STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555703	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Post Acute	523 Hayes Lane Petaluma, CA 94952

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 0552 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility failed to honor the rights of one of two residents (Resident 5) when Resident 5 ' s medical decision-maker, Family Member 2 (FM2) was not asked or notified before starting to give Resident 5 a new pain medication MS (morphine sulphate) Contin (a long-acting pain medication made with morphine, an opiate). This failure resulted in Resident 5 becoming over sedated (state of calmness, relaxation, or sleepiness), requiring naloxone (a medication that reverses the potentially deadly effects of opiate toxicity), when he was administered a new medication before FM2 had been given a chance to consider the risks and benefits or permission for them to give it to him. Finding: During a telephone interview on 7/24/24 at 10 a.m., FM2 stated Resident 5 was riddled with arthritis (joint pain) particularly in his neck and knee. FM2 stated Resident 5 had been prescribed Norco (brand name for a pain medication made with acetaminophen and hydrocodone [an opiate]) scheduled twice daily until about four or six months ago when he was assigned a new doctor (Physician J). At that time the Norco was changed to be given only as needed. FM2 stated Resident 5 was screaming in pain one day, so the nurses called the doctor (Physician J) who ordered morphine 30 mg (milligrams, a unit of measure) instead of going back to the scheduled Norco. FM2 stated Resident 5 was given six doses of the morphine and then on 7/9/24 the nurse (unidentified) called FM2 to tell her Resident 5 was doing well after being given Narcan (brand name for naloxone). FM2 stated she asked the nurse, Why did you need Narcan? and the nurse told her Resident 5 had a bad reaction to morphine. FM2 stated she was angry because she had no idea Resident 5 was taking morphine. FM2 stated she asked the nurse, Where did that (the morphine) come from? You ' re supposed to advise me. When queried, FM2 stated the nurse had given Resident 5 the Narcan because he was not responding (to touch or verbal stimuli). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Actual harm Residents Affected - Few	During a record review on 7/24/24 at 10:45 a.m., Resident 5 ' s face sheet revealed an admitted [DATE] with multiple medical diagnoses including schizoaffective disorder (a mental health condition with symptoms that include delusions [false beliefs], hallucinations, depressed episodes, and manic periods of high energy), osteoarthritis (joint pain) of the knee, spondylitis of the cervical spine (stiff, painful neck), and cognitive (relating to or involving the processes of thinking and reasoning) communication disorder, among others. Resident 5 ' s face sheet further indicated FM2 was his responsible party and his Health Care Decision Maker. Review of Resident 5 ' s physician order, dated 3/7/24, indicated that a new physician, Physician J, was taking over Resident 5 ' s care. Review of Resident 5 ' s medication administration record (MAR) for May 2024 indicated his order for Norco 10/325 mg three time per day was discontinued on 5/8/24, and oxycodone (an opiate pain medication) 10 mg every six hours as needed was started on 5/8/24. Review of Resident 5 ' s July 2024 MAR revealed a physician order with a start date of 7/6/24 for MS Contin Oral Tablet Extended Release 30 mg (Morphine Sulphate) Give one table by mouth two times a day for pain management. Resident 5 ' s July 2024 MAR indicated Resident 5 received a dose of the MS Contin on 7/7/24 at 9 a.m. and 5 p.m., 7/8/24 at 9 a.m. and 5 p.m., and 7/9/24 at 9 a.m. Review of Resident 5 ' s count sheet (a log where the nurses write the date and time each pill is removed in order to keep track of how many pills are left of the medication), not dated, for his oxycodone 10 mg indicated Resident 5 received doses on 7/7/24 at 1 p.m., 7/8/24 at 1:57 p.m. and 8 p.m., and 7/9/24 9:57 a.m. Further review of Resident 5 ' s July 2024 MAR indicated naloxone 0.4 mg was given on 7/9/24 at 4:11 p.m. On 7/9/24 at 5:10 p.m., a MAR note indicated the naloxone was effective. Review of Resident 5 ' s physician progress notes for May 2024 and July 2024 (the months during which Resident 5's pain medications were changed) revealed no documentation of the rationale for the change of medications or any discussion with FM2 regarding the changes to Resident 5 ' s pain medication regimen. Resident 5 ' s physician progress note dated 7/11/24 indicated, Chief complaint: Opioid overdose, AMS (altered mental status). Assessment: . Pt (patient) noted to be [more] lethargic (feeling a lack of energy or interest in doing things) after dose of opioid. Review of Resident 5 ' s nurse progress notes for the month of May 2024 and July 2024 (the months during which Resident 5's pain medications were changed) also revealed no documentation that FM2 was notified of the changes to Resident 5 ' s pain medication regimen. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/24/24 at 3:51 p.m., Licensed Nurse F stated she recalled that on 7/9/24 Resident 5 was seemingly out of it, so I gave Narcan to him. Shortly thereafter Resident 5 turned back into his crying person that he is when he ' s in pain. Licensed Nurse F stated she called Resident 5 ' s doctor (Physician J) and informed him Resident 5 was seemingly out of it and she had given Narcan to him. Licensed Nurse F stated the only thing she noticed that was new for Resident 5 was the morphine. Licensed Nurse F stated the doctor responded to cut the morphine dose in half from 30 mg to 15 mg. Licensed Nurse F stated she called FM2, and she was very angry. Licensed Nurse F stated FM2 told her, I ' m supposed to be notified whenever there ' s a change in medication. When queried, Licensed Nurse F stated Resident 5 was usually sitting up at that time of day when her shift began and she thought it was unusual that he was in bed. Licensed Nurse F stated Resident 5 was awake but not acknowledging her. When asked how Resident 5 communicated at baseline, Licensed Nurse F stated Resident 5 could verbalize that he needed pain meds (medications), and when she brought him his medications, he asked, Do you have pain meds in there (the pill cup)? Licensed Nurse F verified she reassessed Resident 5 throughout the rest of her shift (3 p.m. to 11:30 p.m.) and the naloxone had been effective. When queried, Licensed Nurse F stated she thought the dose of the MS Contin was too high. She thought that to start Resident 5 at 30 mg was too much and it had caused Resident 5 to become over sedated. During an interview on 7/30/24 at 3:12 p.m., Licensed Nurse G verified she entered the order for the MS Contin on 7/5/24. She stated Resident 5 was showing signs the pain medication he was taking (oxycodone 10 mg every six hours as needed) was not working and gave the example that he was refusing turning and calling out in pain. Licensed Nurse G stated he also was not eating because of the neck pain he was having. Licensed Nurse G stated Resident 5 ' s pain medication was ordered PRN (as needed), but she thought something routine (scheduled) would help. Licensed Nurse G stated she contacted Resident 5 ' s doctor (Physician J) and he responded with the order for the MS Contin. When queried, Licensed Nurse G stated she did not recall informing FM2, Resident 5 ' s responsible party (RP), that the doctor (Physician J) ordered the MS Contin. When asked who was responsible for informing the RP of medication changes, Licensed Nurse G stated it would be the nurse ' s responsibility. During an interview on 7/30/24 at 3:51 p.m., Director of Nursing (DON) stated he could not remember why Resident 5 ' s pain medication was changed in May 2024. DON verified it was changed again at beginning of July 2024. DON stated they usually informed the resident ' s RP of a pain regimen change or medication that needed informed consent and they usually specified (documented) in the record that the RP agreed the medication was what they wanted. DON stated that in this case it was not specified in the record. DON stated it was the responsibility of the nurse who took the medication order from the doctor to tell the RP of any changes. DON verified FM2 should have been notified of the changes in treatment for Resident 5 ' s pain. During a phone interview on 8/20/24 at 11 a.m., Medical Director verified the resident or the resident's decision maker or responsible party should be involved in the decision to change a resident's pain medication regimen. When asked who was responsible for having that discussion with the resident or the decision maker, Medical Director stated it could be the resident's doctor, the LVN (licensed vocational nurse), the RN (registered nurse), the DON. When queried, Medical Director stated the rationale for involving the resident or decision maker or responsible party in medication changes was to make sure they were aware of the plan. (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	Review of the package insert information for MS Contin Extended Release on website dailymed.nlm.nih.gov, accessed on 8/15/24, revealed under Warnings section, Morphine may be expected