STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerfield Health Care Center	1280 Summerfield Rd Santa Rosa, CA 95405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on interview and record review, facility staff did not follow physician orders from 2/10/25 to 2/11/25, to ensure Sampled Resident #1 wore a wrist brace on her right wrist at all times. This failure had the potential for Resident #1 ' s right wrist fracture to heal in an incorrect position or for the broken bone pieces to not grow back together properly (Occurs with excessive movement or inadequate stabilization of the fracture site. When a bone is not able to heal properly it will take longer to heal and result in prolonged swelling, tenderness, and pain). Findings: During an interview on 1/28/25 at 1:13 p.m., Family Member A stated she had arrived at the facility to visit Resident #1 on 2/10/25, in the evening to visit Resident #1 and left at 8 p.m. She stated she returned to the facility 2/11/25, at lunch and observed Resident #1 did not have a brace on her left wrist. Family Member A stated the private caregiver had told her she did not know Resident #1 was supposed to have a brace on her right wrist. She stated she questioned the Licensed and Unlicensed staff about the location of the brace, and nobody knew where the brace was. She stated the Physician had ordered Resident #1 to wear the brace / splint 24 hours a day. During an observation on 2/19/25 at 10:55 a.m., in Resident #1 ' s room, a white, dry erase board located opposite Resident #1 ' s foot of the bed indicated, Wear right wrist brace at all times. During an interview on 2/19/25 at 11:01 a.m., with Private Sitter C, she stated there was nothing communicated to her from her company or the facility that mentioned keeping the brace / splint on Resident #1 ' s right wrist. She stated the facility nursing staff had not communicated anything about the brace / splint on Resident #1 ' s right wrist to her. During an interview on 2/19/25 at 11:06 a.m. Unlicensed Staff D stated she had assisted Resident #1 to take a shower. She stated Resident #1 had a neck brace that never came off except for the shower, and then a waterproof brace was applied to her neck. She stated she did not know anything about the splint on Resident #1 ' s right wrist. She did not know if it could be taken off or what had happened to her wrist. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25 at 11:25 a.m. Licensed Staff E stated she was not assigned to Resident #1. She stated she knew that Resident #1 had to wear a cervical collar (a stabilizing device worn around one ' s neck to prevent movement and further injury) all the time but did not know about a brace on her right wrist. She stated she knew that Resident #1 had fallen on her first day in the facility but did not know she had fractured her right wrist. Licensed Staff E was unable to state whether she would know what her special needs were, like to wear a brace on her right wrist 24/7 and never take it off. During a concurrent interview and record review on 2/19/25 at 12:42 p.m., the Director of Rehabilitation Services reviewed Resident #1 ' s medical record and stated she was supposed to wear a cervical collar and a right-hand splint. She stated Resident #1 got the right-hand splint for a fractured wrist after she fell in the facility. She stated Resident #1 was sent to hospital on 1/28/25, two days after she fell on [DATE]. She stated Resident #1 ' s Skilled Nursing Facility ' s (SNF) Physician wrote orders for her to go to the hospital for assessment and placement of a splint on her right wrist. She stated the SNF Physician ' s Order, dated 1/28/25, was to wear the splint 24/7. She stated the doctor wrote orders to monitor the right hand for placement of the splint, circulation of the fingers on the right hand. She stated the daily Nursing Notes indicated staff should complete observation of the right hand and wrist and document it. She stated the risk to the patient for not following the Physician Orders to wear the right wrist brace could result in further injury to Resident #1 ' s wrist. During an interview on 2/19/25 at 1:35 p.m., the Assistant Director of Nursing stated Resident #1 ' s doctor had ordered a right wrist splint 24/7, on 1/28/25, and to monitor every shift for placement and circulation. She stated staff should communicate with each other about the brace, and private sitters could look at the white board in the room that would have important information about the brace. She stated the facility should communicate with private sitters. During a phone interview on 2/20/25 at 3:16 p.m., the Private Sitter ' s Manager stated no one had communicated with his agency or caregivers to ensure the placement of a right wrist brace on Resident #1. He stated it was the responsibility of the nurses to communicate any special concerns or needs to the private sitter. During a phone interview on 2/21/25 at 10 a.m., Private Sitter S stated her responsibility for Resident #1 was to be her companion and be sure she did not fall. She stated she was aware Resident #1 had a broken right wrist with a brace. She stated it was covered with an ace wrap (brace), and Resident #1 kept trying to take it off. She stated the facility nurses and staff had come in and saw that it was off when they gave Resident #1 medications and when they came in to take her to the bathroom, but no one put the brace back on. She stated she left on 2/10/25 at 8 p.m., and the brace was off and when she returned to work on 2/11/25 at 8 a. m., the Resident #1 did not have a brace on her right wrist. During an interview on 2/24/25 at 11:12 a.m., Licensed Staff I stated caregivers did not provide direct patient care and would inform staff of anything special like the need for a resident to go to the bathroom. She stated the caregivers would usually check in with the nurse when they would come to work, and they should have notified the nurse if the right wrist brace was off. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 12:25 p.m., the Director of Nursing stated staff assessed placement of Resident #1 ' s wrist brace, every shift. She stated the wrist brace was not on 2/10/25 or 2/11/25. The Director of Nurses stated the family should have told the sitter to be sure Resident #1 did not take off the wrist brace. During a phone interview on 2/24/25 at 5 p.m., Family Member A stated, during a Care Conference to discuss how Resident #1 ' s wrist brace was not on 2/10/25 or 2/11/25, with the Administrator, Director of Nursing, Social Services and Ombudsman in attendance, she stated the facility admitted they were responsible and, This one was on us. Review of a medical record document title, Progress Notes +New, dated 1/28/25 at 8:46 p.m., indicated, PT WAS NOTED TO BE TRYING TO UNRWAP SPLINT AND FREQUENT REORIENTATION AND EDUCATION PROVIDED TO PREVENT PT FROM REMOVING SPLINT. Review of the medical record document titled, Progress Notes Falls Committee IDT, dated 1/25/25 at 9:01 a. m., indicated, IDT MET AND DISCUSSED PT RECENT FALL. PT WAS admitted TO FACILITY, 1/25/25 @1500 (3 p.m.) . ON 1/26/25 PT HAD A WITNESSED FALL WHILE AT THE NURSES STATION. PT CHAIR ALARM WENT OFF WHEN SHE TOOK A STEP AND TRIPPED ON HER W/C (Wheelchair), AT THIS TIME SHE WAS WITNESSED HITTING HER HEAD AND FALL RESULTED IN MULTIPLE SKIN TEARS (Injury or traumatic wound caused by direct contact of skin to an object resulting in the top layer of skin peeling away) .WHEN ASKED PT REPORTED PAIN TO RT WRIST WITH SUPINATION (Movement). THROUGHOUT SIFT [sic] STAFF NOTED SWELLING AT RT WRIST, MD NOTIFIED AND ORDERED X-RAY To R/O (Rule Out) POSSIBLE FX. WHILE WAITING FOR X- RAY TO BE COMPLETED MD VISITED AND ASSESSED PT. MD REQUESTED TO PLACE SPLINT ON R (Right) WRIST. ONCE X-RAY COMPLETED RADIOLOGIST NOTED ACUTE/SUBACUTE FX (Broken bone) AT RT WRIST. DUE TO INCREASED SWELLING AND PAIN PT WAS SENT TO ER (emergency room) FOR FURTHER EVALUATION. UPON RETURN TO FACILITY PT WAS PROVIDED WITH 1:1 SITTER. SOFT SPLINT APPLIED AT HOSPITAL. ORDER IN PLACE TO MONITOR CSM (Circulation, Sensation and motion) AND SKIN UNDER SPLINT REGULARLY. Review of a medical record document titled, Care Plan Report, dated 1/28/25, indicated, Alteration in musculoskeletal status r/t Fracture of the RIGHT WRIST. Encourage the use of supportive devices (SPECIFY: splints, braces, canes, crutches etc.) as recommended. Potential for a behavior problem r/t (related to) unsafe behaviors, fall risk, impulsive unsafe behaviors, fall risk, behaviors, and cognitive impairment. Review of a medical record document titled, Order Summary Report, dated 1/28/25, indicated RIGHT WRIST SOFT SPLINT: MONITOR FOR CAPILLARY REFILL (Squeeze the fingertip and see how fast the color goes from a whitish back to pink. A method to assess blood flow) AND ANY S/SX (Signs and/or symptoms) OF SWELLING every shift.