set Coordinator (MDSC) stated it was a residents right to choose their own physician. MDSC stated facility could offer them a physician but ultimately resident or their responsible party (RP, person that makes the decision for the resident) makes that decision. MDSC stated Residents 1 and 2 were both responsible for themselves. MDSC stated Resident 1 and 2 ' s request to change physician should be documented in their medical record. MDSC verified there was no PN, IDT note, COC note and CP for Resident 1 from 9/15/24 up to 9/21/24 to indicate he requested a change of physician or that staff talked to him about changing a physician. MDSC verified there was no PN, IDT note, COC note and CP for Resident 2 from 9/16/24 up to 9/21/24 to indicate she requested a change of physician nor that staff talked to her about changing a physician. The MDSC stated Residents 1 and 2 was previously under the care of PCP (Primary Care Physician) but was now under the care of MD (Medical Director). MDSC stated she thought MD assumed Resident 2 ' s care when she was readmitted on [DATE] but she was not sure on when Resident 1 ' s care was transferred to MD. During an interview on 9/30/24 at 11:56 a.m., Resident 1 verified he never asked the facility to change his PCP. Resident 1 stated the only request he made was to speak to PCP but not change physician. Resident 1 stated it was confusing, he did not know who his physician now. Resident 1 stated he wished the facility talked to him first before changing his physician. Resident 1 stated this was his right. During a concurrent interview, PN, IDT note, COC note and CP record review on 9/30/24 at 12:57 p.m., the interim Director of Nursing (DON) stated it was the resident right to choose their physician and the facility could not just change their physician without their request or consent. The interim DON stated it was a violation of residents ' rights to change resident ' s physician without getting their consent or approval first. The interim DON verified there was no PN, IDT note, COC note and CP for Resident 1 from 9/15/24 up to 9/21/24 to indicate he requested a change of physician or that staff talked to him about changing a physician. The interim DON verified there was no PN, IDT note, COC note and CP for Resident 2 from 9/16/24 up to 9/21/24 to indicate she requested a change of physician, nor staff talked to her about changing a physician. During an interview on 9/30/24 1:37 p.m., the Administrator (ADM) stated it was a resident right to choose their physician and facility could not change a resident physician without their consent. The ADM stated that with Resident 2, he thought she made the request to the admission coordinator to change physician and for Resident 1, that he also made a request to change physician. The ADM stated these would be documented on their chart. A review of the facility ' s policy and procedure (P&P) titled Resident ' s Rights, release date of 1/2018, the P&P indicated .to choose an attending physician and participate in decision making regarding his or her care. A review of the facility ' s policy and procedure titled Choice of attending Physician release date of 1/2018, the P&P indicated the resident has the right to choose his or her own attending physician .the resident is informed in writing of the name and contact information for his or her attending physician anytime the information changes.

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide immediate access to any resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842 Based on observation, interview and record review, the facility failed to ensure access to residents when the phones in the facility were left unanswered. This failure resulted in a pharmacy not being able to get in contact with nursing staff to clarify physician ' s ordered medication, and Confidential Complainant not being able to reach staff. This led to Resident 5 not receiving Paxlovid (a medication that helps stop mild-to-moderate COVID-19) for 5 days, and Confidential Complainant unable to discuss an urgent matter with staff. Findings: During a phone call to the facility on [DATE] at 2:30 p.m., the facility ' s phone rang 20 times then rolled over to a message, All our agents are busy. One could leave a message. During an observation on 9/30/24 at 9:50 a.m., a receptionist was sitting at the reception table located to the right of the entrance door, screening people for COVID and answering the facility ' s phone. During a concurrent observation and interview on 9/30/24 at 11:20 a.m., the Receptionist was sitting at a table by the facility entrance door answering the facility ' s phone. The Receptionist state he answered phones Monday through Friday 8:30 a.m. to 5 p.m. The Receptionist