

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Spring Lake Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 Montgomery Drive Santa Rosa, CA 95409	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of 18 sampled residents (Resident 29 and 37) needs and preferences were met when:</p> <ol style="list-style-type: none"> 1. Resident 29's call light was not within reach. This failure had the potential to result in Resident 29 being unable to get assistance as needed. 2. Resident 37 did not receive assistance to get out of bed and dressed earlier in the morning. This failure had the potential to adversely impact Resident 37's quality of life. <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 29's face sheet (demographics), dated 2/10/25, the face sheet indicated Resident 29 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a progressive and irreversible brain disorder that causes a gradual decline in memory, thinking skills and behaviors) and weakness. <p>During an observation on 2/9/25 at 5:56 p.m., in Resident 29's room, Resident 29 was lying in bed with his square pad call light not within his reach.</p> <p>During an interview on 2/9/25 at 6:02 p.m. with the Registered Nurse (RN) 5, RN 5 stated that Resident 29's call light should have been within reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Resident Call System, dated March 2021, the P&P indicated, Make sure the resident is comfortable and that the means to call for assistance is within their reach .</p> <p>52029</p> <ol style="list-style-type: none"> 2. During a review of Resident 37's face sheet (demographics), the face sheet indicated, Resident 37 was admitted on [DATE] with diagnoses that included congestive heart failure (CHF - condition where the heart cannot pump enough blood to meet the body's need for blood and oxygen). <p>During an interview on 2/9/25 at 3:35 p.m., Resident 37 stated she needed assistance from staff for dressing, toileting, and transferring out of bed. Resident 37 stated it often took staff a long time to respond when she used her call light.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview with Resident 37 on 2/10/25 at 9:55 a.m., Resident 37 was observed in her bed wearing a gown. Resident 37 stated she was frustrated because she had been waiting on staff for assistance. Resident 37 stated she wanted to get out of bed and get dressed because she was scheduled for a therapy session at 10 am and she was worried she would miss the session. Resident 37 stated, I want to get up earlier, but I always have to wait for staff to get up in the morning. They don't have enough staff to get us all up in the morning.</p> <p>During a concurrent observation and interview with Resident 37 on 2/12/25 at 9:45 a.m., Resident 37 was observed in her bed wearing a gown. Resident 37 stated she was still waiting on staff to assist her out of bed for the day.</p> <p>During an interview on 2/12/25 at 11:05 a.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated that Resident 37 has complained to him about getting her out of bed. CNA 3 stated that Resident 37 starts to Grumble if she is not out of bed by 9:30 a.m.</p> <p>During a review of Resident 37's Minimum Data Set (MDS - an assessment tool) section GG, dated 1/4/25, MDS indicated, Chair/bed - to - chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) was coded . 02: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>During a review of the facility's policy and procedure (P&P) titled, ADL (acts of daily living) Care, dated 12/19, the P&P indicated, Nursing staff will provide ADL care to each resident daily to meet their individual needs .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>39646</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment when:</p> <ol style="list-style-type: none"> 1. Personal use items including toothbrushes, toothpaste and combs were observed in a shared restroom for Residents 5, 8, 18, and 145 in a unlabeled wash basin (a pink colored wash basin/container for each resident used to store their personal use items). 2. Resident 18's personal use item was observed on Resident 145's (roommates) bedside table. <p>These failures had the potential to cause illness and cross contamination in a medically compromised population.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 2/9/25 at 3:19 p.m. and 3:45 p.m., in a shared restrooms for Resident 5, Resident 8, Resident 18 and Resident 145, personal use items were observed in a unlabeled wash basin. <p>During an interview on 2/10/25 at 4:19 p.m., with Certified Nurse Assistant (CNA) 2, CNA 2 stated the room number should be on the wash basin that holds the resident personal use items, but not the name.</p> <ol style="list-style-type: none"> 2. During an observation on 2/10/25 at 4:01 p.m., in room Resident 18's, Resident 18's wash basin was observed on Resident 145's bedside table. <p>During an interview on 2/10/25 at 4:03 p.m., with CNA 1, CNA 1 stated the wash basins were not shared and Resident 18's wash basin should not be on Resident 145's bedside table.</p> <p>During an interview on 2/10/25 at 4:14 p.m., with the Director of Staff Development (DSD), DSD stated resident names should be written on their wash basins but should not be shared. The roommates' wash basin should not have been on her roommates' table. It was a mistake.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bedside Equipment - Wash Basins, Emesis Basins, Bedpans, & Urinals dated 2020, the P&P indicated, .Bedside equipment including, but not limited to wash basins, emesis basins, bedpans and urinals shall be labeled with resident's first and last name and placed in plastic bag between usage to avoid cross contamination .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to implement the plan of care for two of 18 sampled residents (Resident 29 and Resident 22) when:</p> <ol style="list-style-type: none"> 1. Resident 29 did not have bedside fall safety mats. 2. Resident 22's heels were not elevated off the bed. <p>These failures had the potential to result in subsequent falls with serious injuries and worsening of skin breakdown.