STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Post Acute	450 Hayes Lane Petaluma, CA 94952

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41333 Based on observation, interview and record review, the facility failed to ensure residents who were vegetarian, or no meat food preference, were given a list of planned vegetarian menu items to choose from for their meals for two of two residents, Residents 19, & 158. This failure had the potential to result in feeling of dissatisfaction from the food served due to having to accept what was served without a choice to select from vegetarian menu items. Findings: During an interview on 4/17/24 at 12:44 p.m., in Resident 19's room , stated she is a vegetarian and the food she eats in the facility were repetitive within the same day or in a week. Resident 19 stated that she liked quinoa, soy, because she wanted to lose weight. When asked Resident 19 if the facility gave her a list of vegetarian menu items, Resident 19 stated, No, they don't' provide me a list of vegetarian menu items. Resident 19 stated that she got the same list of menus as everyone else, without the list of alternate vegetarian menu items. Resident 19 stated, she felt the facility did not know how to prepare and cook vegetarian meal. Resident 19 stated that she did not know that the facility had a vegetarian menu. A concurrent observation and record review of the Diet order ticket dated 4/17/24 for Resident 19 indicated, diet order was regular, controlled carbohydrates, small portions, vegetarian. Resident 19 lunch was vegetarian patty, mashed potatoes, spinach au gratin, garlic bread and chocolate peanut butter bar. A concurrent observation and record review of the Diet order ticket dated 4/17/24 for Resident 158 indicated, diet order was regular/thin, controlled carbohydrates. Notes: Only fish or vegetarian products. Resident 158 lunch was vegetarian patty, mashed potatoes, spinach au gratin, garlic bread, chocolate peanut butter bar. During an interview on 4/18/24 at 2 p.m. in Resident 158's room, she stated that she eats fish and vegetables only. Resident 158 stated that she never received the menu that contains alternate vegetarian menu items. Resident 158 stated that it would have been nice to have a list of vegetarian menu items to choose from. (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: 555127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the weekly menu dated 4/15-4/21/24, posted in the hallway of the facility and given to all residents including Resident 19 & Resident 158 indicated the menu for all meals, breakfast, lunch, and dinner. The menu did not indicate an alternative menu of Vegetarian meal plan. A concurrent interview and record review on 4/17/24 at 2:10 p.m. of the facility's vegetarian & vegan menu and recipe stored in a binder, indicated the facility had the complete plan meal with recipe including an emergency menu recipe. Dietary Manager (DM) stated that she had a vegetarian menu plan, and she knew what Resident 19 wanted to eat. DM submitted a weekly menu, included a planned vegetarian alternate menu for all three meals of the day. When asked DM why do you have two separate weekly menu, one menu had the alternate vegetarian menu and other did not have the alternate vegetarian menu, DM stated that she used to give the alternate vegetarian menu to residents few months ago and then stopped. DM stated she only gave the weekly menu without alternative vegetarian menu items to all residents. DM stated she prepared what Resident 19 would like. When asked DM, did you give the planned vegetarian menu to Resident 19 & Resident 158 so they could freely choose the vegetarian meal menu items available, DM answered No. During a concurrent interview and record review on 4/17/24 at 2:30 p.m. with the Registered Dietician (RD), RD stated that she reviewed the menu and recipe monthly. RD reviewed the two separate weekly menus. One weekly menu dated 4/15/24 - 4/21/24 had regular meal menu items with list of an alternate vegetarian menu items. One weekly menu dated 4/15/24-4/21/24 had the regular meal menu without the alternate vegetarian menu. RD stated that residents get the regular meal menu without the alternate vegetarian menu. When asked RD, why do you have two separate menu and only one list given to all residents, RD did not answer. When asked RD, did Resident 19 and Resident 158 received the menu with alternate vegetarian so they would have given a choice for their preferred diet, RD stated No. RD stated, she agreed that the list of vegetarian menu items should have been incorporated so Resident 19 & Resident 158 could have a choice. A review of a document titled RD (Registered Dietician) approval of menus dated 2/29/24 indicated that The RD for the facility has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs of and reflect based on reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups. The RD also will have reviewed the nutritional analysis provided in the quarterly packet. A review of the facility's Policy & Procedure titled Dining and Food Preferences revised 10/22 indicated Individual dining, food and beverage preferences are identified for all residents/patients. Under Procedures 3) The food preference interview will be entered into the medical record. 4) food dislikes, and food and fluid preferences will be entered into the resident profile in the meu management software. 5) The RD to adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups. 8) Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value.