stated the nurses and CNAs (Certified Nursing Assistances) answered the facility phone after hours. The Receptionist stated when he returned from stepping away from the receptionist ' s table, he would check the phone to see if there were any missed calls and would return any missed call. The Receptionist was not aware of the mailbox being set-up for the facility phone system. A review of Resident 5 ' s Admission Record, indicate Resident 5 was admitted on [DATE] with a diagnosis which included autistic disorder (neurological and developmental disorder) catatonic schizophrenia (a mental health disorder) dementia and others. A review of Resident 5 ' s Nurses Progress Note, date 9/16/24 at 1:47 p.m., indicated Resident 5 had tested positive for COVID, was coughing slightly, and Resident 5 ' s physician had been notified. A review of Resident 5 ' s Order Note, dated 9/16/24 at 8:57 p.m., indicated Resident 5 was to receive Paxlovid 300/100 mg (milligrams) one tablet by mouth two times a day for five days, start date 9/17/24, to treat the symptoms of COVID 19. Resident 5 ' s MAR (Medication Administration Record) indicated his physician ordered Paxlovid was not administered from 9/17/24 through 9/21/24, indicating Resident 5 never received Paxlovid. During a concurrent interview and record review on 9/30/24 at 4:50 p.m., the Interim Director of Nursing (DON) was asked why Resident 5 did not receive his Paxlovid. The Interim DON called in Licensed Nurse (LN) A, who was aware of Resident 5 ' s Paxlovid order and stated she documented speaking to the pharmacy. A Nurses Progress Note, dated 9/17/24, indicated: Nurse spoke with pharmacy, and they are processing Paxlovid 300/100. To be followed up with. (continued on next page)

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/24 at 5:03 p.m., when the pharmacy Customer Service Technician was asked why Resident 5 ' s Paxlovid was not delivered, the Customer Service Technician stated notes indicated there was a concern with a drug interaction, so the pharmacy needed clarification. The Customer Service Technician stated the pharmacy tried reaching out to the facility on [DATE], 9/18/24, and the last time on 9/19/24 at 8:30 p.m. The Customer Service Technician stated it was noted the facility was not picking up their phone and the pharmacy even was hung up on. During an interview on 10/1/24 at 11:55 a.m., regarding the phones, the Administrator stated there was a receptionist, whose schedule was Monday through Friday from 8 a.m. to 5 p.m. The Administrator stated the phone system rang throughout facility, Nurse ' s Station, Admission Office, the Administrator ' s office, etc., so any person could and should answer the incoming phone call. The Administrator was not aware of phone calls rolling over to a mailbox after so many rings. During an interview on 10/1/24 at 12:50 p.m., the Maintenance Director stated the facility phone system was new and rang throughout the facility, to all departments. The Maintenance Director was not aware after so many rings the incoming phone call rolled over to a mailbox. The Maintenance Director had not setup a mailbox. During an interview on 10/4/24 at 9:26 a.m., the Confidential Complainant stated he had tried calling the facility on 7/31/24 at 6:44 p.m. but had to leave a voice message. On 8/1/24 the Confidential Complainant tried calling the facility at 8:15 a.m. and at 12:07 p.m., but no one answered the facility ' s phone, and the mailbox was full. The facility Policy/Procedure titled, Telephones Employee Use Of, dated /2018, indicated: . Process: 1. Facility telephones are normally answered from the business office and/or the nurses ' station(s) . The facility job description titled, Receptionist, revised 10/19/15, indicated: Position Summary: . The Receptionist is responsible for answering questions, assisting patients, and directing calls to all appropriate representatives. Responsibilities/Accountabilities: . Respond to inquiries from patients, visitors and employees and refer, when necessary, to the appropriate person or department . Prompt follow up of telephone encounters/actions .