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 29's face sheet (demographics), dated 2/10/25, the face sheet indicated, Resident 29 was admitted to the facility on [DATE], with diagnoses to include of Alzheimer's disease (a progressive and irreversible brain disorder that causes a gradual decline in memory, thinking skills and behaviors) and weakness. <p>During a review of Resident 29's Fall Care Plan, dated 11/18/24, the Fall Care Plan indicated, Resident 29 was at risk for falls and had six previous falls. Resident 29's Fall Care Plan indicated, the intervention for Resident 29 to avoid serious injury was to Place fall mats on both side of bed.</p> <p>During a concurrent observation and interview on 2/10/25 at 5:04 p.m., with Registered Nurse (RN) 5, in Resident 29's room, Resident 29 was lying in bed without a fall mat on the right side of the bed. RN 5 stated Resident 29 needed a fall mat on both sides of the bed.</p> <ol style="list-style-type: none"> 2. During a review of Resident 22's face sheet (demographics), dated 2/13/25, the face sheet indicated, Resident 22 was admitted to the facility on [DATE], with diagnoses to include of dementia (loss of ability to think, remember and reason to levels that affect daily life and activities). <p>During a review of Resident 22's Right Heel Blanchable Redness Care Plan, dated 2/5/25, the Care Plan indicated, Resident 22 had right heel redness and required heels to be elevated while in bed.</p> <p>During multiple observations on 2/9/25 to 2/12/25 at various times in Resident 22's room, Resident 22 was lying in bed with heels touching the mattress.</p> <p>During an interview on 2/12/25 at 3:15 p.m., with Registered Nurse (RN) 8, RN 8 stated Resident 22 had redness to her right heel, and her heels needed to be elevated off the mattress with a pillow to prevent further skin breakdown.</p> <p>During a review of Resident 22's Right Heel Blanchable Redness Care Plan, dated 2/5/25, the Care Plan indicated, Resident 22 had right heel redness and required heels to be elevated while in bed.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52029</p> <p>Based on interview and record review, the facility failed to ensure weekly skin assessments were conducted and documented for one of 18 sampled residents (Resident 21) right heel pressure ulcer (PU- an injury to the skin caused by prolonged pressure on a specific area, often over bony prominences like the heels or tailbone). This failure had the potential to result in delayed treatment and services required to promote wound healing.</p> <p>Findings:</p> <p>During a review of Resident 21's face sheet (demographics), the face sheet indicated Resident 21 was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors and difficulty walking).</p> <p>During an interview on 2/11/25 at 2:05 p.m., with Infection Preventionist/Registered Nurse (IP/RN), IP/RN stated nursing staff should conduct a head-to-toe skin assessment on every resident at least weekly. IP/RN further stated pressure ulcer/wound assessments should be conducted at least weekly to monitor wound healing and document the assessment in the resident's record. IP/RN stated the documentation should include the appearance of the PU including measurements and the treatment provided.</p> <p>During a concurrent interview and review of Resident 21's electronic health record (EHR) on 2/11/25 at 4:12 p.m. with IP/RN, the record indicated:</p> <p>Resident 21's Minimum Data Set (MDS- an assessment tool) dated 11/8/24 indicated, Resident 21 had a right heel Stage II PU (a shallow open sore or blister where the outer layer of skin and some of the deeper layers are damaged).</p> <p>The Physician's Progress Note, dated 12/5/24, indicated, Fluid filled blister to right heel- skin prep to heels every shift, cover with a foam dressing, and monitor.</p> <p>The Wound Care Nurse Practitioner's Progress Note, dated 1/6/25, indicated, Resident 21 had an unstageable (a wound where a thick layer of dead tissue completely covers the wound bed making it impossible to determine the true depth of the wound) right heel PU that measured 2 centimeter (cm- unit of measurement) by 5 cm.</p> <p>There was no documentation in Resident 21's EHR that indicated Resident 21's right heel pressure ulcer was assessed and measured for the weeks of 12/19/24, 12/26/24, 1/16/25, 1/23/25, and 1/30/25. IP/RN stated staff should have conducted and documented assessments to evaluate if Resident 21's PU was healing.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Skin Integrity and Management, dated August 2022, the P&P indicated, Any pressure or non-pressure skin discoloration and/or breakdown will be monitored at least weekly and with any treatment or dressing change.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39646</p> <p>Based on observation, interview, and record review, the facility failed to ensure shower disinfectant was stored in a locked storage container. This failure had the potential to result in unintentional access and harm.</p> <p>Findings:</p> <p>During an observation on 2/9/25 at 4:20 p.m., in Shower room [ROOM NUMBER], there was an unlocked storage container on top of a cupboard with signage stating, Keep locked at all times. The container contained a clear liquid and was labeled Shower disinfectant.</p> <p>During an interview on 2/9/25 at 4:24 p.m., with Restorative Nursing Aide (RNA) 1, RNA 1 stated the storage container should have been locked because the shower disinfectant was stored there.</p> <p>During an interview on 2/11/25 at 10:17 a.m., with the Director of Nursing (DON), the DON stated disinfectant should have been stored in a locked storage container.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, 2025, the P&P indicated, .21. Chemicals used to clean and disinfect environmental surfaces will be stored in a locked container or area inaccessible to others when not in use or under observation by staff.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47844</p> <p>Based on observation, interview, and record review, the facility failed to effectively manage pain for one of 18 sampled residents (Resident 200). This failure resulted in unrelieved pain for Resident 200.</p> <p>Findings:</p> <p>During a review of Resident 200's face sheet (demographics), the face sheet indicated that Resident 200 was admitted to the facility on [DATE], with diagnoses to include disseminated malignant neoplasm (a cancer that has spread to multiple parts of the body).</p> <p>On 2/6/25, Resident 200 was admitted to hospice care (a type of medical care for those with an incurable illness with a life expectancy of six months or less) with comfort focused measures only (palliative care -specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness).</p> <p>During a concurrent observation and interview on 2/10/25 at 10:23 a.m., with Resident 200's daughter, in Resident 200's room. Resident 200 was observed asleep in bed. Resident 200's daughter stated that Resident 200 was new to the facility and that since admission her pain management had not been optimal.</p> <p>During a review of Resident 200's Order Summary Report, dated 2/6/25, indicated that Resident 200 had Oxycodone HCl and Morphine Sulfate ordered for pain as follows:</p> <p>a. oxyCODONE HCl Oral Tablet 20 MG (milligram) (Oxycodone HCl) Give 1 tablet by mouth every 4 hours as needed for Pain.</p> <p>b. Morphine Sulfate (Concentrate) Solution 20 MG/ML (milliliter) Give 0.25 ml by mouth every 1 hours as needed for mild pain (1-3) symptoms 5 (mg)</p> <p>c. Morphine Sulfate (Concentrate) Solution 20 MG/ML (milliliter) Give 0.5 ml by mouth every 1 hours as needed for moderate pain (4-6) symptoms (10mg) .</p> <p>d. Morphine Sulfate (Concentrate) Solution 20 MG/ML (milliliter) Give 1 ml by mouth every 1 hours as needed for severe pain (7-10) symptoms (20mg) .</p> <p>During a concurrent observation and interview on 2/11/25 at 12:26 p.m., with Resident 200, Resident 200 was in bed with meal tray on her bedside table. Resident 200 stated she was currently in pain and asked the licensed nurse more than 30 minutes ago for more pain medication.</p> <p>During an interview on 2/11/25 at 12:29 p.m., with RN 2, RN 2 stated she gave Resident 200 oxycodone (narcotic analgesic pain medication) for pain at 1030 a.m. RN 2 confirmed that she had not reevaluate Resident 200's pain since that time. RN 2 stated, I could have given her [Resident 200] morphine. RN 2 stated she was helping another resident. RN 2 further stated, It is my fault I should have given it.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 200's Medication Administration Record (MAR), dated February 2025, indicated that on 2/11/25, Resident 200 received a PRN dose of Morphine 1mL for severe pain 7/10 at 12:41 p.m. (2 hours and 11 minutes later).</p> <p>During an interview on 2/12/25 at 8:56 a.m. with Resident 200, Resident 200 stated she frequently had pain. Resident 200 stated it would take staff a while to get her pain medications after asking for it. Resident 200 stated some days she only got pain medication every three to four hours. Resident 200 further stated that because of her pain she was unable to eat.</p> <p>During a concurrent observation and interview on 2/12/25 at 10:22 a.m., with Resident 200 in her room, Resident 200 was in bed with her hand on her abdomen. Resident 200 stated RN 7 entered room before 10 a.m. and assessed her pain of 7/10 and then left. Resident 200 stated she requested pain medication and had not received any yet.</p> <p>During an interview on 2/12/25 at 10:29 a.m., with RN 7, RN 7 stated she answered Resident 200's call light and assessed Resident 200 after she complained of pain at a 7/10. RN 7 stated she asked Resident 200 what medication she wanted for pain, and Resident 200 stated morphine. RN 7 stated she informed the medication nurse, RN 6, that Resident 200 was in pain and requested morphine.</p> <p>During an interview on 2/12/25 at 10:44 a.m., with Interim Director of Nursing (DON), Interim DON stated the expectation was that staff assessed resident's pain level, check the MAR to see what medications were ordered and administer pain medication based on resident's pain level, As soon as they can.</p> <p>During an interview on 2/13/25 at 11:13 a.m., with Physician (MD), MD stated that Resident 200 was admitted for hospice related to cancer diagnosis and was on comfort care measures.</p> <p>During a review of Resident 200's Care Plan .risk for acute/chronic pain r/t Cancer ., dated 2/7/25, the Care Plan indicated, .The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The Care Plan indicated the following interventions .Administer analgesia [pain relieving medication] as per orders . Anticipate the resident's need for pain relief and respond immediately to any complaint of pain .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pain Management, dated January 2025, the P&P indicated Overview .c. Managed or prevents pain, consistent with comprehensive assessment and plan of care, .the resident's goals and preferences.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33922</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not greater than five percent when five identified medication errors out of 41 opportunities for medication administration were observed:</p> <ol style="list-style-type: none"> 1. Pradaxa (medication to treat irregular heart rate) was not administered with a full glass of water, as ordered, for one unsampled resident (Resident 14). 2. Furosemide (medication to treat high blood pressure) was given outside of dosing parameter instructions for one unsampled resident (Resident 14). 3. Aspirin (medication used to prevent stroke) was administered at the wrong time for one of 18 sampled residents (Resident 199). 4. Oxybutynin (medication used to treat overactive bladder) was administered at the wrong time for one of 18 sampled residents (Resident 199). 5. Potassium (medication used to treat low blood potassium electrolyte) was administered at the wrong time for one of 18 sampled residents (Resident 199). <p>These failure resulted in an overall facility medication error rate of 12.2%.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 14's face sheet (demographics), the face sheet indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (heart condition which causes an irregular heartbeat). <p>During an observation 2/12/25 at 9:32 a.m., with Registered Nurse (RN) 2 in Resident 14's room, RN 2 administered 1 capsule of Pradaxa. The label on the medication indicated, Give with a full glass of water. Resident 14 swallowed the Pradaxa capsule with two sips of water. RN 2 did not encourage Resident 14 to drink more water and did not monitor the resident's water consumption.</p> <p>During an interview on 2/13/25 at 11:45 a.m., with the Pharmacy Manager (PM), PM stated it was important to consume a full glass of water with Pradaxa because the medication capsule could become stuck in the resident's throat and create an ulceration (open sore).