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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 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview, and record review the facility failed to follow their Abuse Reporting Policy when the Facility (ADM) administrator failed to report abuse within a 24-hour period to the state licensing agency and local authorities. This failure resulted in the lack of protection of Resident 4's resident rights when Resident 4 was not informed that Unlicensed Staff K would be suspended while the abuse investigation was ongoing. Findings: During a record review of Resident 4's Face sheet document, Resident 4 was originally admitted to the facility on [DATE] with Polymyalgia Rheumatica (inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders and hips), Post polio Syndrome (nerve and joint pain with progressive muscle weakness), Neuralgia and Neuritis (a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve) and on 10/1/23, Resident 4 was diagnosed with Parkinsonian Disease with Dyskinesia, with fluctuations. (Involuntary motor movements that vary throughout the day) as well as Cardiac disease, diabetes, and psychiatric diagnosis without psychosis (loss of touch with reality). During a record review of Resident 4's MDS (Minimum Data Set) Section C - BIMS (Brief interview for mental status) Score, dated 2/2/24, Resident 4 has scored consistently a 15/15 BIMS score without deficit. During a record review of Resident 4's PASRR Level I (Preadmission and Resident Review for mental status), dated 8/18/20, indicated, a negative result. Review of the record indicated Resident 4 has never had a positive PASRR I. During a record review of Resident 4's GDR (Gradual Dose Reduction) dated, 11/21/23, signed by Medical Director, indicated Depakote (seizure medication) 125 mg before bed, Cymbalta (given for nerve pain) 20 mg before bed, and Aripiprazole (antidepressant medication) 5 mg given daily. Tapering of the above medications are not recommended due to the resident's symptoms being stable and manageable on the present dose. During a record review of Resident 4's Care plan, revised on 3/5/24, Signed by MDS, page 63, indicated, Resident has Parkinson's Disease, Goal: Resident will remain free of discomfort, monitor mood changes and cognitive decline. Page 64, revised on 3/5/24, Signed by MDS, indicated, Resident has chronic pain related to Polymyalgia Rheumatica, Post Polio Syndrome, Neuralgia and Neuritis: Goal: Resident will verbalize adequate relief of pain or ability to cope. Intervention: anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify and treat the Resident's existing conditions which may increase pain and or discomfort. Monitor and document cause of each pain episode. Remove or limit causes of pain. During an observation in room [ROOM NUMBER] on 4/16/24, at 1:40 p.m., Resident 4, in Bed B, asked Unlicensed Staff K to stop pushing on her back 3 times because it hurt. An argument ensued between Resident 4 and Unlicensed Staff K and Unlicensed Staff K left the room. (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 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/16/24 with Unlicensed Staff K in the hallway at 1:45 p.m., Unlicensed Staff K queried why Resident 4 asked her to stop pushing on her back 3 times. Unlicensed Staff K stated, she had just changed Resident 4's brief and was trying to push the Hoyer Lift (mechanical transfer device) sling under Resident 4 but Resident 4 got upset when she pushed her on her side and told her to stop. Unlicensed Staff K queried if there were any other staff assisting her with the Hoyer Lift Sling. Unlicensed Staff K stated no. Unlicensed Staff K notified Licensed Staff C after the incident occurred. During a record review of Unlicensed Staff K's Human Resource file, indicated, Personnel Action Form dated 4/10/24, signed by ADM. Personnel Action Form revealed a final written warning on 2/20/24 for violation of Resident Rights. Verbal Coaching in Unlicensed Staff K's HR file indicated, Unlicensed Staff K will continue to work on being polite with staff, residents and managers. Will also communicate concerns and issues to supervisor and team for assistance but should be respectful. Unlicensed Staff K will continue to work on her interpersonal skills and direct care with Residents. Other violations noted in Unlicensed Staff K's HR file was dated from 9/12/2018 through to the present time; indicated, Violation of time and attendance Policy, leaving Residents in wet briefs, shower schedule and the need to follow instructions, not rounding on Residents, not repositing Residents, and no call no show when scheduled to work. During an interview with Licensed Staff C on 4/17/24 at 9:30 a.m., Licensed Staff C queried about the incident that occurred between Resident 4 and Unlicensed Staff K on 4/16/24 at 1:40 p.m. Licensed Staff C stated, I documented a Change of Condition on the incident that occurred due to the Resident stating the Unlicensed Staff K was rough with her while changing her brief. Licensed Staff C also stated, Unlicensed Staff K told her that Resident 4 hit her on her left hip. Licensed Staff C stated she left a message for Resident 4's representative, notified the MD (Medical Director), DSD (Director of Staff Development), and the DON (Director of Nursing) about the incident. During a record review of Resident 4's Change of Condition Form, signed by Licensed Staff C, dated 4/16/24 at 2:40 p.m., Resident 4's orientation was documented as Alert and Oriented to Person, Place, Time, and Surroundings. Additional Comments: Unlicensed Staff K reported Resident 4 hit her during brief change on the hip. Asked Resident 4 what happened and resident 4 said she was rough during the brief change. Staff reminded to go with assistance during care. During a review of the investigation note pertaining to the 4/16/24 incident between Resident 4 and Unlicensed Staff K, Investigation note dated, 4/18/24, 7:30 a.m. signed by the SSD (Social Service Director), indicated, Resident 4 stated, the day that Unlicensed Staff K was trying to get the Hoyer sling under her she asked her to be careful as she was having discomfort in her lower back. During a review of the investigation note pertaining to the 4/16/24 incident between Resident 4 and Unlicensed Staff K, dated 4/18/24, signed by DSD, indicated that On 4/16/24 Unlicensed Staff K approached me in my office to inform me crying that her patient Resident 4 had hit her on her right side of her buttocks. During a review of the investigation note pertaining to the 4/16/24 incident between Resident 4 and Unlicensed Staff K, dated 4/16/24, signed by Licensed Staff C, indicated, On April 16th Unlicensed Staff C, indicated, Unlicensed Staff K, told the DSD that she was providing care for Resident 4 and Resident 4 hit her on her hip. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with Resident 4 on 4/17/24 at 1:45 p.m., Resident 4 queried as to what happened when Resident 4 asked Unlicensed K 3 times to stop pushing on her back. Resident 4 stated, Unlicensed Staff K has taken care of me before and she is rude. Resident 4 stated, she wanted to go to Mexican Bingo that day and needed to be lifted into my wheelchair with the Hoyer Lift, but my brief was wet so Unlicensed Staff K had to change my brief before she could transfer me onto the Hoyer Sling and then lift me over to my wheelchair. Resident 4 stated, I have a lot of muscle, nerve, and joint aches especially in my back. Unlicensed Staff K was pushing on my back hard trying to get me on my left side and I was up against the wall. My back was really hurting, and I asked her to stop pushing on me, but she did not. I asked her 2 more times, but she did not stop, finally the third time after I asked her to stop and she did not, I then pushed her arm off my back. Resident 4 queried if she was ever able to make it to Mexican Bingo. Resident 4 said no because my back was hurting so much after that. I asked for my pain medication for my back, but I did not receive it till around 4 p.m. Resident 4 asked if she feels safe in the facility. Resident 4 stated, no, she does not want Unlicensed Staff K taking care of her anymore. Resident 4 stated, they blame me for things I do not do, and they do not listen to my concerns. I have felt really scared here in the past like I just wanted to crawl in a hole and hide. Resident 4 queried if anyone within the facility has gotten back to her regarding the investigation on the incident that occurred on 4/16/24 between her and Unlicensed Staff K. Resident 4 stated, no, no one has told me anything. Resident 4 queried as to when Licensed Staff C and Licensed Staff A came in her room to discuss the incident that occurred between Unlicensed Staff K and her. Resident 4 stated, Licensed Staff A and Licensed Staff C came in about an hour after Unlicensed Staff K pushed on my back. During a review of Resident 4's Medication Administration Record, on 4/16/24, her daily medications were checked off as being administered as well as an addition PRN (as needed) Oxycodone (pain medication) 10mg administered on 4/16/24 at 4:04 p.m., for a pain level of 7/10. During a review of Resident 4's IDT(interdisciplinary team) note, IDT attendees were SSD, DON, MDS, DSM and AD, dated 4/17/24 at 7:09 p.m., IDT note signed by SSD, IDT note indicated, Resident 4's, loss of her cat, her home and independence, but no mention of the Change of Condition Form dated 4/16/24 by Licensed Staff C indicating that Resident 4 stated, Unlicensed Staff K was rough with Resident 4 during a brief change. There was also no mention of the SSD investigative note which indicated, Resident 4 informed SSD that Unlicensed Staff K was attempting to get the Hoyer Sling under Resident 4 without assistance from other staff. No mention of Resident 4's back pain or pain medication that Resident 4 needed after the incident with Unlicensed Staff K. During an interview with the DSD on 4/19/24 at 9:50 a.m., DSD queried as to what the facility's policy indicates for the number of staff members who need to be present when using a Hoyer Lift, DSD stated, minimum of 2 staff members need to be present. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the ADM with 2 other HFENs (Health Facility Evaluator Nurses), (44968) and (41333) in the conference room on 4/18/24 at 12:00 p.m., ADM was queried as to who is the responsible party in the facility to report alleged abuse to the state and local authorities. ADM stated, she is the Abuse Reporter for the facility. ADM queried if she reported the 4/16/24 incident that occurred between Unlicensed Staff K and Resident 4 to the state or local authorities. ADM responded, why would I report a situation where a Resident hit a staff member ADM queried if ADM had performed an investigation on the incident. ADM responded, yes, the DSD and SSD did an investigation, and it was determined that Resident 4 hit a staff member. ADM queried if she had interviewed Resident 4. ADM stated, Resident 4 doesn't want to talk about the incident. Queried ADM about Unlicensed Staff K's HR File that indicated a final written warning dated 2/20/24, due to multiple Resident Rights violations. ADM stated she was not aware of the HR violations on Unlicensed Staff K. ADM informed that Unlicensed Staff K's HR form referencing these violations was signed by her on 4/10/24. ADM stated, she does not remember such a form. This writer read the HR Form out loud to ADM which outlined Unlicensed Staff K's resident rights violations. ADM stated, Unlicensed Staff K just has a flat affect, and she looks mad when she really isn't. ADM queried if she was aware of the Change of Condition Form documented by Licensed C on 4/16/24 where Licensed Staff C had written that Resident 4 complained that Unlicensed Staff K was rough with her during a brief change. ADM stated no, I am not aware. ADM stated, Resident 4 is a very challenging patient and acts out a lot. ADM queried why Unlicensed Staff K who has a history of Resident Rights violations and on her last written warning would be assigned to Resident 4 if she was so challenging. ADM stated, I don't have an answer for you. Requested a copy of the investigation that the ADM stated had been completed on the incident that occurred on 4/16/24 between Unlicensed Staff K and Resident 4. Queried ADM if she knew the survey team were already in the building the entire week, why didn't she let us know about the alleged abuse with Resident 4 and Unlicensed Staff K. ADM stated, why would I, it was a Resident who hit a staff member. HFES (Health Facility Evaluator Supervisor) (35362) recieved email from ADM on 4/18/24 at 8:39 p.m., indicating, We had a patient who hit a staff member on the hip during care. An investigation was started by the DSD which included interviewing the patient (Resident 4) and the staff member and it was determined that the resident stated that she was experiencing back pain during her direct care and for no reason that we are able to determine, she struck out at the staff member. As of today, the patient no longer wants to discuss the incident. During an interview in the conference room with the ADM on 4/19/24 at 9:30 a.m., ADM stated she sent an email late last evening to CDPH HFES (35362) referencing an alleged abuse case between Unlicensed Staff K and Resident 4. ADM stated, we also decided late last night to suspend Unlicensed Staff K for 3 days while we investigate. Requested documentation on the suspension. During a review of Unlicensed Staff K's HR file, Employee Warning / Coaching Document for Unlicensed Staff K dated 4/19/24, indicated, employee is part of an ongoing investigation of abuse-will be suspended from 4/20/24 - 4/23/24 pending the outcome of the investigation. Received a phone call from Unlicensed Staff K, on 4/23/24 at 2:50 p.m., Unlicensed Staff K stated, The administrator just called me and told me that I am being terminated on my 3rd day of suspension for bad care. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the Unlicensed Staff K's Job Description, signed by Unlicensed Staff K, dated 2/13/20, Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors. Cooperate with inter-departmental personnel, as well as other facility personnel to ensure that nursing serves can be adequately maintained to meet the needs of the residents, Create, and maintain an atmosphere of warmth, personal interest, and positive emphasis, as well as a calm environment throughout the unit and shift. Assist residents in preparing for activity and social programs, assist with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. Check resident routinely to ensure that their personal care needs are being met in accordance with their wishes. Turn Bedfast residents at least every two hours, follow established safety precautions in the performance of all duties, report all safety violations, use only equipment you have been trained to use, operate all equipment in a safe manner, ensure that you treat all resident fairly, and with kindness, dignity and respect, report all allegations of resident abuse and or misappropriation of resident property, honor the resident's refusal of treatment request. Report such requests to your supervisor. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Administrative Policy, Revised November 2023, indicated, all reports of resident abuse (including injuries of unknown origin) neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigation are documented and reported. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property injury of unknown source is suspected, the suspicion resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies: a) The state licensing /certification agency responsible for surveying / licensing the facility. b) The local/state ombudsman c) The resident's representative d) Adult protective services e) law enforcement officials f) the resident's attending physician g) the facility medical director 3. Immediately is defined as; within 2 hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Notices include the type of abuse, date, and time the alleged incident occurred, the name(s) of all persons involved in the alleged incident and what immediate action was taken by the facility. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. All allegations are thoroughly investigated. The administrator initiates investigations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. Any evidence that may be needed for a criminal investigation is sealed, labeled, and protected from tampering or destruction. The administrator is responsible for keeping the resident and their representative informed of the progress of the investigation. The administrator ensures that the resident and the person reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associate with the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The individual conducting the investigation as a minimum; reviews the documentation and evidence; reviews the resident medical record to determine the resident physical and cognitive status at the time of the incident and since the incident, observes the alleged victim, including his or her interactions with staff and other resident, interviews the person reporting the incident, inters any witnesses to the incident, interviews the resident or the resident representative, interviews attending physician as needed, interviews staff members on all shift who have had contact with the resident during the period of the alleged incident, interviews the resident roommate, family members, and visitors, interviews other residents to whom the accused employee provides care or services, reviews all events leading up to the alleged incident and documents the investigation complete and thoroughly. Witness statements are obtained in writing, signed, and dated. The witness may write their statement, or the investigator may obtain a statement. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participation the review process. If the ombudsman declines the invitation to participate in the investigation, that information is noted in the investigation record. The ombudsman is notified of the results of the investigation as well as any corrective measures taken. The investigator consults daily with the administrator concerning the progress/findings of the investigation. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. Within in 5 business days of the incident, the administrator will provide a follow-up investigation report. The follow up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. The follow up investigation report will provide as much information as possible at the time of submission of the report. The resident and/or representative are notified of the outcome immediate upon conclusion of the investigation. All relevant professional and licensing boards are notified when an employee is found to have committed abuse. If the investigation reveals that the allegation of abuse is found, the employee is terminated. Any allegations of abuse are filed in the accused employee's personnel record along with any statement by the employee disputing the allegation if the employee chooses to make one. Corrective actions

