

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interview and record review, the facility did not report an alleged abuse allegation for one out of two sampled residents (Resident 6) within 2 hours to California Department of Public Health (CDPH, responsible for and enforces some of the laws in the California Health and Safety Codes), the Ombudsman (official appointed to investigate individuals' complaints) and the local Police Department (PD).</p> <p>This failure put Resident 6 and all the vulnerable residents at risk for abuse to continue.</p> <p>Findings:</p> <p>A review of Resident 6's 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 6'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 6's functional abilities indicated he was dependent on staff for provision of all care.</p> <p>A review of the SOC 341 (form use to report suspected abuse) dated 9/5/24 indicated an incident occurred between Resident 6 and the alleged Licensed Nurse (LN) A on 8/31/24 at approximately 10:00 a.m. The SOC 341 dated 9/5/24 indicated a telephone report was made to law enforcement in Santa [NAME] on 8/31/24 at 4:10 p.m. but there were no other calls made to other agencies on 8/31/24. The SOC 341 dated 9/5/24 also indicated the Ombudsman was not notified of the abuse allegation until 9/5/24. The SOC 341 dated 9/5/24 had no indication the abuse allegation on 8/31/24 was reported to CDPH.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and SOC 341 dated 9/5/24 record review on 10/23/24 at 3:55 p.m., the Administrator (ADM) verified the alleged abuse occurred on 8/31/24 at approximately 10:00 a.m. The ADM stated this was his weakest report. The ADM stated the facility policy was to report abuse allegations to CDPH, the Ombudsman and local PD within 2 hours. The ADM stated the 2-hour reporting time frame was not met for this investigation. The ADM stated the local PD was notified the same day but did not meet the 2-hour reporting time requirement. The ADM verified the Ombudsman was not notified of the abuse allegation until 9/5/24. The ADM stated it was important to ensure abuse were reported timely primarily so all agencies were aware to determine what action to take to ensure resident safety.</p> <p>During a concurrent interview and SOC 341 dated 9/5/24 record review on 10/23/24 at 4:16 p.m., the Interim Director of Nursing (IDON) verified the SOC 341 dated 9/5/24 indicated a telephone report was made to law enforcement to Santa [NAME] PD on 8/31/24 at 4:10 p.m. but there were no other calls made to other agencies on 8/31/24. The IDON also verified the SOC 341 dated 9/5/24 indicated the Ombudsman was not notified of the abuse allegation until 9/5/24. The IDON also verified the SOC 341 dated 9/5/24 had no indication the abuse allegation on 8/31/24 was reported to CDPH. The IDON stated the facility abuse policy was to report abuse allegations to the local PD, the Ombudsman and CDPH within 2 hours. The IDON stated it was important abuse allegations were reported timely to ensure residents safety and to ensure abuse does not happen again.</p> <p>A review of the facility's policy and procedure (P&P) titled Abuse and Neglect Prohibition Policy, release date 6/2022, the P&P indicated, F. Reporting of incidents, investigations and facility's response to the investigation: upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or exploitation, the administrator, or designee will perform the following: all alleged violation immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interviews and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> ensure an appropriate notice of discharge (a written document provided to a patient or their representative usually given before or at time of discharge (in an emergency) which explains why the patient is being discharged and provides information about their next steps and ongoing care) was provided to the resident and/or representative and ensure the Ombudsman (an official appointed to investigate individuals' complaints against maladministration) was notified when one out of two sampled residents (Resident 57) was sent to the emergency department (ED, department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care) on 8/1/24. ensure Licensed Staff were aware to notify the Ombudsman whenever there was a facility-initiated discharge (discharge initiated by the facility) such as transfer to the hospital. <p>These failures could result in potential violations of resident rights, a lack of oversight regarding the discharge process, inability for the ombudsman to investigate potential issues with the discharge which could leave residents vulnerable to inappropriate or unsafe transfers without proper advocacy.</p> <p>Findings:</p> <p>A review of Resident 57's face sheet (demographics) indicated Resident 1 was admitted on [DATE] with a diagnoses of Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform daily tasks), Muscle Weakness and Bipolar Disorder (a mental health condition). Resident 57'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) indicated he had severely impaired cognition.</p> <p>During a concurrent interview and electronic medical record review on 10/22/24 at 4:21 p.m., the Interim Director of Nursing (IDON) verified the Ombudsman was not notified when Resident 57 was sent out to the ED on 8/1/24. The IDON stated there was no notice of transfer completed nor was the Ombudsman notified when Resident 57 was sent out to ED on 8/1/24. The IDON stated whenever a resident gets discharged or transferred to ED, a notice of transfer or discharge should be provided to the resident and or the representative and the Ombudsman would have to be notified within 24 to 48 hours. The IDON stated the Ombudsman notification was important to monitor the wellbeing or whereabouts of the residents, for residents' protection and to prevent inappropriate discharges. The IDON stated the facility policy was to notify the ombudsman whenever a resident was discharged or transferred to the hospital. The IDON stated the facility policy was not followed when the Ombudsman was not notified when Resident 57 was sent out to ED.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 4:52 p.m. Licensed Nurse (LN) C stated she had discharged residents and transferred residents to the hospital but had never sent a copy of the notice of transfer to notify the Ombudsman of transfer to the hospital. When asked what the facility policy with regards to notifying the Ombudsman during transfers and discharges, LN C stated she did not know.</p> <p>During an interview on 10/22/24 at 4:55 p.m., LN D stated as far as she knew, it was not the facility policy to notify the Ombudsman of any discharges or hospital transfers. LN D stated she had helped discharged and transferred a resident to the ED and the Ombudsman was not notified.</p> <p>A review of the facility's policy and procedure (P&P) titled Transfer and Discharge, release date 12/2016, the P&P indicated that an appropriate notice of discharge should be provided to the resident or the representative to notify the resident, and if known, the family member, surrogate, or resident representative of the transfer and the reason for the move provide the name, address, and phone number of the state long term care Ombudsman in cases where a residents' urgent medical needs require more immediate transfer, provide the notice as soon as practicable.