

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews and record reviews, the facility failed to ensure, the enhanced barrier precautions (EBP, an infection control intervention, primarily used in nursing homes, that involve the use of gowns and gloves during high-contact resident care activities to reduce the transmission of infection) were implemented for two out of two residents sampled for infection control (Residents 29 and 45) that had opened wounds.This failure could result in increased transmission of germs and increased risk of infections among residents, staff, and visitors. Findings:A review of Resident 29's face sheet (FS, front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 11/2025 with a diagnosis of Spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing pain, numbness, or weakness in the back, neck, or limbs) and trochanteric bursitis (painful swelling near hip joint).A review of Resident 29's progress note titled skin issues, dated 1/12 /26, indicated Resident 29 acquired a new stage 2 pressure ulcer (stage 2 PU, Partial-thickness loss of skin, presenting as a shallow open sore or wound) on her coccyx (tailbone) while at the facility.A review of Resident 45's face sheet indicated an admission date of 1/2026 with a diagnosis of Dementia (a progressive state of decline in mental abilities) and Syncope (fainting).A review of Resident 45's progress note titled skin issue, dated 1/21/26, indicated Resident 45 had an open wound on his left shin present on admission and the wound was noted with clear watery fluid exudate (wound fluid).During an observation on 1/20/2026 at 11:40 a.m., there was no EBP signage noted by Resident 45's door. The Licensed Nurse (LN) B and the Physician Assistant (PA) who treated Resident 45's wound did not wear a gown when they treated Resident 45's wound. During a concurrent observation and interview on 01/21/2026 at 1:29 p.m., LN B verified Resident 29 was not on EBP but should be placed on EBP since she had a stage 2 PU on her coccyx (tailbone area). During a concurrent observation and interview on 01/21/2026 at 1:31 p.m., LN B verified Resident 45 did not have EBP signage by his door. LN B verified Resident 45 had an open wound on his left lower leg, needing daily treatment and needed to be wrapped with dry dressing. LN B stated Resident 45 should have been placed on EBP and added, it was important that EBP be maintained when caring for Residents with open wounds to prevent cross contamination and to prevent spread of infection. During an interview on 01/21/2026 at 4:20 PM, the Infection Preventionist Nurse (IPN) stated Residents 29 and 45 should have been placed on EBP because they both have an open wound and both their wounds required wound dressing as part of their wound treatment. The IPN stated not placing Residents 29 and 45 in EBP significantly increases the risk of spreading infection.A review of the document from California Department of Public Health (CDPH, state agency responsible for protecting and improving the health of all Californians) titled Enhanced Barrier Precaution (EBP), undated, the document indicated . Providers and staff must also wear gloves and gown for the following high contact resident care activities.wound care: any skin opening requiring a dressing.		

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interviews and record reviews, the facility failed to ensure one out of two residents sampled for restraints (Resident 46) was free from physical restraints that were not required to treat the resident's medical symptoms when:1. No medical symptom identified that required the use of a pommel cushion (a specialized wheelchair or chair cushion with a raised section (pommel) between the legs; can be considered a restraint requiring careful assessment and physician orders for safe use);2. No physician order for the use of the pommel cushion; and3. No ongoing monitoring and evaluation for Resident 46's use of the pommel cushion. These failures could put Resident 46 at risk for movement restrictions and reduced functional independence. Findings: A review of Resident 46's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 7/2025 with a diagnosis of muscle weakness, unspecified abnormalities of gait (the way a person walks) and mobility (ability to move) with a need for assistance with personal care. A review of Resident 46's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 10/18/25, indicated a score of 7 out of 15, consistent with severe cognitive impairment (significant deficits in memory, orientation, and attention, requiring extensive, daily assistance). A review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/18/25, indicated Resident 46 used a wheelchair. A review of Resident 46's physician order summary (POS, a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive), active for 1/2025, did not indicate Resident 46 had an order for use of a pommel