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the Staff Development Coordinator job description, revised 10/2020 indicates, Primary Purpose of this position is to plan, organize, develop, and direct all in-services education programs throughout the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations and as directed by the Administrator to assure that the highest degree of equality resident care can be maintained at all times. During a review of the facility's policy and procedure titled, Lifting Machine, using a Mechanical Positioning and moving machine Revised 9/2023, indicated, the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It not a substitute for manufacturer's training or instructions. General Guidelines: At least 2 nursing assistants are needed to safely move a resident with a mechanical lift. Transferring a resident from bed to chair, toileting or bathing, repositioning, lift design and operation vary across manufactures. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. Steps in the Procedure: Before using a lifting device, assess the resident's current condition, including: Physical: Can the resident assist with transfer? Is the resident's weight and medical condition appropriate for the use of a lift. Cognitive/Emotional: Can the resident understand and follow instruction, does the resident express fear, or appear anxious about the use of the lift? Is the resident agitated, resistant or combative? Measure the resident for proper sling size according to manufactures' instructions. During a review of the facility's policy and procedure titled, Resident Rights revised 12/2021, indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal state laws guarantee certain basic rights to all resident of this facility. These right include the resident right to: a dignified existence, be treated with respect, kindness and dignity, be free from abuse, neglect misappropriation of property, and exploitation, be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident symptoms, self-determination, exercise their rights as a resident of the facility and as a resident or citizen of the United States, be supported by the facility in exercising their rights, exercise their rights without interference, coercion, discrimination or reprisal from the facility, be informed of, and participate in their care planning and treatment, voice grievances to the facility or other agency that hears grievance, without discrimination or reprisal, communicate with outside agencies (local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organization) regarding any matter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Hillcrest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 450 Hayes Lane Petaluma, CA 94952	

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's policy and procedure titled, Dignity revised 2/2021, indicated, Residents are to be treated with dignity and respect at all times. This begins with the initial admission and continues throughout the resident's faculty stay. Individual needs and preferences of the resident are identified though the assessment process. Resident may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with this facility. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by their room number, diagnosis, or care needs. Staff inform and orient residents to their environment. Procedures are explained before they are performed, and residents will be told in advance if they are going to be taken of their usual familiar surroundings. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist resident: for example: promptly responding to a resident request for toileting assistance; and allowing resident unrestricted access to common areas open to the public, unless this poses a safety risk for the resident. Staff are expected to treat cognitively impaired resident with dignity and sensitivity, for example addressing the underlying motives or root causes for behavior: and not challenging or contradicting the resident belief or statements.

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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** 44968 Based on interviews and records review, the facility failed to develop and implement person-centered care plans for one of 15 sampled residents (Resident 20) when Resident 20 had left eye surgery. This failure resulted in a lack of communication between disciplines and care givers that could potentially cause negative outcomes for Resident 20. (Cross reference F684) Findings: A review of the document titled Admission Record indicated Resident 20 was admitted on [DATE] with diagnosis including but not limited to Parkinson's Disease (disorder of the central nervous system that affects movement) and Diabetes Mellitus (disease that result in too much sugar in the blood). A review of the document titled Physician's Progress Notes dated 4/09/24 indicated Resident 20 had a left eye surgery for silicone oil (often used as a retinal [a layer at the back of the eyeball] tamponade [function by keeping the hole in the retina dry] after complex retinal detachment [a painless but serious eye condition] repair) removal and retention. During an interview and concurrent record review with the Director of Nursing (DON) on 4/19/24 at 10:36 a.m. , when the DON was asked about the facility's policy for care planning, the DON stated resident's change of condition should have care plan. She stated nurses in charge of the resident should initiate a care plan then the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) including the DON were responsible to review and make sure the care plan was in place. After review of Resident 20's electronic record, the DON stated there was no care plan developed for Resident 20 to address the care needed after his left eye surgery. During an interview and concurrent record review with Licensed Staff D on 4/19/24 at 10:07 a.m., when Licensed Staff D was asked about the facility's policy for care planning, Licensed Staff D stated nurses were expected to initiate a care plan should a resident have a change of condition. A review of the Facility policy and procedure titled Care Plans, Comprehensive Person-Centered revised on March 2022 indicated, The comprehensive, person-centered care plan: a) includes measurable objectives and time frames; b) describes the services that are to be furnished to obtain or maintain the residents highest practicable physical, mental, and psychosocial well-being.; . e) reflects currently recognized standards of practice for problem areas and conditions.