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842 Based on interview and record review the facility failed to meet professional standards of quality for one of three sampled residents, Resident 6, when a licensed nurse, RN K, did not follow the rights of medication administration (the right patient, the right medication, the right dose, the right time, the right route, right indication) and administered Duloxetine HCl Delayed Release (an antidepressant also used to treat chronic pain) 60 mg (milligrams) to Resident 6, instead of the physician ordered dose of 30 mg, upon Resident ' s 6 ' s request. This failure led to Resident 6 refusing to take her physician ' s ordered dose of 30 mg, which had the potential to cause withdrawal symptoms for Resident 6 and had the potential for other residents not to receive their medications according to physician orders and professional standards. Findings: A review of Resident 6 ' s Admission Record, indicated Resident 6 was admitted on [DATE] with a diagnosis which included sciatica (pain, weakness, numbness, or tingling in the leg) left side, chronic (something that continues over an extended period) pain, migraines (headaches), major depression, muscle weakness, among others. A review of Resident 6 ' s Admission MDS (Minimum Data Set) (an assessment tool), dated 7/22/24, indicated Resident 6 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. A review of Resident 6 ' s Order Summary Report, dated 10/2024, indicated Resident 6 ' s physician had ordered for her to receive Duloxetine HCl (Hydrochloride) Delayed Release 30 mg (milligrams) one capsule one time per day for sciatica right and left side, start date 7/18/24. During an interview on 9/30/24 at 5 p.m. and 10/1/24 at 12:20 p.m., the Interim DON (Director of Nursing) stated Resident 6 ' s physician would not increase the Duloxetine HCl 30 mg dose to 60 mg. The Interim DON stated she found out about RN K administering Resident 6 Duloxetine HCl 60 mg at Resident 6 ' s Care Conference. Resident 6 had stated RN K had been giving her Duloxetine HCl 60 mg instead of the physician ordered dose of 30 mg. The Interim DON stated Resident 6 became angry at her Care Conference because her physician would not increase her Duloxetine HCl dose from 30 mg to 60 mg. The Interim DON stated she asked RN K after Resident 6 ' s Care Conference, and RN K admitted he had given Resident 6 Duloxetine HCl Delayed Release 60 mg one day without Resident 6 ' s physician changing the dosage order. A review of Resident 6 ' s MAR (Medication Administration Record), dated 7/2024, indicated Resident 6 received Duloxetine HCl Delayed 30 mg one capsule starting 7/19/24 at 9 a.m. RN K had administered Resident 6 her AM medications including her Duloxetine on 7/20/24, 9/21/24, and 9/23/24. Starting 9/24/24 Resident 6 refused to take her Duloxetine 30 mg until she was discharged , 8/2/24. A review of the facility policy/procedure titled, Adverse Consequences and Medication Errors, dated 1/2018, indicated: . Process: A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician ' s orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy/procedure titled, Administration Medication, dated 1/2018, indicated: Policy: Medications shall be administered in a safe and timely manner, and as prescribed. Process: . 3. Medications must be administered in accordance with the orders, including any required time frame . 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication . A review of the facility job description titled, RN, revised 10/23/24, indicated: . Responsibilities/Accountabilities: 1. Patient Care: . 2. Provides professional nursing care by utilizing all elements of nursing process . 5. Communication: 1. Completes, maintains, and submits accurate and relevant clinical notes regarding patient ' s condition and care given. 2. Communicates with the physician regarding the patient ' s needs and reports changes in the patient ' s condition obtains/receives physician ' s orders as required.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure the facility ' s policy on death was followed for one out of two sampled resident (Resident 2) when: 1. Resident 2s death was pronounced by a Licensed Vocational Nurse (LVN); and, 2. Staff did not inform the mortuary if an autopsy was to be performed due to Resident 2 ' s unexpected death. These failures may put the residents at risk for missed diagnostic errors and missed opportunities to improve medical treatment. Findings: A review of Resident 2s face sheet (demographics) indicated Resident 2 was readmitted on [DATE] with a diagnoses of Muscle Weakness and Dysphagia (difficulty swallowing). Resident 2s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents) dated [DATE] score was 12 out of 15 indicating moderately impaired cognition. Resident 2s face sheet also indicated she was self-responsible (makes decision for herself). A review of Resident 2s Physician Order for Life Sustaining Treatment (POLST, a physician ' s order that outlines a plan for end of life care reflecting both a patient ' s preferences and a physician ' s judgment based on a medical evaluation) dated [DATE] indicated to attempt Cardiopulmonary resuscitation (CPR, an emergency treatment done when breathing or heartbeat has stopped) and Full Treatment (goal was to prolong life by all medically effective means). Resident 2 suddenly