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interview and record review, the facility did not complete the Minimum Data Set (MDS, a standardized process for evaluating a resident's health and functional abilities in a nursing home) Discharge Assessment (DCA, a required part of the process for evaluating the health of a resident and their discharge plans when they leave a nursing home) for one out of two sampled residents (Resident 28). This failure could potentially lead to improper care planning on Resident 28's new discharge setting which could also potentially put Resident 28's safety at risk.</p> <p>Findings:</p> <p>A review of Resident 28's face sheet (demographics) indicated Resident 28 was admitted on [DATE] with a diagnoses of Dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). Resident 28'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 11/8/23 indicated a severely impaired cognition. Resident 28's functional abilities indicated she was mostly dependent on staff for provision of care.</p> <p>A review of Resident 28's MDS 3.0 Kardex (informational filing system that is used as a quick reference) indicated Resident 28 was missing an MDS DCA when she was discharged on [DATE].</p> <p>During a concurrent interview and MDS 3.0 Kardex record review on 10/25/24 at 8:50 a.m., the Interim Director of Nursing (IDON) verified Resident 28 did not have an MDS DCA. The IDON stated Resident 28 was already discharged on [DATE]. The DON stated it was important the MDS assessments were done timely because these assessments were the backbone of residents' assessments and should paint an accurate picture of residents' current status. The IDON stated the DCA included the current residents' status upon discharge and should have been completed. The IDON stated failure to complete the MDS DCA could put the resident at risk for rehospitalization .</p> <p>During an interview on 10/25/24 at 9:13 a.m., the Minimum Data Set Coordinator (MDSC) stated she was aware that some of her MDS assessments were late. MDSC stated ensuring MDS assessment were done accurately and timely was important because the MDS assessment would show residents' current status, what their needs were and how to meet those needs. MDSC stated it was important to ensure DCA's were completed because these assessments were also used when residents were reintegrated back into the community. The MDSC stated when residents' gets discharged from the facility and were ordered home health services (HHS, a wide range of health care services that you can get in your home for an illness or injury), based on MDS DCA, then these disciplines would have an idea on resident's current status and what their needs were.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/25/24 at 9:13 a.m., the MDSC stated MDS assessments not completed timely do not paint an accurate picture of residents' current status. MDSC stated it was important that MDS assessments were done accurately and timely. MDSC stated not completing an MDS assessment timely could result in inaccurate data and error in reports.</p> <p>A review of the facility's policy and procedure (P&P) titled MDS Accuracy, updated 2023, the P&P indicated the facility conducts a comprehensive assessment to identify a patient needs per the guidelines set by the (Resident Assessment Instrument (RAI, tool that helps nursing home staff in gathering definitive information on a resident's strengths and needs) manual: Discharge Assessment</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</p> <p>Based on interview and record review, the facility failed to provide the resident and/or their responsible party with a summary of the resident's Baseline Plan of Care for four of 18 sampled residents (Resident 45, 48, 54, and 108). This failure had the potential to limit communication with the resident and/or their responsible party on how the facility planned to manage the resident's needed services and treatments while at the facility, which could have led to the resident feeling stressed, uneasy and lack of trust with the staff providing care, leading to negatively affecting the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>1. A review of Resident 45's Admission Record, indicated Resident 45 was admitted to the facility on [DATE], with a diagnosis including Acute (short-term condition) and Chronic (ongoing condition) Respiratory (breathing) failure with Hypoxia (having to little oxygen), Morbid Obesity (excessive body fat), Chronic Congested Heart Failure (a weakened heart condition that occurs when the heart can't pump enough blood to the body), Atrial Fibrillation (irregular heart beat), Tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and help with breathing), Stage 2 Pressure Ulcer (an open wound that has broken through the top layer of skin and part of the layer below) of Sacral Region (lower back), muscle weakness, amongst others.</p> <p>A review of Resident 45's Baseline Care Plan v1.1-V1, signed and dated by a Licensed Vocational Nurse (LVN) on 8/10/24, indicated Resident 45 was his own responsible party, initial admission goals was to promote his strength, initial discharge goals was to return to the community, Resident 45 was alert and oriented, needed two person physical assist with personal hygiene, toilet use, dressing and transferring, one person physical assists with bed mobility (positioning while in bed), used oxygen therapy (treatment that provides extra oxygen to people who have breathing problems or lung diseases), occasionally incontinent (lacking control) of bowel, a current medication list was provided to Resident 45 and Resident 45 reconciled the medication list (the process of comparing a patient's current medication orders to all the medications a patient has been taking), amongst other information and goals. Under Section: 5. Baseline Care Plan Summary and Signatures: B.: Signature of Resident and Representative, 1. Resident signature and date, was left blank. There was no indication Resident 45 received a copy of his Baseline Care Plan and a current list of his medications.</p> <p>During an interview on 10/24/24 at 11:44 a.m., Resident 45 stated he did not receive any paperwork. Resident 45 stated he did not sign his Baseline Care Plan and he never received a current list of medications.</p> <p>2. A review of Resident 48's Admission Record, indicated Resident 48 was admitted to the facility on [DATE], with a diagnosis including Cerebrovascular Disease (stroke), Type Two Diabetes (high blood sugar), Major Depression, Urinary Tract Infection (bacteria infection of the urinary tract), Muscle Weakness, Hemiplegia (partial or complete paralysis of one side of the body), Alcohol Use, Dysphagia (partial loss of the ability to use or understand language), amongst others.