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NAME OF PROVIDER OR SUPPLIER Hillcrest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 450 Hayes Lane Petaluma, CA 94952	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to assess and monitor for signs of after surgery complications for one of 15 sampled residents (Resident 20) when Resident 20 had left eye surgery. This failure had the potential for Resident 20 to develop an unidentified bacterial eye infection which could result in Resident 20's discomfort. Findings: A review of the document titled Admission Record indicated Resident 20 was admitted on [DATE] with diagnosis including but not limited to Parkinson's Disease (disorder of the central nervous system that affects movement) and Diabetes Mellitus (disease that result in too much sugar in the blood). A review of the document titled Physician's Progress Notes dated 4/09/24 indicated Resident 20 had a left eye surgery for silicone oil (often used as a retinal [a layer at the back of the eyeball] tamponade [function by keeping the hole in the retina dry] after complex retinal detachment [a painless but serious eye condition] repair) removal and retention. During an interview and concurrent record review with Licensed Staff D on 4/19/24 at 10:07 a.m., when Licensed Staff D was asked about the facility policy for resident's who had a change of condition (COC), Licensed Staff D stated nurses would monitor the resident for any complications from the COC. Licensed Staff D concurred that Resident 20's left eye surgery was considered a COC. When Licensed Staff D was asked what should the nurses monitor after Resident 20's eye surgery, Licensed Staff D stated nurses would monitor for signs of eye infection like eye discharges, redness, itching and eye discomfort. During an interview with the Director of Nursing (DON) on 4/19/24 at 10:36 a.m., when the DON was asked about her expectation from the nurses after Resident 20 had eye surgery, the DON stated she expected the nurses to assess and monitor for any signs of complications from the eye surgery, like eye infection and pain every shift for seventy two (72) hours as standard practice and document their observations. After review of the nurses' progress notes from 4/9/24 to 4/19/24 with the DON, the DON stated there was no documentation from the nurses to show Resident 20 was assessed and monitored for signs of complications after the eye surgery. Review of the Facility policy and procedure titled Acute Condition Changes - Clinical Protocol revised on March 2018 under Monitoring and Follow-up indicated, The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly.

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observation, interviews and records review, the facility failed to ensure one of 15 sampled residents (Resident 47) was free from pain and discomfort when Resident 47 was not given pain medication as requested prior to Pressure ulcer (also known as bedsore - damage to an area of the skin caused by constant pressure on the area for a long time) treatment. This failure resulted in Resident 47 to experience pain and discomfort during the pressure ulcer treatment. Findings: A review of the document titled Admission Record indicated Resident 47 was admitted on [DATE] with diagnosis including but not limited to Left Side Hemiplegia and Hemiparesis (the loss of the ability to move [and sometimes to feel anything] one side of the body) and unstageable pressure ulcer (A full thickness skin loss in which the base of the ulcer is covered by slough [a necrotic [dead] tissue characterized as yellow, tan, green or brown in color and may be moist, loose and stringy in appearance] and /or eschar [a necrotic tissue characterized as dry, thick, leathery tissue that is often tan, brown or black]) to sacrum (the triangular bone just below the backbone). A review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents) dated 3/25/24 indicated Resident 47 had a BIMS score of 15 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive [relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 13 to 15 is cognitively intact). A review of the document titled Order Summary Report dated 4/17/24 indicated a Physician's Order written on 3/19/24 for the following pain medications: Acetaminophen (also known as Tylenol - help to treat minor aches and pains) 325 mg (milligram-a unit of mass) tablet to give 2 tablets every six hours as needed for mild pain (a numerical pain scale of 1-3); Oxycodone (help to relieve moderate to severe pain) 5 mg tablet to give half tablet every six hours as needed for moderate pain (a numerical pain scale of 4-6) and to give one tablet every six hours as needed for severe pain (a numerical pain scale of 7-10). A review of the document titled Order Summary Report dated 4/17/24 indicated a Physician's Order for Resident 47 written on 4/03/24 to apply Santyl ointment (used to remove damaged tissue from chronic skin ulcers and severely burned areas) to sacrum every day. A review of the document titled Surgical Consult dated 4/16/24 indicated Resident 47 had an unstageable pressure injury (the breakdown of skin integrity due to pressure) measuring 4.8 cm. (centimeter - unit of length) in length, 2.5 cm. in width, and depth (deepness) was unknown. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation in Resident 47's room on 4/18/24 at 10:29 a.m., Resident 47 was awake and agreed for this writer to observe the pressure ulcer treatment with Licensed Staff A. Family Member B was also at bedside. When Licensed Staff A entered Resident 47's room, Resident 47 asked Licensed Staff A for his pain medication. Licensed Staff A told Resident 47 that he was not due for pain medicine until 11:00 a.m. Licensed Staff A did not ask Resident 47 if he had pain and proceeded with the pressure ulcer treatment. When this writer asked Resident 47 if he had pain, he stated, yes, my shoulder and left leg. When Licensed Staff A was applying Santyl ointment to the wound area, Resident 47 stated, ouch! When Family Member B asked Resident 47 where the pain was, Resident 47 stated, it hurts whatever he was doing down there. During an interview with Licensed Staff A on 4/18/24 at 2:11 p.m., when Licensed Staff A was asked if he administered pain medication to Resident 47 prior to pressure ulcer treatment, Licensed Staff A stated no. Licensed Staff A stated Resident 47 did not have a scheduled pain medication. However, he stated Resident 47 always gets his pain medication at 11:00 a.m. prior to therapy treatment as per Family Member B's instructions. Licensed Staff A stated he would normally administer pain medication to other residents thirty minutes prior to pressure ulcer treatment. When Licensed Staff A was asked how would pain affect Resident 47 during pressure ulcer treatment, he stated Resident 47 could experience worsened pain and discomfort. During an interview and concurrent record review with the Director of Nursing (DON) on 4/18/24 at 2:39 p.m., when the DON was asked about her expectations from the nurses when providing pressure ulcer treatment to Resident 47, the DON stated she expected the nurses to assess for pain prior to wound treatment and administer pain medication when needed. After review of the Physician's Order, the DON verified Resident 47 had orders for PRN (as needed) pain medications. When the DON was asked how important is pain management for the residents, she stated, it should be on top of the list. She stated the resident could not eat, sleep, or could not participate with treatment if he/she was in pain. During an interview with Licensed Staff C on 4/19/24 at 10:22 a.m., when Licensed Staff C was asked how would nurses ensure resident was kept comfortable during pressure ulcer treatment, she stated pressure ulcer could be painful for the resident and should be medicated prior to the treatment. When Licensed Staff C was asked when should nurses administer PRN pain medications to the residents, she stated it should be given to the resident immediately after assessing the resident's level of pain. A review of the Facility policy and procedure titled Pain Assessment and Management (no date) indicated, The pain management program is based on facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 41333 Based on observation, interview and record review, the facility failed to ensure the posted daily staffing schedule had an additional required information such as census (number of residents in the facility), the total numbers of Licensed and Unlicensed staff and the actual hours worked individually, reflect staff absences on that shift due to call-outs and illness, and clearly identify the staff's name in a clear and readable format. This failure had the potential to result in poor and inadequate care that compromised the health and safety of residents. Findings: During a concurrent observation and interview on 4/18/24 at 4 p.m. with the Administrator (ADM), during a tour to the nurses' station where the daily staffing was located, the daily staffing for Licensed and Unlicensed nurse was located inside a binder. ADM stated that the daily staffing was readily available to read to all visitors, staff, and residents. During a concurrent interview and record review on 4/18/24 at 4 p.m. at the nurses' station, when Administrator (ADM) was asked do you have the census written on the daily staffing, ADM answered no. When asked ADM, how do you differentiate the staff's name listed on the daily staff list as there were no last name or last name initial, since you have multiple staff with the same first name, ADM answered, yes, she does not see the last name. ADM stated, she would change the format of the posting for daily staff assignments.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44968