cushion. A review of Resident 46's care plans (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed), did not indicate Resident 46 used a pommel cushion. During a concurrent observation and interview on 01/20/2026 at 11:46 a.m., Resident 46 was noted sitting on a pommel cushion on the seat of her wheelchair. Resident 46 stated she was not sure why it was there and added, sometimes it gets uncomfortable using the pommel cushion and pointing to her groin and inner thigh. During an interview on 01/20/2026 at 11:48 a.m., the interim Director of Nursing (iDON) verified Resident 46 was sitting on a pommel cushion on her wheelchair. The iDON stated the pommel cushion was used because Resident 46 was at risks for falls. During a concurrent interview and record review on 01/21/2026 at 3:25 p.m. with the Licensed Nurse (LN) B, Resident 46's POS for 1/2025 and care plans were reviewed. LN B verified the Resident 46 had no physician's order for the pommel cushion, Resident 46 had no assessment completed prior to the use of pommel cushion, there was no CP created for Resident 46's use of the pommel cushion, and no indication staff were monitoring Resident 46 while using pommel cushion. During an interview on 01/21/2026 at 3:40 p.m., LN B stated pommel cushions need to have a physician order and an assessment prior to resident use. LN B stated without proper assessment, pommel cushion could be considered a restraint (a device that limits movements). During a concurrent interview and record review on 01/21/2026 at 4:15 p.m., with the iDON, Resident 46's assessments, POS and CP were reviewed. The iDON verified there was no assessment for Resident 46 completed prior to the use of the pommel cushion, nor a physician order for Resident 46 to use the pommel cushion. The iDON acknowledged the facility could not provide documentation that would prove the use of pommel cushion was safe and necessary for Resident 46. The iDON stated it was important that staff monitor Resident 46 while she was using the pommel cushion as incorrect use of pommel cushion could lead to improper positioning, pain and restrict movement. During an interview on 01/22/2026 at 9:16 a.m., LN E stated it was important there was a CP when using pommel cushion because the CP provides a clear pathway to provide safe care to the residents. LN E stated while Resident 46 was using a pommel cushion, staff still needed to monitor Resident 46 to ensure her safety and that the pommel cushion did not restrict her movement. LN E (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the staff were not monitoring Resident 46 for use of the pommel cushion. During a concurrent observation and interview on 01/22/2026 at 9:30 a.m., the Director of Rehabilitation services (DOR) changed the pommel cushion Resident 46 was using to an anti-thrust cushion (a specially shaped wheelchair seat designed to prevent slipping out of their chair). During an interview on 01/22/2026 at 11:31 a.m., The DOR acknowledged that no therapist assessment was completed before the facility implemented a pommel cushion for Resident 46. The DOR stated pommel cushions can be uncomfortable and restrictive, and after assessing Resident 46, determined an anti-thrust cushion was more appropriate. A review of the facility's policy and procedure (P&P) titled Use of Restraints, revised 10/2022, the P&P indicated .physical restraints is defined as anything near or on the body which restricts movement. A review of the facility's P&P titled Resident Rights, dated 8/2022, the P&P indicated .staff respects each resident's personal rights which include but not limited to .be accorded safe, healthful and comfortable accommodations.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews and record reviews, the facility failed to ensure two out of two residents sampled for grooming (Residents 29 and 16) received care to maintain grooming when their fingernails were long with brownish material underneath. This failure could negatively affect the residents' sense of dignity and be an infection control concern. Findings: A review of Resident 29's face sheet (FS, front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 11/2025 with a diagnosis of Spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing pain, numbness, or weakness in the back, neck, or limbs) and trochanteric bursitis (painful swelling near hip joint). A review of Resident 29's care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) for focus .self care and mobility deficit., initiated on 12/01/25, indicated staff were to check nail length and trim and clean on bath day and as necessary. A review of Resident 16's face sheet indicated an admission date in 11/2024 with a diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and Major Depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 16's CP for focus .self care and mobility deficit., initiated on 7/13/25, indicated staff were to check