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 48's Baseline Care Plan v1.1-V1, signed and dated by the MDSC (Minimum Data Set Coordinator) on 6/25/24, indicated Resident 48 was his own responsible party but deferred to his daughter, needed an interpreter to communicate with a doctor or health care staff, family or significant other involved in his care discussion, initial admission goals was for resolution of sepsis (resolve a severe infection) and improvement in overall functioning with therapy treatment to facilitate return to home, discharge goal was to return to the community, left sided weakness because of a stroke, needed one person physical assist for eating, personal hygiene, toilet use, dressing and bathing, transferring and walking, used a wheelchair, alert but cognitively impaired (memory deficit), always incontinent of urine and bowel, had fallen at home within the last month and times one while at the hospital, and a current medication list was provided to Resident 48's representative, and the medication list was reconciled with Resident 48's representative, amongst other information and goals. Under Section: 5. Baseline Care Plan Summary and Signatures: B.: Signature of Resident and Representative, 1. Resident signature and date, was left blank and 2. Representative signature and date, indicated Resident 48 was his own responsible party, daughter very involved, but representative did not sign and date. There was no indication Resident 48 and/or Resident 48's responsible party received a copy of Resident 48's Baseline Care Plan and a current list of his medications.</p> <p>3. A review of Resident 54's Admission Record, indicated Resident 54 was admitted to the facility on [DATE], with a diagnosis including Fracture of Right and Left Lower Legs, Muscle Weakness, Need for Assistance with Personal Care, amongst others.</p> <p>A review of Resident 54's Baseline Care Plan v1.1-V1, signed and dated by a RN (Registered Nurse) on 10/8/24, indicated Resident 54 was his own responsible party, initial discharge goals was to return to the community, needed one person physical assist with personal hygiene, toilet use, dressing, bathing, bed mobility (moving from one bed position to another) and transferring from the bed to wheelchair, cognitively intact, and Resident 54 was thrown from his motorcycle causing bilateral wrist and ankle fractures and was on non-weight bearing status and was going to have physical therapy (PT: treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise), occupational therapy (OT: focuses on things you want and need to do in your daily life), amongst other information and goals. The question under Section 3. Health Conditions: D. Medications: 3. Current medication list provided to resident/representative was not marked Yes or No and D. 4. Indicated: Resident 54's medication list was not reconciled with Resident 54. Under Section: 5. Baseline Care Plan Summary and Signatures: B.: Signature of Resident and Representative, 1. Resident signature and date, Resident 54's name was typed in and no date. There was no indication Resident 54 received a copy of his Baseline Care Plan and a list of his current medications.</p> <p>During a concurrent observation and interview on 10/21/24 at 11:58 a.m., Resident 54 had casts on his right and left wrist and left ankle. Resident 54 stated he had been in a motorcycle accident. Resident 54 stated he did not receive a copy of his Baseline Care Plan and a list of his current medications.</p> <p>4. A review of Resident 108's Admission Record, indicated Resident 108 was admitted to the facility on [DATE], with a diagnosis including concussion (brain injury), aphasia (loss of ability to understand or express speech) following a stroke, fracture of the pelvis, multiple ribs and fifth lumbar (lower back), colostomy (surgical procedure that bypasses part of the colon and redirects your poop to come out of a new hole in your abdomen, called a stoma), open wound left buttocks, muscle weakness, amongst others.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 108's Baseline Care Plan v1.1-V1, signed and dated by a RN (Registered Nurse) on 10/8/24, indicated Resident 108 was his own responsible party, was to receive PT and OT, goal was to return to the community, needed one person physical assist with personal hygiene, toilet use, dressing and bathing, one person assist with bed mobility and transferring from the bed to wheelchair or walker, Resident 108 was cognitively intact, a current medication list was provided to Resident 108 and the medication list was reconciled with Resident 108, amongst other information and goals. Under Section: 5. Baseline Care Plan Summary and Signatures: B.: Signature of Resident and Representative, 1. Resident signature and date, Resident 108's name was typed in and no date. There was no indication Resident 108 received a copy of his Baseline Care Plan and a current list of his medications.</p> <p>During an interview on 10/24/24 at 10:16 a.m., the IDON (Interim Director of Nursing) stated the IDT (Interdisciplinary Team: a group of healthcare professionals who work together to plan and coordinate patient care.), which included the Minimum Data Set Coordinator (MDSC), Social Services, Activities, Dietary, amongst others, should complete their part of the Baseline Care Plan. The MDSC represented the nursing section of the Baseline Care Plan. The IDON stated, Yes, the resident was supposed to get a copy of the Baseline Care Plan and a list of their current medications, which the resident's nurse was supposed to go over with the resident. The IDON stated, Yes, the resident or the representative should sign and date the Baseline Care Plan, and the resident or their representative should receive a copy of the Baseline Care Plan and a current list of the medications. The IDON stated if the resident's name was just typed into the signature box, no one could not tell if the resident was given a copy of their Baseline Care Plan and a list of their current medications. The IDON stated the resident or their representative needed to sign and date the Baseline Care Plan.</p> <p>During an interview on 10/24/24 at 11:31 a.m. the MDSC stated normally social service would make a copy of the resident's Baseline Care Plan and medication list, have the resident sign and date their Baseline Care Pan indicating they received a copy, then the signature page would be uploaded into the resident's electronic medical record. The MDSC stated this has not been happening lately because there was no social service staff.</p> <p>During an interview on 10/24/24 at 12:05 p.m., Resident 108 stated he never received a copy of his Baseline Care Plan or a list of his current medications.</p> <p>The facility Policy/Procedure titled, Baseline (Initial) Plan of Care, dated 12/2016, indicated: Policy: It is the policy of this facility to provide each resident with an interim (initial) plan of care developed within 48 hours of admission that addresses identified risk areas and resident's initial individual needs . Responsible Discipline: The DON and/or its designee shall be responsible for the implementation of this policy .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on interviews and record reviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1.the Restorative Nursing Assistant (RNA, a certified nursing assistant (CNA) who has specialized training in therapeutic rehabilitation) process was followed when one out of two sampled residents (Resident 6) did not have a weekly summary completed by the RNA and there were no monthly summary meetings in Resident 6's electronic medical chart 2. the RNA followed the splint (provide a slow force to stretch the contracture- tightening of muscles that causes the joints to shorten, and improve mobility) order for both hand flexion contracture (shortening and hardening of muscles, resulting to deformity) management for one out of two sampled resident (Resident 6). <p>These failures placed Resident 6 at risk for further contracture, pain and development of wound.