Based on interviews and records review, the facility failed to ensure Ophthalmic (pertaining to the eye) medications were administered according to the doctor's order for two of 15 sampled residents (Resident 20 and Resident 41) when:

1. a. Resident 20 who had left eye surgery did not receive the ordered Ofloxacin Ophthalmic Solution 0.3%, (an antibiotic used to treat bacterial infections of the eye) three days after the medication was ordered, and (b) Resident 20 did not receive the medication according to the ordered administration time. These failures had the potential risk for Resident 20 to develop bacterial eye infection and eye discomfort. (Cross reference F684)

2. Resident 41 who had a diagnosis of Glaucoma (an eye diseases that can cause vision loss and blindness) did not receive his eye medications according to the ordered administration time. These failure had the potential risk for Resident 41 to experience eye pain and deterioration of visual function.

Findings:

Resident 20

During an interview with Resident 20 on 4/15/24 at 4:02 p.m., Resident 20 stated he had a new order for eyedrop after his eye surgery and did not get the medication until after two days. Resident 20 stated he was supposed to have the eyedrops at 8:00 a.m.; 12:00 p.m.; 4:00 p.m.; and 8:00 p.m. but the nurses were late in giving his eye drops.

A review of the document titled Admission Record indicated Resident 20 was admitted on [DATE] with diagnosis including but not limited to Parkinson's Disease (disorder of the central nervous system that affects movement) and Diabetes Mellitus (disease that result in too much sugar in the blood).

A review of the document titled Physician's Progress Notes dated 4/09/24 indicated Resident 20 had a left eye surgery for silicone oil (often used as a retinal [a layer at the back of the eyeball] tamponade [function by keeping the hole in the retina dry] after complex retinal detachment [a painless but serious eye condition] repair) removal and retention.

A review of the document titled Order Summary Report indicated a Physician's Order written on 4/10/24 for Ofloxacin Ophthalmic Solution 0.3%, to give one drop in left eye four times a day.

a.