nail length and trim and clean on bath day and as necessary. During a concurrent observation and interview on 01/20/2026 at 9:53 a.m., Unlicensed Staff C verified Resident 16's fingernails were long, dirty and had brownish materials underneath. Unlicensed Staff C stated Resident 16 was dependent on staff for nail care. During an interview on 01/20/2026 at 9:59 a.m., Unlicensed Staff D stated it was not acceptable that residents' fingernails were long and had dirty, blackish or brownish materials underneath. Unlicensed Staff D stated staff should ensure residents' nails were always kept clean and trimmed because if their fingernails were long and dirty, residents could spread germs and could get sick. During an interview on 01/20/2026 at 10:08 a.m., the interim Director of Nursing (iDON) stated it was the expectation that staff ensure residents' fingernails were trimmed, clean with no brownish materials underneath. During a concurrent observation and interview on 01/20/2026 at 3:10 p.m., it was noted Resident 29's fingernails were long and dirty. Resident 29 stated no one had offered to clean or trim her nails. Resident 29 stated she wanted someone to take care of it. During a concurrent observation and interview on 01/20/2026 at 3:20 p.m., the Infection Preventionist Nurse (IPN) verified Resident 29's fingernails were long and had dirt underneath. The IPN stated Resident 29's fingernails being long and dirty was not acceptable due to infection concerns. The IPN stated it was expected that staff would provide nail care for Resident 29. The IPN stated residents having long and dirty fingernails could result in infections and spread of germs. A review of the facility's policy and procedure titled Activities of Daily Living (ADL), revised 5/2020, it indicated .a resident who is unable to carry out ADLs receives the necessary care and services to maintain good nutrition, grooming and personal and oral hygiene.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews and record reviews, the facility failed to preserve skin integrity for one out of two residents (Resident 29) sampled for pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) when pressure ulcer preventative measures were not consistently implemented for Resident 29. This failure resulted in Resident 29 developing a stage 2 pressure ulcer (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on her coccyx (tailbone) while at the facility. Findings: A review of Resident 29's face sheet (FS, front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 11/2025 with a diagnosis of Spinal stenosis (narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing pain, numbness, or weakness in the back, neck, or limbs) and trochanteric bursitis (painful swelling near hip joint). A review of Resident 29's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 12/2/25, indicated a score of 12, consistent with moderately impaired cognition (mental action of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 29's Minimum Data Set assessment (MDS, a federally mandated resident assessment tool), dated 12/2/25, indicated Resident 29 was totally dependent on staff with toileting hygiene and it indicated Resident 29 required moderate assistance (level of care where the helper provides some, but less than half of the effort to complete an activity) from staff to roll from lying on back to left and right side and return to lying on back on the bed. The assessment also indicated that Resident 29 was at risk for developing pressure ulcers and Resident 29 did not have any unhealed pressure ulcers at that time. A review of Resident 29's Braden form (an assessment tool commonly used in health care to assess and document a client's risk for developing pressure ulcer), dated 12/27/25, indicated Resident 29's score was 12, consistent with a high risk for developing pressure ulcers due to being constantly moist, bedfast (confined to bed), with very limited mobility and required moderate to maximum assistance when moving Resident 29. A review of Resident 29's progress note titled skin issues, dated 1/12 /26, the progress note indicated new skin issue. Location: Coccyx. Issue type: Pressure ulcer/injury. Progress: new: new wound Pressure ulcer staging: stage 2 pressure ulcer/injury-partial thickness skin loss with exposed dermis wound acquired: in-house. A review of Resident 29's interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) post review, dated 1/14/26, indicated Resident 29 had a Stage 2 pressure ulcer on her coccyx from incontinence (no or insufficient voluntary control over urination or defecation) and laying on her back. A review of Resident 29's care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) titled the Resident has stage 2 pressure ulcer to coccyx, initiated 1/14/26, the interventions included to avoid positioning Resident 29 flat on her back, relieve pressure on Resident 29's pressure off her