</p> <p>During of review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 1/21, the P&P indicated, Medications are administered as prescribed in accordance with manufacturer's specifications . At least 4 ounces of water or other fluid are given with oral medications. Please note, some medications need to be given with more liquid.</p> <ol style="list-style-type: none"> 2. During a review of Resident 14's face sheet (demographics), the face sheet indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (heart condition which causes an irregular heartbeat). <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview 2/12/25 at 9:32 a.m., with Registered Nurse (RN) 2 in Resident 14's room, RN 2 obtained Resident 14's blood pressure and heart rate. RN 2 stated, Resident 14's systolic blood pressure (SBP- measurement of the force of blood in the arteries when the heart beats) was 117, and the resident's heart rate was 85. RN 2 administered one tablet of Furosemide to Resident 14.</p> <p>Resident 14's Medication Administration Record (MAR) was reviewed with RN 2, the MAR indicated, Hold [Furosemide] for SBP less than 120, HR less than 60.</p> <p>RN 2 stated, It's ok to give the [Furosemide] because the heart rate was above 60.</p> <p>During an interview on 2/13/25 at 11:03 a.m. with the Medical Director (MD), MD stated RN 2 should not have administered Furosemide when Resident 14's SBP was 117 because it could have caused the resident's blood pressure to drop.</p> <p>During of review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 1/21, the P&P indicated, Medications are administered as prescribed.</p> <p>3. During a review of the face sheet (demographics), the face sheet indicated, Resident 199 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure) and treatment for a broken hip.</p> <p>During a concurrent observation and interview on 2/12/25 at 10:37 a.m., with Registered Nurse (RN) 5 in Resident 199's room, RN 5 administered one tablet of Aspirin to Resident 199. Resident 199's Medication Administration Record (MAR) was reviewed with RN 5. The MAR indicated the medication was past due. RN 5 stated, I got behind. RN 5 stated morning medications should have been administered at 9 am.</p> <p>During a review of Resident 199's Physician's Order, dated 2/10/25, the order indicated, Aspirin Oral Tablet Chewable 81 milligrams (mg-unit of measurement). Give 1 tablet by mouth two times a day. The scheduled time on the order was 9 a.m.</p> <p>During an interview on 2/12/25 at 11:15 a.m. with the Director of Nursing (DON), the DON stated morning medication pass should start at 8 a.m. and medications should be given by 10 a.m. DON stated Resident 199's medications should have been given on time and RN 5 should have notified her that she was behind on her medication pass.</p> <p>During a review of the facility's Medication Administration Schedule [undated], the Medication Administration Schedule, indicated, Medications should be administered .two times daily- 9 a.m. and 5 p.m.</p> <p>During of review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 1/21, the P&P indicated, Medications are administered within one hour of the scheduled time.</p> <p>4. During a review of Resident 199's face sheet (demographics), the face sheet indicated, Resident 199 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure) and treatment for a broken hip.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 2/12/25 at 10:37 a.m. with Registered Nurse (RN) 6 in Resident 199's room. RN 6 administered one tablet of Oxybutynin to Resident 199. Resident 199's MAR was reviewed with RN 6. The MAR indicated the medication was past due. RN 6 stated, I got behind. RN 6 stated morning medications should have been administered at 9 a.m.</p> <p>During a review of Resident 199's Physician's Order, dated 2/8/25, the order indicated, Oxybutynin Chloride 5 milligrams (mg-unit of measurement) tablet. Give 1 tablet by mouth two times a day. The scheduled time on the order was 9 a.m.</p> <p>During an interview on 2/12/25 at 11:15 a.m. with the Director of Nursing (DON), the DON stated morning medication pass should start at 8 a.m. and medications should be given by 10 a.m. DON stated Resident 199's medications should have been given on time and RN 6 should have notified her that she was behind on her medication pass.</p> <p>During a review of the facility's Medication Administration Schedule [undated], the Medication Administration Schedule, indicated, Medications should be administered .two times daily- 9 a.m. and 5 p.m.</p> <p>During of review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines,dated 1/21, the P&P indicated, Medications are administered within one hour of the scheduled time.</p> <p>5. During a review of Resident 199's face sheet (demographics), the face sheet indicated, Resident 199 was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure) and treatment for a broken hip.</p> <p>During a concurrent observation and interview on 2/12/25 at 10:37 a.m. with Registered Nurse (RN) 6 in Resident 199's room. RN 6 administered one tablet of Potassium Chloride to Resident 199. Resident 199's Medication Administration Record (MAR) was reviewed with RN 6; the MAR indicated the medication was past due. RN 6 stated, I got behind. RN 6 stated morning medications should be administered at 9 a.m.</p> <p>During a review of Resident 199's Physician's Order dated 2/8/25, the order indicated, Potassium Chloride Oral Tablet 20 milliequivalents (meq- unit of measurement). Give 1 tablet by mouth two times a day. The scheduled time on the order was 9 a.m.</p> <p>During an interview on 2/12/25 at 11:15 a.m. with the Director of Nursing (DON), the DON stated morning medication pass should start at 8 a.m. and medications should be given by 10 a.m. DON stated Resident 199's medications should have been given on time and RN 6 should have notified her that she was behind on her medication pass.</p> <p>During a review of the facility's Medication Administration Schedule [undated], the Medication Administration Schedule, indicated, Medications should be administered .two times daily- 9 a.m. and 5 p.m.</p> <p>During of review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 1/21, the P&P indicated, Medications are administered within one hour of the scheduled time.