A review of the document titled Pharmaceuticals Shipping Manifest dated 4/14/24 indicated the Ofloxacin 0.3% eye drop was received on 4/14/24 at 10:53 p.m.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review with Licensed Staff D on 4/19/24 at 10:07 a.m., Licensed Staff D stated Resident 20 had left eye surgery and currently receiving antibiotic eye drops. A review of the Medication Administration Record (MAR) for Resident 20 with Licensed Staff D from 4/10/24 to 4/13/24 indicated 3 with the nurse's initials under the Ofloxacin order. When Licensed Staff D was asked what 3 stand for, she stated to hold (an order to suspend the medication administration under specific conditions) the medication and to see nurses' notes for reason of holding the medication. However, after review of the nurses' progress note with Licensed Staff D, Licensed Staff D stated the progress note did not indicate reason for holding the medication. She stated the medicine could be unavailable. When Licensed Staff D was asked about the risks for Resident 20 for the delayed administration of eye antibiotic after his eye surgery, she stated Resident 20 could be at risk for eye infection and eye pain. During a review of the MAR for Resident 20 and concurrent interview with Licensed Staff C on 4/19/24 at 10:31 a.m., Licensed Staff C verified the order for Ofloxacin was written on 4/10/24 and that nurses documented 3 from 4/10/24 to 4/13/24. When Licensed Staff C was asked why was the eye antibiotic not given for three days, Licensed Staff C stated she called the pharmacy and was told the medicine won't be delivered until 4/16/24 due to Resident 20's medical insurance. When Licensed Staff C was asked if Resident 20's physician was notified that the medicine won't be delivered until 4/16/24, she stated she was not sure if Resident 20's physician was notified. When Licensed Staff C was asked about the risks for Resident 20 for the delayed administration of the eye antibiotic, Licensed Staff C stated Resident 20 had the potential risk for eye infection, swelling, redness, pain and burning sensation. During an interview with the Director of Nursing (DON) on 4/19/24 at 10:36 a.m., when the DON was asked about the facility's medication administration policy for new ordered antibiotic, the DON stated antibiotic medications should be given as soon as possible, within 4 hours. When the DON was asked if she was aware that the Ofloxacin delivery was delayed due to Resident 20's medical insurance, the DON stated no. She stated if she was notified that the medicine could not be delivered on time, she could fill up an authorization form to expedite the process to avoid the delay. The DON stated risks for delayed treatment would be eye infection. b. A review of the document titled Medication Administration Audit Report indicated Resident 20 received Ofloxacin Ophthalmic Solution 0.3% one drop to his left eye on the following dates and times: - On 4/15/24, Resident 20 received the medication at 12:22 p.m. for the scheduled 8:00 a.m. dose. - On 4/16/24, Resident 20 received the medication at 10:15 a.m. for the scheduled 8:00 a.m. dose; and 6:00 p.m. for the scheduled 4:00 p.m. dose. - On 4/17/24, Resident 20 received the medication at 11:04 a.m. for the scheduled 8:00 a.m. dose; and 6:28 p.m. for the scheduled 4:00 p.m. dose. - On 4/19/24, Resident 20 received the medication at 1:57 p.m. for the scheduled 8:00 a.m. dose; and 6:14 p.m. for the scheduled 4:00 p.m. dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/20/24, Resident 20 received the medication at 10:04 a.m. for the scheduled 8:00 a.m. dose; 6:31 p.m. for the scheduled 4:00 p.m. dose; and 10:55 p.m. for the scheduled 8:00 p.m. dose. - On 4/21/24, Resident 20 received the medication at 4:40 p.m. for the scheduled 12:00 p.m. dose. During an interview with Licensed Staff D on 4/22/24 at 1:34 p.m., when asked about the facility's policy for medication administration, Licensed Staff D stated nurses could administer scheduled medications an hour early or an hour late and expected to document on the resident's MAR immediately after administering the medications. Resident 41 During an interview with Resident 41 on 4/15/24 at 3:38 p.m., Resident 41 stated he often gets his medicines including his eye drops a couple of hours late. He stated he was supposed to get the eyedrops three times a day in the morning, at noon and at night. A review of the document titled Admission Record indicated Resident 41 was admitted on [DATE] with diagnosis including but not limited to Glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight) and Hypertension (High Blood Pressure). A review of the document titled Order Summary Report indicated a Physician's Order written on 2/26/24 for Prolensa Ophthalmic Solution 0.07% (used to treat pain or swelling of the eye following cataract surgery [a procedure to remove the lens of the eye] to give one drop in right eye two times a day for Glaucoma; a Physician's Order written on 3/19/24 for Brinzolamide-Brimonidine Ophthalmic Suspension 1-0.2% (used to treat increased pressure in the eye caused by glaucoma) to give one drop in right eye two times a day for Glaucoma, and Timolol Maleate Ophthalmic Solution 0.5% (used to treat high pressure inside the eye due to glaucoma) to give one drop in right eye two times a day for Glaucoma. A review of the document titled Medication Administration Audit Report indicated Resident 41 received Brinzolamide-Brimonidine Ophthalmic Suspension 1-0.2%; Timolol Maleate Ophthalmic Solution 0.5%; and Prolensa Ophthalmic Solution 0.07% on the following dates and times: - On 4/16/24, Resident 41 received the medications at 10:19 a.m. for the scheduled 8:00 a.m. dose. - On 4/17/24, Resident 41 received the medications at 11:45 a.m. for the scheduled 8:00 a.m. dose. - On 4/20/24, Resident 41 received the medications at 10:13 a.m. for the scheduled 8:00 a.m. dose. - On 4/21/24, Resident 41 received the medications at 4:40 p.m. for the scheduled 12:00 p.m. dose. During an interview with the DON on 4/23/24 at 1:41 p.m., when the DON was asked about the facility's policy for medication administration, she stated nurses have one hour before and one hour after the scheduled time to give the medications and nurses were expected to document as soon as the medications were given to the residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility policy and procedure titled Medication Administration General Guidelines dated 9/2018 indicated, Medications are administered in accordance with written orders of the prescriber . Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation interview and record review, the facility failed to follow their Medication Storage Policy, when 3 expired COVID 19 Vaccines and 1 box of Arginaid (wound healing nutrition) were found in the facility's Medication Storage room and another expired box of Arginaid was found in Medication Cart 1. This failure had the potential to result in Residents being injected with an expired ineffective COVID 19 vaccine resulting in an unvaccinated status as well as expired deteriorated Arginaid being ineffective for wound healing. Findings: During an observation on [DATE] at 12:55 p.m., in Medication Cart 1, observed 1 box of Arginaid to be expired with an expiration date of [DATE]. During an observation on [DATE] at 12:59 p.m., in the Medication Storage room, observed 1 box of Arginaid to be expired with an expiration date of [DATE]. During an observation on [DATE] at 1 p.m., in the Medication Storage room, 3 expired Covid 19 vaccines were observed with an expiration date of [DATE] in the medication refrigerator as well as 1 box of expired Arginaid found on the shelf with an expiration of [DATE]. During an interview with Licensed Staff C on [DATE] at 1:10 p.m., Licensed Staff C queried as to the risk to Resident safety if the Resident were to receive an expired Covid 19 vaccine. Licensed Staff C stated, she thinks the risks would be the Resident would not be effectively vaccinated due to the deterioration of the COVID 19 medication in the vial. Licensed Staff C queried as to what the risks would be to Resident safety if the Resident were to receive expired Arginaid for their wound. Licensed Staff C responded, she doesn't believe the expired Arginaid would be beneficial to support wound healing and the wound could get larger. During a review of the facility's policy and procedure titled, Medication Storage dated, 2007, indicated, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Medication storage conditions are monitored on a regular basis as a random quality assurance check. During a review of the Infection Preventionist Job Description, Revised [DATE], indicated, monitor the designated shelf life of sterizlied and packaged supplies; reprocess as necessary. Order inventories of vaccines to be adminsitered to staff and residents in a timely manner.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41333 Based on observation, interview and record review, the facility failed to ensure two of two residents, Resident 9 and Resident 19, received action, obtain feedback, and conduct systematic investigations to improve quality of care, quality of life and resident's safety during Quality Assurance and Performance Improvement (QAPI) meetings when: 1) The Director of Staff Development (DSD) did not report an incident reported by an Ombudsman of verbal abuse and mocking (imitating behavior) towards Resident 9 by Unlicensed Staff L. DSD did not inform the Administrator of the abuse allegation. ADM was the abuse coordinator. 2) Resident 19 attempted to complain to DSD regarding an alleged verbal abuse by Unlicensed Staff M & Unlicensed Staff N . DSD did not follow up with Resident 19 about the allegation and did not inform ADM nor the Inter Department team (IDT) during their daily IDT meeting & monthly meetings of QAPI. Findings: (1) During a concurrent interview and record review on 4/19/24 at 9:39 a.m. the Director of Staff Development (DSD) stated that she was the supervisors for the Certified Nursing Assistance (CNA). When asked the DSD if an Ombudsman reported to her about a CNA who was verbally aggressive to a resident, DSD answered yes. DSD stated that the Ombudsman reported to her about a staff who was imitating a resident. DSD filled out a form titled Employee warning/coaching documentation for Unlicensed Staff L (CNA). A review of the form dated 2/26/24 indicated that Ombudsman notified DSD/DON (Director of Nursing) Under Action taken verbal warning, corrective action by employee was an in-service title residents/patients' rights and will not imitate noise of resident's voice/sound. When asked DSD, did you inform the Administrator (ADM) regarding the alleged verbal abuse incident, DSD answered not sure, maybe I have. DSD stated she knew that the Director of Nursing (DON) was aware of this alleged abuse. When asked DSD, did you notify a law enforcement and State Agency, DSD answered No. During an interview on 4/1824 at 11:32 a.m., the administrator (ADM) stated that she was the Abuse Coordinator. ADM stated her managers made rounds once per week, talked with residents, report any type of abuse to social worker, managers, to reach out to family or conservator. ADM stated that all types of abuse was to be reported to her. ADM stated that once she received any allegation of abuse that she would investigate, interview resident, staff to determine if abuse occurred. ADM stated that part of the abuse was to report to State Agency, Ombudsman, Law enforcement, and Medical Doctor. When asked ADM, did you know about an incident happened between Unlicensed staff L allegedly imitating the noise that Resident 9 made, ADM stated, she was not aware of that incident. ADM stated that no one had informed her. When asked ADM, what was your expectation from your management when there was an alleged abuse, DM stated that she expected her management to inform her of alleged abuse. ADM stated that they meet Monday thru Friday in the morning for management meeting. When asked ADM if she recalled any report about this incident between Unlicensed Staff L and Resident 19 during the daily meeting, ADM stated No. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) During a concurrent interview and record review on 4/17/24 at 12:44 p.m., in Resident 19's room, Resident 19 stated that Unlicensed Staff M and N scolded her saying you are stressing me out. Resident 19 stated that she was upset from being scolded, so she said that she yelled at them back. Resident 19 stated that she informed the DSD briefly and DSD said that she would be back, it happened approximately last week, not sure of the exact date. Resident 19 stated that she did not hear back from DSD. Resident 19 stated that Unlicensed Staff M & N were not assigned to her anymore. During an interview on 4/18/24 at 11:32 a.m. ADM stated that she was not aware that Resident 19 had a verbal altercation with the Unlicensed Staff M & N. ADM stated that DSD did not mention it to her. ADM stated that she met with the Management Team (IDT) from Monday through Friday to discussed new issues. When asked ADM, do you recall when your Management Team discussed these verbal altercations between Unlicensed nurses L, M & N and Residents 9 and Resident 19, ADM stated No, she was not aware. During an interview on 4/19/24 at 10:30 a.m. with the DSD, DSD stated Resident 19 requested to speak to her for an alleged verbal altercation between resident and staff. DSD stated, she recalled that Resident 19 wanted to speak to her, but she was not able to go back to Resident 19's room. When asked DSD, did you inform another management or ADM that Resident 19 would like to report a verbal altercation, DSD stated No. During a concurrent interview and record review on 4/22/24 at 1:19 p.m. ADM stated that if a resident complains, it would be discussed in management (IDT) meeting. ADM stated that during IDT meeting daily, the abuse events were discussed or reported. ADM stated that the Ombudsman never informed her regarding abuse that involved Resident 9 and Unlicensed Staff L. ADM stated that the Ombudsman asked her about a specific last name of an Unlicensed Staff, but she never told her why. ADM stated that the topic or issues discussed during QAPI, personnel improvement plan and employee health files. When asked ADM, during your QAPI meeting, had any of your management mentioned anything about alleged verbal altercation or abuse, ADM stated, No, there were no discussion. A review of the facility's Policy & Procedure titled Quality Assurance and Performance Improvement (QAPI) Plan revised 4/2014 indicated This facility shall develop, implement and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolved identified problems Under objectives, 1) Provide a means to identify and resolve present and potential naive outcomes related to resident care and services: 3) Provide structure and processes to correct identified utility and/or safety deficiencies: 4) Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; 5) Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively ad to delineate lines of authority, responsibility and accountability. Under Authority: 1) The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program. 