</p> <p>Findings:</p> <p>A review of Resident 6's face sheet (demographics) indicated Resident 6 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 6'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 6's MDS assessment dated [DATE] functional abilities indicated he was dependent on staff for provision of all care.</p> <p>A review of Resident 6 Physician Order Summary (POS, a table view of a patient's orders that includes information such as the order item, category, frequency, status, and when the order was entered) for 9/1/24 up to 10/31/24 indicated an order for RNA to don/doff splint to both hands for 2 to 4 hours or as tolerated daily for 90 days.</p> <p>During a concurrent observation and interview on 10/23/24 at 3:40 p.m., Resident 6 was noted with both of his hand flexed. Resident 6 stated he had contracture on both his hand and RNA was supposed to put on a splint on both of his hands daily, however RNA only put the splint on his hands for about 30 minutes daily. Resident 6 stated he knows for sure it should be more than that. Resident 6 stated he did not know why the RNA was in a rush to take the splint off. Resident 6 stated he wished the RNA would follow the doctor's order. Resident 6 stated he thought 30 minutes of using the splint on his hands were ineffective. Resident 6 thought felt like his contracture was getting worse and his hands were getting weaker. Resident 6 stated he could tolerate up to 2 hours of splint before but now he was not so sure. He stated maybe he could not anymore because the RNA would only put the splint on for 30 minutes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review of physician order on splint, dated 9/25/24, on 10/24/24 at 9:23 a.m., the Director of Rehabilitation (DOR) stated an RNA order needs a physician order and must be followed. The DOR clarified the splint order for 2 to 4 hours as tolerated meant if Resident 6 felt discomfort or pain before the prescribed time which is 2 to 4 hours, then the RNA may take off the splint. The DOR reiterated the minimum amount of time a splint should be used for Resident 6 was 2 hours. The DOR stated if Resident 6 was unable to tolerate 2 to 4 hours of splint, this should have been reported to her so an adjustment to the time or the splint would have to be made. The DOR stated that so far, there were no report from the RNA that Resident 6 was not tolerating the splint. The DOR stated Resident 6 receiving 30 to 40 minutes of splint treatment was a concern and should have been reported to her as soon as possible and would need to be addressed right away. The DOR stated in order for a splint to be effective the minimum amount of time it should be worn was 2 hours. The DOR stated not following the order for splinting for Resident 6 put him at risk for further contracture, pain and further decrease of hand mobility. The DOR stated the RNA process involved monthly meetings between RNA, the DOR and the Director of Staff Development and a weekly summary should also be completed by the RNA. The DOR was unable to provide documentation for 9/2024 and 10/2024 monthly RNA meeting for Resident 6. DOR stated monthly meeting was important because it tracked residents' progress or lack of progress, if an adjustment to treatment was needed and to evaluate if current treatment was still appropriate. The DOR stated the RNA process was not followed in Resident 6's case which could put him at risk for decreased quality of life.</p> <p>During an interview on 10/24/24 at 9:37 a.m., the Interim Director of Nursing (IDON) stated RNA order need to have a physicians order and needs to be followed. The IDON stated Resident 6 receiving 30 minutes of splint treatment on his hands did not meet the physicians order for 2 to 4 hours of splint as tolerated. The IDON stated Resident 6 wearing the splint for only 30 minutes was a concern because for the splint to be effective, the minimum amount of time it should be worn was 2 hours. The IDON stated not wearing the splint as prescribed put Resident 6 at risk for further contracture.</p> <p>During a concurrent interview and RNA documentations for 10/2024 record review on 10/24/24 at 9:55 a.m., Restorative Nursing Assistant (RNA) B stated Resident 6 was able to tolerate 2 to 4 hours of splint on both hands when he was released from skilled services and transitioned to RNA program. RNA B stated the splint was important to prevent contracture. RNA B stated that for a month now, Resident 6 was only able to tolerate 40 minutes of wearing splint on his hands. When asked if this was a change in Resident 6 status, she stated yes. When asked if this change was something she would report to the DOR she stated yes. RNA B stated she might have mentioned this to the DOR but it was not her focus. When asked what her focus was, RNA B did not respond. When asked if an RNA order needs a physician order, RNA B stated yes. RNA B also stated the RNA order must be followed. RNA B verified the order for splint was for RNA to don/ doff splint to both hands for 2 to 4 hours or as tolerated daily. When asked if the doctors' order was followed when Resident 6 was only getting 40 minutes of splint treatment, she stated no. RNA B stated splint was important to prevent contracture. RNA B stated the RNA process involved monthly meetings with the RNA, DOR, the DSD and completion of weekly summary. RNA B was not able to provide documentations RNA weekly summaries were completed for Resident 6. RNA B stated if weekly summaries or monthly meetings or summaries were not done, it could be a risk for residents' being in a program that does not work or was inappropriate for them. RNA B stated Resident 6 had been wearing splint for about 30 to 40 minutes as a treatment for his contracture for a month at least.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the form titled Restorative Care Process provided by the DOR on 10/24/24 at 9:23 a.m., it indicated the resident is identified for need or restorative range of motion program by physician order .if complication are present, a physician order should be obtained with clarification and approval before beginning the program .the physical or occupational therapist should serve as a consultant when question arise the monthly range of motion documentation is filed in the residents clinical record form.</p> <p>A review of the facility's policy and procedure (P&P) titled Standard for RNA Program, release date of 9/2019, the P&P indicated the RNA will be responsible for administering the restorative program on a daily basis and will assure that each patient is treated according to the therapist guidelines .the RNA will report any change in a patient's status to the therapist, DON, Dietitian, etc., in a timely manner .Documentation: Daily and weekly documentation will be done on the RNA Flowsheet .if the treatment is refused or withheld, it will be documented, and licensed nurse will be made aware .the RNA will document: the treatment provided, the endurance and tolerance level .document how the resident is progressing towards his/her goal(s) and compare with the last week or month .document how the resident responds to the program in relation to behavior .