expired on [DATE]. During an interview on [DATE] at 10:25 a.m., Licensed Nurse (LN) A stated if a resident was not on hospice (end of life care, prioritizes comfort and quality of life by reducing pain and suffering) who were full code and unexpectedly expired, then death should be investigated, and local police department (PD) should be notified to determine the cause of death. LN A stated two nurses should verify residents ' death. LN A stated a Registered Nurse (RN) would pronounce a residents ' death. During a concurrent interview and POLST dated [DATE] record review on [DATE] at 11:16 a.m., the Minimum Data Set Coordinator (MDSC) stated Resident 2 was not on hospice. MDSC stated Resident 2 had multiple illness but not sick enough to be placed on hospice. When asked if Resident 2s death was unexpected, MDSC stated yes. MDSC stated if a resident was not on hospice and suddenly expired, death could be coroners ' case. The MDSC verified Resident 2 POLST indicated to attempt CPR and full treatment. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:24 p.m., LN D stated he was not aware of the facility policy on death but knew death was verified by 2 nurses and RN pronounce a resident ' s death. LN D stated sudden and unexpected death should be investigated to know the cause of death and to remove doubts on sudden deaths. During a concurrent interview, POLST dated [DATE] and progress note dated [DATE] record review on [DATE] at 12:57 p.m., the interim Director of Nursing (DON) verified Resident 2s POLST indicated she was a full code (attempt CPR with full treatment). The DON verified the progress note (PN, document that details residents ' clinical status) on [DATE] 12:46 a.m. indicated Resident 2 expired on [DATE] at approximately 2025. The PN further indicated, Resident 2 was found unresponsive with no pulse and no respiration. The DON verified the PN did not indicate 911 was called, nor was an autopsy requested. The DON stated since Resident 2 was a full code and was not on hospice, 1 staff should have performed CPR and 1 staff should have called 911. The DON stated staff should have continued performing CPR until paramedics arrive who will then relieve the nurse and give CPR. The DON stated at this time, if the CPR was unsuccessful, the paramedics would pronounce death. The DON verified there was only 1 nurse when Resident 2 expired who happened to be an LVN and it was a concern because he should have called 911. The DON stated the facility policy was for nurse to request mortuary for an autopsy and then they would call the local PD if an investigation was needed. The DON stated staff should have notified the mortuary that Resident 2 was an unexpected death. The DON stated in Resident 2s case, the facility ' s death policy was not followed when the nurse did not call 911, an LVN pronounced Resident 2s death and no autopsy was requested to the mortician for Resident 2s sudden death. The DON stated Resident 2s death could have been a coroner case that could have been investigated to determine cause of death and to make sure there was no foul play. A review of the facility ' s policy and procedure (P&P) titled Death of A Resident-Documenting release date , d+[DATE], the P&P indicated a resident may be declared dead by a licensed physician or registered nurse with physician authorization in accordance with state law .inform the mortician if an autopsy is to be performed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842 Based on interview and clinical record review, the facility failed to ensure residents were free from significant medication errors for 2 of 3 sampled residents (Resident 5 and Resident 6) when physicians ' order for medication administration were not followed: 1. Resident 5 never received Paxlovid (an antiviral medication) to treat symptoms of COVID-19 which could lead to hospitalization and death and 2. a licensed nurse did not follow physician orders and administered Duloxetine HCl Delayed Release (an antidepressant also used to treat chronic pain) 60 mg (milligrams) to Resident 6, instead of the physician ordered dose of 30 mg, upon Resident ' s 6 ' s request. These medication errors resulted in to 1. Resident 5 not having a speedy recovery, and 2. Resident 6 becoming upset and refusing to take her physician ' s ordered dose of 30 mg, which had the potential to led to withdrawal symptoms. Findings: A review of Resident 5 ' s Admission Record, indicate Resident 5 was admitted on [DATE] with a diagnosis which included autistic disorder (neurological and developmental disorder) catatonic schizophrenia (a mental health disorder) dementia and others. A review of Resident 5 ' Nurses Progress Note, date 9/16/24 at 1:47 p.m., indicated Resident 5 had tested positive