STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056411	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Post Acute	3751 Montgomery Dr 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure medications were stored and maintained in accordance with professional standards of practice for one of five residents (Resident 1) when, two medications pills were found left unattended at the bedside of Resident 1 without authorization for bedside storage or self-administration.This deficient practice created the potential for medication errors, diversion, or harm to Resident 1 or other residents.Findings:In a record review of Resident 1's admission Record (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility with diagnoses that included hypertension (high blood pressure), atrial fibrillation (heart rhythm disorder where the heart beats irregularly and rapidly), heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs) and dementia (a progressive state of decline in mental abilities).In an observation and interview on 9/3/25 at 11:00 a.m., Resident 1 was sitting at her bedside table. On the table was a small cup containing two pills: one small white pill and one oval white/cream-colored pill. Resident #1 was unable to identify the pills or state how long they had been there.In an interview on 9/3/25 at 11:39 a.m., Licensed Nurse 1 (LN 1) confirmed two pills had been left on Resident 1's bedside table. LN 1 stated the medications were Resident 1's heart medications that were withheld because Resident 1's heart rate and blood pressure (the force exerted by blood against the walls of the arteries as it circulates throughout the body) were too low to give the medications. LN 1 admitted she accidentally left the medication cup on the bedside table and acknowledged this created a risk for Resident 1, as taking the medications with low blood or heart rate could have caused further cardiovascular compromise, (a situation where the heart is unable to adequately pump blood to meet the body's needs which can lead to a variety of symptoms and complications, including chest pain, shortness of breath, confusion and loss of consciousness). She also acknowledged the pills could have been ingested by another resident, particularly a confused or wandering resident, resulting in harm to the resident.In an interview on 9/3/25 at 11:50 a.m., with the Director of Nursing (DON), the DON confirmed she was aware LN 1 left medications at Resident 1's bedside. The DON agreed that leaving medications unattended at the bedside was unsafe for the resident and acknowledged that it was possible for another resident to enter Resident 1's room and consume the unattended medications.A review of Resident 1's the Order Summary Report for active orders, did not indicate Resident 1 could take her own medications.A review of Resident 1's active Care (written document outlining a resident's specific health, personal, and social needs, developed after an initial assessment and updated regularly), the plan did not indicate that Resident 1 could take her own medications.Review of facility policy titled, Medication Storage in the Facility - Bedside Medication Storage,, dated May 2022, indicated, .A written order for the bedside storage of medications should be present in the resident's medical record, and the manner of storage should prevent access by other residents. Review of facility policy titled, Medication Administration - General Guidelines, dated May 2022, indicated, . For residents not in their room or otherwise. unavailable to receive medications during the pass, after completing the medication pass, the nurse returns the missed medications to secured storage.