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</p> <p>Based on interview and record review, the facility failed to follow through with notifying a resident's physician of the RD's (Registered Dietitian) recommendation for the nutritional supplement, Med Pass (helps provide extra calories and protein to help patients gain weight or recover from illness) for one of eighteen sampled residents (Resident 30), who had lost 16 pounds in one month (8.65% unplanned weight loss), which is severe weight loss. This led to Resident 30 losing more weight, which could prevent Resident 30's right heel ulcer (pressure sore is an injury to the skin and underlying tissue) from healing or cause it to become worse, and could cause an overall decline in Resident 30's physical wellbeing.</p> <p>Findings:</p> <p>A review of Resident 30's Admission Record indicated Resident 30 was admitted to the facility on [DATE], with a diagnosis including Cellulitis of the Left Lower Leg (a bacterial infection that affects the skin's deeper layers), Muscle Weakness, Abnormalities of Gait (a manner of walking or moving on foot) and Mobility (the ability of a patient to change and control their body position), Needs Assistance with Personal Care, Type Two Diabetes (high blood sugar), amongst others.</p> <p>A review of Resident 30's Weights documented from 11/9/23 through 6/3/24, indicated the following:</p> <p>10/3/2024 at 7:09 a.m. - 154.0 lbs. (pounds)</p> <p>9/4/2024 at 7:36 a.m. - 158.0 lbs.</p> <p>9/2/2024 at 2:21 p.m. - 157 lbs.</p> <p>8/26/2024 at 2:34 p.m. - 157 lbs.</p> <p>8/19/2024 at 11:34 a.m. - 158.0 lbs.</p> <p>8/14/2024 at 11:08 a.m. - 162 lbs.</p> <p>8/12/2024 at 2:44 p.m. - 160 lbs.</p> <p>8/6/2024 at 6:53 a.m. - 160 lbs.</p> <p>7/15/2024 at 10:23 a.m. - 170 lbs.</p> <p>7/8/2024 at 7:55 a.m. - 169 lbs.</p> <p>7/2/2024 at 12:03 p.m. - 165.0 lbs.</p> <p>6/24/2024 at 8:00 a.m. - 170 lbs.</p> <p>6/17/2024 at 1:54 p.m. - 171. lbs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/10/2024 at 7:51 a.m. - 175 lbs.</p> <p>6/7/2024 at 9:12 p.m. - 185 lbs.</p> <p>Resident 30 had lost 16 lbs., from 185 to 169 lbs, in one month, from 6/7/24 through 7/8/24, which is a 8.65% unplanned weight loss, which equals severe weight loss.</p> <p>A review of the RD's (Registered Dietician) Nutrition/Dietary Note, dated 7/3/24, indicated Resident 30 had lost 10 lbs/5.7% in one month, which indicated a weight loss greater than 5%, equaling severe weight loss. The RD indicated Resident 30 would benefit from some protein supplementation (a meal that contains a significant amount of protein relative to carbohydrates and fats) to aid in right heel wound healing. The RD recommendations were large portions of protein at meals and lab work.</p> <p>Resident 30 had lost 9 lbs. in one month, from 7/8/24 through 8/6/24, which is a 5.33% unplanned weight loss, which equals severe weight loss.</p> <p>A review of Resident 30's CPAC-Nursing - SBAR (Situation, Background, Assessment, and Recommendation) Form and Progress Note, dated 7/15/24, indicated Resident 30 lost 10 lbs. in one month, a 5.7 % unplanned weight loss, which equals severe weight loss.</p> <p>A review of the RD's Nutrition/Dietary Note, dated 8/7/24, indicated Resident 30 had lost 5lbs times one month, 10lbs. in three weeks based on weekly weights. Staff said Resident 30 was not eating much. Recommendations was to continue weekly weights and lab work.</p> <p>A review of the RD's, Nutrition/Dietary Note, dated 8/23/24, indicated Resident 30 had lost 4lbs. times one week. The RD's recommendations: Reduced Med Pass 120 ml (milliliters) every day at 2 p.m. and continue weekly weights times four weeks.</p> <p>A review of Resident 30's Order Summary Report, dated 10/2024, indicated Sugar Free Med Pass 2.0 one time a day 120 ml every day was ordered 10/17/24 and to start 10/18/24. Resident 30's MAR (Medication Administration Record), dated 10/2024, indicated the Sugar Free Med Pass 2.0 was started on 10/18/24. NOTE: the RD had recommended Reduced Med Pass 120 ml on 8/23/24 and the Med Pass was not started until two months later.</p> <p>Resident 30 had lost 27 lbs. in three months, from 6/7/24 through 9/4/24, a 14.59% unplanned weight loss, which equals severe weight loss.</p> <p>During an interview on 10/23/24 at 9:15 a.m. the RD stated she ran Weight Reports for one month, three months and six months weights to monitor for resident weight loss. The RD stated she came to the facility on ce per week and was a part of the weekly Interdisciplinary Team (IDT: a collaborative session where a variety of professionals work together to plan and coordinate patient care) Weight meetings. The RD stated she e-mailed a RD Recommendation, form to the DON, which included Resident 30's recommendation for: 1. reduced sugar Med Pass 120 ml every day at 2 p.m. and 2. to continue weekly weights, on 8/23/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 10/23/24 at 10:19 a.m., the IDON (Interim Director of Nursing) stated once she received the RD Recommendation forms by e-mail, she would either hand deliver the recommendations to the nurse taking care of the resident or e-mail the recommendation(s) if the RD Recommendation forms came in on the weekend or late at night. The nurse would then contact the resident's physician to obtain an order. The IDON stated the nurse would then give the RD Recommendation form back to the IDON showing the nurse did call the physician to obtain an order. The IDON stated she would then give the RD Recommendation form(s) to the MDSC (Minimum Data Set Coordinator), who would make sure the RD recommendation(s) were followed through. The IDON stated she received the RD Recommendation forms, dated 8/23/24 and 8/28/24, which included Resident 30's recommendation, dated 8/23/24, reduced sugar Med Pass 120 ml every day at 2 p.m. by e-mail on 8/28/24. The IDON stated she e-mailed the RD Recommendation form to LN (Licensed Nurse) L on 8/28/24 at 11:08 p.m., but it was never followed through with by LN L. The IDON stated Resident 30's RD recommendation for reduced sugar Med Pass 120 ml every day because of unplanned weight loss was not ordered until 10/17/24, two months later.</p> <p>During an interview on 10/23/24 at 2:30 p.m., LN C stated she would look at the facility e-mails once per shift, but the IDON would normally call the Nurses Station or go to the Nurses Station with the RD Recommendation form(s). LN C stated she would call the resident's physician to inform the physician of the RD's recommendation(s) and to obtain an order or LN C stated she would fax the RD Recommendation form(s) to the physician if after hours. LN C stated LN L mainly worked at the sister facility.</p> <p>The facility Policy/Procedure titled, Weight Assessment and Interventions, dated 11/2017, indicated: Policy: It is the policy of the facility to monitor patient's weight. Special Considerations: The threshold for significant unplanned and undesired weight loss will . 