for COVID, was coughing slightly, and Resident 5 ' s physician had been notified. A review of Resident 5 ' s Nurses Progress Notes, dated 9/16/24 and CPAC-Transfer Sheet - V4, dated 9/16/24 at 4:30 a.m., indicated Resident 5 had been transferred to the ED (Emergency Department) because of large back tarry emesis (vomiting, a symptom of internal bleeding) and diarrhea (water loose stools). Emesis and diarrhea are signs of COVID. A review of Resident 5 ' s Order Note, dated 9/16/24 at 8:57 p.m., indicated Resident 5 was to receive Paxlovid 300/100 mg (milligrams) one tablet by mouth two times a day for five days, start date 9/17/24, to treat the symptoms of COVID 19. Resident 5 ' s MAR (Medication Administration Record) indicated his physician ordered Paxlovid was not administered from 9/17/24 through 9/21/24, indicating Resident 5 never received Paxlovid. During a concurrent interview and record review on 9/30/24 at 4:50 p.m., the Interim Director of Nursing (DON) was asked why Resident 5 did not receive his Paxlovid. The Interim DON called in Licensed Nurse (LN) A, who was aware of Resident 5 ' s Paxlovid order and stated she documented speaking to the pharmacy. LN A stated the DON, who no longer worked at the facility, was aware of the issue with the Paxlovid not arriving from the pharmacy. The Interim DON stated the previous DON should have followed through and contacted the pharmacy. The Interim DON stated the DON was there to help nurses with issues; the only one to suffer was the resident. 2. Review of Resident 6 ' s Admission Record, indicated Resident 6 was admitted on [DATE] with a diagnosis which included sciatica (pain, weakness, numbness, or tingling in the leg) left side, chronic (something that continues over an extended period) pain, migraines (headaches), major depression, muscle weakness, among others. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 6 ' s Admission MDS (Minimum Data Set) (an assessment tool), dated 7/22/24, indicated Resident 6 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. A review of Resident 6 ' s Order Summary Report, dated 10/2024, indicated Resident 6 ' s physician had ordered for her to receive Duloxetine HCl (Hydrochloride) Delayed Release 30 mg (milligrams) one capsule one time per day for sciatica right and left side, start date 7/18/24. During an interview on 9/30/24 at 5 p.m. and 10/1/24 at 12:20 p.m., the Interim DON (Director of Nursing) stated Resident 6 ' s physician would not increase the Duloxetine HCl 30 mg dose to 60 mg. The Interim DON stated she found out about RN K administering Resident 6 Duloxetine HCl 60 mg at Resident 6 ' s Care Conference. Resident 6 had stated RN K had been giving her Duloxetine HCl 60 mg instead of the physician ordered dose of 30 mg. The Interim DON stated Resident 6 became angry at her Care Conference because her physician would not increase her Duloxetine HCl dose from 30 mg to 60 mg. The Interim DON stated she asked RN K after Resident 6 ' s Care Conference, and RN K admitted he had given Resident 6 Duloxetine HCl Delayed Release 60 mg one day without Resident 6 ' s physician changing the dosage order. The Interim DON stated what if Resident 6 had side effects from RN K increasing Duloxetine HCl dose without a physician order, a very unsafe call. A review of the facility Policy/Procedure titled, Adverse Consequences and Medication Errors, dated 1/2018, indicated: . Process: A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician ' s orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services . A review of the facility Policy/Procedure titled, Administration Medication, dated 1/2018, indicated: Policy: Medications shall be administered in a safe and timely manner, and as prescribed. Process: . 3. Medications must be administered in accordance with the orders, including any required time frame . 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication . A review of the facility job description titled, RN, revised 10/23/24, indicated: . Responsibilities/Accountabilities: 1. Patient Care: . 2. Provides professional nursing care by utilizing all elements of nursing process . 5. Communication: 1. Completes, maintains, and submits accurate and relevant clinical notes regarding patient ' s condition and care given. 2. Communicates with the physician regarding the patient ' s needs and reports changes in the patient ' s condition; obtains/receives physician ' s orders as required . The Facility job description titled, Director of Nursing, revised 10/19/15, indicated: . Responsibilities/Accountabilities: . 3. Clinical Leadership: . 3.6. Monitors nursing care to ensure positive clinical outcomes . 5. Quality Improvement: . 5.3. Ensure that Physician Orders are followed as prescribed .