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on observation, interview and record review, the facility failed to ensure the safety of one of two sampled residents (Sampled Resident #1), when facility staff provided inadequate supervision consistent with her needs. Resident #1 was assessed as being a fall risk due to a history of falls, having decreased mobility, generalized weakness, restlessness and cognitive impairment. In addition, facility staff were aware Resident #1 had impulsive and unsafe behaviors and because of this, required a 1:1 sitter (one person supervising one patient) during her recent hospitalization , yet it failed to provide this same level of supervision while at the facility, unless Resident #1's family member paid for it, and this, only after Resident #1's fall. These failures to provide the services and care required to keep Resident #1 safe, resulted in Resident #1 falling in the first 24 hours after admission which resulted in a head injury, two seizures, skin tears and a fractured right wrist. Findings: During a telephone interview on 2/18/25 at 1:13 p.m., Family Member A stated Resident #1 had fallen at home and had been hospitalized from 1/20/25 to 1/25/25, for a broken neck. She stated Resident #1 was admitted to the Skilled Nursing Facility on 1/25/25. She stated she was informed on 1/26/25, that Resident #1 had fallen in the facility. She stated she was informed on 1/28/25, that Resident #1 was transferred to the hospital for a right wrist fracture and application of a splint (device to stabilize a body part and prevent movement), as a result of the fall on 1/26/25. Review of a facility document for Resident #1, untitled, indicated, DATE/TIME OF FALL: 01/26/25 0855 am. Seizure 855 (8:55 a.m.). Seizure 910 (9:10 a.m.). The document indicated the Right and Left Pupil was pinpoint (A pinpoint sized pupil after a fall could indicate a serious head injury and should be considered a medical emergency, as it might signify brain damage, potential bleeding within the skull, or nerve damage affecting the eye muscles, requiring immediate medical attention) and sluggish (After a head injury, pupils may not constrict in response to light. This can be a sign of a serious brain injury) 0855 (8:55 a.m.) - 1140 (11:40 a.m.). The document indicated the movement of Resident #1's arms was, Impaired (Impaired arm movement after a head injury can occur due to damage to the brain. Symptoms include decreased range of motion, difficulty lifting or moving the arm, clumsy hand movements. After a seizure some people find they have temporary weakness or can't move part of their body) from 0855 (8:55 a.m.) - 1140 (11:40 a.m.). Review of Resident #1's Admission record indicated she was admitted [DATE], with diagnoses that included Unspecified Non-Displaced Fracture of Second Cervical Vertebra (A break in the neck that did not move out of alignment. Often treated with immobilization and a cervical collar), Difficulty Walking, Need for assistance with personal care, Difficulty Swallowing, Cognitive Communication Deficit (Impairment of memory, changes in behavior, mood swings, agitation and trouble learning) and Unsteadiness (A disorder that contributes to loss of balance and difficulty walking). Resident #1 had a Brief Interview of Mental Status (BIMS) (An evaluation that determines a dementia diagnosis. A score of 12-15 indicated no cognitive defect, 9-11 indicated moderate cognitive defect and 0-8 indicated severe cognitive defect) score of 6 out of 15, indicating a severe cognitive deficit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/19/25 at 11:01 a.m., Private Sitter C stated she was a private caregiver (providing 1:1 supervision) for Resident #1. She stated she was hired by the family after Resident #1 fell . She stated she was responsible to be sure that Resident #1 did not attempt to get up and possibly fall. She stated Resident #1 was very fast and, you had to be right next to her to catch her when she is trying to stand up and walk. During an interview on 2/19/25 at 11:25 a.m., Licensed Staff E (LS E) stated she was familiar with Resident #1's care and knew that on the day of her admission, Resident #1 had fallen. She stated Resident #1 was a high risk for falls, had a Tab Alarm (Alarm -- A battery-operated alarm attached to the resident and a wheelchair or bed that would initiate a loud alarm to notify staff the resident had attempted to stand) on her wheelchair. LS E stated, when Resident #1 fell , she was in a wheelchair with an alarm, at the nursing station on her first day and had tried to stand up twice. She stated staff were able to prevent her from falling the first