to have additive effects when used in conjunction with . other opioids . that cause central nervous system depression because respiratory depression (slow, shallow breathing), hypotension (low blood pressure), and profound sedation or coma may result. Section titled Dosage and Administration revealed, During periods of changing analgesic (pain medication) requirements including initial titration (changing the dose according to patient response), frequent contact is recommended between physician, other members of the healthcare team, the patient, and the caregiver/family. Review of facility job description Charge Nurse, dated 3/2019, indicated under Essential Duties section, Encourage the resident and his/her family to participate in the development and review of the resident ' s plan of care. Review of facility policy Resident Rights, last revised 2/2021, revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: . be informed of, and participate in, his or her care planning and treatment .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility failed to follow up on a stat (immediately, urgent) laboratory (lab, a facility that provides controlled conditions in which scientific or technological research, experiments, and measurement may be performed) order for one of two sampled residents (Resident 5) when a stat urinalysis (UA, a basic test that examines the contents of a urine sample to identify conditions that may need treatment) and culture and sensitivity (C&S, a lab test that checks which bacteria are in the urine and which antibiotic will kill the bacteria) specimen for Resident 5 was rejected by the lab on 7/15/24 and a new urine specimen was not collected. This failure caused a delay in diagnosis and treatment for Resident 5, which caused his health to worsen requiring hospitalization on [DATE] where he was diagnosed with septic shock (sepsis [a serious condition in which the body responds improperly to an infection] may progress to septic shock, a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs) and acute cystitis (bladder infection). Finding: During a telephone interview on 7/24/24 at 10 a.m., Family Member 2 (FM2) stated that after 7/9/24, Resident 5 laid lethargic (feeling a lack of energy or interest in doing things) for a few days. FM2 stated she then got a phone call from the nurse supervisor on approximately 7/13/24 that Resident 5 had blood in his urine, and they were waiting for the doctor to authorize cultures. FM2 stated that on Tuesday 7/16/24 she got a call from her son that Resident 5 was not well, Resident 5 was white, shivering, lethargic and curled up in bed in a fetal position. FM2 stated Resident 5 went to the hospital with sepsis. FM2 stated, I think if they hadn ' t called (911) because my son told them to he (Resident 5) would have been dead by the next day. When queried, FM2 stated the facility ' s nurses ' lack of action made her feel angry. During a record review on 7/24/24 at 10:45 a.m., Resident 5 ' s face sheet revealed an admitted [DATE] with multiple medical diagnoses including schizoaffective disorder (a mental health condition with symptoms that include delusions [false beliefs], hallucinations, depressed episodes, and manic periods of high energy), dysphagia (difficulty swallowing), and cognitive (relating to or involving the processes of thinking and reasoning) communication disorder, among others. Resident 5 ' s record indicated FM2 was his responsible party and his Health Care Decision Maker. Review of Resident 5 ' s SBAR form (situation, background, assessment, and recommendation; a communication tool), dated 7/14/24 at 4:26 p.m., indicated Resident 5 had increased confusion, required more assistance with ADLs (activities of daily living, such as bathing, dressing, eating, toileting), and had blood in his urine. The SBAR indicated that Licensed Nurse H had notified Resident 5's doctor, Physician J, of his change in condition, and Licensed Nurse H was awaiting a reply. Review of Resident 5 ' s physician order, dated 7/14/24, indicated, Obtain UA and C&S STAT. Review of Resident 5 ' s nurse progress note dated 7/14/24 at 11:54 p.m., indicated Licensed Nurse G had collected the urine specimen for a STAT UA and C&S and she notified the lab that the specimen was ready for pickup. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 5 ' s nurse progress notes dated 7/15/24 at 4:40 a.m., 7/15/24 at 9:31 p.m., and 7/16/24 at 1:14 p.m. all indicated Resident 5 was being monitored for continued confusion and blood in urine, but there was no documentation that the nurses followed up with the lab for the results of the stat UA and C&S. Review of Resident 5 ' s lab results for the stat UA and C&S, dated 7/15/24 at 2:10 p.m., indicated, Specimen Requires Recollection and a New Order Placed if Results are Needed. The lab results also indicated the reason the test was not performed was, Specimen Mislabeled - Missing Info. During an interview on 7/24/24 at 2:39 p.m., when queried, Infection Preventionist (IP) stated she did not track Resident 5 ' s urine sample because she was busy doing Covid response testing. IP stated the stat order for the UA was put in on Sunday (7/14/24) and the lab picked up the urine sample on Monday morning (7/15/24). IP stated the UA was not performed due to missing information and the lab did not call her. She did not know if the lab called Resident 5's nurse (Licensed Nurse K). IP stated usually the lab would call for critical values or if a test needed to be redone. IP stated that before nurses come to shift, they should always check results and there should be endorsement (report of information for continuity of care) from nurse to nurse to follow up on results. IP stated that if the results do not come back the same day it was collected, the nurse should call the lab that day. IP stated that in Resident 5 ' s case the PM shift (3 p.m. to 11:30 p.m.) nurse (Licensed Nurse L) should have called the lab Monday (7/15/24) before they left and notified the doctor so they could tell us what to do next. During an interview on 7/30/24 at 3:12 p.m., Licensed Nurse G stated she cared for Resident 5 (3 p.m. to 11:30 p.m.) after Licensed Nurse H put in the change in condition note (7/14/24). Licensed Nurse G stated she collected the urine sample on 7/14/24. Licensed Nurse G stated Resident 5 was confused and he definitely had a fair amount of sediment (particles that make the urine cloudy) in his urine, so she encouraged fluids while they waited for the lab results. Licensed Nurse G stated it was the nurses ' responsibility to follow up with the lab. Licensed Nurse G stated that the nurse who was on when the results came in was responsible for following up on the results. Licensed Nurse G stated every nurse after the sample was sent out should follow up with the lab for results. When queried, Licensed Nurse G stated that if a sample was rejected the nurse should notify the doctor and the responsible party, and then get a new sample if they can, then make a new order for it to be picked up again. When asked how Resident 5 was acting when he was confused (on 7/14/24), Licensed Nurse G stated he was alert to self only (he did not know the date, time, where he was or why he was there). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/24 at 3:35 p.m., Licensed Nurse H stated that when she worked with Resident 5 on Sunday (7/14/24) he had hematuria (blood in his urine) and increased confusion. She stated she informed the doctor right away. Licensed Nurse H stated she endorsed to the oncoming shift, Licensed Nurse G, that she was waiting for a response from Physician J. Licensed Nurse H stated Resident 5 seemed more confused, he had some underlying confusion, just every now and then he would say something that was inappropriate, not lethargic just a marked change in mentation. Licensed Nurse H stated Resident 5 had the condom catheter (a urinary device that fits over the penis and drains urine to a collection bag) at that point to help heal the open skin on his scrotum. Licensed Nurse H stated she collected the urine specimen in a container and put it in the refrigerator, and then Licensed Nurse G put the urine in the tubes for the urine test. Licensed Nurse H stated that if there was a stat lab at change of shift, the oncoming nurse was responsible for following up on the results. Licensed Nurse H stated that with the lab it just depended on how busy they were, if it was a critical result they would call, but usually they would fax the results to them. Licensed Nurse H stated the lab should call if the specimen was rejected but the nurse is also responsible to follow up if results were pending. Licensed Nurse H stated that if the results had not been received by the end of her shift she would go online and see if the results were ready or not. When asked if it would it say online if the specimen was rejected, Licensed Nurse H stated it would say test incomplete and results not available see attachment and at that point she would just call. During an interview on 7/30/24 at 3:51 p.m., when asked how he monitored residents with a change in condition, Director of Nursing (DON) stated they did a daily clinical IDT (interdisciplinary team, typically includes the nursing leadership, social services, and medical records) to