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on interview and record review, the facility failed to ensure the daily maximum dosage of acetaminophen (medication used to treat pain) did not exceed 2,000 milligrams (mg- unit of measurement) per physician's order for one unsampled resident (Resident 36). This failure had the potential to result in hepatotoxicity (damage to the liver caused by exposure to harmful substances).</p> <p>Findings:</p> <p>During a review of Resident 36's face sheet (demographics), dated [DATE], the face sheet indicated Resident 36 was admitted to the facility on [DATE], with diagnoses to include chronic hepatitis (long term inflammation of the liver). Resident 36 expired on [DATE].</p> <p>During a concurrent interview and record review on [DATE] at 10:19 a.m., with the Director of Nursing (DON), Resident 36's Medication Administration Records (MAR) for the months of [DATE], [DATE], [DATE], and [DATE] were reviewed and indicated the following:</p> <p>a. In [DATE], Resident 36 had an order for acetaminophen 500 mg one tablet three times a day for pain, not to exceed (NTE) 2,000mg in 24 hours and an additional order for acetaminophen 500mg two tablets three times a day for pain, NTE 2,000mg in 24 hours.</p> <p>The DON calculated the total dosage given to Resident 36 was 3500mg of acetaminophen on [DATE] and [DATE], and total of 4500mg of acetaminophen on [DATE].</p> <p>b. In [DATE], indicated Resident 36 had an order for acetaminophen 500mg two tablets three times a day for pain, NTE 2,000mg in 24 hours.</p> <p>c. In [DATE], indicated Resident 36 had an order for acetaminophen 500mg two tablets three times a day for pain, NTE 2,000mg in 24 hours.</p> <p>d. In [DATE], indicated Resident 36 had an order for acetaminophen 500mg two tablets three times a day for pain, NTE 2,000mg in 24 hours.</p> <p>The DON calculated the total dosage of acetaminophen given to Resident 36 was over the maximum dosage for 25 days in [DATE], and 30 days in [DATE] and [DATE]. Resident 36 received more than 2,000mg in 24 hours for three months. The DON stated, That's crazy, it should have been clarified.</p> <p>During a concurrent interview and record review on [DATE] at 11:16 a.m., with Medical Director (MD), Resident 36's Monthly Medication Review (MMR), dated [DATE] was reviewed. The MMR indicated the pharmacist's recommendation was to clarify the acetaminophen order. MD stated the order should have been clarified and Yeah that's on me. MD further stated for elderly patients with history of hepatitis and seizures, the maximum recommended dose of acetaminophen was 2,000mg in 24 hours.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:53 a.m., with Pharmacist (Pharm), Pharm stated she completed Resident 36's MMR and sent them to the facility's medical director and DON. Pharm stated the order should have been clarified immediately. Pharm stated exceeding the daily limit of acetaminophen for a prolonged period, three months, had a potential for Resident 36 to experience hepatotoxicity. Pharm further stated, Yeah that's a pretty significant error.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Orders, Noting Of, dated February 2009, the P&P indicated, The nurse shall verify each order for completeness, clarity, appropriateness of dose .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated [DATE], the P&P indicated, Medications are administered in accordance with written orders of the prescriber .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39646</p> <p>Based on observation, interview, and record review, the facility failed to store and label drugs and biologicals properly when:</p> <ol style="list-style-type: none"> 1. Controlled drugs (drugs that are regulated by law due to their potential for abuse and addiction) were being discarded in a container that was not secure or permanently affixed to the wall. This failure had the potential to result in drug diversion (illegal distribution or abuse of prescription drugs.) 2. Resident 29's oxygen humidifier bottle was opened and undated. This failure had the potential to result in an increased risk for bacteria growth and progression of respiratory illness. <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 2/11/25 at 2:25 p.m., with Registered Nurse (RN) 2 in the Medication Room, there was a Smart Sink (a green container with openings on the left and right side) sitting on the countertop. It contained a glass bottle, pills, and packaging. RN 2 stated that was where narcotic medications were disposed of when the Director of Nursing (DON) was not in the facility. <p>During an interview on 2/11/25 at 2:41 p.m., with the DON, the DON stated she was unfamiliar with the Smart Sink purpose and its location.</p> <p>During an interview on 2/13/25 at 11:47 a.m., with the Pharmacist, the Pharmacist stated the Smart Sink should have been removed from the Medication Room.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Disposal of Medications, dated 2023, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances (or those classified as such by state regulation) are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal and state laws and regulations.</p> <p>50669</p> <ol style="list-style-type: none"> 2. During a review of Resident 29's face sheet (demographics) dated 2/10/25, the face sheet indicated Resident 29 was admitted to the facility on [DATE], with diagnoses to include pneumonia (infection of the lungs). <p>During a record review of Resident 29's Medication Administration Record (MAR), dated 2/10/25, the MAR indicated, oxygen via nasal cannula (NC- a thin, flexible tube that delivers oxygen through the nose).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/9/25 at 5:56 p.m., in Resident 29's room, an Oxygen in use, sign was posted outside the door. Resident 29 was receiving humidified oxygen at 3 liters per minute via NC. The humidifier bottle was unlabeled with the date opened.</p> <p>During an interview on 2/9/25 at 6:02 p.m. with Registered Nurse (RN) 5, RN 5 stated the humidifiers did not need to be dated.</p> <p>During an interview on 2/12/25 at 2:41 p.m., with the Director of Staff Development (DSD), the DSD stated humidifier bottles needed to be dated when opened.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, dated July 2022, the P&P indicated, Label humidifier with the date opened .