two times, by getting her to sit down. LS E stated, when Resident #1 attempted to stand up a third time, staff were not positioned close enough to get to her in time, and she fell . She stated, after the fall, the family hired a private sitter who showed up later. During an interview on 2/19/25 at 11:47 a.m., the Director of Admissions stated, generally hospital case managers would call them to see if they would admit a resident. She stated she would read all the notes from the hospital, But I am not clinical staff and would give the admission paperwork to the Director of Nursing or the Director of Rehabilitation to review, to determine if the facility could accept the patient's admission. She stated she remembered Resident #1's admission documentation review and had determined that she would require a lot of care. She stated, I informed the family that since [Resident #1] had a 1:1 sitter in the hospital for safety, they we could admit her and try to provide her with everything she needed to be safe, but they might have to hire a private sitter if needed. She stated Resident #1 did not have a sitter when she was first admitted to the facility but had exceeded staff members' ability to provide safe care in the first 24 hours, and Resident #1 fell and broke her wrist. She stated she called the family to tell them it would be best if Resident #1 had a 1:1 sitter. During an interview on 2/19/25 at 11:57 a.m., the Social Services Director stated resident care plans were documented by each Department after admission. The Social Services Director stated the Admissions Department would have prepared for the resident's admission by reading the hospital information and then discussing the details at the morning report. She stated, after a resident's admission it was not common to have a resident on a 1:1 sitter right away. She stated the facility would attempt other interventions before they initiated a sitter, like distraction, activities, sitting at the nursing station, tab alarms. She stated they had a lot of things to try before they attempted a 1:1 sitter on Resident #1 because a 1:1 could be a big staffing expense. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/19/25 at 12:42 p.m., the Director of Rehabilitation stated, upon admission, nurses completed a fall assessment to determine if a resident was a high risk for falls. She stated, after a resident fell , the Director of Nursing, Assistant Director Nursing and she would meet to develop a plan to create the right interventions to prevent any more falls for that resident. She stated, first interventions would have been redirection, then audible alarms (Tab Alarm), move the resident to a room closer to the nursing station, and then discuss any fall at an Interdisciplinary Team (IDT - Key staff members meet to discuss resident-specific care needs) meeting. She stated, at the facility, a 1:1 had been initiated only a few times for safety, but not always. She stated, for Resident #1, the staff had attempted redirection and an audible alarm. She stated it did not prevent the fall and stated she did what high risk for falls interventions had been care planned. During the same interview and record review, the Director of Rehabilitation reviewed Resident #1's medical record. She stated Resident #1 was admitted on [DATE], fell on [DATE], and went to the hospital on 1/28/25, for a fractured right wrist and application of a soft splint. She stated Resident #1 was severely cognitively impaired and was impulsive. She stated Resident #1 would get up fast. She stated, because of the impulsivity, she recommended a 1:1 sitter after this fall. She stated she did not know why the facility did not provide a 1:1 sitter. She stated a 1:1 sitter was not considered for Resident #1 upon admission because there were other interventions that were attempted. During an interview on 2/19/25 at 1:35 p.m , the Assistant Director of Nursing stated the Admissions Department would assess all new admits for needs, including the need for a 1:1 sitter. She stated, if a resident needed to have a sitter in the hospital, the resident might need to have one at the facility too. She stated they would try everything else before the use of a 1:1 sitter because the use of a sitter would be a last resort. The Assistant Director of Nursing stated they were doing all the fall prevention interventions, and Resident #1 fell . She stated Resident #1's family was notified a sitter was needed because they did not have staff for a private sitter. During