back with pillow, to use pillows to position and off load pressure areas and to encourage small frequent positional changes. A review of Resident 29's Certified Nursing Assistant (CNA) task titled bed mobility, dated from 12/29/25 up to 1/23/25, indicated Resident 29 was only being repositioned by staff once every shift. A review of Resident 29's CNA's task titled Bladder and Bowel Urinary Incontinence, dated from 1/1/26 up to 1/12/26, it indicated staff would only check Resident 29 for incontinence mostly at the beginning and end of their shift only. The longest interval noted was 10 hours on 1/12/25 when the incontinence check occurred at 10:28 a.m. and the next one did not occur until 8:56 p.m. During an observation in Resident 29's room on 01/20/2026 at 10:13 a.m., Resident 29 was lying on her back in bed. During an observation in Resident 29's room on 01/20/2026 at 12:00 p.m., Resident 29 was lying on her back in bed. During an observation in Resident 29's room on 01/20/2026 at 2:12 p.m., Resident 29 was lying on her back in bed. During a concurrent observation in Resident 29's room and interview on 01/20/2026 at 3:10 p.m., Resident 29 was lying on her back in (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. Resident 29 stated she had a wound on her back and had been lying on her back since this morning. Resident 29 stated staff did not get her up in bed and she would lay in bed the whole time. Resident 29 stated nobody comes to reposition her from side to side frequently. Resident 29 stated she mostly stays in bed. Resident 29 stated she was told she got the wound on her back because she did not move in bed and because she gets wet from her urine. Resident 29 stated staff was not prompt on changing her briefs and staff do not reposition her, leaving her stuck on her back for long periods. Resident 29 stated the wound on her back was an added discomfort. During a concurrent interview and record review on 01/22/2026 at 9:52 a.m. with the Registered dietician (RD), the IDT note dated 1/14/25 was reviewed. The RD verified Resident 29 was at risk for skin breakdown and verified the IDT note on 1/14/26 indicated that Resident 29's pressure ulcer was due to incontinence and laying on her back. The RD stated Resident 29's pressure ulcer was preventable. During a concurrent interview and record review on 01/22/2026 at 9:58 a.m. with the interim Director of Nursing (iDON), Resident 29's: IDT note dated 1/14/26, CNA tasks titled bed mobility from 12/29/25 up to 1/14/25, bowel and bladder from 1/1/26 up to 1/14/26 were reviewed. The iDON verified the IDT note dated 1/14/26 indicated Resident 29's pressure ulcer was caused by incontinence and laying on back. The iDON stated Resident 29's pressure ulcer was acquired in house and could have been prevented. The iDON verified based on the bed mobility documentation, Resident 29 was only being repositioned once per shift. The iDON verified the toileting task indicated Resident 29 was not being checked and changed every 2 hours and Resident 29 only was checked for incontinence at the beginning and end of shift, with one time as long as 10 hours had passed since Resident 29 was last checked for incontinence. The iDON stated these were not acceptable and could result in Resident 29's further skin breakdown. The iDON stated based on these documentations, there was a failure to implement interventions that were consistent with Resident 29's needs and recognized standard of practice, when Resident 29 was not being repositioned, checked and changed for incontinence as often as she should be. During an interview on 01/22/2026 at 2:57 PM, Unlicensed Staff A, a certified nursing assistant (provides basic patient care), stated to prevent development of pressure ulcers, it was important to turn and reposition resident's every 2 hours and to check and change for incontinence every 2 hours or more often as needed per facility policy. Unlicensed Staff A stated it was important to reposition resident every 2 hours at least even though a resident was already on a low air loss (LAL, mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup). During an interview on 01/22/2026 at 4:40 PM, Licensed Nurse (LN) B stated Resident 29 required the staff to turn and reposition her frequently at least every 2 hours. LN B stated to prevent pressure ulcers developing, it was also important for staff to check residents for incontinence at least every 2 hours or more often as needed. A review of the facility's policy and procedure P&P) titled Skin Integrity and Management, revised 8/2022, the P&P indicated .avoidable means the resident developed a pressure ulcer and that the skilled nursing facility did not do one or more of the following. implement interventions that are consistent with resident needs, resident goals and recognized standards of practice. The resident should not develop pressure ulcer unless clinically unavoidable.		