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	056259	A. Building B. Wing	10/01/2024

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Northvine Postacute Care	446 Arrowood Dr Santa Rosa, CA 95407

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interviews and record reviews, the facility failed to ensure: 1. The call light (a device used by residents to call for assistance from staff) was always functioning for one out of two sampled residents (Resident 1). 2. A touch pad call light was provided for one out of two sampled residents (Resident 1) who had difficulty using a call button per his request. 3. The call light or an alternative was available for one out of two sampled residents (Resident 7). These failures resulted in: A. Resident 1 worried he could not call staff for assistance if there was an emergency situation and Resident 1 yelling for help instead of using the call light. B. Resident 7 was at risk for staff not meeting his needs and late provision of care. Findings: A review of Resident 1s face sheet (demographics) indicated Resident 1 was admitted on [DATE] with a diagnoses of Muscle Weakness, Chronic Pain Syndrome (CPS, pain that lasts over 3 months) and Spinal Cord Disease (SCD, nerve damage that cause permanent severe problems, such as paralysis (loss of the ability to move (and sometimes to feel anything) in part or most of the body) or impaired bladder and bowel control). Resident 1 ' s Minimum Data Set (MDS,) assessment dated [DATE] indicated he was dependent on staff for provision of care.Resident 1s Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents) dated 8/29/24 score was 15 out of 15 indicating intact cognition. A review of Resident 7s face sheet indicated he was admitted on [DATE] with a diagnoses of Muscle Weakness and Need for Assistance with Personal Care. Resident 7s MDS dated [DATE] indicated he was dependent on staff for oral, toileting and personal hygiene. Resident 7s BIMS dated 7/31/24 score was 15 out of 15 indicating intact cognition. During an observation on 9/30/24 at 11:54 a.m., there was no call light button noted in or around Resident 7s bed, table or drawer. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 9/30/24 at 11:56 a.m., Resident 1s call light wirings were slightly exposed. Resident 1 stated his call light was on since 11:00 a.m. but no one came. Resident 1 stated when the button was pushed down it meant the call light was activated and there should be a light outside his room that would alert staff someone in his room needed help. When the surveyor checked to see if there was a light outside his room to indicate his call light was activated, the light outside his room was not on. The surveyor checked the call light and pressed the button to see if it would activate the light outside his room, but it did not. Resident 1 stated his call light had not been working properly for about a week and a half and had asked multiple staff to fix it or replace it, and had even asked to get this call light button changed to a touch pad since it was getting more difficult for him to push the call button. Resident 1 stated both his hands were weak. Resident 1 stated the request for touch pad was made a week and a half ago and nobody had even gone to him to give him an update on this request. Resident 1 stated his call light was working sometimes but more often it was not working. Resident 1 stated it was frustrating because he resorted to yelling when he needed help, then staff gets upset and would not go to him because he was yelling. Resident 1 stated staff replaced his call light, but the same thing happened, his call light still did not work properly even when staff had replaced it. Resident 1 stated nothing works in this place, this place is a joke. Resident 1 stated his call light not working properly all the time was making him nervous because it was a means for him to alert staff if he needed help. Resident 1 stated staff did not like it if he yelled. Resident 1 stated sometimes he could not help but yell because there was no other way to call the staff attention if his call light was not working properly. Resident 1 pointed out the exposed wiring of his call light and stated that could be the reason why his call light did not work properly this time. Resident 1 stated he was worried something might happen to him and he could not call for help because his call light was broken. When asked if his roommate Resident 7 uses a call light when he needed help, Resident 1 stated he had seen Resident 7 press his call light to ask staff for assistance. During an interview on 9/30/24 at 12:16 p.m., Certified Nursing Assistant (CNA) E stated Resident 1 ' s call light had been working on and off. CNA E stated his call light was broken yesterday and was not fixed yet when she went home. CNA E stated there was no maintenance staff yesterday, so she had not reported it. CNA E stated call light was important and should always be functional because this was a communication tool for the residents. CNA E stated call light were used by residents to call staff if they needed help. CNA E stated all residents should have a call light that was within reach and was always functioning. CNA