an interview with the Director of Nursing (DON) on 2/24/25 at 9:45 a.m., she stated the facility Falls Committee had determined Resident #1's fall on 1/26/25, was not unusual. She stated the Falls Committee was the IDT, and they met on 1/28/25, to do a Root Cause Analysis (RCA -- An analysis for falls that involved identifying the underlying factor that contributed to the fall, which would include looking at patient-related factors, environment, staff training, communication and problems with fall prevention protocols; the goal was to pinpoint the primary causes to implement targeted interventions and prevent future falls) of Resident #1's fall. The DON stated the only fall investigation documentation was the IDT Note, dated 1/28/25. She stated there was no RCA documented. She stated the IDT had determined Resident #1 had a witnessed fall as a result of Resident #1's impulsive behavior and tripped, fell and needed a 1:1 sitter for safety. She stated the Falls Committee had determined Resident #1 was a high-risk resident, had been placed in a wheelchair by the nurses station with a tab alarm and had fallen. She stated she did not know if staff had tried a different intervention to prevent a fall after Resident #1's two attempts to stand up. She stated, Why would they? They had stopped two prior attempts. She stated she did not know if staff were within arm's length of Resident#1 when she was in the wheelchair by the nurses station. She stated the facility had tried everything for Resident #1 but not a 1:1 sitter. The DON stated Admissions determined if a resident was an appropriate admission for the facility, and the facility knew Resident #1 had sitters in the hospital and that a sitter might be needed. She stated there was no reason to provide a 1:1 sitter for her even though she had documentation from the hospital that Resident #1 had behaviors and required a sitter during her hospitalization . She stated the facility had done everything for a high-falls risk patient and, Sometimes residents just fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the same interview the Director of Nursing stated Resident #1 was assessed at a high risk of 16 upon admission, and staff did everything but a 1:1 to ensure Resident #1 was safe. She stated the Tab Alarm had prevented a fall twice, and when Resident #1 attempted to stand a third time, she just tripped and fell . The DON stated no 1:1 sitter was placed on Resident #1 after the fall because she was not trying to get up after the fall. She stated, She wasn't trying to do much after the fall. She stated neuro checks (An evaluation of the nervous system to help determine if there is a brain injury. Neuro checks include Mental Status, Strength, Pupil Response) were done after the fall, and the Physician came in later that night and determined through examination that Resident #1 needed an X-ray (used for diagnosis and treatment) to determine if she had a broken right wrist. During an interview on 2/24/25 at 11:25 a.m., Licensed Staff J stated Resident #1 had a 1:1 sitter for her impulsive behavior. She stated Tab Alarms were used to notify staff if a resident was trying to stand up. She stated the resident would have to be within reach of a staff member to prevent a fall. During an interview and concurrent record review on 2/24/25 at 11:40 a.m., the Director of Nursing stated Resident #1 only had two interventions on her care plan for high risk for falls, on 1/25/25. A review of a document titled, Care Plan Report, dated 1/25/25, indicated, GOAL Will be free of falls through the review date INTERVENTIONS Bed in lowest position at night Needs a safe environment: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, side rails as ordered, handrails on walls, personal items within reach. The DON stated the interventions on the care plan, initiated on 1/25/25, did not prevent Resident #1 from falling. She stated it was appropriate to initiate a care plan for high risk for falls upon admission and then add the interventions later. During an interview and record review on 2/24/25 at 12:15 p.m., the Director of Nursing reviewed the Tab Alarm document titled, Attendant Magnet Alarm Owner's Manual. It indicated, Introduction Attendant Alarms/Alerts are battery powered monitors that alert you with an alarm when a resident attempts to leave their bed, chair or wheelchair. Attendant Alarms/Alerts are intended to be used on wheelchairs, standard upright chairs and beds to assist caregivers trained in its use. Attendant