1 month - 5% weight loss/gain is significant, 3 months - 7.5% weight loss/gain is significant . Process: . 3. Any weight changes of 5% or more since the last weight assessment will retake the next day for confirmation. If the weight is verified, nursing will immediately notify the RD .</p> <p>The facility job description titled, Corporate Dietician, revised 10/19/2015, indicated: . Responsibilities/Accountabilities: . 5. Monitors and evaluates effectiveness of nutritional interventions, 6. Ensures appropriate and timely documentation of . recommended interventions and follow-up .</p> <p>The facility job description titled, DON, revised 10/19/2015, indicated: . Responsibilities/Accountabilities: 3.6. Monitors nursing care to ensure positive clinical outcomes, .3.10. Ensures a process is in place to provide shift-to-shift communication between incoming and outgoing nursing staff .</p> <p>The facility job description titled, Licensed Vocational Nurse, revised 10/19/2015, indicated: . Responsibilities/Accountabilities: . 3. Provision of Direct Patient Care: . 3.2. Communicates pertinent data to RN and/or physician . 8. Participates in shift-to-shift communication between incoming and outgoing nursing staff .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132</p> <p>Based on observation, interviews and record reviews, the facility failed to provide the necessary behavioral health care and services (a range of treatments and services that address a person's mental and emotional health) for one out of two sampled residents (Resident 27). This failure put Resident 27 at risk for worsening of mental health symptoms, poor physical health, social isolation, and decreased quality of life.</p> <p>Findings:</p> <p>A review of Resident 27's face sheet (demographics) indicated Resident 27 was admitted on [DATE]. Resident 27's Minimum Data Set (MDS, a standardized process for evaluating a resident's health and functional abilities in a nursing home) assessment dated [DATE] indicated an active diagnoses of Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily living) and Persistent Mood Disorder (a continuous, long-term form of depression, persistent feeling of low self-esteem, failure and hopelessness). Resident 27'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 9/8/24 score was 7 out of 15 indicating severely impaired cognition. Resident 27's functional abilities indicated she was dependent on staff for provision of all care.</p> <p>A review of Resident 27's Physician Order Summary (POS, a table view of all a patient's orders, including the category, order item, frequency, status, and when the order was entered) indicated Resident 27 was receiving an Antipsychotic (AP, used to treat psychotic disorder, a mental disorder that causes a person to lose touch with reality) 7.5 milligram (mg, a unit of measure) at bedtime, and 2 Antidepressants (AD, drug used to treat depression) for depression and insomnia (difficulty falling/staying asleep).</p> <p>A review of Resident 27's electronic medication administration record (EMAR, digital version of the paper records used to document a patient's medications) for 8/2024, 9/2024 and 10/2024 indicated her behaviors included self isolation, withdrawal and hallucination.</p> <p>During an observation on 10/21/24 at 10:15 a.m., Resident 27 was up in wheelchair. Resident 27 was crying but denied pain or discomfort. Resident 27 was unable to verbalize why she was crying.</p> <p>During an observation on 10/21/24 at 10:21 a.m., Certified Nursing Assistant (CNA) K stated Resident 27 cried no matter what staff did. CNA K stated Resident 27 cried while she was in bed, when she wanted to transfer into wheelchair, but when Resident 27 was in her wheelchair, she would still cry. CNA K stated sometimes he thought Resident 27 would only stop crying when she got tired from crying. CNA K stated no one really knew why Resident 27 always cried. CNA K stated they try to cater to whatever she requested them to do whenever she cried. CNA K stated sometimes this helped, other times it did not.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 10/23/24 at 10:28 a.m., Resident 27 was observed to be crying in bed. Resident 27 denied pain. Resident 27 stated she wanted to get up in bed. Licensed Nurse (LN) D was in the opposite room passing medication. The Infection Preventionist (IP) went inside Resident 27's room and told her someone would assist her shortly. Resident 27 continued to cry.</p> <p>During a concurrent observation and interview on 10/23/24 at 10:35 a.m., Resident 27 continued to cry. LN D stated crying was Resident 27's behavior. LN D stated Resident 27 did this all the time. LN D stated Resident 27 mostly did this in the morning but usually calmed down after lunch. LN D stated Resident 27 was anxious that was why she cried. LN D stated Resident 27 wanted to get up and transfer to her wheelchair but her aide was currently helping another resident. LN D stated they would attend to her shortly.</p> <p>During an interview on 10/24/24 at 3:36 p.m., when asked what were Resident 27's behavior, the Minimum Data Set Coordinator (MDSC) stated Resident 27's behavior included yelling, crying and hallucination. The MDSC stated she knew Resident 27 still cried and yelled a lot but was not sure if Resident 27 still exhibits hallucinations. When asked what could be causing Resident 27's behaviors, MDSC stated she wasn't sure but stated Resident 27 had a lot of issues. MDSC verified Resident 27 was not receiving behavioral health care services and treatment. MDSC stated Resident 27 was receiving an antipsychotic and an antidepressant and was showing behaviors so Resident 27 should be receiving behavioral health care services. MDSC stated Resident 27 had behavioral issues such as crying and yelling and these behaviors were still an ongoing issue. MDSC stated Resident 27 would benefit from receiving behavioral health care services and treatment because Resident 27 had a lot of issues. When asked why Resident 27 was not receiving behavioral health care services and treatment, the MDSC stated, Resident 27 fell through the crack and there was no one that came to the facility to provide the services.</p> <p>During an interview on 10/25/24 at 10:31 a.m., LN I stated Resident 27 did continue to exhibit behaviors of crying and yelling. When asked if he knew how often and what could be causing Resident 27's crying and yelling, LN I stated Resident 27 cried and yelled daily but was not sure what was the root cause of Resident 1's crying and yelling. LN I stated staff tried to address Resident 1's crying and yelling as it arose. LN I stated Resident 1 did not receive behavioral health care and services because it was not available in the facility. When asked why, LN I stated he did not know. LN I stated Resident 27 behavior of crying and yelling out might improve if she was receiving behavioral health care and services. LN I stated Resident 27 should be receiving behavioral health care and services to find out what might be causing Resident 1's behavior as it might help with behavior modification.