STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healdsburg Hospital D/P Snf	1375 University Avenue Healdsburg, CA 95448

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36790 Based on observation, interviews and records review, the facility failed to develop a person-centered individualized care plan for 1 of 8 sampled residents (Resident 7.) This failure had the potential for facility staff to not provide adequate care to Resident 7's eyes which could cause further damage to his eyes and/or blindness. Findings: During on observation on 8/13/24 at 10:25 a.m., in Resident 7's room, Resident 7 had his right eye covered with a gauze dressing. Resident 7's left eye was open and seemed to be looking at the HFEN. During an interview on 8/13/24 at 2:57 p.m., Licensed Nurse C stated Resident 7 has his eye covered because his medical condition causes the eye to be swollen preventing the eye lids from closing. He got eye drops and the dressing to prevent his eye from drying out. During an interview and concurrent record review on 8/14/24 at 3:35 p.m., Licensed Nurse C reviewed the electronic care plan for Resident 7, and it was determined that an individualized care plan concerning Resident 7's vision had not been written. The facilities policy Person-Centered Care Plan, dated 8/2024, indicated a Person-Centered Care Plan will be written for each resident. The plan will be based on the medical, functional, and psychosocial needs of the resident and will include instructions for providing effective and person-centered care that meets the professional standards of quality care.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healdsburg Hospital D/P Snf	1375 University Avenue Healdsburg, CA 95448

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48660 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice when two of three residents (Resident 16 and Resident 5) did not have their enteral tube (a soft, flexible tube which enters a surgically created opening in the abdominal wall and is used to administer food, fluids, and medications to a person that cannot receive food, fluid, or medications through their mouth) flushed (the process of gently pushing water through the tube to clean it) before and after medication administration. This failure had the potential to cause a blockage in the enteral tube and delay the administration of critical medications (priority medications that should not be omitted or delayed). Findings: Record review of a document titled, Face Sheet (resident demographics) for Resident 16, indicated Resident 16 was admitted to the facility on [DATE]. Record review of a document titled, Problem List for Resident 16, indicated Resident 16 had the following diagnoses: traumatic brain injury with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level, encounter for PEG (percutaneous endoscopic gastrostomy [the procedure to insert an enteral tube into the abdomen]), fecal incontinence (loss of conscious control over bowel movements), and gastroesophageal reflux disease (GERD - a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus). During an observation on 8/14/24 at 10:32 AM, Licensed Nurse A prepared and administered the following medications through an enteral tube to Resident 16: Docusate 100 Milligrams (mg - a unit of weight measure), three liquid packets of 10 milliliters (ml - a unit of liquid measure) each (a medication used to prevent or treat constipation [a blockage and/or hardening of stool in the intestinal tract]). Senna 8.6 mg, one tablet (a medication used to prevent constipation). Famotidine 20 mg, one tablet (a medication used to treat stomach ulcers, heartburn, acid indigestion, and gastroesophageal reflux disease). Gabapentin 300 mg, one capsule (a medication used to treat or prevent seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause temporary changes in muscle tone, behavior, sensations, or awareness] or to treat nerve pain). Potassium Chloride 1.5 grams (gm - a unit of weight measure), mixed with 15 ml of water (a medication used in the management and treatment of hypokalemia [a condition where potassium [an important chemical in the body] levels are too low in the blood]). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healdsburg Hospital D/P Snf	1375 University Avenue Healdsburg, CA 95448