review all resident changes in condition. When asked if they reviewed Resident 5 on 7/15/24 and 7/16/24, DON stated he was out that week. When queried, DON stated the MDS (minimum data set, an assessment tool) nurse ran the clinical IDT when he was out or the Director of Staff Development (DSD). DON stated that in Resident 5 ' s case, follow up should have happened every shift with the lab results. When asked when the nurse should have called the lab, DON stated the nurse should have called by PM shift on 7/15/24, the day it was picked up and reported as rejected. During an interview on 8/13/24 at 2:49 p.m., when asked the facility process for clinical IDT meetings, DSD E stated the clinical IDT rounds are done after the daily stand-up meeting in the conference room. DSD E stated the medical records department brings all the documentation, and the IDT looked at anyone who had a change in condition, a fall, medication change, the new admits, hospitalization s. DSD E stated they reviewed everything, such as what happened in the previous 24-hours or over the weekend, then they came up with a care plan. When asked what the IDT would review for a resident with acute confusion and hematuria, DSD E stated they would look for lab results, see what happened, did a UA get done, do we have results, did they start antibiotics, get a culture, what symptoms the resident had. When queried, DSD E stated that if DON was not available it would be herself and the MDS nurse leading the clinical IDT rounds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/13/24 at 2:54 p.m., when asked the facility process for clinical IDT meetings, MDS Nurse stated they did clinical IDT every day after the stand-up meeting. MDS Nurse stated they talked about resident changes in condition, was it care planned, reported to the doctor, reviewed new orders, was it documented in a progress note or was a SBAR done. MDS Nurse stated that if DON was not available the DSD would do the clinical IDT. MDS Nurse verified the clinical IDT discussed Resident 5 on 7/16/24. When asked if the IDT talked about the UA that was ordered for Resident 5 on 7/16/24, MDS Nurse responded, When they were waiting for the results, that was the time he was sent out (to the hospital). When reminded that Resident 5 was sent to the hospital in the evening of 7/16/24 and clinical IDT met in the morning, MDS Nurse stated there was an assistant to the DON that was supposed to follow up on these things like lab results. After multiple queries, MDS Nurse did not respond to what was discussed regarding Resident 5 ' s change in condition or lab results at clinical IDT on 7/16/24. During a phone interview on 8/20/24 at 11 a.m., Medical Director stated there were a lot of reasons a UA would be ordered if a resident had confusion and hematuria, such as blood clots in the bladder or urethra, infection, or a fistula (an abnormal connection between the urethra and another hollow organ). Medical Director stated the UA was usually ordered stat because it was the fastest way to get information and they typically got results in 24 hours or less. Review of Resident 5's nurse progress note dated 7/16/24 at 7:20 p.m., indicated, Pt's (patient's) grandson requested pt's LN (licensed nurse) to call pt's daughter immediately, he did not elaborate further. Three LN's assessed pt. Nurse progress note described outcome of head-to-toe assessment and vital signs (blood pressure, temperature, pulse, respirations, and oxygen saturation [a measurement of how much oxygen is being carried by red blood cells]). Vital signs were normal except oxygen saturation was 81% on room air (normal oxygen saturation is 90 to 100%), oxygen was applied. Further review of nurse progress note indicated, Lungs with diminished breath sounds . Condom catheter in place, gross hematuria noted . This nurse (Licensed Nurse L) called pt's daughter, [FM2 named], to report assessment. Pt's daughter stated she wanted pt to be transferred to the ER (emergency room). This nurse (Licensed Nurse L) phoned and messaged MD (medical doctor) and then called 911. Review of the ambulance crew documentation on 7/16/24 indicated the 911 call came in at 6:36 p.m., the crew arrived at the facility at 6:41 p.m., and arrived at the hospital emergency department with Resident 5 at 7:03 p.m. The ambulance crew documented that they were responding to a call that Resident 5 had an altered mental status and crackles in his lungs (sounds heard through a stethoscope [a medical instrument for listening to the action of someone's heart or breathing], can be a sign of fluid in the lungs). The ambulance crew further documented that upon arriving to Resident 5 ' s room, Resident 5 was alert and sitting up in bed, he had shallow, labored breathing, rapid pulse, and his skin was hot and dry to the touch. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital emergency department (ED) documentation dated 7/16/24, revealed Resident 5 ' s temperature at 7:16 p.m. (40 minutes after 911 was called) was 101.7 degrees Fahrenheit axillary (arm pit) and his pulse was 120 beats per minute (normal pulse is 60 to 100 beats per minute). Review of the ED document History of Present Illness, dated 7/16/24 at 7:12 p.m., indicated a Code Sepsis was called and Resident 5 was diagnosed with sepsis, hypoxia (low oxygen levels), and acute cystitis with hematuria. Resident 5 ' s respiratory rate was elevated in the ED, with a rate as high has 43 breaths per minute at 8:23 p.m. (normal respiratory rate is 12 to 20 breaths per minute). While in the ED, Resident 5 ' s blood pressure was dropping, by 8:50 p.m. (approximately 2 hours and 15 minutes after 911 was called) his blood pressure was 63/47, and he was started on a Levophed drip (an intravenous [directly into the vein] medication that treats low blood pressure) and sent to the intensive care unit (ICU). Review of the hospitalist ' s (a physician who only sees patients in the hospital) note dated 7/16/24 at 9:19 p.m., indicated one of Resident 5 ' s diagnoses was Severe sepsis with septic shock. Review of Resident 5 ' s hospital lab work, dated 7/16/24, indicated Resident 5 ' s white blood cell count was 20 K/uL (a unit of measure) (elevated white blood cells can indicate the body is fighting an infection, normal level is 3.5 to 11 K/uL), his arterial blood gas (measures the amount of oxygen and carbon dioxide in your blood) results showed an oxygen level of 42 mmHg (a unit of measure) (normal oxygen level in the arteries is 83 to 100 mmHg), and his UA indicated his urine had many bacteria (normally urine is sterile [has no bacteria]). Review of facility policy Request for Diagnostic Services, last revised 4/2007, indicated, Orders for diagnostic services will be promptly carried out as instructed by the physician ' s order. Review of facility job description Charge Nurse, dated 3/2019, indicated under Essential Duties section, Performs nursing assessments regarding the health status of the resident / patient.

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Ridgeway Post Acute	523 Hayes Lane Petaluma, CA 94952

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27532 Based on observation, interview and records review, the facility failed to ensure one Unlicensed Staff (Unlicensed Staff B) wore an N95 respirator to care for COVID-19 positive residents. This failure can result to the spread of infection to other facility residents and staff and cause an outbreak of COVID-19 in the facility further endangering the lives of the already frail elderly residents of the facility. Findings: During an observation on 7/24/24, at 1:07 PM, this Surveyor knocked on the door of room [ROOM NUMBER] where Resident 6 and Resident 7 were roomed-in. Unlicensed Staff B opened the door and was observed wearing a gown, gloves, and a surgical mask pulled low on her face exposing her nose. During an interview on 7/24/24, at 2:33 PM, Licensed Staff C confirmed she also noted Unlicensed Staff B was wearing a surgical mask with her nose showing over the top of the mask. During an interview on 7/24/24, at 2:38 PM the Infection Preventionist (IP) confirmed Resident 6 and Resident 7 in room [ROOM NUMBER] were COVID-19 positives. When asked what the expectations from staff are assigned in COVID-19 positive rooms, the IP stated staff should wear full Personal Protection Equipment (PPE) consisting of gown, N95 mask, goggles, gloves and dispose of PPEs in the red bin inside the room before leaving. When staff are outside, they can switch to regular mask. The purpose is to reduce transmission from the patient. On continued interview on 7/24/24, at 2:51 PM, the IP stated she had conducted in-service training of all staff including to wear an N95 mask when going into a room with COVID-19 positive patients. Upon conclusion of the interview and on her way out of the conference room, the IP stated some staff are hard-headed and do not practice what was taught to them. A review of the facility policy titled, Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents from 2001 MED-PASS, Inc. revised 9/2022, indicated, staff who enter the room of a resident with suspected or confirmed SARS-COV-2 (COVID-19) infection will adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) - approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face.