

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Valley of the Moon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 347 Andrieux St Sonoma, CA 95476	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food according to professional standards for food safety for a facility census of 27 residents when: A large dented can was stored in the ready-for-use dry storage area, Expired food items were stored in the ready-for-use dry storage area, An opened food package was stored without any labeling in the ready-for-use dry storage area, and; Scratched and peeling plastic cutting boards were in use in the food preparation area. These failures created the potential for food contamination and food-borne illness for a vulnerable resident population. Cross-reference F908. 1. During a concurrent observation and interview on 7/13/26 at 9:15 a.m. with the Dietary Manager (DM), a large dented can of pinto beans was found in the ready-for-use area. The DM stated the can should have been removed from stock. 2. During a concurrent observation and interview on 7/13/26 at 9:20 a.m. with DM, two opened containers of cake icing with expiration dates of 5/6/26, and a bag of whole wheat noodles with an expiration date of 6/19/26, were found in the ready-for-use area. The DM stated these items should have been discarded. 3. During a concurrent observation and interview on 7/13/26 at 9:30 a.m. with DM, an opened, unlabeled package of tortillas was found stored with sealed packages. The DM stated the package should have been labeled with an open date and use-by date. 4. During a concurrent observation and interview on 7/13/26 at 9:40 a.m. with DM, several plastic cutting boards with deep scratches, and one with peeling plastic particles, were observed in the kitchen. The DM agreed the boards required replacement to allow proper cleaning and to prevent plastic particles from entering food. During a phone interview on 7/16/26 at 10:05 a.m., the Registered Dietitian (RD) stated dented cans increased the risk of botulism (a serious illness caused by a toxin that attacks the body's nerves; causing difficulty breathing, muscle paralysis, and even death) and should not be used. The DM stated the importance of discarding expired foods and properly labeling opened items to prevent food-borne illness. She also stated that damaged cutting boards should be discarded to avoid bacterial growth and prevent plastic fragments from entering resident food. A review of facility policy and procedure (P & P) titled, Dry Storage - Food and Nutrition Services, dated 7/2023, indicated, all food products will be labeled with a use-by date. If the use-by date is unknown the food product must be labeled with a received date while the use-by date is determined. food that has exceeded its use-by date is discarded. damaged, spoiled or recalled products, shall be segregated and held in designated areas. cans will be inspected for rust, bulging, leaking, and dents. any food items compromised must be discarded immediately and replaced. A review of facility P & P titled, Cutting Boards, dated 4/2026, indicated, once the cutting board becomes excessively worn and or develops hard to clean grooves, it should be discarded.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F689 - Free of Accident Hazards/Supervision/DevicesBased on interview and record review, the facility failed to ensure a timely post-fall risk evaluation assessment was completed following a resident fall, for one of three sampled residents, (Resident 32), reviewed for falls.This failure resulted in a missed opportunity to identify and address additional fall risk factors before Resident 32 experienced a second fall in the facility and placed him at an increased risk for potential injury. Findings:A record review of Resident 32's admission record (facility demographic) indicated, Resident 32 was admitted to the facility on [DATE], with initial diagnoses including but not limited to a heart attack (when a blocked artery stops blood and oxygen from reaching a section of the heart) and dementia (a progressive state of decline in mental abilities).A record review of a change in condition assessment dated [DATE], indicated Resident 32 experienced a fall in the facility.A record review of a change in condition assessment dated [DATE], indicated Resident 32 experienced a second fall in the facility on 7/11/26.A record review of a Fall Risk Evaluation assessment dated [DATE], indicated Resident 32's fall risk evaluation assessment was not completed after the fall he sustained on 7/07/26, until 7/13/26, which was six days after his first fall on 7/07/26 and two days after his second fall on 7/11/26.During an interview and concurrent record review on 7/13/26, at 3:26 p.m., Licensed Nurse 1 (LN 1) reviewed the only two fall risk evaluations listed in Resident 32's medical record at that time; one dated 7/06/26, labeled, Admission, which resulted in a score of 16 indicating Resident 32 had a high risk for falls, and another evaluation dated 7/13/26, labeled, Change in Condition which resulted in a score of 2 which LN 1 confirmed was incomplete. LN 1 stated the post-fall risk evaluation assessment indicated that it was created by Director of Nursing 1 (DON 1), whose name LN 1 did not recognize, as this person was not employed by the facility.During an interview and concurrent record review on 7/14/26, at 2:41 p.m., Licensed Nurse 2 (LN 2) stated that, in accordance with facility practice, a new post-fall risk evaluation assessment should be completed within 24 hours after a resident fall in the facility, and confirmed Resident 32 fell on 7/07/26, the day after he was admitted to the facility. LN 2 confirmed DON 1, who was not the same DON at this facility, was the person who created Resident 32's post-fall risk evaluation assessment and that DON 1 had only answered the first two questions of the evaluation, on the morning of 7/13/26, specifically in response to Resident 32's fall that occurred on 7/07/26. LN 2 stated he finished answering the questions and completed the rest of Resident 32's post-fall risk evaluation assessment and then electronically signed the document on the afternoon of 7/13/26.During an interview and concurrent record review on 7/14/26, at 3:00 p.m., Licensed Nurse 3 (LN 3) stated that, in accordance with facility practice, a new post-fall risk evaluation assessment should be completed and documented within 24 hours following a resident fall in order to determine whether new fall risk factors, including triggers, exist and whether additional interventions are needed in the resident's care plan. LN 3 stated that failure to complete a post-fall risk evaluation assessment timely for a resident who has fallen in the facility, places the resident at an increased risk for a fall reoccurrence. LN 3 confirmed Resident 32 sustained two falls within one week of his admission to the facility and stated that based on his experience while working at the facility, this was an unusual occurrence for a resident to fall twice within one week of admission.During an interview and concurrent record review on 7/14/26, at 3:28 p.m., the facility's Director of Nursing 2 (DON 2) confirmed Resident 32's post-fall risk evaluation assessment was created on the morning of 7/13/26, in response to Resident 32's fall on 7/07/26, by her colleague, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON 1, who did not work at her facility, but helped her out by auditing her staff members' charting in residents' records, as she did with Resident 32's post-fall assessment which was then completed and signed by LN 2 on the afternoon of 7/13/26. DON 2 admitted Resident 32's post-fall risk evaluation assessment was not completed timely after his fall on 7/07/26, and confirmed it should have been completed immediately after Resident 32's initial fall, to identify any potential need for new interventions to reduce Resident 32's risk of a fall reoccurrence. DON 2 confirmed Resident 32 did sustain a second fall on 7/11/26, before any post-fall risk evaluation assessment had been completed following his first fall on 7/07/26. A review of the facility policy titled Assessing Falls and Their Causes, revised 2018, indicated, Falls are a leading cause of morbidity and mortality among the elderly in nursing homes. After a fall: . Complete an incident report no later than 24 hours after a fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Identifying Causes of a Fall or Fall Risk: Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Performing a Post-Fall Evaluation: . After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair with using his or her arms, walk several paces, and return to sitting, and will document the results of this effort. Documentation: . When a resident falls, the following information should be recorded in the resident's medical record: 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls.		