</p> <p>During an interview on 10/25/24 at 10:40 a.m., the Interim Director of Nursing (IDON) stated Resident 27 needed behavioral health care and services to help determine the root cause of Resident 27's behavior and to possibly address Resident 27's behavior with behavior modification. The IDON stated Resident 27 was qualified to be seen by behavioral health care and services because she was on psychiatric medications and she was exhibiting negative behaviors such as crying and yelling which might cause her distress. The IDON verified Resident 27 did not receive behavioral health care and services at this time. The IDON stated she should be seen by behavioral health care and services to help address her behaviors. The IDON stated not receiving behavioral health care and services placed Resident 27b at risk for emotional distress and unmet needs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/25/24 at 10:50 a.m., the MDSC stated Resident 27 should receive behavioral health care and services. The MDSC stated not receiving behavioral health care and services could put Resident 27 at risk for behavior to escalate, anxiety and poor quality of life.</p> <p>A review of the facility's policy and procedure (P&P) titled Behavioral Health Services , release date 1/2023, the P&P indicated the purpose of the behavioral health was the prevention and treatment of mental disorders .assisting residents to access counselling (individual or group counselling services) to the fullest degree possible .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</p> <p>Based on observation, interview, and record review the facility failed to:</p> <ol style="list-style-type: none"> 1. Implement EBP (Enhanced Barrier Precautions: a set of infection control guidelines that use personal protection equipment [PPE: gown and gloves] to reduce the spread of multidrug-resistant organisms [MDROs: a bacteria that has become resistant to an antibiotic [medication that treats a bacterial infection]] for two of 18 sampled residents (Resident 30 and Resident 108) and five unsampled residents (Resident 8, Resident 9, Resident 212, Resident 213, and Resident 214), who had wounds and required dressing changes, and/or indwelling medical devices, such as a foley catheter (a flexible tube that is inserted into the bladder to drain urine or a gastrostomy tube (G-tube: is a tube that is surgically inserted through the abdominal wall and into the stomach to provide a way to deliver nutrition, fluids, and medications directly to the stomach.) and 2. Ensure a service technician wore a hairnet and beard covering when entering the kitchen to service a refrigerator. <p>These failures had the potential for: 1. Residents with wounds or indwelling medical devices were at higher risk of acquiring an MDRO and/or could serve as sources of transmission within the facility. MDROs can cause serious infections that are hard to treat, which can lead to increased morbidity (disease and illness) and mortality (death) for residents and 2. Food becoming contaminated causing foodborne illnesses to spread in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an interview on 10/22/24 at 9:05 a.m., Resident 30 stated he had a dressing on his right foot. Resident 30 stated the wound nurse, who came to the facility on ce per week, changed the dressing yesterday. <p>During an interview on 10/24/24 at 10:44 a.m., the IDON (Interim Director of Nursing) stated Resident 30 was admitted to the facility with a right heel PU (pressure ulcer: wound in the skin and tissue caused by prolonged pressure on an area). The IDON stated Resident 30 was being seen by wound doctor.</p> <p>During an interview on 10/24/24 2:30 p.m., the IIP (Interim Infection Preventionist) stated he did not believe the facility had implemented EBP. The IIP stated any resident who had a history of MDRO or had active MDRO, needed wound care, and/or had an indwelling device such as a Foley catheter, IV (intravenous method of administering fluids within a vein), G-tube, amongst other internal devices, should be on EBP. The IIP stated EBP should have been started but because the IP quit, EBP never was implemented at this facility. The IIP stated implementing EBP was important to prevent the spread of infections, control the spread from staff to resident, resident to staff and/or resident to resident. The IIP stated EBP was very individualized. The IIP stated residents on EBP should have signage posted outside their room indicating they were on EBP and a PPE cart with gowns and disposable gloves outside the resident's room. The IIP stated the staff had not been trained on EBP.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/24/24 at 4 p.m. there was no signage for EBP noted on the outside of any resident's room nor PPE carts.</p> <p>During an interview on 10/25/24 at 9:26 a.m., LN (License Nurse) I stated the wound care NP (Nurse Practitioner) came every Monday and LN I rounded with the NP. LN I stated Resident 30 had a diabetic (high blood sugar) PU (pressure ulcer: chronic Wound in the skin and tissue of the foot caused by a number of factors related to diabetes) on his right heel. LN I was asked to give surveyor a list of residents on wound care to see, which residents should have been on EBP.</p> <p>A review of the Preliminary Wound Reports, dated 10/21/24, signed by a Family Nurse Practitioner (FNP), indicated, Resident 8, Resident 9, Resident 30, Resident 108, Resident 212, and Resident 214 were all receiving wound care by an FNP. Note: EBP had not been implemented for Resident 8, Resident 9, Resident 30, Resident 108, Resident 212, and Resident 214.</p> <p>A review of Resident 212's Admission Recorded indicated Resident 212 was admitted to the facility on [DATE], with a diagnosis including a Stage Four PU (Pressure Ulcer which deep, to the bone) located at the Sacral Region (lower back), Retention of Urine (unable to empty bladder), History of Urinary Tract Infections (infection occurs when bacteria enter the urinary tract) among others.</p> <p>A Review of Resident 212's Order Summary Report, dated 10/2024, indicated Resident 212 had an order for an Indwelling Catheter (tube that goes into the bladder) to bedside drainage because of urine retention, start date 9/24/24. Note: EBP had not been implemented for Resident 212, who had an indwelling device.</p> <p>A review of Resident 213's Admission Record indicated Resident 213 was admitted to the facility on [DATE], with a diagnosis including a stroke, dysphagia (difficulty swallowing), among others.</p> <p>A review of Resident 213's Order Summary Report, dated 10/2024, indicated Resident 213 had an order for Enteral Feed, every shift via G-Tube feeding (tube for feeding patient that goes into the stomach) dated 10/14/24. Note: EBP had not been implemented for Resident 213, who had an indwelling device.</p> <p>The facility policy/procedure titled, Enhanced Barrier Precautions, dated 6/2022, indicated: Policy: It is the policy of this facility to ensure that isolation procedure standard is based on the most up-to-date infection control practice. Purpose: The purpose of this policy is to establish and provide guidelines for isolation precautions as well as prevent transmission of infectious agents in the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Responsible Discipline: The Director of Nurses (DON) and/or its designee shall be responsible for implementation and enforcement of this policy. This responsibility maybe designated to the Facility's Infection Control Preventionist. Definitions: Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Key Points: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care .