Alarms/Alerts are intended to help augment caregivers' comprehensive resident mobility management programs. They are not a substitute for the visual monitoring and care of residents by trained caregivers. This device is not designed to replace good care giving practices including, but not limited to the following: Direct resident supervision, adequate care plans and training for staff personnel regarding fall prevention, patient repositioning and elopement. WARNING - This device is not appropriate for all patients and residents. A caregiver should determine appropriateness as part of the resident's care plan and assessment. She stated it was the first time she had reviewed the document. She stated she did not know if Resident #1 was within arm's reach of a staff member when she fell , and stated they had done everything to prevent a fall. She stated Resident #1 was not on a 1:1 upon admission or upon assessment of impulsive behavior. Review of a facility Admission document titled, Acknowledgments, dated 1/25/25, indicated, 1 on 1 SITTER [Facility Name] does not provide sitters to sit with patients who are requiring additional 1 on 1 supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a facility document titled, FALL RISK EVALUATION, dated 1/25/25, indicated, Resident: (Resident #1) Score: 16 Category: High Risk. (High Likelihood of a fall occurring) .A. MENTAL STATUS RESIDENT STATUS/ CONDITION a. MENTAL STATUS 4. DISORIENTED X 3 (A person who is difficult to arouse.). B. HISTORY OF FALLS (Past 3 Months) b. HISTORY OF FALLS 4. 3 or MORE FALLS in past 3 months. Review of a medical record document titled, Progress Notes +NEW, dated 1/26/25 at 9:16 a.m., indicated, PT HAD A WITNESSED FALL AT THE NURSES STATION. PT CHAIR ALARM (Tab Alarm) WENT OFF AND TOOK A STEP AND TRIPPED WITH HER OWN WC (Wheelchair), PT HIT THE R (right) TEMPORAL (Near the temple) SIDE OF HEAD ON A WC (Wheelchair) NEXT TO HER, NEURO CHECKS (Tests conducted to check for brain injury, included pupil response to light, orientation, alertness, arm strength and coordination, ability to follow instructions) IN PLACE. NEW SKIN TEAR NOTED TO R INNER HAND NEAR THUMB, L (left) SHIN SKIN TEAR, CLEANED AND PAT DRY AND PADDED DRESSING. WHILE GETTING WOUND CARE PT STARTED TO SEIZE (Convulse -- Involuntary muscular contractions and relaxations) FOR ABOUT 30 SEC (seconds), PT WAS TAKEN TO HER ROOM AND STARTED TO SEIZE AGAIN FOR ABOUT 15 SEC. PT WAS RESPONSIVE TO GENTLE SHAKING, HYPOTENSIVE EPISODES (Low Blood Pressure) NOTED ELEVATED LEGS AND BP (Blood Pressure) WENT UP TO 101/34, PINPOINT PUPILS (A neuro check to see the eyes response to light. A pinpoint response is when the pupil exposed to light, is very small. Can mean indication of brain injury). PT WAS REPOSITIONED TO HER SIDE IN CASE OF RECURRENT SEIZURE. Review of the medical record document titled, Progress Notes Falls Committee IDT, dated 1/25/25 at 9:01 a. m., indicated, IDT MET AND DISCUSSED PT RECENT FALL. PT WAS admitted TO FACILITY, 1/25/25 @1500 (3 p.m.) ADMITTING DX: CLOSED NON-DISPLACED FX (Fracture -- Break) OF 2ND CERVICAL VERTEBRAE (Broken neck) AFTER GLF (Ground-Level Fall), ATHEROSCLEROTIC HEART DISEASE OF CORONARY ARTERY (Hardening of the arteries), HX (History) RECURRING FALLS, COGNITIVE IMPAIRMENT (Dementia) DIZZINESS. ON ADMISSION PT PRESENTED A&O (Alert and Oriented) X l (Knows who they are but not where they are, what time it is, or what is happening to them) AND HIGH FALL RISK R/T (Related to) HX OF FALLS, COGNITION, AND POOR SAFETY AWARENESS (Unable to respond quickly to dizziness resulting in falls and injury). SAFETY MEASURES PUT IN PLACE, LOW BED, AUDIBLE ALARM (Tab Alarm), AND KEPT AT NURSES STATION WHILE AWAKE. ON 1/26/25 PT HAD A WITNESSED FALL WHILE AT THE NURSES STATION. PT CHAIR ALARM WENT OFF WHEN SHE TOOK A STEP AND TRIPPED ON HER W/C (Wheelchair), AT THIS TIME SHE WAS WITNESSED HITTING HER HEAD AND FALL RESULTED IN MULTIPLE SKIN TEARS (Injury or traumatic wound caused by direct contact of skin to an object resulting in the top layer of skin peeling away). NURSES IMMEDIATELY ASSESSED PT (Patient) AND INITIATED FALL PROTOCOL WITH ROUTINE NEURO CHECKS (Checking pupil response time, orientation, strength and coordinating of arms and legs after a head injury to determine short term or long-term injury). WHILE TREATING PTS (Patient's) SKIN TEARS PT WAS NOTED TO BE HYPOTENSIVE (Low blood pressure) AND NURSE DESCRIBED SEIZURE LIKE ACTIVITY. WHEN ABLE STAFF ASSISTED PT BACK TO ROOM AND WITNESSED ANOTHER EPISODE