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	01/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48660 Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident 1) of two sampled residents when licensed nurses did not communicate Resident 1's treatment orders written by a Wound Care Physician Assistant (PA - a licensed medical professional whose duties include ordering labs, medications, and treatments) for a wound on the left heel to the Attending Physician (a physician who is responsible for a patient's care in a hospital or skilled nursing facility) for approval and a signature. This failure decreased the facility's potential to ensure Resident 1's wound care treatments were ordered and carried out. Findings: A review of Resident 1's admission record indicated he was admitted on [DATE] with relevant diagnoses including: Type 2 Diabetes Mellitus (a disease that occurs when blood sugar is too high) with Diabetic Polyneuropathy (a complication of diabetes that affects nerves that branch out from the spinal cord to the arms, hands, legs, and feet), Unspecified Severe Protein-Calorie Malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), Essential Hypertension (a condition where blood pressure is elevated and there is no clear cause), Chronic Congestive Heart Failure (a long-term condition where the heart cannot pump enough blood throughout the body), and Peripheral Vascular Disease (a condition in which narrowed blood vessels reduce blood flow to the arms and legs). A review of Resident 1's clinical record included the following documents: A Skin and Wound Evaluation, dated 8/14/24, indicated Resident 1 was admitted to the facility with a stage 3 pressure wound (a deep wound that extends through the entire thickness of the skin) on his coccyx (a small bone located at the end of the spine). A Skin and Wound Evaluation, dated 8/15/24, indicated Resident 1 was admitted to the facility with a suspected deep tissue injury (a pressure injury where the underlying tissues are damaged without a visible open wound, often appearing as a purple or maroon discoloration on intact skin) on the left heel. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note written by the Wound Care PA on 9/11/24 indicated, debridement was performed today on the left heel wound .For the left heel wound add bacitracin [an ointment used to treat skin infections] to the treatment . A Progress Note written by the Wound Care PA on 10/16/24 indicated, wound bed noted with more slough [a layer of dead tissue that separates from the underlying healthy tissue], increase dressing frequency .Obtain wound culture please. An Order Summary Report, dated 9/11/24 through 12/1/24, did not include an order for bacitracin to be applied to the left heel nor a wound culture of the left heel. A Treatment Administration Record (TAR), dated September 2024 and October 2024 did not include bacitracin as a treatment administered to Resident 1's left heel. During an interview on 1/22/25 at 11 a.m., the Director of Nursing (DON) confirmed Resident 1 did not have an order for or results of a wound culture in his clinical records. The DON further stated it was the responsibility of the treatment nurse (the nurse responsible for accompanying with Wound Care PA to assess and treat residents) to report to and follow up with the Attending Physician when new wound care orders were received from the PA. During an interview on 1/22/25 at 12:44 p.m., Licensed Nurse A (LN A) stated the Wound Care PA ordered a wound culture if something questionable was observed during a wound assessment. LN A stated the usual process included the Wound Care PA verbally communicating with the treatment nurse during rounds or via e-mail transmission of the Wound Care PA's progress notes. During an interview on 1/23/25 at 11:16 a.m., Licensed Nurse B (LN B) stated the usual procedure had been for the Wound Care PA to communicate new orders to the treatment nurse either verbally or via e-mail transmission of the Wound Care PA's progress notes. LN B stated an order for a topical treatment (such as bacitracin) would have been in the TAR if the order was placed. LN B stated if no record was found for bacitracin, it meant the order had not been entered in the electronic medical system. During an interview on 1/23/25 at 11:30 a.m., Licensed Nurse C (LN C) stated if a wound care order from the Wound Care PA had not been communicated to the Attending Physician via electronic medical records or in person, then the physician's orders had not been followed. LN C further stated nurses were required to follow physician's orders. In an interview on 1/23/25 at 12:11 p.m., the Attending Physician confirmed it was not his standard practice to read the wound care notes. The Attending Physician also verified the Wound Care PA did not put orders into the electronic record system but instead communicated orders to the nursing team which then communicated those orders to the Attending Physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy & Procedure (P&P) titled Verbal Orders dated 2001 indicated, Verbal orders shall only be given .when the attending physician is not immediately available to write or sign the order . Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf .The individual receiving the verbal order must write it on the physician' order sheet as ' v.o.' (verbal order) .The individual receiving the verbal order will .read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed .record the ordering practitioner's last name and his or her credentials (MD [Physician], NP [Nurse Practitioner], PA, etc.); and . record the date and time of the order .The practitioner will receive and countersign verbal orders during his or her next visit.