

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555590	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Healdsburg Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop activity care plans for the residents when three of five residents sampled for activities (Residents 7, 9, 13) did not have an activities care plan. This failure had the potential to result in activities that do not meet the needs of the residents. During a record review and concurrent interview on 7/8/26 at 10:52 a.m., when asked for the location of the activity care plan in the electronic medical record, Nurse Manager navigated to a flow sheet in Resident 13's chart for documentation of activities and stated the flow sheet was considered the care plan for activities. Review of Resident 13's flow sheet for activities indicated several general one-word categories of activities, such as music, but did not indicate what the resident's preferred activities were or how the resident's personal activities needs would be met. During an interview on 7/8/26 at 2:07 p.m. with Nurse Manager and Quality Manager, Nurse Manager stated the electronic medical record (eMR) was not set up to have care plans for activities. Nurse Manager stated they would have to put in a request to the eMR company for them to make a customized activity care plan for the residents. Nurse Manager verified the flow sheet where activities were documented was not individualized with the residents' preferred activities. Nurse Manager verified the social worker's progress notes with the residents' preferred activities did not replace a care plan. Nurse Manager stated having a personalized activities plan for their resident population was very important. Quality Manager stated an activity care plan was important so that anyone can see in the medical record what the resident's preferences were, such as whether a resident liked Mexican music or country music, or liked action movies or liked to watch football, so staff knew to put the game on when they came in the room. Review of Resident 7's face sheet (demographics) indicated Resident 7 was admitted on [DATE] with a primary diagnosis of traumatic brain dysfunction (disruption of normal brain function caused by an outside force-such as a bump, jolt, or penetrating object). Resident 7's MDS (minimum data set, an assessment tool) dated 5/5/26 indicated Resident 7 was not able to complete a cognitive assessment. Review of Resident 9's face sheet indicated Resident 9 was admitted on [DATE] with a primary diagnosis of stroke (a disruption of blood flow to the brain caused by a blocked or a ruptured blood vessel). Resident 9's MDS dated [DATE] indicated Resident 9 was not able to complete a cognitive assessment. Review of Resident 13's face sheet indicated Resident 13 was admitted on [DATE] with a primary diagnosis of persistent vegetative state (a condition where a person with severe brain damage appears to be awake but has no conscious awareness of themselves or their environment). Review of Resident 13's MDS dated [DATE] indicated Resident 13 was not able to complete a cognitive assessment. Review of facility policy and procedure Person-Centered Care Plan, last revised 10/2024, indicated, [Facility named] will establish a Multidisciplinary, Person-Centered Care Plan (Plan) for each resident who is admitted for care and (continued on next page)		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment. The Plan will be comprehensive based on the medical, functional and psychosocial needs of the resident with time limited goals. The following elements must be present in every Care Plan: . Person-Centered care that focuses on resident choice, such as choosing activities . Each resident's person-centered care will be implemented based on their Plan of Care.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility's staff failed to complete comprehensive assessments of residents when two of five residents sampled for activities (Residents 9 and 13) did not have completed activity assessments through family interview. This failure had the potential to result in activities that are not personalized for residents who are no longer able to communicate their preferences. During a record review and concurrent interview on 7/8/26 at 1:30 p.m., MDS Coordinator reviewed Resident 9's activity assessments dated 3/23/26 and 3/22/25 and verified they had not been completed. MDS Coordinator also reviewed Resident 9's activity assessment at the time of her admission in March of 2024 and verified it had not been completed, which meant Resident 9 had never had an activity assessment completed at this facility. MDS Coordinator stated the social worker was responsible for conducting the activity assessment with the residents' family since their resident population were unable to communicate for the most part. MDS Coordinator stated Resident 9 had two sons who were involved in Resident 9's care and that Resident 9's activity assessments should have been completed. Continuing the record review and concurrent interview on 7/8/26 at 1:30 p.m., MDS Coordinator reviewed Resident 13's activity assessments dated 1/29/26 and 1/28/26 and verified they had not been completed. MDS Coordinator stated Resident 13 had family that were involved in her care and the activity assessments should have been completed. MDS Coordinator stated the facility had a social worker at the time that Residents 9 and 13's activity assessments were due to be completed. During an interview on 7/8/26 at 2:07 p.m., Nurse Manager stated having a personalized activities plan for their resident population was very important. Review of facility policy and procedure Minimum Data Set (MDS) Assessments, last revised 4/2026, indicated, [Facility named] will submit . all required Minimum Data Set (MDS) assessments, according to the MDS guidelines. The MDS Assessment is divided into sections and Interdisciplinary team members other than nursing may complete their sections, as coordinated by an MDS nurse. Each discipline is responsible for completion of their section by the specified due date.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility did not ensure the posted daily staffing information included the required elements: 1. Facility name 2. The current date 3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides. 4. Resident census. This failure resulted in residents, visitors and staff not having access to the required information and had the potential for the facility not to meet the required daily nurse staffing hours per patient day. During an observation on 7/7/26 at 11:35 a.m., the staffing assignment sheets were observed posted at the nursing station and contained licensed and unlicensed staff assigned to specific resident rooms. During an interview on 7/7/26 at 11:50 a.m., the Nurse Manager stated they did not publicly post the required hours per resident, only the staffing assignment. The Nurse Manager stated she did not know what the Hours Per Resident Day (HPRD) was.		