2) The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40402 Based on observation, interview, and record review the facility failed to follow the Antibiotic Stewardship Clinician Roles Policy, when (Resident 7) was started on Keflex (antibiotic) 500 milligrams BID (twice daily) indefinitely without judicious antibiotic tracking and surveillance from the Infection Preventionist for 41 days. This failure had the potential for (Resident 7) to develop antibiotic resistance. Findings: During a review of the medical record for Resident 7, observed MD order, authored by MD 1, dated 3/7/24 indicated, Start PO (orally) Keflex 500 mg BID Indefinity. Monitor for rash-if rash or itching, contact ID (Infectious Disease) office. Follow up 3 months. During a review of the medical record for Resident 7, Admission Face sheet, dated 1/2/24, indicated, no diagnosis for Facial Rash. During an interview on 4/16/24 at 1:35 p.m., with Resident 7 in room [ROOM NUMBER] C, Resident 7 was observed to not have a rash on her face. Resident 7 queried as to why she was taking an antibiotic called Keflex. Resident 7 stated, she was not sure. Resident 7's BIMS score (Brief Interview for Mental Status - assesses knowing, learning, and understanding) was 12 out of 15. During an interview with the DON on 4/16/24 at 10 a.m., in the conference room, DON queried as to why an order for Keflex 500 mg BID was ordered for Resident 7 indefinitely. DON responded because Resident 7 had a face rash. DON queried for the physical assessment and ongoing documentation noting the face rash. No physical assessment or documentation was provided noting that Resident 7 had a face rash. During a review of the medical record for Resident 7, observed Care Plan, dated 1/2/24, authored by Licensed Staff C, update to Care Plan completed by MDS coordinator on 4/16/24. Focus - The resident is on antibiotic therapy Keflex 500 mg related to infection facial rash. During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff C, dated 3/7/24, indicated, Resident returned from appointment with MD 1 and started resident on Keflex 500 mg indefinitely and to monitor facial rash, follow up in 3 months. During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff E, dated, 3/10/24, indicated, continue antibiotic for facial rash. During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff D, dated, 3/11/24, indicated, continues with antibiotic for facial rash. During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff E, dated, 3/27/24, indicated, continue antibiotic for facial rash. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff D, dated 4/8/24, indicated, on antibiotic for facial rash. During an interview with the DON in the conference room on 4/16/24 at 2 p.m., DON queried as to what the facility's Antibiotic Stewardship Policy indicated about monitoring, tracking and surveillance of antibiotics. DON stated she did not question the indefinite Keflex order on Resident 7 because if the doctor writes indefinite who am I to question the order. DON queried as to the Antibiotic Stewardship Policy for start and stop dates as it pertains to facility's Antibiotic Stewardship Policy. DON stated, I am not sure. DON queried as to what National Standards the facility uses for their Infection Control and Prevention Policy as well as their Medication Administration Policy. DON stated, I just call the pharmacy and ask them. I am not aware of what National Standards the facility follows. DON queried if the facility had an Infection Preventionist on staff. DON stated, our Infection Preventionist left in December of 2023 and I have been filling in. During a review of the medical record for Resident 7, observed nurses note, authored by Licensed Staff E, dated, 4/17/24, indicated, continue antibiotic indefinitely. During an interview with the DON on 4/19/24 at 3 p.m., in the conference room, DON stated, I investigated Resident 7's Keflex order and the diagnosis of facial rash was incorrect. The antibiotic was prescribed for osteomyelitis (bone infection) of left hip. DON stated, I checked the labs on 4/17/24 and called our Medical Director who gave me a verbal order to discontinue Resident 7's Keflex. DON queried if Resident ever had a facial rash in the facility. DON responded, no. During a review of the medical record for Resident 7, observed Communication Record dated, 4/17/24 at 6:55 p.m., authored by DON, indicated, Keflex oral capsule 500 mg, give 1 capsule by mouth two times a day for facial rash. Discontinue as per Medical Director of the facility. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's policy and procedure titled, Antibiotic Stewardship - Staff and Clinician Training and Roles Revised 2016, indicated, The facility will educate and train staff and practitioners about the facility Antibiotic Stewardship Program, including appropriate prescribing, monitoring and surveillance of antibiotic use and outcomes. Nursing and Direct Care Licensed Staff - Nurses will receive initial orientation and ongoing training on: The facility's Antibiotic Stewardship Program, including the need for judicious use of antibiotics; how to utilize the standardized assessment and communication tool for resident suspected of having an infection; How to communicate with resident and family about he need for appropriate use of antibiotic; specific information that should be reported to the physician or provider upon identifying sign and symptoms of possible infection and specific information that should be obtained when an order for an antibiotic is received. Director of Nursing and the Infection Preventionist - Administration and management personnel with clinical oversight responsibilities will receive initial orientation and ongoing training on: the facility's antibiotic Stewardship Program; the rationale for judicious use of antibiotics; how to use surveillance tools to monitor infection rates, antibiotic usage patterns and outcomes; how and when to gather data to present to the Infection Prevention and Control Committee for scheduled meetings; and individual roles and responsibilities in maintain antibiotic stewardship. The DON will monitor individual resident antibiotic regimens, including reviewing clinical documentation supporting antibiotic orders; and compliance with start/stop dates and/or days of therapy. The IP will audit, and the DON will provide feedback to providers on antibiotic prescribing practices. IP will monitor over time and report to the IPCC. a) measures of antibiotic start, resident days, and days of therapy. b) antibiotic susceptibility patterns (antibiogram data for specific timeframe) and c) negative outcomes or events related to antibiotic use for example C difficile infections, adverse drug event and antibiotic resistance rates. The IP will obtain, and the DON will provide to healthcare practitioners, educational resources and materials about antibiotic resistance and opportunities for improved antibiotic use. During a review of the facility's policy and procedure titled, Facility Assessment revised, April 2023, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. The team responsible for conducting, reviewing and updating the facility assessment includes the following: Administrator, A representative of the governing body, Medical Director, DON, and Infection Preventionist. Once the reviews of the resident needs and the facility resources are conducted, the facility assessment consists of systematically evaluating how well aligned these are. Each department provides input on current or potential gaps in care or services due to possible misalignment or lack of appropriate resources. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed. This assessment is based on information acquired during a facility-based infection control risk assessment, as well as a community-based risk assessment. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility's policy and procedure titled, Administrative Management (Governing Board) Revised April 2023, indicated, The governing board shall be responsible for the management and operation of the facility. The facility's governing board is the supreme authority and has full legal authority and responsibility for the management and operation of our facility. The administrator is appointed by and accountable to the governing board. The governing board is responsible for but is not limited to: Oversight of facility care and services in accordance with professional standards of practice and principles. Establishment and ongoing review of all administrative programs governing facility management and operations, including Corporate Compliance Program .Quality Assurance and Performance Improvement program, and Staff orientation, training and development programs. Creation of and participation in the annual facility-wide assessment: Provision of a safe physical environment equipped and staffed to maintain the facility and services. During a review of the DON's job description, revised October 2020, indicated, Safety and Sanitation Ensure that nursing services personnel follow established infection prevention and control procedures. During a review of the Infection Preventionists job description, revised October 2020, indicated, Primary Purpose of this position is to plan, organize develop, coordinate, and direct the facility infection prevention and control program and its activities in accordance with the current federal, state, and local standards, guidelines and regulations that govern such programs and as directed by the Administrator and the infection Prevention and Control Committee. Administrative Functions: Plan develop, implement, evaluate and oversee the infection prevention and control program in accordance with current regulations and guidelines governing skilled nursing facilities. Establish and maintain an infection surveillance program that is based on standardized definitions of infections. Review, summarize and report data relative to key infection prevention and control initiatives including antibiotic stewardship, healthcare acquired infections, immunization programs and outbreaks. Present findings from special investigations and make recommendations to the Infection Prevention and Control Committee. Participate in the annual facility assessment, perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, etc., as necessary.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40402 Based on observation, interview and record review, the facility failed to provide a fully credentialed Infection Preventionist (nurse who surveys and monitors infection prevention and control). This failure had the potential for Residents to obtain infections and be placed on unnecessary medications due to lack of infection control surveillance. During an interview with the DON on 4/16/24 at 10:30 a.m., DON queried as to who the Infection Preventionist is for the facility. DON stated, the nurse who has been working as the Infection Preventionist (Licensed Staff H) resigned 12/29/23. DON stated, Licensed Staff H and Licensed Staff I have been filling in. DON queried for the facility's staffing sign in sheets for Licensed Staff H and Licensed Staff I from 1/3/24 to 4/15/24. DON also queried for the timecard accounting for License Staff H and Licensed Staff I from 1/3/24 to 4/15/24. During a record review of Licensed Staff H's timecard for the time frame 1/3/24 to 4/15/24. License Staff H's worked day shift on 1/19/24, 1/25/24, 2/1/24, 2/5/24, 2/8/24, 2/18/24, 2/19/24, 2/23/24, and 2/29/24. During a record review of Licensed Staff H's Staffing Sign in sheets for 1/19/24, 1/25/24, 2/1/24, 2/5/24, 2/8/24, 2/18/24, 2/19/24, 2/23/24, and 2/29/24, Licensed Staff H's timecard revealed that none of these dates was Licensed Staff H signed in to work as the Infection Preventionist. During a record review of Licensed Staff H's HR File, Certificate of Training for Infection Prevention 2-Day Course from CDPH (California Department of Public Health), dated, 9/12/19. No other Infection Preventionist training was found in Licensed Staff H's file as well as no annual continuing education CEU's. During a record review of Licensed Staff I's timecard for the time frame of 1/3/24 to 4/15/24, Licensed Staff I worked day shift on 1/4/24, 1/11/,24, 1/12/24, 1/16/24, 1/17/24, 1/25/24, 2/1/24, 2/5/24, 2/6/24, 2/12/24, 2/18/24, 2/20/24, 2/22/24, 2/26/24, 3/26/24 and was signed in on the Staffing Sign In sheets as the Infection Preventionist. Licensed Staff I worked as an Infection Preventionist from 1/3/24 -4/15/24 for a total of 15 shifts. During a record review of Licensed Staff I's HR File, Certificate of Training for infection Prevention 2-Day Course from CDPH, dated, March 1, 2024. This Certificate was 2.5 months after License Staff H resigned. Licensed Staff I started working as an Infection Preventionist on 1/4/23 without Infection Preventionist certification. No other credentialing prior to March 1, 2024, was found in Licensed Staff I's HR File. During an interview with the DON on 4/15/24 at 10:30 a.m., DON queried for the facility's policy for Infection Preventionist. No policy received. DON queried if both the DON position and the DSD position required a full-time nurse. DON responded, yes. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the CDPH's Entrance Conference Worksheet, dated 4/15/24, Line 21, indicated, Name of facility's infection preventionist (IP). Documentation of the IP's primary professional training and evidence of completion of specialized training in infection prevention and control. This information was requested in writing from the ADM but no name or certification was received for the facility's Infection Preventionist. During a review of the facility's policy and procedure titled, Antibiotic Stewardship - Staff and Clinician Training and Roles Revised 2016, indicated, The facility will educate and train staff and practitioners about the facility Antibiotic Stewardship Program, including appropriate prescribing, monitoring and surveillance of antibiotic use and outcomes. Nursing and Direct Care Licensed Staff - Nurses will receive initial orientation and ongoing training on: The facility's Antibiotic Stewardship Program, including the need for judicious use of antibiotics; how to utilize the standardized assessment and communication tool for resident suspected of having an infection; How to communicate with resident and family about the need for appropriate use of antibiotic; specific information that should be reported to the physician or provider upon identifying sign and symptoms of possible infection and specific information that should be obtained when an order for an antibiotic is received. Director of Nursing and the Infection Preventionist - Administration and management personnel with clinical oversight responsibilities will receive initial orientation and ongoing training on: the facility's antibiotic Stewardship Program; the rationale for judicious use of antibiotics; how to use surveillance tools to monitor infection rates, antibiotic usage patterns and outcomes; how and when to gather data to present to the Infection Prevention and Control Committee for scheduled meetings; and individual roles and responsibilities in maintain antibiotic stewardship. The DON will monitor individual resident antibiotic regimens, including reviewing clinical documentation supporting antibiotic orders; and compliance with start/stop dates and/or days of therapy. The IP will audit, and the DON will provide feedback to providers on antibiotic prescribing practices. IP will monitor over time and report to the IPCC. a) measures of antibiotic start, resident days, and days of therapy. b) antibiotic susceptibility patterns (antibiogram data for specific timeframe) and c) negative outcomes or events related to antibiotic use for example C difficile infections, adverse drug event and antibiotic resistance rates. The IP will obtain, and the DON will provide to healthcare practitioners, educational resources and materials about antibiotic resistance and opportunities for improved antibiotic use. During a review of the facility's policy and procedure titled, Facility Assessment revised, April 2023, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. The team responsible for conducting, reviewing, and updating the facility assessment includes the following: Administrator, A representative of the governing body, Medical Director, DON, and Infection Preventionist. Once the reviews of the resident needs and the facility resources are conducted, the facility assessment consists of systematically evaluating how well aligned these are. Each department provides input on current or potential gaps in care or services due to possible misalignment or lack of appropriate resources. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed. This assessment is based on information acquired during a facility-based infection control risk assessment, as well as a community-based risk assessment. (continued on next page)

