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	05/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27532 Based on observation, interviews, and record reviews, the facility failed to ensure the rights of five (5) unsampled residents (Resident 20, Resident 55, Resident 69, Resident 76 & Resident 63) and three (3) of 24 sampled residents (Resident 3, Resident 51 & Resident 42) were honored and respected, when: 1) facility staff did not answer or respond to call lights or call for assistance, making residents wait for 20 minutes or more; 2) the facility did not follow its Smoking Policy, when Resident 42 wheeled himself across the facility's parking lot to smoke without staff supervision, and; 3) facility staff entered and exited the building using the slider doors in the residents' rooms that opened to the back patio. These failures: 1) caused Resident 20 to feel terrible after she urinated in her bed while waiting, Resident 55 to fear for the safety of his spouse/room mate when she attempted to get out of bed after waiting for a long time, Resident 69 feeling bad after soiling his bed/linen while waiting, Resident 76 to urinate in bed and sleep on a wet bed until he morning shift came; 2) had the potential of Resident 42 being hit by a vehicle or having a smoking accident, and; 3) caused residents to feel that they had no privacy (Residents 63, Resident 3, and Resident 51). Findings: 1. During an interview on 5/13/24, at 1:17 PM, Resident 20 stated, staff working the night shift did not come when called and she had peed in bed and felt terrible about it. A review of Resident 20's quarterly Minimum Data Set (MDS - a federally-mandated clinical assessment of all residents' functional capabilities in Medicare and Medicaid certified nursing homes helping nursing home staff identify health problems), dated 4/16/24, indicated Resident 20 had a Brief Interview for Mental Status score of 13 (BIMS - mandatory tool used to screen and identify the cognitive condition of residents upon admission. A score of 13 to 15 suggests the patient is cognitively intact), and always did not have control of her urination and bowel movement. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3751 Montgomery Dr Santa Rosa, CA 95405	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24, at 9:28 AM, Resident 55, whose roommate was his wife, stated there were times his wife had to wait 20 minutes to half an hour to get assistance. Resident 55 stated his wife sometimes tried to get up because the wait was too long, and he was afraid she might fall. A review of Resident 55's quarterly MDS, dated [DATE], indicated he had a BIMS of 13. During an interview on 5/13/24, at 11:58 AM, Resident 69 stated wait time for staff assistance was 20 minutes to a half hour. Resident 69 stated sometimes he soiled his bed and did not appreciate soiling himself and felt bad because he had to wait and get cleaned. A review of Resident 69's quarterly MDS, dated [DATE], indicated he had moderately impaired cognition with a BIMS of 10, was occasionally unable to control urination and always unable to control bowel movement. A review of a physician order, dated 1/11/24 indicated to monitor Resident 69's bowel movement every shift every two days and to administer bowel care and make sure Resident 69 had a bowel movement. During an interview on 5/13/24, at 10:46 AM, Resident 76 stated two to three times, a Certified Nursing Assistance (CNA) did not help and left him when he asked to be assisted to use a urinal. Resident 76 stated he had urinated in bed and had gone to sleep lying on his wet bed until the CNA in the morning cleaned him and his bed. Resident 76 stated he had reported the incident to a nurse, who told him she would investigate. A review of Resident 76's admission MDS, dated [DATE], indicated he had a BIMS score of 13, always did not have control of urination and frequently did not have control of bowel movement. A review of the facility's policy, titled: Resident Rights and Dignity, taken from the Nursing Services Policy and Procedure Manual for Long-Term Care 2001, MED-PASS, Inc. revised 2/21, indicated: Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of the facility. The rights include the resident's right to a dignified existence; be treated with respect, kindness, and dignity; among others. 40402 2. During an observation on 5/13/24 at 8:15 a.m., Resident 42 was in a wheelchair smoking alone in the smoking area. No other residents or staff were present in the smoking area. During an interview on 5/13/24 at 8:45 a.m., with Resident 42, Resident 42 was queried if he was aware of the facility's smoking policy. Resident 42 stated he was told that this facility was a non-smoking facility. Resident was queried if he was at the smoking area earlier this morning at 8:15 a.m. Resident 42 stated he was but he had to sit out front of the facility yesterday and bum cigarettes and matches so he could smoke. Resident 42 stated the staff kept trying to force him to take nicotine (stimulant found in tobacco) patches instead of allowing him to go outside to smoke. Resident 42 stated he had refused every nicotine patch that they tried to force on him. Resident 42 stated he told the DON that he would not take the nicotine patches when he was admitted . Resident 42 stated he had been asking how he could obtain cigarettes, since he was admitted , but no one is helping him. Resident 42 was queried if anyone at the facility had ever asked him the amount of tobacco he was smoking prior to him being admitted to the facility. Resident 42 stated he had never been asked how much he was smoking before he came to the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3751 Montgomery Dr Santa Rosa, CA 95405	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Staff C, on 5/13/24 at 9:50 a.m., Licensed Staff C was queried about the facility's smoking policy. Licensed Staff C stated they were a non-smoking facility; We do not have a smoking polic. Licensed Staff C was queried about the facility's Safe Smoking Evaluation assessment and if it was completed on Resident 42 upon admission. Licensed Staff C stated he did not believe the form was completed, due to this facility being a non-smoking building. A Smoking policy and Safe Smoking Evaluation assessment was requested from medical records for Resident 42; only the Smoking policy was received. Review of Resident 42's medical record, revealed a face sheet with an admitted [DATE]. The face sheet also indicated a diagnosis of Nicotine Dependence. Review of Resident 42's Medication Administration Record for May, indicated Resident 42 had refused all nicotine patches offered to him. Resident 42's care plan, reviewed on 5/13/24, indicated Nicotine patches offered on 4/24/24 and patient has been refusing the patches. MD aware. Review of the Entrance Conference Worksheet indicated the facility had, no smokers in the building. In addition, the Team Coordinator indicated the DON informed her there were no smokers in the building. The Facility had no non-smoking waivers. During a review of the facility's policy and procedure titled, Smoking Policy-Resident, dated 10/2023, indicated, This facility has established and maintains safe resident smoking practices Prior to and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences .Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes, a) current level of tobacco consumption b) method of tobacco consumption c) desire to quit smoking d) ability to smoke safely with or without supervision (per completed Safe Smoking Evaluation) .The staff consults with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation .Any smoking-related privileges, restrictions, and concern (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues .Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Resident Rights, dated, 2/2021, indicated, Employees shall treat all residents with kindness, respect, and dignity Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident right to: a dignified existence, be treated with respect, kindness, and dignity, be free from abuse, neglect, self-determination, communication with and access to people and services, both inside and outside the facility, exercise his or her rights as a resident of the facility and as a resident or citizen of the United States, be supported by the facility in exercising his or her rights, exercise his or her rights without interference, coercion, discrimination or reprisal from the facility, be informed about his or her rights and responsibilities, be informed of and participate in, his or her care planning and treatment, participate in decision-making regarding his or her care, voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without, have the facility respond to his or her grievances, examine survey results, communicate with outside agencies (local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations), regarding any matter. During a review of the facility's policy and procedure titled, Governing Body revised 4/2024, indicated, It is the policy of this facility to have a Governing Body, or designated persons functioning as a Governing Body. The Governing Body is responsible for establishing and implementing policies regarding the management and operation of the facility. The Governing Body of the facility is currently comprised of the following individuals: Administrator, DON, Market Leader, Clinical Market Leader, and Medical Director. Procedure: 1) The Governing Body will provide support and direction to the facility as is appropriate and consistent with applicable Federal regulations. 2) The Governing Body will appoint the Administrator who is: 2.1 Licensed by the State 2.2 Responsible for management of the facility 2.3 Reports to and is accountable to the Governing Body. 3. The Governing Body is responsible for and accountable for the QAPI Program, in accordance with applicable Federal regulations. 4. The Governing Body will receive information from the Administrator relative to the operations of the facility on a regular basis and, in any event, no less than quarterly. 38322 3. During a concurrent interview and observation on 5/13/24 at 9:46 a.m., Resident 3 stated facility staff were cutting through her room to enter/exit the facility instead of using the main doors. Resident 3's room had sliding doors that led to the outside patio. Resident 3 stated she had concerns about her privacy when staff used her room to exit or enter the building, as this was a, matter of respect. Record review of Resident 3's MDS (Minimum Data Sheet-An assessment tool), dated 5/01/24, indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 15, which indicated her cognition was intact (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). During an interview on 5/13/24 at 10:37 a.m., Resident 63 stated staff entered and exited the building through her room using the sliding doors. Record review of Resident 63's BIMS score triggered in the LTCSP (Long Term Care Survey Process-Software to perform recertification surveys in nursing facilities, which obtains information directly from the facility's MDS) was 13, which indicated her cognition was intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24 at 10:43 a.m., Resident 51 stated staff had been observed entering and exiting the building through the sliding doors in her room, without asking for permission. Record review of Resident 51's MDS, dated [DATE], indicated her BIMS score was 15, which indicated her cognition was intact. During a confidential Resident Council interview on 5/14/24 at 2:43 p.m., five of the 12 residents in attendance stated staff were using their slider doors in their rooms that faced the back patio, to enter and exit the building, passing through their rooms as a short cut, rather than using the exit door at the end of the hall. Anonymous Resident 1 stated it made her feel like she had no privacy. Anonymous Resident 7 stated he did not like it. Anonymous Resident 4 stated his room did not face the back of the building, but his room was the only space he had so it would bother him if the staff did that. During an interview on 5/16/24 at 1:52 p.m., Licensed Staff F stated, if staff needed to get to the back patio from the hall, they were to use the exit door at the end of the hall. When queried, Licensed Staff F stated, out of respect for the residents' privacy, it was not appropriate to pass through residents' rooms to get to the patio. Review of the most recent Minimum Data Sets (MDS, an assessment tool) of the residents in attendance at the confidential interview, revealed three residents were cognitively intact (BIMS (Brief Interview for Mental Status) scores of 13 to 15) and seven had moderate cognitive impairment (BIMS scores between 8 and 12). A review of the facility's policy, titled, Resident Rights, last revised 2/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to: . privacy and confidentiality .

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 38322 Based on interview and record review, the facility did not ensure residents knew how to contact the Department to file a complaint. This failure had the potential to prevent residents from contacting the Department when they did not have the contact information and may not feel comfortable asking for it. Findings: During a confidential Resident Council interview on 5/14/24 at 2:30 p.m., 12 out of 12 residents in attendance, did not know where to find the contact information for the Department in order to file a complaint. Anonymous Resident 1 stated residents' rights were reviewed at the Resident Council meetings, but they had not discussed where to find the contact information for the Department. Review of Anonymous Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/28/24, indicated a BIMS score of 15 (Brief Interview for Mental Status, a score of 15 indicates cognitively intact). Further review of the most recent BIMS scores of the residents in attendance at the confidential interview revealed two more residents were cognitively intact (for a total of three, including Anonymous Resident 1), and seven had moderate cognitive impairment (BIMS scores between 8 and 12). During an interview on 5/15/24 at 11:08 a.m., the Activities Director confirmed she was the staff member coordinating the Resident Council meetings for the residents. The Activities Director stated they met for the meetings the last Tuesday of every month and went over old business. The Activities Director was asked if she had discussed with the residents where to find the State contact information to file complaints. The Activities Director stated she had not talked about this information with the residents during the Resident Council meetings. During an interview with the Medical Records Director on 5/15/24 at 3:50 p.m., he was asked to provide the policy on providing residents with the information to contact the State. This was also written on a piece of paper handed to him along with other requested documents. The following day, on 5/16/24 at 9:10 a.m., the Medical Records Director stated the facility did not have a policy on this. Review of facility policy, Resident Rights, last revised 2/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: . x. communicate with outside agencies (e.g. local, state, or federal officials, state and federal surveyors .) regarding any matter.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 38322 Based on interview and record review, the facility failed to ensure the survey binder was updated for three years, with the results of complaint and facility-reported incident investigations, and failed to ensure the residents were notified of its location. This failure resulted in the facility's residents not having access to the results of the most recent investigations completed by the Department. Findings: During a record review and concurrent interview on 5/14/24 at 2:02 p.m., review of the survey binder in the hallway outside the Administrator's office revealed there were no complaint or facility-reported incident investigation results or plans of correction added to the binder since 2021. When queried, the Director of Nursing verified there were no investigation results added to the binder since 2021. The DON stated the reason was the facility had not had any deficiencies from the Department since the survey in 2021. During a confidential Resident Council interview on 5/14/24 at 2:32 p.m., 12 out of 12 residents did not know where to find the binder with the Department's inspection results. Anonymous Resident 1 stated they reviewed residents rights at the Resident Council meetings, but the location of the survey binder had not been reviewed. Review of Anonymous Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/28/24, indicated a BIMS score of 15 (Brief Interview for Mental Status, a score of 15 indicates cognitively intact). Further review of the most recent BIMS scores of the residents in attendance at the confidential interview revealed two more residents were cognitively intact (for a total of three, including Anonymous Resident 1) and seven had moderate cognitive impairment (BIMS scores between 8 and 12). During a concurrent interview and record review on 5/15/24 at 9:44 a.m., the Administrator and Surveyor reviewed the binder that contained the facility's survey findings from previous years. The binder was right next to the lobby, in a visible area, but only had survey findings from 2018 to 2021. The binder had not been updated since 2021. This was confirmed by the Administrator. The Administrator stated this was his responsibility and confirmed he did not update it. The Administrator stated he would update it as soon as possible. The Administrator confirmed the facility had received deficiencies after 2021 (That were not available in the binder). During an interview on 5/15/24 at 11:08 a.m., the Activities Director confirmed she was the staff member coordinating the Resident Council meetings for the residents. The Activities Director stated they met for the meetings the last Tuesday of every month and went over old business. The Activities Director was asked if she had discussed with the residents where to find the binder with the survey results. The Activities Director stated she had not talked about this information with the residents during the Resident Council meetings. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Medical Records Director on 5/15/24 at 3:50 p.m., he was asked to provide the policy on providing residents with the information of where to find the survey binder. This was also written on a piece of paper handed to him, along with other requested documents. The following day, on 5/16/24 at 9:10 a.m., the Medical Records Director stated the facility did not have a policy on this. Review of facility policy, Resident Rights, last revised 2/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: . w. examine survey results.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility did not ensure four of twenty-four sampled residents (Resident 2, Resident 3, Resident 63 & Resident 51) experienced a comfortable noise level at the facility. This finding had the potential to result in inability for the residents to rest and sleep, necessary for the body's renewal and well-being. Findings: During a concurrent interview and observation on 5/13/24 at 9:46 a.m., Resident 3 stated the noise level was too high at all times of the day and night. Resident 3 stated she had heard staff talking loudly and laughing spontaneously as late as 10:30 p.m., disturbing residents. Record review of Resident 3's MDS (Minimum Data Sheet-An assessment tool), dated 5/01/24, indicated her BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 15, which indicated her cognition was intact (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). During an interview on 5/13/24 at 10:37 a.m., Resident 63 stated there was a lot of noise at night as staff were too busy talking on their cell phones or laughing. Record review of Resident 63's BIMS score triggered in the LTCSP (Long Term Care Survey Process-Software to perform recertification surveys in nursing facilities, which obtains information directly from the facility's MDS) was 13, which indicated her cognition was intact. During an interview on 5/13/24 at 10:43 a.m., Resident 51 stated experiencing a high noise level during the night. Resident 51 stated the noise was caused by both, staff, and other residents. Record review of Resident 51's MDS, dated [DATE], indicated her BIMS score was 15, which indicated her cognition was intact. During an interview on 5/14/24 at 8:45 a.m., Anonymous Resident 2 stated he had been at the facility for a little over week. He stated his room was noisy, and that last night was the first night in a long time that it had actually been quiet. During an interview on 5/14/24 at 8:48 a.m., Anonymous Resident 3 stated he had been at the facility for a week. He stated he had not slept well since his admission. He stated he was losing sleep because of the noise in the hallway at night. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review on 5/13/24 at 3:12 p.m., the past four months of Resident Council meeting minutes were reviewed. All minutes indicated at the top that the notes were taken by the Activities Director. Resident Council Meeting Minutes for April 2024, March 2024, February 2024, and January 2024, revealed complaints of loud staff and students in hallways. Resident Council Meeting Minutes, dated 4/30/24, revealed, New Business: . *IDT (Interdisciplinary Team) is loud when coming out of stand-up morning meeting. Noise level has been improving. NOC shift (typically 11 p.m. to 7 a.m.) still needs some improvements. On NOC one CNA (Certified Nursing Assistant) and a Nurse are very [NAME] [sic] when they are together. Resident Council Meeting Minutes, dated 3/26/24, revealed, New Business: NOC shift is loud and not answering call lights in a timely manner. Burst of loud noise, voices and laughter usually happens at 4-8 a.m. Resident Council Meeting Minutes, dated 2/27/24, revealed, Old business: . Noise at all times all departments (loud outburst). New students are loud. New business: . Noise level has improved somewhat but there seems to be a loud burst of laughter and conversation, and this can happen at any given time of day and night. Students continue to be [NAME] [sic] even after they have been told to lower their voices. Resident Council Meeting Minutes, dated 1/30/24, revealed, Old business . front staff come to visit back staff during NOC shift and will have conversations. New business: . Noise at all times all departments (loud outburst). New students are loud. During a confidential interview with the Resident Council on 5/14/24 at 2:30 p.m., several residents felt the staff were still too noisy even after repeatedly raising this concern in the Resident Council meetings for the last four months. Anonymous Resident 1 stated that at 10:30 p.m., there was too much chatter amongst the staff. Anonymous Resident 4 stated he preferred to keep his door closed because he did not want to hear what was going on at 2:30 a.m. Anonymous Resident 5 stated staff told her she was not permitted to keep her door closed even though she would like to. Anonymous Resident 6 stated last night was bad (the noise) because two men were having a conversation in the hall for 30 minutes, and Anonymous Resident 6 could not go to sleep. Anonymous Resident 6 stated the noise and lack of sleep did not make her feel good. Anonymous Resident 4 stated a person needed two things to sleep, a dark room and a quiet room. Anonymous Resident 4 stated the staff just needed training. During an interview on 5/16/24 at 11:58 a.m., the Activities Director stated she followed-up on issues brought up at Resident Council meetings by bringing the issue up with the IDT. The Activities Director stated they would go over the issues, and then they would develop a QAPI (a Quality Assurance Performance Improvement project) or they passed the issue on to the corresponding department. The Activities Director stated she followed-up with the Resident Council president on whether or not an issue was resolved by having informal conversations outside of the meetings. The Activities Director stated the Resident Council president would sometimes catch her in the hall and tell her, this has or hasn't worked. When asked about the noise level in the facility, the Activities Director stated she had put in the minutes the noise had been improving. The Activities Director stated all the issues that had been brought up at the Resident Council meetings had been continuing, they have continuous work. When asked how she documented an issue had been resolved, the Activities Director stated that in the minutes it was, not brought up anymore. Review of facility policy, Homelike Environment, last revised 2/2021, indicated, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: . comfortable sound levels.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38322 Based on interview and record review, the facility failed to ensure the Resident Council knew how to file a grievance. This failure could potentially result in residents' issues going unresolved. Findings: During a record review on 5/13/24 at 3:12 p.m., the past four months of Resident Council Meeting Minutes were reviewed. All minutes indicated at the top, that the notes were taken by the Activities Director. Resident Council Meeting Minutes, dated 3/26/24, revealed, New Business: . The council has asked for SS (Social Services) department to attend meeting with them and go over theft and loss, grievance an [sic] other SS related question they may have and to meet the news [sic] staff in SS. Section of minutes titled, Department concerns, revealed, Social Service: R.C. (Resident Council) has invited SS to attend next meeting to go over grievances and theft and loss. Resident Council Meeting Minutes, dated 4/30/24, revealed, New Business: *SS still to meet with the resident council. During a confidential interview on 5/14/24 at 2:43 p.m., 10 out of 12 residents in attendance did not know how to file a grievance. Anonymous Resident 1 stated the Social Services Director (SSD) had not been able to attend a Resident Council meeting to explain the grievance process to them because the SSD had to pick up her kids from school at the same time as the Resident Council meetings. During an interview on 5/16/24 at 11:58 a.m., the Activities Director verified the SSD had been invited to the Resident Council meeting but had not been able to attend last month. The Activities Director stated the SSD was planning on scheduling a special meeting with the Resident Council as soon as they could find a time that worked for everyone. Review of Anonymous Resident 1's Minimum Data Set (MDS, an assessment tool), dated 2/28/24, indicated a BIMS score of 15 (Brief Interview for Mental Status, a score of 15 indicates cognitively intact). Further review of the most recent BIMS scores of the residents in attendance at the confidential interview revealed two more residents were cognitively intact (for a total of three, including Anonymous Resident 1) and seven had moderate cognitive impairment (BIMS scores between 8 and 12). Review of facility policy, Grievances, last revised/reviewed 1/2022, revealed the grievance official was the SSD. The policy did not address how residents would be informed of their right to file a grievance or how residents would be informed of the grievance process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3751 Montgomery Dr Santa Rosa, CA 95405	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility failed to notify the Long-term Care Ombudsman's office of one of three residents sampled for a closed record review, Resident 209, when he was hospitalized . This failure could potentially prevent the Ombudsman from advocating for a vulnerable resident who may require advocacy services. Findings: Review of Resident 209's medical record revealed an admitted [DATE], with medical diagnoses including fracture (break) of shaft of humerus (bone of upper arm) left arm, fracture of shaft of humerus right arm, cognitive communication deficit, and muscle weakness, among others. Resident 209's Progress Notes indicated a note, dated 2/17/24 at 3:15 p.m., Swelling to [left] arm noted to be worse. Increased swelling down arm and increased warmth noted. [Patient] to be sent out. During a record review and concurrent interview on 5/16/24 at 3:37 p.m., the Medical Records Director provided Resident 209's document, Notice of Proposed Transfer / Discharge, dated 2/17/24. When queried, the Medical Records Director stated the form had been completed by Licensed Staff G. Review of the form revealed the form did not have Resident 209's name on it, and the section, Date Discharge Notice Mailed to Long Term Care Ombudsman, was left blank. The section, Transfer/Discharge to the following location, indicated, [local acute care hospital] ER (emergency room). In the section The transfer/discharge is necessary for your welfare and your needs cannot be met in the facility: (a) The specific needs that cannot be met are: was written, clinical change of condition. During a record review and concurrent interview on 5/16/24 at 3:38 p.m., Licensed Staff G verified Resident 209's Notice of Proposed Transfer/Discharge form had her signature at the bottom. When asked who was responsible to fill in the section for the date the notice was mailed to the Ombudsman, Licensed Staff G stated, I think it's Social Services. During a record review and concurrent interview on 5/16/24 at 3:40 p.m., the Social Services Assistant searched in binders and in her computer, and stated she could not find any documentation that the Ombudsman's office was notified of Resident 209's transfer to the hospital on 2/17/24. When queried, the Social Services Assistant stated the process was the nurse filled out the Notice of Transfer/Discharge form, gave it to them in social services, and they (Social Services) notified the Ombudsman of the transfer to the hospital, usually by fax. When asked what happened with Resident 209's notice, the Social Services Assistant stated, I don't know what happened. The Social Services Assistant verified the Notice of Transfer/Discharge did not have Resident 209's name on it. She stated the nurse wrote the date where the resident's name was supposed to be. During an interview on 5/17/24 at 1:17 p.m., when queried, the Social Services Director (SSD) stated that if the Social Services office got a Notice of Transfer/Discharge form with no name on it, she expected the Social Services staff to go to the nurse who filled it out and find out the name. The SSD verified she expected staff to inform the Ombudsman's office, by fax, of hospital transfers as soon as reasonably possible. When asked the reason for the Ombudsman notification, SSD stated, In case someone wants to contest their discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In response to a request for the facility policy and procedure for Ombudsman notifications of transfers, All Facilities Letter (AFL) 17-27 was provided. Review of AFL 17-27, dated 12/26/17, indicated, Effective January 2, 2018, AB 940 requires a LTC (Long-Term Care) facility to notify the local LTC Ombudsman at the same time notice is provided to the resident or the resident's representatives when a facility-initiated transfer or discharge occurs. The facility is required to provide a copy of the notice to the LTC Ombudsman as soon as practicable if a resident is subject to a facility-initiated transfer to a general acute care hospital on an emergency basis.

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NAME OF PROVIDER OR SUPPLIER: Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3751 Montgomery Dr Santa Rosa, CA 95405	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility did not ensure one (1) of twenty-four (24) sampled residents (Resident 78) and one (1) of four (4) discharged residents (Resident 209) had comprehensive care plans developed when: 1. Resident 78 did not have a comprehensive care plan for activities that reflected her admission activities assessment, and; 2. Resident 209 did not have a comprehensive care plan developed for a broken arm. These findings had the potential to result in boredom and frustration for Resident 78, for not participating in her activities of interest. For Resident 209, this finding had the potential to result in inability for staff to care for his broken arm properly, poor quality of care and harm. Findings: 1. Record review indicated Resident 78 was admitted to the facility on [DATE], with medical diagnoses including Amyotrophic Lateral Sclerosis (A nervous system disease that weakens muscles and impacts physical function) and Dysphagia (Difficulty swallowing), according to the facility Face Sheet (Facility demographic). During multiple observations since the beginning of the survey, on 5/13/24 at 8:30 a.m., to the end of the survey on 5/17/24 at 3:30 p.m., Resident 78 was not involved in any activities at all. Resident 78 spent every hour of every day staring at the wall, with a private caregiver who did not engage in communication with her. Resident 78's bedside table and dresser did not have reading/writing/painting or drawing supplies, or any other supplies for activity purposes. Record review of a facility document titled, Activity-Admission Evaluation, dated 2/23/24 at 3:15 p.m., indicated Resident 78's activity interests included drawing, painting, music, reading, writing, and gardening. This evaluation also indicated, [Resident 78] is alert and oriented to place and time. She used to be a speech therapist, has some difficulty speaking and uses a white board to communicate. She likes to read, keep up with the news and to watch classic movies. This evaluation was signed as completed by the Activities Director on 3/03/24. Record review of Resident 78's care plan for activities, initiated on 3/03/24, had the following interventions, All staff to converse with the resident while providing care .Communicates with communication board . Encourage ongoing family involvement .Ensure adaptive equipment is provided .Provide with daily activities schedule. This care plan did not indicate Resident 78 liked drawing, painting, music, reading, writing, and gardening, as she had indicated during her Admission-Activity Evaluation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Activities Director on 5/16/24 at 11:58 a.m., she was asked what was the purpose of the activity admission evaluation for residents. The Activities Director stated the purpose was to get to know the residents and find out what activities they liked to do. The Activities Director was asked if the initial care plan for activities was required to be developed based on this initial activity evaluation. The Activities Director confirmed the care plan was required to be based on the activity evaluation. The Activities Director was asked if supplies for independent activities were provided to the residents after the initial activity evaluation. The Activities Director stated these supplies were offered if available at the facility. During the interview, minutes later, with concurrent record review, on 5/16/24 at 12:02 p.m., the Activities Director reviewed Resident 78's, Activity-Admission Evaluation, dated 2/23/24 at 3:15 p.m., and stated, that although she (Activities Director) had signed this evaluation, she was not the person who interviewed Resident 78 about her preferred activities. The Activities Director was asked how she was able to complete this evaluation for Resident 78, without an interview. The Activities Director stated the staff member who interviewed Resident 78 regarding her activities of interest took notes, that the Activities Director used to complete this evaluation on the computer. The Activities Director reviewed Resident 78's care plan for activities, and was asked if drawing, painting, music, reading, writing, and gardening (present in Resident 78's initial activity evaluation) were written on Resident 78's activities care plan. The Activities Director confirmed these activities were not there. The Activities Director was asked if she had provided Resident 78 drawing/painting/reading and gardening supplies or materials. The Activity Director confirmed she had not provided Resident 78 with these supplies. Record review of the facility policy titled, Activity Assessment, last revised in March of 2021, indicated, It is the policy of this facility to provide ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities based on the comprehensive assessment and care plan and the preferences of each resident. 38322 2. During a record review on 5/15/24 at 12:53 p.m., Resident 209's face sheet indicated an admitted [DATE], with medical diagnoses including fracture (break) of shaft of humerus (bone of upper arm) left arm, fracture of shaft of humerus right arm, cognitive communication deficit, and muscle weakness, among others. Resident 209's physician history of present illness note from his Emergency Department visit on 2/14/24 (prior to his admission), indicated Resident 209 had a right fractured arm in a sling from a fall in January 2024. Review of Resident 209's care plan revealed he did not have a care plan for the fractured arm. During an interview on 5/17/24 at 11:01 a.m., Licensed Staff L stated she remembered Resident 209, and she remembered that he had a sling on his arm when she did his admission skin assessment. Licensed Staff L stated a patient with a broken arm should have a care plan for the fracture. During a record review and concurrent interview on 5/17/24 at 11:53 a.m., the Director of Nursing (DON) stated the purpose of the care plan was to know what was going on with the patient and to get the latest information on the patient. The DON verified Resident 209's right arm fracture should have been included on his care plan. The DON reviewed Resident 209's care plan, and stated the right arm fracture was not on the care plan because they had not even opened his care plan yet at the time he fell and broke his left arm, and, then we just focused on the left humerus fracture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled, Care Planning, last revised in November of 2019, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .The care plan is developed by the IDT.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were followed, when: 1. A Licensed Vocational Nurse (Licensed Staff A) left several medications in a resident's bedside table without a physician order, and; 2. Licensed Vocational Nurses were signing for the administration of intravenous medications they had not administered. These findings had the potential to result in inaccurate medical records, medication errors, and harm to the residents of the facility. Findings: 1. Record review indicated Resident 3 was admitted to the facility on [DATE], with medical diagnosis including Alcoholic Cirrhosis (A late stage of alcohol-related liver disease that causes the liver to become scarred, swollen, and stiff) according to the facility Face Sheet (Facility demographic). During an interview and observation on 5/13/24 at 9:46 a.m., Resident 3 was in her wheelchair, inside her room, with six cups of medications, with medications inside, sitting on top of her bedside table. Two of the six cups appeared to contain liquid medications. The rest of the medication cups contained pills and tablets. Resident 3 stated they were her morning medications, that she still had not taken. Resident 3 stated the nurse on duty had left them there for her to take later. During an interview on 5/13/24 at 10:13 a.m., Licensed Staff A, confirmed he was the assigned nurse for Resident 3, and stated he had left Resident 3's morning medications in her bedside table at around 9 a.m., that morning. Licensed Staff A stated Resident 3 liked to keep them there. Licensed Staff A also stated, She [Resident 3] gets flustered if not left. Licensed Staff A was asked if Resident 3 had a physician order for self-administration of medications. Licensed Staff A reviewed Resident 3's medical record on his computer, and stated she [Resident 3] had an order to self-administer supplements that were purchased by her. Record review of Resident 3's active medication administration orders for May 2024, indicated, OK FOR RESIDENT TO KEEP SELF PURCHASED SUPPLEMENT AT BEDSIDE. This order was initiated on 11/25/21. No other active orders were present in Resident 3's medical record that allowed her to self-administer her medications or keep them on her bedside table after being prepared by the assigned nurse. Record review of Resident 3's medication administration record indicated Resident 3 had several medication supplements scheduled at 8 a.m., 9 a.m., and 10 a.m. on 5/13/24, including Ascorbic Acid (Vitamin C) and Calcium. One of the medications, scheduled at 8 a.m. on 5/13/24, was, Potassium CL (Chloride) 10 meq (Milliequivalents) = 7.5 ml (Milliliters) Liquid Give 10 mEq by mouth one time a day for low potassium. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an article written by Mayo Clinic (A nonprofit American academic medical center focused on integrated health care, education, and research) titled, Potassium Supplement, last updated on 5/1/24, indicated laboratory tests might be necessary while taking potassium to ensure the potassium blood levels were adequate. In addition, this article indicated this medication could cause slow or irregular heartbeat, shortness of breath or difficulty breathing. During a second observation on 5/13/24 at 12:30 p.m., Resident 3 was having lunch in her room, and the six cups of medication were still sitting on her bedside table untouched, filled with medications. Resident 3 was asked the reason she had not taken her morning medications, and she responded, I have not gotten to them yet. During an interview on 5/15/24 at 10:29 a.m., Licensed Staff A confirmed one of the six medication cups sitting on Resident 3's bedside table the morning of 5/13/24, was potassium 7.5 ml. According to Licensed Staff A, all other medications were supplements. Licensed Staff A stated the potassium liquid was delivered by the facility pharmacy and was not self-purchased by Resident 3. Licensed Staff A stated he left these medications on Resident 3's bedside table at around 9 a.m. on 5/13/24, and signed them as administered right away on Resident 3's Medication Administration Record. Licensed Staff A stated he did not go back to Resident 3's room to ensure Resident 3 had taken the medications. When asked if he was allowed to leave the potassium on Resident 3's bedside table to take later, Licensed Staff A stated, I have to, she does not want to be bothered. Licensed Staff A stated he had worked at the facility for about three years and received training on medication administration upon hire, but nothing had been mentioned about leaving residents' medications on their bedside tables for self-administration. During an interview on 5/17/24 at 2:44 p.m., the facility's Medical Director confirmed potassium chloride did not fall into the category of self-purchased supplements that were allowed to be left on Resident 3's bedside, according to the physician order that indicated, OK FOR RESIDENT TO KEEP SELF PURCHASED SUPPLEMENT AT BEDSIDE. The Medical Director stated the potassium was not a supplement, but a physician-prescribed medication. Record review of the facility's undated job description for, Licensed Vocational Nurse, indicated, The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the residents' attending physicians or the Medical Director of the facility, with an emphasis on assessment, illness prevention and health care management .Specific Requirements .Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care. 38322 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a record review on 5/16/24 at 9:23 a.m., Resident 2's Physician Orders included orders, dated 4/25/24, for ceftazidime (an antibiotic) 1 gram (a unit of measure) intravenously (IV, administered directly into a vein) every 8 hours for 5 days, 10 mL (milliliter, a unit of measure) flush before and after IV medication administration (saline injected to ensure the IV is working before giving the medication and to clear the medication out of the IV when it is done), and 10 mL flush every shift through the IV (to keep the IV open). Resident 2's Medication Administration Record (MAR) indicated the saline flushes were signed by the LVN on duty. The MAR indicated the ceftazidime on 4/27/24 at 1:18 p.m., was signed off by an LVN with a note, IV [NAME] [sic] BY DUTY RN, [RN named]. On 4/27/24 at 11:35 p.m., an LVN signed off on the MAR for the saline flushes with a note they were done by the RN on duty. On 4/28/24 at 2:52 a.m., an LVN charted signed off the ceftazidime on the MAR with a note, IV hung by RN on duty [RN named]. On 4/29/24 at 2:28 p.m., an LVN signed off on the MAR for the ceftazidime with a note, duty RN [NAME] [sic] IV. Continuing the record review on 5/16/24 at 9:23 a.m., review of Resident 210's Physician Orders revealed orders, dated 4/30/24, for ceftriaxone (an antibiotic) 2 grams once daily IV until 6/3/24, and an order for 10 mL NS (normal saline) flush before and after each use for the IV. Review of Resident 210's MAR revealed one dose of ceftriaxone (on 5/14/24) and 12 saline flushes were signed off by LVNs with notes they were given by an RN. During a record review and concurrent interview on 5/16/24 at 11:30 a.m., Licensed Staff N reviewed Resident 210's MAR and the notes for the saline flushes signed off by the LVN's. Licensed Staff N stated the nurse who administered the medication should sign the MAR. Licensed Staff N stated LVN's did not give anything through IV's. The Director of Nursing (DON) reviewed Resident 210's MAR and MAR notes and verified the LVN is signing off the flushes for the RN's. The DON stated the RN who gave the flush should be signing the MAR, and she would educate the RN's to sign the flushes so the LVN's did not have to. When queried, the DON stated it was not in their scope of practice for LVN's to give IV medications. Review of facility policy and procedure, Administering Medications, revised 4/2019, indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to ensure that three of six sampled residents (Resident 78, Resident 33 and Resident 4), who did not participate in social activities, were provided with activities of interest, and supplies to engage in these activities (For resident 78). This failure had the potential to result in boredom, depression and frustration to the residents involved. Findings: Resident 78 Record review indicated Resident 78 was admitted to the facility on [DATE], with medical diagnoses including Amyotrophic Lateral Sclerosis (A nervous system disease that weakens muscles and impacts physical function) and Dysphagia (Difficulty swallowing), according to the facility Face Sheet (Facility demographic). During multiple observations since the beginning of the survey, on 5/13/24 at 8:30 a.m., to the end of the survey on 5/17/24 at 3:30 p.m., Resident 78 was not involved in any activities at all. Resident 78 was spending every hour of every day staring at the wall, with a private caregiver who did not engage in communication with her. Resident 78's bedside table or dresser did not have reading/writing/painting or drawing supplies, or any other supplies for activity purposes. Record review of a facility document titled, Activity-Admission Evaluation, dated 2/23/24 at 3:15 p.m., indicated Resident 78's activity interests included drawing, painting, music, reading, writing, and gardening. Record review of Resident 78's care plan for activities, initiated on 3/03/24, did not indicate Resident 78 liked drawing, painting, music, reading, writing and gardening, as indicated in her Activity Admission Evaluation, dated 2/23/24 at 3:15 p.m. (above). During a concurrent interview and record review with the Activities Director on 5/16/24 at 11:58 a.m., she confirmed drawing, painting, music, reading, writing, and gardening were not on Resident 78's care plan for activities. The Activities Director was asked if she had provided Resident 78 drawing/painting/reading and gardening supplies or materials. The Activity Director confirmed she had not provided Resident 78 with these supplies. Resident 33 Record review indicated Resident 33 was admitted to the facility on [DATE], with medical diagnoses including Heart Failure (Inability for the heart to pump enough blood to meet the body's needs), according to the facility Face Sheet. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple observations since the beginning of the survey, on 5/13/24 at 8:30 a.m., to the end of the survey on 5/17/24 at 3:30 p.m., Resident 33 was not involved in any activities at all. Resident 33 was in her room and the hallways of the facility sitting in her wheelchair with her eyes closed, or in bed sleeping. During an interview with Resident 33 on 5/15/24 at 1:02 p.m., she stated she liked reading and sports. A book was observed on her bed. Record review of Resident 33's quarterly activity evaluation, dated 2/19/24 at 9:34 a.m., indicated, Describe Resident's participation/responses in activities . [Resident 33] prefers to stay in her room and observe her surroundings. She occasionally enjoys attending musical activities, trivia, word games, etc. There was no mention in this assessment that Resident 33 liked sports and reading. This document was completed by Activities Assistant K. Record review of Resident 33's quarterly activity evaluation, dated 11/21/23 at 9:53 a.m., indicated, Describe Resident's participation/responses in activities . [Resident 33] enjoys observing her surroundings in her room as well as in the hallways. She occasionally enjoys attending some daily activities such as movie time, outside social, serenity room, etc. Another question included in this same document, inquired for the following, Describe Resident's favorite activities, special accomplishments, and/or new interests . (response was the same as the answer above) [Resident 33] enjoys observing her surroundings in her room as well as in the hallways. She occasionally enjoys attending some daily activities such as movie time, outside social, serenity room, etc. This document was completed by Activities Assistant K. Record review of Resident 33's care plan for activities, initiated on 7/16/21, and last revised on 2/26/24, did not indicate Resident 33 liked sports or reading. It did say she loved to talk about baseball, but nothing else regarding sports was mentioned. During a concurrent interview and record review with Activities Assistant K on 5/15/24 at 2:40 p.m., she was presented with the quarterly activity evaluations she had documented for Resident 33 and was asked if she was copying and pasting Resident 33's activities evaluation responses from previous quarters. The Activities assistant confirmed she copied and pasted the activities evaluation responses from previous quarters for Resident 33. Activities Assistant K was asked if she interviewed Resident 33 about her preferred activities during the last activities evaluation, dated 2/19/24 at 9:34 a.m. The Activities Assistant confirmed she did not interview Resident 33 about her preferred activities and based the responses on the evaluation on her observations only. Activities Assistant K also stated she did not create or revise care plans for activities for any residents. Resident 4 Record review indicated Resident 4 was admitted to the facility on [DATE], with medical diagnoses including Pneumonitis (Inflammation of lung tissue), according to the facility Face Sheet. During multiple observations since the beginning of the survey, on 5/13/24 at 8:30 a.m., to the end of the survey on 5/17/24 at 3:30 p.m., Resident 4 was not involved in any activities other than watching TV. Resident 4 was always in her bed, either watching TV or staring at the walls or windows in her room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3751 Montgomery Dr Santa Rosa, CA 95405	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/24 at 11:27 a.m., Resident 4 stated she liked to paint, draw, read books and socialize with staff. Record review of Resident 4's quarterly activity evaluation, dated 6/27/23 at 3:35 p.m., indicated, [Resident 4] prefers to stay in her room and watch television. She enjoys visits from her family and friends, and going outdoors to get fresh air when the weather is nice out. [Resident 4] enjoys wheeling herself around in her electric wheelchair. There was no mention in this evaluation that Resident 4 liked to paint, draw, read books and socialize with staff. This document was signed as completed by Activities Assistant K. Record review of Resident 4's quarterly activity evaluation, dated 2/28/24 at 1:26 p.m., indicated, [Resident 4] prefers to stay in her room and watch television. She enjoys visits from her family and friends, and going outdoors to get fresh air when the weather is nice out. [Resident 4] enjoys wheeling herself around in her electric wheelchair. (Same exact wording as used in the quarterly activity evaluation, dated 6/27/23 at 3:35 p.m., above). There was no mention in this evaluation that Resident 4 liked to paint, draw, read books and socialize with staff. This document was signed as completed by Activities Assistant K. Record review of Resident 4's care plan for activities, created on 1/03/23, and last revised on 3/21/24, did not indicate Resident 4 liked to paint, draw, read books and socialize with staff. During a concurrent interview and record review with Activities Assistant K on 5/17/24 at 9:36 a.m., Activities Assistant K confirmed she copied and pasted part of her quarterly activity evaluations for Resident 4, from previous evaluations. Activities Assistant K also confirmed she did not interview Resident 4 about her preferred activities but based her quarterly activity evaluations on observations only. Activities Assistant K was asked if she was required to interview the residents during the quarterly activity evaluations. Activities Assistant K confirmed she was required to interview them. Record review of the facility policy titled, Activity Assessment, last revised in March of 2021, indicated, It is the policy of this facility to provide ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities based on the comprehensive assessment and care plan and the preferences of each resident. Record review of the facility policy titled, Activities Program, last revised in March of 2019, indicated, It is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies, and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence .Activities are planned according to the resident's preferences, needs and abilities. Every resident will be interviewed for preferences.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility failed to accurately assess the fall risk of one of three residents sampled for closed record review (Resident 209). This failure could have potentially contributed to Resident 209 falling when his risk level was inaccurate. Finding: During a record review on 5/15/24 at 12:53 p.m., Resident 209's face sheet indicated an admitted [DATE], with medical diagnoses including fracture (break) of shaft of humerus (bone of upper arm) left arm, fracture of shaft of humerus right arm, cognitive communication deficit, and muscle weakness, among others. Resident 209's physician history of present illness note, from his Emergency Department visit on 2/14/24 (prior to his admission), indicated Resident 209 had a right fractured arm in a sling from a fall in January 2024. Review of Resident 209's care plan revealed he did not have a care plan for the fractured arm. Resident 209's admission assessment, dated 2/14/24, did not include the sling or mention the arm fracture. Resident 209's falls risk assessment, dated 2/14/24, indicated he was at medium risk of falls, and the risk assessment did not include Resident 209's diagnosis of a fracture. Review of Resident 209's Fall Committee Progress Note, dated 2/15/24 indicated, . patient was found on the floor atapprox [sic] 1230am by the CNA (Certified Nursing Assistant). patient was unable to move his left shoulder and [complained of] pain, nurse called 911 to send patient out. Patient returned from ED at Approx 9am, report was given that patient was noted to have a Left Humerus [Fracture] . During a record review and concurrent interview on 5/17/24 at 11:01 a.m., Licensed Staff L stated she remembered Resident 209, and she remembered that he had a sling on his arm when she did his admission skin assessment. Licensed Staff L stated the sling should have been documented under the skin assessment portion of his admission assessment. Licensed Staff L reviewed Resident 209's admission assessment, dated 2/14/24, and verified she did not document his sling or his fractured arm. Licensed Staff L reviewed Resident 209's fall risk assessment, dated 2/14/24, and verified the nurse who completed it should have clicked the box including a fracture diagnosis as a risk factor. During a record review and concurrent interview on 5/17/24 at 11:53 a.m., the Director of Nursing (DON) reviewed Resident 209's admission assessment and verified Resident 209's right arm sling should have been included on his admission assessment. The DON reviewed Resident 209's fall risk assessment, dated 2/14/24, and verified the right arm fracture was not included as a risk factor and should have been. When queried, the DON stated, if a fall risk assessment was not accurate, they might not put the right precautions in place for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Fall Risk Assessment, not dated, indicated, Policy: It is the policy of this facility to identify the resident who is at risk for potential falls, and to initiate a preventative plan of care to reduce fall occurrence. The fall risk [assessment] will be completed on admission and quarterly thereafter. Purpose: To ensure that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview and record review, the facility failed to follow its Nursing Staff Competency Policy, Facility Assessment Policy and Resident rights Policy, for one sampled Resident (Resident 306), as evidenced by: 1. Licensed Staff B did not have updated annual competencies for Change of Condition assessment and documentation. 2. The DSD did not have the qualifications to perform her job and did not have a system to track staff participation for required staff training's. This failure had the potential to result in Resident 306 not receiving emergency care in a timely manner and for Residents in the facility being potentially at risk due to incompetent staff. Findings: 1. During a review of Resident 306's medical record, History and Physical, from the transferring hospital, dated, [DATE], authored by MD 1, indicated, Resident 306 was [AGE] years-old with medical comorbidities including; Subacute Frontal Lobe Stroke (hypertension (high blood pressure in the blood vessels), atrial (upper chamber of heart) fibrillation (irregular heart beat), pulmonary hypertension (high blood pressure in the lungs), pericardial effusion (buildup of extra fluid in the space around the heart), Parkinson's Disease (brain disorder that causes uncontrollable movements causing difficulty with balance and coordination), Chronic Kidney Disease (decreased ability of the kidneys to filter wastes and excess fluids from the blood, which are then removed in your urine). Frontal lobe syndrome is a broad term used to describe the damage of higher functioning processes of the brain such as motivation, planning, social behavior, and language/speech production), Rhabdomyolysis (damaged skeletal muscle breaks down quickly and leaks into the blood), Acute metabolic encephalopathy (Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most) and Acute hypoxic respiratory failure (decreased oxygen in the tissues in the body that causes one to stop breathing) which required intubation (tube down the throat then into the lungs connected to a breathing machine). Labs on the History Physical form indicated [NAME] Blood Count 11.8 (normal range 3.8 -10.8). During a record review of Resident 306's medical record, the facility face sheet revealed an admitted [DATE], diagnoses were, but not limited to; Stroke Frontal Lobe, Acute Respiratory Failure with Hypoxia, Sepsis (whole body infection), Elevated [NAME] Blood Cell Count, Encephalopathy, Myocardial Infarction (Heart stopped beating), Atrial Fibrillation, Congestive Heart Failure (the heart fails to pump adequately), Atelectasis (collapsed lung due to losing air). During a record review of Resident 306's medical record, Physician Orders for Life-Sustaining Treatment (POLST), dated, [DATE], indicated, Attempt CPR (Cardiopulmonary Resuscitation) (heart and oxygen resuscitation). The form was noted to have both Resident 306 and MD1 signatures. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 306's medical record, Initial Admission Record, dated [DATE], authored by Licensed Staff M, indicated she was admitted from acute care, and her Advanced Directive was full code status (heart and oxygen resuscitation), her admitting oxygen was 94% as read by pulse Oximetery (device that is placed on a finger that registers the amount of oxygen in the blood), the Facility Admission form also indicated, Urinary indwelling Catheter (tube in bladder) was in place due to urinary retention (some urine remains in the bladder even after urinating). During a review of Resident 306's medical record, Order Summary Report, dated [DATE], indicated, Oxygen: Start Oxygen at 2 liters per minute for shortness of breath, chest pain, 02 saturation less than 90% and notify MD every shift, Enhanced Barrier Precautions: Wear gloves and gown for High-Contact Resident Care activities every shift. During a review of Resident 306's medical record, Progress Note, dated, [DATE], authored by Licensed Staff P, indicated, Patient is alert and oriented times 3 within baseline, no new respiratory issue noted patient is currently on 2 L nasal cannula and tolerating it well. Vital signs are stable. Patient is on bladder scan per MD orders. During a review of Resident 306's care plan, initiated on [DATE], authored by, Licensed Staff O, indicated, Has Oxygen Therapy related to Congestive Heart Failure, respiratory failure, atelectasis. Goal: Will have no signs and symptoms of poor oxygen absorption through the review date, Interventions: Change residents position every 2 hours to facilitate lung secretion movement and drainage. Monitor for signs and symptoms of respiratory distress and report to MD as needed: Respirations, Pulse Oximetery, increase heart rate, restlessness, confusion, atelectasis, accessory muscle usage to breath. Provide reassurance and allay anxiety: Stay with the resident during episodes of respiratory distress. Use Enhanced Barrier Precautions. During an interview with the Infection Preventionist (IP) on [DATE] at 12 p.m., the IP was queried what she considered high contact, as it pertained to Enhanced Precautions Isolation. The IP stated she would expect staff who were touching a resident with wounds, to be wearing a gown and gloves. During a review of Resident 306's medical record, Occupational Therapy Treatment Encounter Note, dated [DATE], authored by Licensed Staff D, indicated, Patient initially stated she could not do anything as she felt she was dying, and her anxiety medication was not ordered. RN stated the meds were waiting for MD signature. During a review of Resident 306's medical record, Occupational Therapy Treatment Encounter Note, dated [DATE], authored by Licensed Staff D, indicated, Patient found in supine. Patient appeared to have an increased level of confusion today. 02 found set at 2 L and 02 saturation was 83%. Heart rate fluctuated 123 to 53 beats per minute. Consulted with Licensed staff B then elevated 02 to 4 liters. During an interview with Licensed Staff B on [DATE] at 12:35 p.m., Licensed Staff B was queried if she called the doctor to report a Change in Condition for Resident 306 on [DATE], when Resident 306's heart rate was racing from 52 beats per minute to 123 beats per minute and her 02 saturation was 83%. Licensed Staff B stated she did not. Licensed Staff B was queried if she had spoken with the MD to get an order to increase Resident 306's O2 to 4 L on [DATE]. Licensed Staff B stated she did not. Licensed Staff B was queried for Resident 306's most current 02 order. Licensed Staff B looked in the computer where she pointed to the electronic order, dated [DATE] for 02 2 L. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Staff D on [DATE] at 12:30 p.m., Licensed Staff D was queried if Licensed Staff B was the nurse for Resident 306 on [DATE], during the time Licensed Staff D was administering Occupational Therapy to Resident 306. Licensed Staff D stated, yes, she consulted with Licensed Staff B regarding the unstable heart rate and low 02 saturation of 83%. Licensed Staff D stated it was Licensed Staff B who told her to increase the 02 to 4 L. During a review of the Laboratory results in Resident 306's medical record, dated [DATE], indicated her [NAME] Blood Cell Count was high at 14.5 (normal results 3.8 - 10.8), Neutrophil (type of white blood cell) count was high at 13427 (normal results are 1500 - 7800) and Platelet Count (red blood cell that assists in clotting the blood) was high at 849 (normal results ,d+[DATE]). During a review of Laboratory results in Resident 306's medical record, dated [DATE], indicated her [NAME] Blood Cell Count is high at 18.9 (normal results are 3XXX,d+[DATE].8), Neutrophil count was high at 17483, (normal results are 1500 -7800), Platelets were high at 1118 (normal results ,d+[DATE]). During a review of Laboratory results in Resident 306's medical record, dated [DATE], Urinalysis (test for the urine) indicated, Leukocyte Esterase was 3+, (normal result is 0), [NAME] Blood Cells - Packed, (normal less than 5), Red Blood Cells ,d+[DATE], (normal result less than 2), Bacteria - Many, (normal result is 0), Amorphous Sediment - Moderate, (normal result is 0) Result - Greater than 100,000 DFU/ml of Gram-negative bacilli isolated. Normal result is 0. During an observation of Resident 306 on [DATE] at 11:40 a.m., Resident 306 appeared to be using accessory muscles to breath. Resident 306 was bent over, leaning into the left side rail of the bed. An 02 nasal cannula was in Resident 306's nose infusing 3.5 liters of oxygen. Resident 306 stated, I cannot breath can you help me? Resident 306 appeared very anxious, confused and was cyanotic (blue tint). During an observation and interview on [DATE] at 11:41 a.m., with Licensed Staff B, the Surveyor let Licensed Staff B know that Resident 306 was on 02 at 3.5 Liters, and she was using her accessory muscles to breath, was cyanotic and complained of shortness of breath. Licensed Staff B and the Surveyor went into Resident 306's room, where Licensed Staff B checked Resident 306's pulse Oximetery and pulse rate. Resident 306's pulse rate was 49, and her pulse 02 saturation was 83%, her left middle finger. Licensed Staff B moved the pulse Oximetery to her right hand and placed it on her right middle finger, where it read a pulse rate of 49 and an 02 saturation of 84%. Resident 306 was anxious and confused, asking what was going on. Licensed Staff B was not reassuring Resident 306 or explain what was happening. The Surveyor asked Licensed Staff B why there was an isolation cart in the hallway outside of Resident 306's room. Licensed staff B stated, I do not know why. Licensed Staff B did not use hand sanitizer prior to entering room, nor did she have gloves or a gown on while touching Resident 306. Resident 306 had two booties on her feet, which were elevated, due to skin wounds. Licensed Staff B was queried what her next step was, knowing Resident 306 had a pulse rate of 49 and oxygen saturation of 83%. Licensed Staff B did not respond. Licensed Staff B did not listen to Resident 306's lungs or heart rate. Licensed Staff B was queried whether Resident 306 was a Full Code. Licensed Staff B stated, I do not know. When the DON became aware of Resident 306's status, she stated she would call the MD 1 immediately for stat labs and a Chest X-ray. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 306's medical record at [DATE] at 11:55 a.m., and 02 order, dated [DATE], read: Continuous 02 2 liters for shortness of breath, chest pain, for 02 saturation less than 90 %. No other 02 parameters or 02 titration orders were written by the MD for Resident 306, before [DATE] at 11:55 a.m. During a record review of Resident 306's chart, an MD order, dated [DATE], indicated, Enhanced Barrier Precautions: Wear gloves and gown for High -Contact Resident Care Activities every shift. During a record review of Resident 306's chart, an MD order, dated [DATE], indicated, Bactrim DS oral Tab , d+[DATE] mg. Give 1 Tablet by mouth every 12 hours for UTI for 5 days. A copy of Licensed Staff B's Human Resources File was requested from medical records, along with her Nursing Competencies, but no Nursing Competencies were received for Licensed Staff B. During a record review of Resident 306's chart, there was no documentation from Licensed Staff B for the [DATE] 11:45 a.m., Change of Condition, Vital Signs, pulse Oximetery or Licensed Staff B's assessment on the hypoxic, bradycardic (low heart rate below 60) incident which took place with Resident 306. On [DATE] at 4:31 p.m., during an interview with the Administrator in the conference room, with the Survey Team present, the Administrator was queried as to how he knew his nurses had completed their competencies. The Administrator stated, We have a process within the facility, and I know it is not effective and is confusing, but it works for us. The Administrator was queried if there was tracking and surveillance of the staff whose competencies were not up to date. The Administrator stated he would have to check with the DSD. The Administrator was asked what were the facilities mandatory competencies. The Administrator could not list them nor could he list who had completed them. The Administrator stated, I know this system is not effective but it's a system . During an interview with the Administrator on [DATE] at 9:15 a.m., the Administrator produced Licensed Staff B's Nursing Skills Fair Competency for 2021, 2022, and 2023. The Nursing Skills Fair Competencies for 2021 and 2023, were not signed by either Licensed Staff B or the DSD. The check lists did not have any notation of the educational source or material used for the Nursing Skills Fair check-off list. The Administrator stated he brought a list of annual competencies that needed to be completed by staff. After checking competencies for Licensed Staff B, it was noted Licensed Staff B did not have updated annual competencies for Change of Condition or Guidelines for Oxygen Safety. Since 2021 and 2023, the Nursing Skills Fair Competencies were not signed by either Licensed Staff B or the DSD (Director of Staff Development), and there was no official record that License Staff B had completed the Code Blue Nursing Skills Fair Competencies or any other Competencies for Skills Fair for 2021 and 2023. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the job description for Licensed Staff B, dated, [DATE], indicated, The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the residents' attending physician or the Medical Director of the facility, with an emphasis on assessment, illness prevention and health care management. You will also assist in modifying the treatment regimen to meet the physical and psychosocial needs of the resident, in accordance with established medical practices and the requirements of this state and the policies and goals of this facility. Confer with the Medical Director and the attending physician regarding specific residents assigned to you. Consult with the physician concerning resident evaluation and assist the Director of Nursing Services in planning and developing the nursing services to be performed for the resident. Examine the resident and his/her records and charts to distinguish between normal and abnormal findings to recognize early stages of serious physical, emotional or mental problems. Determine when to refer the resident to a physician for evaluation, supervision, or directions. Implement and maintain established policies, procedures, objective, quality assurance, safety and environmental and infection control. Interpret these to the physician, resident, family, members, and public as appropriate. Participate in facility surveys (inspections) made by authorized government agencies. Supervises and assists in management of the infection control program including ensuring that personal protective equipment is used tin the handling of infectious materials by nursing personnel. Assists in the development of preliminary and comprehensive assessment of the nursing needs of each resident are performed in furthering of the resident care planning policy. Chart nurse's notes in professional and appropriate manner that timely, accurately, and thoroughly reflects the care provided to the resident, as well as the resident's response to the care. Chart all reports of accident's/incidents involving residents. Chart all changes in resident condition and the response to those changes. Chart all communications with the resident's attending physician regarding the resident, the resident's treatment, or the response to that treatment. Must possess the ability to make independent decision when circumstances warrant such action. Must possess the ability to deal tactfully with personnel, residents, family members, visitors, government agencies/personnel and public. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations and guidelines that pertain to long-term care. Must possess leadership and supervisory ability and the willingness to work harmoniously with and supervise other personnel. Must have patient, tact, and a cheerful disposition and enthusiasm, as well as the willingness to handle difficult residents. Interacts with residents, personnel, visitors, government agencies/personnel under all conditions and circumstances. Must be able to relate to and work with ill disabled, elderly, emotionally upset, and, at times, hostile people within the facility. During a review of the facility policy titled, Change in a Resident's Condition or Status, dated, 2021, indicated, Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical / mental condition and/ or status. The nurse will notify the resident's attending physician on call when there has been an accident or incident involving the resident, significant change in the resident's physical/emotional/mental condition, need to alter the resident's medical treatment significantly, significant change of condition is a major decline or improvement in the resident's status that will normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and requires interdisciplinary review and /or revision to the care plan. Prior to notifying the physician the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the interact SBAR Communication Form. Regardless of the resident's current mental or physical condition, a nurse or healthcare provide will inform the resident of any changes in his/her medical care or nursing treatments. (continued on next page)

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of the facility policy titled, IPCP Standard and Transmission-Based Precautions, revised , d+[DATE], indicated, Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions and excertions, except sweat, may contain transmissible infectious agents. Use and type of PPE is based on the predicted staff interaction with residents and the potential for exposure to blood, bloody fluids, or pathogens. (Gloves are to be worn when contact with blood, body fluids, mucous membranes, non-intact kin, or potentially contaminated surfaces or equipment are anticipated as well as correct hand hygiene). Enhanced Barrier Protection: used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident to resident.

During a review of the facility policy titled, Nursing Staff Competency, dated ,d+[DATE], indicated, It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physic, mental, and psychosocial well being of each resident, as determined by resident assessment and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required. Competency - measurable pattern of knowledge skills abilities, behavior, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Competency in skills and techniques necessary to care for resident's needs include but not limited to: Resident rights, person centered care, basic nursing skills, infection control, identification of changes in condition, compliance, and ethics. Demonstration of competency may be accomplished in a variety of methods. Which may include but is not limited to: Lecture with return demonstration for physical activities or skills, pre and post test for documenting and knowledge. Demonstrate ability to use tools, devices, or equipment that were the subject of training and used to care for resident, reviewing adverse events and remediation that occurred and an indication of gaps in competency or demonstration to perform activities that in scope of practice that an individual is licensed or certified to perform. The staff's ability to use and integrate by knowledge and skills will be assessed and evaluated by staff already determined to be competent in these skills. Director of Staff Development, Nurse Manager or designee must validate all skills listed on the form for competent performance. Each nursing staff member shall compete an annual competency assessment and additional competency assessments as needed based on the resident population needs in accordance with the facility assessment. The facility will conduct annual or bi-annual skills fair or equivalent to facilitate completion of skills and competency evaluation. Validation of all skills is required, as per the Orientation and Skills Check list forms. Successfully completed Orientation and Skills Check are required prior to the employee's annual evaluation. Record of each staff development program shall be maintained.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 3751 Montgomery Dr Santa Rosa, CA 95405	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy titled, Oxygen Administration, dated, ,d+[DATE], indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order, and review residents care plan. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: Signs and symptoms of cyanosis, hypoxia, Vital signs, lung sounds, oxygen saturation and other applicable labs. Documentation: note the date, time, name, title of the staff member, rate, oxygen flow, route, and rationale, the frequency and duration of the treatment, the reason for PRN administration, all assessment data obtained before, during and after the procedure, how the resident tolerated the procedure. Reporting: Report other information in accordance with facility policy and professional standard of practice. During a review of the facility's policy titled, Facility Assessment Tool, dated ,d+[DATE], indicated, 3.2 Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the resident at any given time. 3.3 Staff training/education and competencies - Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education training, competency instruction and testing policies. 39621 2. During an initial interview with the Director of Staff Development (DSD) on [DATE] at 3:12 p.m., she presented a binder, with the in-person training's provided to staff, within the last four months at the facility. These training's included bowel & bladder, urinary tract infections, abuse, pressure injuries, and infection control, among others. The DSD provided the staff sign-in sheets for these training's. The DSD was asked if these trainings were mandatory, to which she responded they were. Some of the sign-in sheets for specific trainings, presented to the Surveyor, included less than twenty staff signatures, while others had more than forty signatures, and Certified Nursing Assistants (CNAs) signed for the majority of these trainings. The DSD was asked how she tracked staff participation in the required trainings, to which she responded, Staff are expected to attend the trainings. The DSD was asked again, how she tracked staff participation, and again, she responded staff were expected to attend the trainings, and follow-up if they missed a training. The DSD was asked to provide evidence the following day (on [DATE]), that five sampled Licensed Nurses, chosen by the Surveyor, had been provided with the following trainings: Bowel & bladder, urinary tract infections, abuse, pressure injuries, and infection control, since these were trainings offered in-person, as DSD stated all her in-person trainings were mandatory. During a second interview with the DSD on [DATE] at 1:30 p.m., the DSD presented evidence of all the mandatory trainings (requested on [DATE] at 3:12 p.m.) provided to four of the five sampled Licensed Nurses, but the evidence presented included trainings the staff had taken using an online training platform, with no participation in the in-person trainings the DSD offered. At this time, the DSD clarified her statement, about staff being required to take her in-person trainings, and stated that if staff missed her in-person trainings, they could take them through this online training platform. For the fifth sampled Licensed Nurse (Licensed Staff H), the DSD was unable to provide evidence of the following trainings: 1. Bowel & bladder (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Pressure injuries 3. Urinary tract infections No evidence was provided by the DSD, indicating Licensed Staff H had taken these trainings through in-person participation or using the training platform. The DSD stated that a training taken by Licensed Staff H, titled, Change in Condition, on the online training platform, included the training on bowel & bladder, pressure injuries & urinary tract infections, however, the DSD did not provide evidence this training covered all those areas (bowel & bladder, pressure injuries and urinary tract infections). The DSD was asked to provide the tracking system for staff participation and reiterated the online training platform offered all the mandatory trainings. During an interview with the Administrator on [DATE] at 4:31 a.m., in the conference room with four Surveyors present, the Administrator was asked to provide the following day (on [DATE]) the list of annual mandatory trainings, in writing, for Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants, and evidence all night shift staff had taken these mandatory trainings. During record review on [DATE] at 8:15 a.m., of the documents provided by the Administrator, indicated the following refresher annual mandatory trainings were required for Licensed Nurses: 1. Abuse, Neglect, and Exploitation in the Elder Care Setting 2. Care of the LGBTQ (Acronym for lesbian, gay, bisexual, transgender, and queer or questioning) Resident in California 3. Reporting Elder and Dependent Adult Abuse 4. Sexual Harassment for Employees 5. Techniques for Safe Swallowing and Feeding 6. Understanding Sexual Harassment for Supervisors Record review of the first employee training file reviewed, which belonged to Licensed Staff I, indicated only the following two mandatory trainings had been provided to him: 1. Reporting Elder and Dependent Adult Abuse in California (Taken on the online training platform on [DATE]). 2. Sexual Harassment for Employees (Taken on the online training platform on [DATE]). The two trainings mentioned above were three years overdue since they were annual mandatory trainings. Record review on [DATE] at 8:25 a.m., of the second night shift employee training file, which belonged to Licensed Staff J, indicated she had not been provided with the mandatory annual refresher training on care of the LGBTQ resident in California, since [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility job description titled, Director of Staff Development, indicated, The primary purpose of your job position is to plan, organize, develop, and direct all in-service educational programs throughout the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations .to assure that the highest degree of quality resident care can be maintained at all times.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Post Acute	3751 Montgomery Dr Santa Rosa, CA 95405

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 39621 Based on interview and record review, the facility failed to establish a QAPI/QAA program (Quality Assurance Performance Improvement/Quality Assessment and Assurance-A program that involves a systematic approach to quality assurance and performance improvement. It is designed to identify areas of improvement and develop strategies to improve the quality of care provided to the residents) that reassessed the effectiveness of their interventions to correct quality deficiencies. In addition, the data collected for some of the quality improvement projects clearly indicated the interventions were ineffective, but this was not identified by the Administrator. This failure had the potential to result in inability to correct deficiencies, which could have caused low quality of care and harm to the residents of the facility. Findings: During a concurrent interview and record review with the Administrator on 5/17/24 at 1:41 p.m., the Administrator stated they were working on a project to reduce the call light response time. After discussing the interventions in place to reduce the call light response time, the Administrator was asked how they tracked data related to call light response time to ensure the interventions were effective or not effective. The Administrator stated their call light system had a feature that allowed data to be pulled, to compile it. The Administrator stated he had pulled out this data a few months prior, but had not kept the data, and had not pulled it again. The Administrator also stated residents were asked about the call light response time during angel rounds (A facility program where one member of the Interdisciplinary Team met with one resident to discuss different aspects of care) but had no documentation of this. The Administrator provided a document titled, Guardian Angel, dated 7/27/23 (10 months old) to show they were conducting these angel rounds, but this document, which consisted of an interview that was conducted with Resident 3, did not indicate she was asked about the call light response time. During the interview and concurrent record review with the Administrator on 5/17/24 at 1:41 p.m., he stated the facility was also working on a project to reduce the number of resident falls. The Administrator was asked about the interventions they had initiated to prevent falls. The Administrator only shared one intervention to prevent falls, and this was for staff to spend more time working on the change of condition documentation after a fall. Data presented to the Surveyor through the Administrator's computer, indicated that in February 2024, the facility had 11 falls, but in March of 2024, the number of falls increased to 22 (100% increase in the number of falls compared to the previous month). The Administrator was asked if he felt the interventions in the QAPI program were effective in reducing the number of falls, and the Administrator stated they were. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview and concurrent record review with the Administrator on 5/17/24 at 1:41 p.m., he stated the facility was also working on a project to reduce the number of lost or stolen resident items. The Administrator shared that one of the interventions to reduce the number of missing items (specifically hearing aids) was to store them in a safe place. Data presented to the Surveyor through the Administrator's computer, indicated that in February of 2024, there were zero reported missing items. In March of 2024, there were zero reported missing items, but in April of 2024, there were four reported missing items (A 400% increase in missing items compared to the previous months). The Administrator was asked if he felt the interventions in the QAPI program, to reduce the number of missing items were effective, and he stated they were. Record review of the facility policy titled, Quality Assessment and Performance Improvement, last revised in September of 2020, indicated, The purpose of the QAPI Plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual's highest practicable physical, mental and social well-being .The plan will include: 3. Feedback, data systems, and monitoring.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 27532 Based on observation, interview and records review, the facility failed to ensure the sanitary storage of a resident's portable plastic urinal after use. This failure had the potential to increase the risk of infection and disease transmission from bacteria and other microbes, breeding inside the portable urinal. Findings: During the initial tour and resident interview on 5/13/24, at 10:20 AM, the strong smell of urine in a resident room was noted. Resident 32 occupying Bed C stated he used a portable urinal to urinate in bed and his Certified Nursing Assistant (CNA) rinsed his urinal from time to time or occasionally. During a follow-up observation on 5/14/24, at 8:47 AM, Resident 71, occupying bed A in the same resident room, was seated bedside parallel to his bed with his bedside table in front of him. The smell of urine got stronger upon approaching the resident. Resident 71's portable urinal was noted on top of his overbed table beside his drinking mug. During an interview on 5/14/24, at 9:55 AM, the portable urinal of Resident 71 was pointed to Licensed Nurse A (LN A) and asked what he thought about it. LN A stated: That is disgusting, that is very unsanitary. LN A removed the portable urinal from the overbed table and placed the urinal under the table, while stating there was a place under the table where the urinal could be placed. A review of the facility procedure titled, Offering, or removing a Bedpan or Urinal, taken from the Nursing Services Policy and Procedures Manual for Long-Term Care 2001 MED-PASS, Inc, revised 2/18, indicated: If the resident prefers to keep a urinal at his bedside, check it frequently. Empty and clean it as necessary. After assisting the resident, take the urinal into the bathroom, empty the urinal into the commode and flush the commode, clean the urinal, wipe dry with a clean paper towel, store the urinal per facility policy. The policy did not specify what to use to clean the urinal and did not mention what to do with a urinal used by a resident with a urinary tract infection, whether to sterilize the urinal or dispose of it entirely.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 27532 Based on observation, interview and record review, the facility failed to ensure the safety and functional environment in the kitchen, when cracks and missing tile on the kitchen floor were not repaired. This failure could cause dirt to build up on the floor, attracting cockroaches and rodents, and could cause trips and falls among the kitchen staff. Findings: During an initial observation in the kitchen on 5/13/24, at 8:35 AM, a sunken circular cut on the tile, with dark matter or accumulated dirt along the edges, beside the drain on the contaminated side of the dishwashing section of the kitchen, was noted. During continued observation in the kitchen on 5/13/24, at 8:37 and 8:42 AM, cracks on the floor tile, below the low temperature dishwasher and cracks on floor tiles, by the clean side of the dishwashing section of the kitchen, were noted. During a follow-up visit at the kitchen on 5/14/24, at 11:27 AM, a broken tile on the floor, by the corner of the kitchen center island near the entrance door, was noted. During an interview on 5/14/24, at 11:29 AM, the Maintenance Supervisor explained the circular cut on the tile on the contaminated side of the dishwashing section by the drain, was a clean-out drain. If there was a clog in the drain, that was where they inserted the, snake to unclog the drain. The broken tile by the foot of the kitchen center island, the cracks on the floor by the dishwasher and the foot of the clean side of the dishwashing section, was shown to the Maintenance Supervisor. When asked what should be done with the cracks and missing tile on the kitchen floor, the Maintenance Supervisor stated he must change the tiles. During a concurrent record review and interview on 5/14/24, at 2:48 PM, the Maintenance Supervisor stated the facility had a proposed grease trap project and presented nine pages of paper, including an electronic mail and floor plans. A review of the electronic mail, dated 5/7/24, indicated it came from an [Facility Corporation Name] Project Manager to the facility Administrator, notifying of plans for a Grease Trap project to be submitted for approval to the Department of Health Care Access and Information (HCAI), formerly known as the Office of Statewide Health Planning and Development (OSHPD). The rest of the papers were floor plans of the facility and the kitchen, but did not provide details or a description of the project. The Maintenance Supervisor stated the project would include moving the location of the grease trap to the back of the building and replacing the kitchen floor. Still the project needed to be approved first and the kitchen floor needed repair. Review of the Food Code 2017 indicated: It is the standard of practice to ensure materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: smooth, durable, and easily cleanable for areas where FOOD ESTABLISHMENT operations are conducted.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 39621 Based on interview and record review, the facility did not have a system to track staff compliance in mandatory trainings. This finding had the potential to result in inadequate staff competency to care for the residents, within professional standards or practice, poor quality of care, and harm to the residents of the facility. Findings: During an initial interview with the Director of Staff Development (DSD) on 5/15/24 at 3:12 p.m., she presented a binder, with the in-person training's provided to staff, within the last four months at the facility. These training's included bowel & bladder, urinary tract infections, abuse, pressure injuries, and infection control, among others. The DSD provided the staff sign-in sheets for these training's. The DSD was asked if these trainings were mandatory, to which she responded they were. Some of the sign-in sheets for specific trainings, presented to the Surveyor, included less than twenty staff signatures, while others had more than forty signatures, and Certified Nursing Assistants (CNAs) signed for the majority of these trainings. The DSD was asked how she tracked staff participation in the required trainings, to which she responded, Staff are expected to attend the trainings. The DSD was asked again, how she tracked staff participation, and again, she responded staff were expected to attend the trainings, and follow-up if they missed a training. The DSD was asked to provide evidence the following day (on 5/16/24), that five sampled Licensed Nurses, chosen by the Surveyor, had been provided with the following trainings: Bowel & bladder, urinary tract infections, abuse, pressure injuries, and infection control, since these were trainings offered in-person, as DSD stated all her in-person trainings were mandatory. During a second interview with the DSD on 5/16/24 at 1:30 p.m., the DSD presented evidence of all the mandatory trainings (requested on 5/15/24 at 3:12 p.m.) provided to four of the five sampled Licensed Nurses, but the evidence presented included trainings the staff had taken using an online training platform, with no participation in the in-person trainings the DSD offered. At this time, the DSD clarified her statement, about staff being required to take her in-person trainings, and stated that if staff missed her in-person trainings, they could take them through this online training platform. For the fifth sampled Licensed Nurse (Licensed Staff H), the DSD was unable to provide evidence of the following trainings: 1. Bowel & bladder 2. Pressure injuries 3. Urinary tract infections (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility job description titled, Director of Staff Development, indicated, The primary purpose of your job position is to plan, organize, develop, and direct all in-service educational programs throughout the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations .to assure that the highest degree of quality resident care can be maintained at all times.