</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure all kitchen staff were evaluated for competency skills when two kitchen staff were unable to effectively test the 3-compartment sink (3 sinks that separate the wash, rinse and sanitizer-manual procedure for cleaning and sanitizing dishes) sanitizer. This failure had the potential for residents to be served food on unclean dishes, which can result in food borne illnesses (a sickness caused by consuming food, or drinks contaminated with harmful substances) in a medically fragile population of 47 residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/9/25 between 3:50 to 3:55 p.m., with Executive Chef (EC) in the kitchen, EC tested the quaternary ammonium (quat- a group of chemicals that are used in disinfectants) in the 3-compartment sink. EC placed the strip in the mixture of quat sanitizer with water, for 10 seconds and the color of the strip changed to dark green. EC checked the color against the color chart on the test kit. EC confirmed the test strip read 600-800 ppm (parts per million- unit of measurement) and stated, Oh that's darker than it should be. EC repeated the same process, and the test strip result was 1000 ppm, EC stated he was unsure why the reading of the sanitizer was still high. The EC stated the level should be 200-400 ppm.</p> <p>During a concurrent observation and interview on 2/10/25 at 11:19 a.m., with Dishwasher (DW) 1 in the kitchen, DW 1 was standing in front of the 3-compartment sink, washing dishes. DW 1 was asked to complete a quat test for the sanitizer sink. DW 1 stated he was unsure how to test the sanitizer mixture. DW 1 placed the strip in the sanitizer mixture, for 3 seconds and the color of the strip turned green. DW 1 checked the color against the color chart on the test kit and confirmed the test strip read 400-600 ppm, which was not within the normal range.</p> <p>During an interview on 2/13/25 at 9:25 a.m., with EC, EC stated he did not properly demonstrate the 3-compartment sink quat test. EC further stated he was responsible for training all kitchen staff.</p> <p>During a review of EC's Job Description, dated 7/21/23, the Job Description indicated, Supervises cooking personnel and insures proper sanitation procedure for the entire kitchen area . Insures that competency in the positions is maintained . monthly in-service trainings . sanitation inspections .</p> <p>During a review of the facility's policy and procedure (P&P) titled, On-The-Job Training, dated January 2025, the P&P indicated, On-the-job training is implemented for the purpose of . training concerning use of specific hazardous substance .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation guidelines were followed when:</p> <ol style="list-style-type: none"> 1. Two kitchen staff did not wear hair nets while in the kitchen. 2. Five of five green cutting boards were not in good repair. 3. Dented cans were not discarded. 4. Six boxes of dry goods were stored directly on the floor. 5. Multiple food items were expired. 6. Multiple food items were unlabeled and undated. 7. Sanitizer for the vegetable wash was expired. <p>These failures posed the risk for food borne illness in a medically fragile resident population of 47.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on [DATE] at 4:02 p.m. with Executive Chef (EC) in the Kitchen, the Server entered the kitchen and loaded a cart with food items, without a hair net. EC stated, No, she needs a hair net immediately.</p> <p>During a concurrent observation and interview on [DATE] at 10:13 a.m. with Certified Executive Chef (CEC) in the Kitchen, Dishwasher (DW) 2 was washing dishes, without a hair net. CEC stated, No, he needs a hair net.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Dress Guidelines for Food Service Management and Clinical Nutrition Staff, dated [DATE], the P&P indicated, Hair restraints are worn by all when in the kitchen .</p> <p>2. During a concurrent observation and interview on [DATE] at 3:44 p.m. with EC in the Kitchen, five out of five green cutting boards had deep grooves with brown, green and orange grim build up. EC stated, These are gross and definitely need to be replaced.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cutting Boards, dated [DATE], the P&P indicated, Replace all cutting boards with grooves and pits ,d+[DATE]-inch or deeper that cannot be cleaned and sanitized using routine cleaning and sanitizing procedures .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent observation and interview on [DATE] at 10:07 a.m., with CEC in the Dry Storage Room, two dented cans were stored on the canned goods rack. CEC stated they are dented and need to be disposed of.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, dated [DATE], the P&P indicated, .dented cans . are to be returned .</p> <p>4. During a concurrent observation and interview on [DATE] at 10:06 a.m., with CEC in the Dry Storage Room, six boxes of dry goods were stored directly on the floor. The CEC stated, Nothing should be placed on the floor.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, dated [DATE], the P&P indicated, Store dry and staple items at least 6 above the floor .</p> <p>5. During a concurrent observation and interview on [DATE] at 2:54 p.m., with EC in the Dry Storage Room, one box of thickened cranberry juice cocktail use by date was [DATE], and one box of thickened water use by date was [DATE]. EC stated expired items needed to be thrown out.</p> <p>During a concurrent observation and interview on [DATE] at 3:02 p.m., with EC in the Refrigerator 1, there was one large jar of Thai Chili Peppers use by date was [DATE], one container of jellied cranberry sauce use by date was [DATE], and one bottle cultured buttermilk expiration date was [DATE]. EC stated expired items needed to be thrown out.</p> <p>During a concurrent observation and interview on [DATE] at 3:25 p.m., with EC in the Refrigerator 2, one large ham use by date was [DATE], one large tray of chicken breast use by date was [DATE], 15 trays of bacon use by date was [DATE], and 12 pork boneless center cut loins use by date was [DATE]. EC stated expired items needed to be thrown out.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, dated [DATE], the P&P indicated, Foods past the use by, sell by, best by or enjoy by date should be discarded .</p> <p>6. During a concurrent observation and interview on [DATE] at 3:20 p.m., with EC in the Freezer, there were three premade vegan meatloaves and an one container of opened chocolate ice cream unlabeled and undated. EC stated all items needed to be labeled and dated, otherwise thrown out.</p> <p>During a concurrent observation and interview on [DATE] at 3:27 p.m. with EC in the Refrigerator 2, there were two packages of Prosciutto, three packages of smoked salmon, 19 trays of bacon unlabeled and undated. EC stated all items needed to be labeled and dated, otherwise thrown out.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, dated [DATE], the P&P indicated, Cover, label and date unused portions and open packages .</p> <p>7. During a concurrent observation and interview on [DATE] at 10:33 a.m. in the Kitchen, with Certified Executive Chef (CEC). Mushrooms were being washed in the vegetable 2-compartment sink with sanitizer. The sanitizer had an expiration date of [DATE]. EC stated, Oh that's definitely expired and needed to be discarded.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure that all resident personal foods were labeled and dated in the communal refrigerator. This failure had the potential for residents to consume expired food that could lead to the increased risk of food borne illness (a sickness caused by consuming food contaminated with harmful substances).</p> <p>Findings:</p> <p>During an observation on [DATE] at 2:40 p.m., of the Residents' communal refrigerator located in the Hydration Room, there was a pizza box that contained pizza, and a package that contained crackers, cheese, and salami. The box and package were unlabeled with resident names, room numbers, and undated.</p> <p>During an interview on [DATE] at 5:22 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Oh no, they need the date with room number.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Use and Storage of Food Brought to Residents From the Outside, dated [DATE], the P&P indicated, Food Storage: the outside food must be stored in an appropriate container, labeled with the resident's name and room number, the date the food was brought to the resident and the use-by date .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>50669</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two outside dumpsters had a lid. This failure had the potential to attract pests and/or rodents that carried diseases and could result in food borne illness (a sickness caused by consuming food, or drinks contaminated with harmful substances) in a medically fragile population of 47 residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 2/9/25 at 4:08 p.m., with the Executive Chef (EC) in the outside loading dock area, one compactor dumpster did not have a lid to cover the overflowing garbage that contained food and waste. The EC stated the dumpster should have a lid.</p> <p>During a review of the U.S [United States] Food and Drug Administration's (FDA) Food Code, dated 2022, the FDA Food Code indicated in Section 5-501.15 Outside Receptacles, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Solid Waste Disposal, dated January 2025, the P&P indicated, Keep lids closed on all outside trash receptacles .</p>

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NAME OF PROVIDER OR SUPPLIER Spring Lake Village		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 Montgomery Drive Santa Rosa, CA 95409	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39646</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infections when:</p> <p>1 a-d. The facility was not following Enhanced Barrier Precautions (EBP-Centers for Disease Control Recommendations to wear personal protective equipment when caring for residents with an indwelling medical device) for four of 18 sampled residents (Resident 148, Resident 14, Resident 21, and Resident 10).</p> <p>All Facilities Letter (AFL memo issued by the California Department of Public Health), dated 6/13/2024, indicated, skilled nursing facilities should implement EBP per Centers for Disease Control (CDC) guidance as part of infection control for certified skilled nursing facilities.</p> <p>CDC Recommendations, dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>2. Resident 196's unlabeled urinal was stored on his bedside table.</p> <p>3. Resident 29's nasal cannula (a thin, flexible tube that delivers oxygen through the nose) was found on the floor.</p> <p>These failures placed the residents at risk for cross contamination and possible spread of infections.</p> <p>Findings:</p> <p>1 a. During a concurrent observation and interview on 2/12/25 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1 in Hallway 100, Resident 148 was observed with an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag). There was no signage posted to alert staff that Resident 148 required Enhanced Barrier Precautions. LVN 1 stated she has never heard of EBP, so she does not follow EBP.</p> <p>During an interview on 2/12/25 at 2:13 p.m., with Infection Preventionist Registered Nurse (IP/RN) and the Director of Staff Development (DSD), the IP/RN and DSD stated they did not know what EBP was, therefore, they had not developed a policy and procedure or trained staff regarding EBP.</p> <p>52029</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1 b. During a review of Resident 14's face sheet (demographics), the face sheet indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included sepsis (a life-threatening complication of an infection) and urinary tract infection (bladder infection).</p> <p>During a concurrent observation and interview on 2/9/25 at 4:06 p.m. with Resident 14, Resident 14 had an indwelling midline catheter (flexible tube inserted through the skin into a large vein in the arm used to administer IV antibiotics). There was no signage posted to alert staff that Resident 14 required Enhanced Barrier Precautions. Resident 14 stated that she was receiving Intravenous (IV) antibiotics (medicine that kills bacteria or stops their growth) for a urinary infection.</p> <p>During an observation on 2/10/25 at 4:10 p.m. in Resident 14's room, Infection Preventionist/Registered Nurse (IP/RN) administered IV antibiotics through Resident 14's midline catheter. IP/RN was not wearing a gown during the observation.</p> <p>During an observation on 2/11/25 at 9:20 a.m., Registered Nurse (RN) 10 assisted Resident 14 in transferring from her bed to a wheelchair and into the bathroom. RN 10 was not wearing gloves or a gown.