E stated, if a call light was broken or if a resident did not have a call light, it could be a safety issue. CNA E stated residents might have no means to call staff for help if needed. During an observation on 9/30/24 at 12:21 p.m., CNA B verified Resident 7 did not have a call light. During an interview on 9/30/24 12:34 p.m., CNA E stated she was aware Resident 7 did not have a call light today. CNA E stated she thought staff might have gotten it to switch from Resident 1s call light which was broken. CNA E verified Resident 7 uses a call light but Resident 1 uses it more frequently than he did and that was probably why staff took Resident 7's call light to replace Resident 1's call light. CNA E stated it was wrong to take Resident 7s call light because both Residents 1 and 7 need to have a working call light to alert staff if they needed help and for their safety. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/24 at 12:37 p.m., LN (Licensed Nurse) D stated he was not aware Resident 1's call light was not working this morning. LN D verified Resident 7 did not have a call light nor any alternative that he could use to call staff attention if he needed help. LN D verified Resident 7 used a call light to ask for help or if he needed something. LN D stated it was important that all residents have a working call light at all times because it was for communication, a way for residents to call staff for help or if they needed something. LN D stated Resident 1 had difficulty using both hands and would benefit from using a touch pad. During a concurrent interview and maintenance log record review on 9/30/24 at 12:57 p.m., the interim Director of Nursing (DON) verified Resident 1 requested for a touch pad but no log entry was made for a defective call light. The interim DON stated she was also not aware Resident 1's call light was not working properly nor that Resident 7 had no call light. The interim DON stated staff should not take another resident ' s call light for another resident to use because both residents needed a call light to call staff for help. The interim DON stated the expectation was for staff to report to the nurses or supervisor if there was a defective call light so they could report it to the maintenance. When asked what staff should have done when there was no maintenance available on weekends, the DON did not respond. As for the touch pad, the DON stated Resident 1 had difficulty using both hands and could benefit from using a touch pad. The DON stated there would be no reason why Resident 1 could not have a touch pad if it would be easier for the resident. The DON stated she would have maintenance look into it. The DON stated it was important all residents had a fully functioning call light to ensure residents have means to call staff if they needed help. The DON stated it was for residents ' safety and dignity. During an interview on 9/30/24 at 2:23 p.m., the Maintenance Director stated he was not aware there was a request for Resident 1's touch pad. The Maintenance Director stated he had not checked the maintenance logbook in a while. When asked how often they check the facility ' s call light for functionality, he was silent. The Maintenance Director stated there was no available touch pad for Resident 1 at this time and there had been no touch pad ordered for Resident 1 yet. The Maintenance Director stated it was important for all the residents to have a functioning call light because they use it to call staff for help. A review of the facility ' s policy and procedure (P&P) titled Answering the Call Light released date 1/2018, the P&P indicated the purpose was to ensure timely response to the residents ' requests and needs .report all defective call light to the nurse supervisor promptly .document any significant request or complaint made by the resident and how the requests or complaints was addressed.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interviews and record reviews, the facility failed to implement their smoking policy when one out of two sampled residents (Resident 1) was allowed to vape (an electronic cigarette, to inhale and exhale vapor containing nicotine and flavoring produced by a device designed for this purpose) inside his room, and implement the smoking assessment recommendation for one out of two sampled residents (Resident 1) when Resident 1 was allowed to vape without staff supervision. These failures put Resident 1 ' s roommates at risk for second hand vape exposure (to fine and ultrafine particles that contain nicotine, that might exacerbate respiratory ailments like asthma (narrowing of airways), and constrict arteries (blood vessels tighten) which could trigger a heart attack, and put Resident 1's safety at risk for burns, device/battery explosion and accidents. Findings: A review of Resident 1s face sheet (demographics) indicated Resident 1 was admitted on [DATE] with a diagnoses of Muscle Weakness, Chronic Pain Syndrome (CPS, pain that lasts over 3 months) and Spinal Cord Disease (SCD, nerve damage that cause permanent severe problems, such as paralysis (loss of the ability to move (and sometimes to feel anything) in part or most of the body) or impaired bladder