</p> <p>2. During an observation on 10/21/24 at 8:45 a.m., there was a black hair in the kitchen handwashing sink. When inspecting the inside of the refrigerator located in the food prep area, there was a blond hair hanging on the refrigerator rack.</p> <p>During an observation on 10/21/24 at 3:29 p.m., there was a piece of orange tape with a black hair located on top of the handwashing sink faucet.</p> <p>During an observation on 10/23/24 at 11:20 a.m., a service technician came into the kitchen to work on the refrigerator located in the food prep area wearing a baseball cap. The technician had a beard, which was not covered. The Certified Dietary Manager (CDM) was asked if the service technician's attire was appropriate. The CDM stated he had a baseball cap on. The CDM was asked if the service technician's baseball cap was covering his hair and if his beard was covered. The CDM told the service technician he needed to put on a hairnet and a beard cover.</p> <p>During an interview on 10/23/24 at 3:41 p.m., the CDM stated when a service technician came into the kitchen, the sevice technician needed to put on a hairnet and a beard cover before entering the kitchen and wash their hands before working on anything in the kitchen.</p> <p>The facility policy/procedure titled, Dressed Code, 2023, indicated: Purpose: Appropriate dress in the Food & Nutrition Services Department. Procedure: Personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutrition Services Department . Proper Dress: . 6. Hat for hair, if hair is short, which completely covers the hair. 7. Hair net for hair, if hair is long (over the ears or longer). 8. If applicable, beards and mustaches (any facial hair) must wear beard restraint .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35842</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests when flies were seen flying throughout the facility. The facility did not adequately address the pest problem, leading to residents being bothered by flies in their room while trying to rest and eat their meal. Flies were seen flying in the kitchen, which could lead to contamination of food being prepared and the spread of disease.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 10/21/24 at 10:08 a.m., a fly was flying around Resident 30's bed. Resident 30 stated he had been having a fly issue and pointed to a plug-in bug trap, which trapped flies, and a sticky fly paper trap hanging on the side of the curtain rod. There were multiple dead flies in the plug-in bug trap and a few dead flies on the sticky fly paper trap. Resident 30 stated the cartridge inside the plugin bug trap had not been changed for several weeks. Resident 30 had a portable fly fan on his overbed table too. Resident 30 stated he normally did not get up because of his right foot ulcer (wound in the skin that can get infected).</p> <p>During an observation on 10/21/24 at 10:28 a.m., Resident 13, was resting in bed and was wearing light washed jeans, when two black colored flies landed on his jeans.</p> <p>During a concurrent interview and observation on 10/21/24 at 11:05 a.m., flies were flying in Resident 108's room. Resident 108 stated he has been having an issue with flies and had asked his girlfriend to bring him a fly swatter.</p> <p>During an interview on 10/21/24 at 1:05 p.m., Resident 8 was sitting on the side of her bed having lunch. Resident 8 stated there has been a fly issue. Resident 8 stated she had her own fly swatter.</p> <p>During an interview on 10/21/24 at 1:17 p.m., Resident 108 stated he had just finished eating spaghetti, but two flies were flying around in his room while he was eating, so he went back to bed to cover himself up to avoid the flies.</p> <p>During an observation on 10/21/24 at 3:29 p.m., in the kitchen a fly was seen on a cart used to deliver food and drinks to the residents. The Certified Dietary Manager (CDM) killed the fly with a fly swatter and asked a Dietary Aide to disinfect the cart.</p> <p>During a kitchen observation on 10/22/24 at 3:30 p.m., two flies were flying around in the kitchen. One fly was flying around the dishwasher and the other fly was on the window in the dry goods pantry.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Northvine Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 446 Arrowood Dr Santa Rosa, CA 95407	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/22/24 04:10 p.m., the Administrator (ADM) stated there has been a fly problem this summer. The ADM stated the Pest Control Company thought the increase in flies was because of the compost (the natural process of recycling organic matter, such as leaves and food scraps, into a valuable fertilizer) on the outside near the Garden Hall. The surveyor pointed out to the ADM the surveyor assigned to rooms in the Garden Hall had not seen any flies. Mostly in rooms in the [NAME] Hall and in the kitchen. The ADM was asked about the fly issue in Resident 30's room who had a plug-in bug trap and a sticky fly paper trap with many fiels trapped. The ADM stated the Pest Control Company did not spray for flies, only for ants and spiders.</p> <p>During a medication pass observation on 10/23/24 at 8:51 a.m., Resident 19 asked Licensed Nurse D to open the curtain over her window. When Licensed Nurse D pulled back the curtain, a fly was noted to be crawling on the window. When Licensed Nurse D returned to the hall outside Resident 19's door, a fly was buzzing around the hall next to the medication cart.</p> <p>During an observation on 10/23/24 at 8:55 a.m., a fly that was crawling around on the floor in front of room [ROOM NUMBER] flew up and landed on the arm of the surveyor.</p> <p>During an observation on 10/23/24 at 4:04 p.m., a fly was buzzing around the hall outside room [ROOM NUMBER].</p> <p>During an interview on 10/24/24 at 9:11 a.m., Certified Nursing Assistant (CNA) H stated she has worked at the facility for about six months. CNA H stated, Yes there has been a fly issue.</p> <p>During an interview on 10/25/24 at 1:20 p.m., Licensed Nurse (LN) F stated she started working at the facility three weeks ago and there has been a fly issue in the [NAME] hallway, with multiple flies flying around. LN F stated the flies had been swarming all over her medication cart and throughout the hallway.</p> <p>During an interview on 10/25/24 at 1:34 p.m. CNA G confirmed a problem with flies in the facility.</p> <p>A review of a Pest Control Report, dated 10/10/24, indicated the Pest Control Company had recommended for a back door from being propped open to prevent flies from coming into the facility. The pest report indicated the service technician was targeting ants and rodents such as mice and rats.</p> <p>The facility policy/procedure titled, Pests Control, dated 4/2018, indicated: Policy: It is the policy of the facility to maintain an ongoing pest control program to ensure the building premises and its grounds are kept free of insects, rodents, and other pests. Purpose: To ensure that facility is free of insects, rodents and other pest that could compromise the health, safety and comfort of residents, staff and visitors.</p> <p>38322</p> <p>46132</p>		