</p> <p>During an interview on 2/12/25 at 10:58 a.m. with RN 10, RN 10 confirmed she assisted Resident 14 from her bed to the bathroom and did not wear a gown. RN 10 stated that she was unaware of EBP.</p> <p>During an interview on 2/12/25 at 2:13 p.m., with Infection Preventionist Registered Nurse (IP/RN) and the Director of Staff Development (DSD), the IP/RN and DSD stated they did not know what EBP was, therefore, they had not developed a policy and procedure or trained staff regarding EBP.</p> <p>1 c. During a review of Resident 21's face sheet (demographics), the face sheet indicated, Resident 21 was admitted to the facility on [DATE], with diagnoses which included obstructive and reflux uropathy (a disorder that occurs when urine can't drain normally and flows backward into the kidneys).</p> <p>During a review of Resident 21's Order Summary Report, dated 12/2/25, the Order Summary Report indicated, Foley Catheter (a tube inserted into the bladder in order to drain urine into a collection bag) Care every shift.</p> <p>During an observation on 2/9/25 at 3:19 p.m., in Resident 21's room, there was no signage posted to alert staff that Resident 14 required Enhanced Barrier Precautions.</p> <p>During an interview on 2/12/25 at 11:05 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated that when he changed Resident 21's catheter drainage bags he did not wear a gown. CNA 3 stated he did not know about EBP.</p> <p>During an interview on 2/12/25 at 11:53 a.m., with Resident 21, Resident 21 stated staff did not wear gowns when they changed his catheter bag.</p> <p>During an interview on 2/12/25 at 2:13 p.m., with Infection Preventionist Registered Nurse (IP/RN) and the Director of Staff Development (DSD), the IP/RN and DSD stated they did not know what EBP was, therefore, they had not developed a policy and procedure or trained staff regarding EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1 d. During a review of Resident 10's face sheet (demographics), the face sheet indicated, Resident 10 was admitted on [DATE], with diagnoses which included urinary retention (condition that makes it difficult to empty the bladder).</p> <p>During a review of Resident 10's Physician's Order, dated 2/10/25, the order indicated, Resident 10 had an indwelling catheter.</p> <p>During an observation on 2/9/25 at 4:18 p.m., in Resident 10's room, Resident 10 was lying in bed. Resident 10's catheter bag was observed at the foot of the bed. There was no signage posted to alert staff that Resident 10 required Enhanced Barrier Precautions.</p> <p>During an interview on 2/12/25 at 11:05 a.m., with CNA 3, CNA 3 stated that he changed and drained Resident 10's catheter drainage bag. CNA 3 stated he did not know about EBP and confirmed he did not wear a gown while performing high contact care activities with the resident.</p> <p>During an interview on 2/12/25 at 2:13 p.m., with Infection Preventionist Registered Nurse (IP/RN) and the Director of Staff Development (DSD), the IP/RN and DSD stated they did not know what EBP was, therefore, they had not developed a policy and procedure or trained staff regarding EBP.</p> <p>47844</p> <p>2. During an observation on 2/9/25 at 3:44 p.m., in Resident 196's room, a urinal was on his bedside table. The urinal was unlabeled with his first and last name.</p> <p>During an interview on 2/9/25 at 4:27 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that Resident 196's urinal should have been labeled with his first and last name. LVN 2 stated his urinal should not have been on his bedside table.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bedside Equipment - Wash Basins, Emesis Basins, Bedpans, and Urinals, dated November 2020, the P&P indicated, Guidelines .2. Bedside equipment including, but not limited to . urinals shall be labeled with resident's first and last name and placed in plastic bag between usage to avoid cross contamination.</p> <p>50669</p> <p>3. During a review of Resident 29's face sheet (demographics), dated 2/10/25, the face sheet indicated Resident 29 was admitted to the facility on [DATE], with diagnoses of pneumonia (infection of the lungs).</p> <p>During a concurrent observation and interview on 2/9/25 at 5:59 p.m., with Certified Nurse Assistant (CNA) 5 in Resident 29's room, the nasal cannula was on the floor. CNA 5 picked up the nasal cannula off the floor and stated, It should be in this bag.</p> <p>During an interview on 2/12/25 at 2:39 p.m., with the Infection Preventionist Registered Nurse (IP/RN), the IP/RN stated plastic bags were attached to the top of oxygen concentrators for staff to put the nasal cannula in when not in use to prevent contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, dated July 2022, the P&P indicated, When nasal cannula or oxygen mask is not in use, place in a plastic bag or other infection prevention pouch to prevent contamination .</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>39646</p> <p>Based on interview and record review, the facility failed to maintain an effective infection control training program related to Enhanced Barrier Precautions (EBP [Centers for Disease Control guidance to wear personal protective equipment when caring for residents with an indwelling medical device designed to reduce the spread of infections]). (cross reference to F880). This failure had the potential to negatively affect the facility's ability to maintain a safe environment to prevent the spread of infectious diseases among the 47 residents in the facility.</p> <p>Findings:</p> <p>During an interview on 2/12/25 at 2:13 p.m., with Infection Preventionist Registered Nurse (IP/RN) and the Director of Staff Development (DSD), the IP/RN and DSD stated they did not know what EBP was, therefore, they had not developed a policy and procedure or trained staff regarding EBP.</p> <p>During a review of the All Facilities Letter (AFL memo issued by the California Department of Public Health), dated 6/13/2024, indicated, skilled nursing facilities should implement EBP per Centers for Disease Control (CDC) guidance as part of infection control for certified skilled nursing facilities.</p> <p>During a review of the CDC Recommendations, dated 4/2/24, indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities (personal hygiene, linen change, providing medications and treatments such as wound dressing change) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p>