and bowel control). Resident 1's Brief Interview for Mental Status (BIMS, mandatory tool used to screen and identify the cognition, the process of acquiring knowledge and understanding through thought, experience, and the senses of residents) dated 8/29/24 score was 15 out of 15 indicating intact cognition. Resident 1's face sheet also indicated he was self-responsible (able to make decision for himself). A review of Resident 1 ' s Minimum Data Set (MDS) (an assessment tool), dated 8/29/24, indicated he was dependent on staff for provision of care, and he had impaired function of both his upper extremities. A review of Resident 1's Smoking Safety Screen (done to assess resident ' s safety when smoking) dated 8/14/24 indicated he had contractures of his hands and was safe to smoke with supervision. During a concurrent observation and interview on 9/30/24 at 11:56 a.m., Resident 1 was noted with two hand held vaping device on his overbed table colored black and orange/yellow. When asked if this was a vaping device, Resident 1 smiled and stated this was a charger. During an interview on 9/30/24 at 4:47 p.m., the Social Services Director (SSD) stated Resident 1 kept his vape in his room. SSD stated he was not allowed to vape in his room but continued to do so. SSD stated everyone knew he vaped in his room. SSD stated vaping was considered smoking and was not allowed inside the facility, let alone inside resident rooms. SSD stated Resident 1 shared his room with 3 other residents. SSD stated the designated smoking area was outside the facility and Resident 1 should use his vape there, and not inside his room. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/30/24 at 5:00 p.m., the Administrator (ADM) stated vaping was considered smoking and was not allowed in residents rooms. ADM stated the designated smoking area was outside the facility. ADM stated Resident 1 should not be allowed to vape in his room. The ADM stated there was no separate policy for vaping. The ADM stated the facility ' s smoking policy applied to vaping as well. During an interview on 9/30/24 at 5:05 p.m., Certified Nursing Assistant (CNA) J stated she had seen Resident 1 vape in his room. CNA J stated Resident 1 had been doing it for as long as she could remember. CNA J stated residents were not allowed to vape inside the facility. During an interview on 9/30/24 at 5:06 p.m., Licensed Nurse (LN) H stated she was aware Resident 1 vaped in his room and everybody was aware he was vaping in his room. LN H stated staff did not supervise him when he vaped. When asked why Resident 1 was allowed to vape in his room, LN H stated it was hard for staff to get him out of bed. During an interview on 9/30/24 at 5:15 p.m., Resident 1 admitted he had been vaping in his room for a very long time, for months. Resident 1 admitted the two devices observed on his over bed table earlier was a vaping device, which he stated, was now kept inside his drawer. Resident 1 stated nobody told him he could not vape in his room. Resident 1 stated staff allowed him to vape in his room. When asked if staff supervised him when he vaped, he stated no. Resident 1 stated he suspected he was allowed to vape in his room because it took a lot to get him out of his bed and staff did not want to deal with it. During an interview on 9/30/24 at 5:19 p.m., CNA I stated Resident 1 vaped in his room and she had actually assisted him when he asked to vape in his room, around 3:00 p.m. today after she gave him a shower. When asked if she supervised Resident 1 when he vaped in his room, she stated no. CNA I stated staff did not watch him when he vaped. CNA I stated staff only put the vape in his hand and Resident 1 did the rest. CNA I stated vaping was considered smoking and Resident 1 should not be vaping in his room. CNA I stated Resident 1 should be vaping in the designated smoking area outside the facility. CNA I stated no one was really asking Resident 1 to stop vaping in his room and Resident 1 was allowed to vape in his room ever since she was employed here. When asked how long Resident 1 had been vaping in his room, CNA I stated Resident 1 had been vaping in his room for a very long time. CNA I stated risk of using vape includes explosion and accidents and the risk for Resident 1 ' s roommates was that he was exposing them to harmful chemicals which could make them sick. A review of the facility policy and procedure (P&P) titled Smoking Policy release date of 1/2023, the P&P indicated smoking is only permitted in designated resident smoking area . An article National institute for Occupational Safety and Health (NIOSH, agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness) titled Exposure to electronic cigarette in indoor workplaces indicated electronic cigarettes can negatively affect indoor air quality and pose a risk of secondhand exposure in workplaces. Environmental Protection Agency (EPA, agency that conducts research and protects people and the environment from significant health risks) stated prohibiting e-cigarette use inside or near buildings, vehicles and other enclosed spaces is the only way to eliminate exposure to secondhand e-cigarette aerosol and health risks that may come with it.