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Administrative Management (Governing Board) Revised April 2023, indicated, The governing board shall be responsible for the management and operation of the facility. The facility's governing board is the supreme authority and has full legal authority and responsibility for the management and operation of our facility. The administrator is appointed by and accountable to the governing board. The governing board is responsible for but is not limited to: Oversight of facility care and services in accordance with professional standards of practice and principles. Establishment and ongoing review of all administrative programs governing facility management and operations, including Corporate Compliance Program .Quality Assurance and Performance Improvement program, and Staff orientation, training and development programs. Creation of and participation in the annual facility-wide assessment: Provision of a safe physical environment equipped and staffed to maintain the facility and services. During a review of the DON's job description, revised October 2020, indicated, Safety and Sanitation Ensure that nursing services personnel follow established infection prevention and control procedures. During a review of the Infection Preventionists job description, revised October 2020, indicated, Primary Purpose of this position is to plan, organize develop, coordinate, and direct the facility infection prevention and control program and its activities in accordance with the current federal, state, and local standards, guidelines and regulations that govern such programs and as directed by the Administrator and the infection Prevention and Control Committee. Administrative Functions: Plan develop, implement, evaluate and oversee the infection prevention and control program in accordance with current regulations and guidelines governing skilled nursing facilities. Establish and maintain an infection surveillance program that is based on standardized definitions of infections. Review, summarize and report data relative to key infection prevention and control initiatives including antibiotic stewardship, healthcare acquired infections, immunization programs and outbreaks. Present findings from special investigations and make recommendations to the Infection Prevention and Control Committee. Participate in the annual facility assessment, perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, etc., as necessary.