OF SEIZURE LIKE ACTIVITY AND HYPOTENSION. WHEN ASKED PT REPORTED PAIN TO RT (Right) WRIST WITH SUPINATION (Movement). THROUGHOUT SIFT (SIC - Shift) STAFF NOTED SWELLING AT RT WRIST, MD NOTIFIED AND ORDERED X- RAY To R/O (Rule Out) POSSIBLE FX. WHILE WAITING FOR X- RAY TO BE COMPLETED MD VISITED AND ASSESSED PT. MD (Medical Doctor) REQUESTED TO PLACE SPLINT ON R WRIST. ONCE X-RAY COMPLETED RADIOLOGIST NOTED ACUTE/SUBACUTE (Rapid Onset/Less Acute) FX (Fracture/Broken bone) AT RT WRIST. DUE TO INCREASED SWELLING AND PAIN PT WAS SENT TO ER (emergency room) FOR FURTHER EVALUATION. UPON RETURN TO FACILITY PT WAS PROVIDED WITH 1:1 SITTER. SOFT SPLINT APPLIED AT HOSPITAL. ORDER IN PLACE TO MONITOR CSM (Circulation, Sensation and Motion) AND SKIN UNDER SPLINT REGULARLY. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerfield Health Care Center	1280 Summerfield Rd Santa Rosa, CA 95405

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record document titled, Progress Notes, dated 1/26/2025 at 9:16 a.m., Change in Change of Condition (CoC), dated 1/26/25 at 9:16 a.m., CoC - Falls Witnessed fall at nurses station. Chair alarm rang, pt took a step out of WC and fell into another WC. Pt hit Rt (Right) temporal head on WC metal frame. Skin tear sustained right inner hand, Shin Skin tear to left shin. While getting supplies for the skin tears, pt seized for 30 seconds. Transferred resident to room and she seized for 15 seconds. Pinpoint pupils. Review of the medical record document titled, Care Plan Report, dated 1/25/25, indicated, At risk for falls r/t RECENT HISTORY OF FALLS, FALL WITH FRACTURE, COGNITIVE IMPAIRMENT. Review of the medical record document titled, Care Plan Report, dated 1/25/25, indicated, Alteration in musculoskeletal (Muscle/Skeleton) status r/t R WRIST PAIN. Needs a safe environment: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, handrails on walls, personal items within reach. Bed in lowest position. Review of the medical record document titled, Care Plan Report, dated 1/25/25, revised 1/29/25, indicated, Has acute/chronic pain r/t GROUND LEVEL FALL, CERVICAL VERTEBRAE (Spinal Neck Bones) FX, DYSPHAGIA (Difficulty Swallowing), R WRIST FX. Review of a medical record document titled, Care Plan Report, dated 1/28/25, indicated, Alteration in musculoskeletal status r/t Fracture of the RIGHT WRIST. Encourage the use of supportive devices (SPECIFY: splints, braces, canes, crutches etc.) as recommended. Potential for a behavior problem r/t (Related To) unsafe behaviors, fall risk, impulsive unsafe behaviors, fall risk, behaviors, and cognitive impairment. Review of a medical record document titled, Order Summary Report, dated 1/28/25, indicated, RIGHT WRIST SOFT SPLINT (Brace To Prevent Movement): MONITOR FOR CAPILLARY REFILL (Squeeze the fingertip and see how fast the color goes from a whitish back to pink. A method to assess blood flow) AND ANY S/SX (Signs and/or symptoms) OF SWELLING every shift. Review of a facility Policy and Procedure titled, Admission Assessment and Follow Up: Role of the Nurse, revised September 2012, indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. Conduct an admission assessment (history and physical), including: a. A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission. b. Relevant medical, social, and family history. c. A list of active medical diagnoses and patient problems (such as recurrent falling or impaired mobility), especially those most related to reasons for admission to the facility and those that are affecting function, behavior, cognition, nutrition, hydration, quality of life, likelihood of functional recovery, and ability to participate in activities and to socialize. d. Current medications and treatments .9. Conduct supplemental assessments (following facility forms and protocol) including: a. Activity level; b. Pain assessment; c. Fall risk assessment; d. Neurological assessment; e. Skin assessment; f. Functional assessment - ability to perform ADLs (Activities of Daily Living); and g. Behavioral assessment. (continued on next page)

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	056364	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Facility Policy and Procedure titled, Falls and Fall Risk, Managing, revised December 2007, indicated, Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of a Facility Policy and Procedure titled, Safety and Supervision of Residents, revised July 2017, indicated, Policy Statement Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.