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Polyethylene Glycol (PEG) 17 gm, mixed with enough water to dissolve the powder (a medication used to prevent constipation). Licensed Nurse A administered each medication separately and flushed Resident 16's enteral tube with a small amount of water (approximately 5 ml) between each medication. Licensed Nurse A did not flush the enteral tube before administering medications to Resident 16. Licensed Nurse A did not flush the enteral tube after administering medications to Resident 16. During an interview on 8/14/24 at 11:25 AM, Licensed Nurse A stated she flushed Resident 16's enteral tube with approximately 5 ml of water between each medication administered through the enteral tube. Record review of a document titled, Face Sheet (resident demographics) for Resident 5, indicated Resident 5 was admitted to the facility on [DATE]. Record review of a document titled, Problem List for Resident 5, indicated Resident 5 had the following diagnoses: traumatic brain injury (TBI - A traumatic brain injury refers to a brain injury that is caused by an outside force. TBI can be caused by a forceful bump, blow, or jolt to the head or body, or from an object entering the brain), seizure disorder, encounter for PEG, abdominal distension (abdomen is measurably swollen beyond its normal size, often due to trapped gas), and pneumonia (an infection that inflames air sacs in one or both lungs, which may fill with fluid.) During an observation on 8/14/24 at 12:39 PM, Licensed Nurse A prepared and administered the following medications through an enteral tube for Resident 5: Simethicone 125 mg, one tablet (a medication used to treat excessive gas in the digestive tract). Clonazepam 0.5 mg, four tablets (a medication used to treat seizure disorders and anxiety disorders [A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities]). Oxycodone 5 mg, one tablet (a medication used to treat pain). Milk of Magnesia (MOM) 5ml (a medication used as a dietary supplement of magnesium [an important chemical in the body]). Levetiracetam, 1500ml (a medication used to treat seizure disorders). Licensed Nurse A administered each medication separately and flushed Resident 5's enteral tube with a small amount of water (approximately 5 ml) between each medication. Licensed Nurse A did not flush the enteral tube before administering medications to Resident 5. Licensed Nurse A did not flush the enteral tube after administering medications to Resident 5. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healdsburg Hospital D/P Snf	1375 University Avenue Healdsburg, CA 95448

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 4:03 PM, the Director of Nursing (DON) stated the facility policy was to always flush before and after enteral tube medication administration. The DON further stated the policy specified a minimum flush of 15 ml of water before and after medication administration through an enteral tube. Record review of a Policy and Procedure titled, Medication Administration Through a Feeding Tube, last approved on 3/2021, indicated flush feeding tube with 15-30 ml of warm water before administering medications. The Policy and Procedure further indicated flush the feeding tube with at least 15 - 30 ml of warm water after the completion of the medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555590	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healdsburg Hospital D/P Snf	1375 University Avenue Healdsburg, CA 95448

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36790 Based on observation and interview and facility policy review, the facility failed to ensure food items were stored in a manner that complied with food handling practices to prevent food-borne illness (illness caused by the ingestion of contaminated food or beverages), when two bowls of prepared food were in the walk-in refrigerator without any labeling and several food items were opened and without labels in the dry storage area. This failure had the potential to result in the rapid growth of pathogenic (capable of causing disease) microorganisms (e. g. bacteria, virus etc.) that could cause food-borne illnesses and could affect the residents of the facility. Findings: During an observation on 8/12/24 at 9:15 a.m., food items in the freezers were labeled with the arrival date. Food items in the refrigerators had the arrival date. Food items in dry storage were labeled with the arrival date. On 8/14/24 at 9:30 a.m., during an observation in the dry storage area, several open food packages were found without a label, starting with a large open box that contained the oatmeal in plastic bag, but no label. An open box of Nilla wafers, 1 bag of tortilla chips, an 8-ounce box of pasta and a box of pancake mix had been opened and partially used but were without labels to show an opened date or use by date. During an interview on 8/14/24 at 9:45 a.m., Kitchen Staff E stated that upon delivery, the items were labeled with a Received Date. The boxes and bags of the food products taken out of the shipping boxes also get the Received Date. When the food packages are opened, they should have a new label that showed the date received, date opened and a use by date. During an observation on 8/14/24 at 9:50 a.m., the walk-in refrigerator was found to have open items unlabeled. One item was a bowl of cooked and cut up chicken, covered with plastic wrap. No label was found. The second item was a dark colored sauce in a bowl, covered in plastic wrap and not labeled. During an observation and concurrent interview on 8/14/24 at 9:53 a.m., Kitchen Staff D removed the items and stated there should be labels that include the received date, open date, and use by date. Kitchen Staff D stated staff could generate labels electronically. Kitchen Staff D stated he would need to talk with staff. The facilities policy and procedure titled Food and Supply Storage, dated 6/2023, indicated: Cover, label and date unused portions and open packages. Complete all sections of the [NAME] orange label or other approved labeling system. The policy is to store food items and supplies in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption.