STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555184	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Avenue Healthcare	1044 Heartwood Ave. Vallejo, CA 94591

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) when: 1. Facility staff failed to accurately document the use of BiPap ((Bilevel Positive Airway Pressure) machine is a non-invasive ventilator used to assist breathing by delivering pressurized air through a mask, improving oxygen levels) for Resident 1 as ordered by her physician,2. Facility staff administered an opioid medication (controlled drug highly effective for severe, acute, or chronic pain but carries significant risks of addiction, misuse, and overdose) on two occasions without adequate indication for use to Resident 1, and3. Facility failed to order Narcan (naloxone: a life-saving, over-the-counter nasal spray that rapidly reverses opioid overdoses in 2-3 minutes) for Resident 1 while she was being given an opioid medication.These failures resulted in Resident 1's emergency transfer to an acute care hospital after an opioid overdose. 1. During a review of Resident 1's Facesheet (contains resident's demographics, diagnoses, physician etc.) dated 4/14/26, Facesheet indicated Resident 1 was diagnosed with the following conditions: Acute Respiratory Failure (life-threatening emergency where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide; a waste product), Heart failure (chronic condition where the heart cannot pump enough blood to meet the body's needs), Chronic Kidney Disease stage 3 (a middle stage chronic disease where kidneys struggle to filter waste, often causing symptoms like fatigue, fluid retention, and back pain), Obstructive sleep apnea (disorder where throat muscles relax excessively during sleep, causing the airway to collapse and breathing to stop repeatedly), and Morbid (severe) obesity with alveolar hypoventilation (is a serious breathing disorder in obese individuals characterized by chronic daytime increased carbon dioxide in the blood and inadequate ventilation-moving air into and out of the lungs; causing low blood oxygen).During a review of Resident 1's Medication Administration Record (MAR), dated January 1st through 31st, 2026, the MAR indicated, an order for BIPAP.apply at bedtime. MAR indicated, X for each day in January, indicating the order was not performed.During a review of Resident 1's Medication Administration Record (MAR), dated February 1st through 28th, 2026, the MAR indicated, an order for BIPAP.apply at bedtime. MAR indicated, X for each day in February, indicating the order was not performed.During a review of Resident 1's Medication Administration Record (MAR), dated March 1st through 31st, 2026, the MAR indicated, an order for BIPAP.apply at bedtime. MAR indicated, X for each day in March, indicating the order was not performed.During an interview and concurrent Resident 1's clinical record review on 4/14/26, at 11:30 a.m., with Director of Nursing (DON), DON stated, she is covering as the DON for this facility. DON stated, she sees in the medical record Resident 1 had an order for Bipap. DON stated, the PM [afternoon shift] nurses are supposed to place the Bipap on the resident and document when it was carried out. DON stated, there is no documentation in the MAR that nurses applied the Bipap for Resident 1 for March 2026. DON stated, the order should specify the time the Bipap machine should be put on and removal time, it does not. DON further stated, she was aware of the importance of using a Bipap is to help the patient breath and correct their C02 [Carbon Dioxide] problem. DON stated, If the patient is not using it [Bipap] there is a chance for respiratory distress.2.During a review of Resident (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1's Order Summary Report dated 3/13/26, report indicated Resident 1 had a physician order for Morphine Sulfate (a Schedule II controlled opioid medication with high potential for abuse that is used to manage severe acute or chronic pain, that carries significant risks of addiction, abuse, and life-threatening respiratory depression-breathing is too slow or shallow causing high carbon dioxide levels) 15 milligrams (mg, unit of measurement). Order indicated, Give 1 tablet by mouth every 6 hours as needed for severe pain (7-10/10), pain is rated on a numerical scale from zero (no pain) to 10 (worst pain imaginable); 1-3 for mild pain, 4-6 for moderate pain and 7 -10 for severe pain.During an interview on 4/14/26, at 11:38 a.m., with DON, DON stated, it is her expectation the nurses follow all physician orders for pain medication. DON further stated, the nurses should follow the pain level verbalized by the patient [resident] and give the pain medication that corresponds to the number given by the resident and the order directions. DON stated, we should be giving the least powerful [strength] pain medication needed to resolve the pain.During a concurrent interview and record review on 4/14/26, at 11:53 a.m., with DON, Resident 1's MAR dated March 2026 was reviewed. The MAR indicated, Resident 1 was administered Morphine Sulfate 15 mg on 3/15/26 at 1638 (4:38 p.m.) with a pain level charted as 5 (moderate pain) administered by Licensed Nurse (LN 1). MAR indicated, Resident 1 was also given Morphine Sulfate on 3/16/26 at 1817 (6:17 p.m.) with a pain level charted as 6(moderate pain) administered by LN 1. DON stated, the two administrations above were not appropriate based on the pain level charted and as per the physician orders. DON further stated, there is a potential for adverse effects if a resident is given a pain medication stronger than their stated pain, one of them for Morphine is respiratory distress.During a review of Resident 1's Change in Condition dated 3/16/26, at 2145 (9:45 p.m.) indicated, Shortness of breath.-Pulse oximetry [the measure of oxygen saturation in the blood, normal value is considered around 95-100%] O2 [oxygen] 46.0%. Change in condition further indicated, Notified MD resident was sent out [to Hospital 1] for SOB [shortness of breath].During an interview on 4/16/26, at 1:44 p.m., with LN 1, LN 1 stated, she was the nurse who gave Resident 1 Morphine on 3/16/26 at approximately 6 p.m. LN 1 stated, on 3/16/26 around 9 p.m. another staff member approached her and asked her to check on Resident 1. LN 1 stated she checked on Resident 1 who was in her room in her wheelchair complaining of shortness of breath. LN 1 stated, she checked her oxygen saturation and she was desaturating (experiencing low blood oxygen (hypoxemia)). LN 1 stated, so I gave her some oxygen. When I rechecked it [oxygen level] it kept desaturating and I called 911. LN 1 stated, When the paramedics came they said she [Resident 1] was in distress and they had to increase the oxygen to 15 liters [a high flow oxygen setting used to treat severe low blood oxygen] with a mask on. LN 1 further stated, she saw paramedics take Resident 1 to the hospital, When I came back to work they said she [Resident 1] was diagnosed with an overdose.During a review of Resident 1's ED [emergency department] Provider Note dated 3/16/26, from local Acute care hospital (Hospital 1), note indicated, Differential diagnosis [a step by step process to distinguish specific disease from others that present with similar symptoms] includes, but is not limited to: -Opiate overdose: Opiate overdose is likely given the recent administration of 15 mg morphine, associated lethargy [state of sleepiness or deep unresponsiveness], hypoventilation [breathing that is too shallow or slow to meet the body's needs, causing dangerous carbon dioxide buildup (hypercapnia) and low oxygen], and response to Narcan. -Acute respiratory failure with hypoxia [low oxygen level in blood]: Acute respiratory failure with hypoxia is present, evidenced by low oxygen saturation and cyanosis [a bluish discoloration of the skin, lips, or nail beds, typically caused by low oxygen levels in the blood], likely secondary to [a direct result] opioid-induced respiratory depression. -Acute encephalopathy: [group of conditions which cause brain dysfunction] Acute encephalopathy is present, manifested by confusion and inability to answer questions, likely secondary to hypoxia and opioid toxicity [overdose, degree of damage e.g. to vital organs]. ED provider note further indicated, 2335 [11:35 p.m.] Narcan given and patient became more alert and oriented. Tue [DATE], 0003 [12:03 a.m.] Required another 2 mg of IV [intravenous, through the vein] Narcan. Will start Narcan drip [continous intravenous infusions used (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to manage severe opiod overdose]. 0140 [1:40 a.m.] Narcan drip was initiated and [Resident 1's] symptoms did improve. She became more alert . Disposition: Admit to hospital Condition: Critical.During a review of Resident 1's General Discharge Summary from Hospital 1, dated 3/16/26-3/24/26 indicated, Reason for admission: Patient presents with: Altered mental status [sudden change in baseline mental status ranging from confusion, delirium to coma] : BIBA [brought in by ambulance] from [facility name] c/o [complaining of] ALOC [altered level of consciousness] and low sats [oxygen level in blood]. Per EMS [emergency medical services] patient found to be 50% on RA [room air] on their arrival. EMS states patient was given 15 mg morphine @ 1800 [6 p.m.]. Was given 4 mg of Narcan by EMS and patient became more responsive.History of Present Illness.Respiratory distress and hypoxemia [low oxygen levels in the blood] -episodes of cyanosis .Precipitating [immediate triggers or events or conditions leading to] factors and interventions -Received 15 mg of morphine at [facility name] around 6pm. DC summary further indicated, to stop taking Morphine Sulfate medication.3. During a review of Resident 1's Order Summary Report dated 4/14/26, report indicated, Naloxone was ordered on 3/24/26 (11 days after Morphine Sulfate was ordered).During an interview on 4/14/26, at 12:10 p.m., with DON, DON stated, Narcan should be ordered once the opioid is ordered. DON stated, Resident 1 was ordered Morphine Sulfate on 3/13/24, and was not ordered the Narcan until 3/24/26.During an interview on 4/14/26, at 12:27 p.m., with LN 2, LN 2 stated, When we order a narcotic [opioid] we also have to order Narcan as well.During an interview on 4/16/26, at 1:18 p.m., with Medical Doctor (MD) 1, MD 1 stated, he will reference his resident's medical record prior to ordering an opioid to make sure the medication is appropriate. MD 1 stated, Morphine Sulfate may not be appropriate for residents who are on dialysis (a life-sustaining treatment for kidney failure) or have chronic kidney disease stage 4 (severe kidney function loss) because the medication can stay in their system longer. MD 1 stated, Narcan should automatically be ordered when an opioid is ordered. MD 1 further stated, he ordered the Morphine for Resident 1. MD 1 stated, he could not find in the medical record the exact reason for ordering the medication Morphine Sulfate. MD 1 stated, he expects the nurses to follow the pain scale and give pain medications based on the order's listed pain level.During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated 2025, the P&P indicated, 4. Medications are administered in accordance with prescriber orders.