STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555836	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbol Residences of Santa Rosa	300 Fountaingrove Parkway Santa Rosa, CA 95403

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38335 Based on observation, interview, and record review, the facility failed to ensure supervision to prevent accidents for one resident (Resident 1) when: 1. Resident 1 eloped from the facility and was found face down on the pavement; and, 2. The Wander Monitoring System (WMS, an alarm system compromised of a monitor placed on the resident and placed on facility exits used to prevent residents from wandering or seeking to leave the facility) ordered by the physician to be implemented for Resident 1 was not functional. These failures resulted in Resident 1 ' s obtaining trauma to the right eyebrow and a laceration which required stiches and decreased the facility ' s potential to ensure the safety of residents at risk of elopement to leave the facility undetected placing the resident at risk for injury or harm. Findings: 1. Review of Resident 1 ' s clinical record showed Resident 1 was admitted to the facility on [DATE], with a diagnosis which included Traumatic Subdural Hemorrhage (a collection of blood between the brain and skull caused by a head injury) and unspecified dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). Review of Resident 1 ' s Minimum Data Set (MDS, an assessment tool), dated 12/26/24, indicated a Brief Interview for Mental Status (BIMS) score of 6 which meant Resident had severe cognitive impairment. A review of a care plan regarding Resident 1 ' s high risk for falls related to dementia, impulsiveness, wandering, and poor safety awareness, initiated on 6/19/24, indicated, [Resident 1 ' s goal was to] not sustain .injury through the review date [of 3/1/25] .[Interventions staff were to implement to assist Resident 1 to meet her goal included] Encourage and assist [Resident 1] with remaining in common, supervised areas when awake [Initiated 1/10/25] .Provide resident a safe environment [Initiated 10/15/24] . A review of a care plan regarding Resident 1 ' s potential for impaired behavioral patterns, initiated on 10/25/24, indicated, [Resident 1 ' s goal was to] have no injury related to impaired behavioral pattern through review date [of 3/1/25] .[Interventions staff were to implement to assist Resident 1 to meet her goal included] Monitor/Record occurrence of targeted behavior [which included] Exit Seeking . (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: 555836	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER: Arbol Residences of Santa Rosa		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 Fountaingrove Parkway Santa Rosa, CA 95403	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s progress note dated 1/12/25 at 11:06 p.m., indicated, [Resident 1] was found outside [the facility on] the pavement by facility staff around 19:40 hrs [7:40 p.m.] Staff notified this nurse and other care staff. [Resident 1] found on the pavement face down to ground, with bleeding noted on pavement . [Resident] was noted to be bleeding from the right top corner of eye, noted laceration to area with a hematoma . A review of the hospital history and physical dated 1/12/24, indicated Resident 1, .was found wandering outside without her walker and had fallen causing abrasion [damage to the skin caused by scraping] and trauma of the right eyebrow .She [has] extensive swelling of the right eye which is currently closed due to edema [when fluid accumulates in body tissues] .Assessment and Plan .[Resident 1] with .Closed head injury causing a right eyebrow laceration [a tear or cut in the skin] and significant right orbital [eye socket] ecchymosis [blood vessels damaged by trauma causing leakage to surrounding tissues] . A review of the hospital discharge summary dated 1/14/25, indicated Resident 1 was, Date of Discharge: 1/14/25 .Seen by trauma team [and had her] laceration sutured [stiches]. A review of the facility ' s policy and procedure titled Wandering and Elopements, revised March 2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm . 2. A review of Resident 1 ' s TAR dated January 2025 indicated Resident 1 had an order for licensed staff to, .check placement of [Wandering] Device .every shift- Start Date 1/17/25 at [7 a.m.] and -D/C Date- 1/22/25 at [6:37 a.m.]. During an interview on 1/17/25 at 1:20 p.m., the Infection Preventionist (IP) confirmed Resident 1 was wearing a WMS and the system was not fully functioning. The IP stated there was only one alarm for the entire facility which was located the front door. The IP also stated the two additional doors residents could exit from did not have alarms. The IP stated the maintenance department checked the alarm located at the exit, and nursing staff checked the monitor on the resident to ensure both components of the WMS worked. The IP stated the facility did not have a policy and procedure for maintenance testing of the WMS nor did the facility have the manufactures instructions for use. During an observation and concurrent interview on 1/17/25 at 4 p.m., Unlicensed Staff A stated this was her first evening taking care of Resident 1 and she was unaware Resident 1 had a WMS device. Unlicensed Staff A then lifted the resident ' s pant leg and observed a WMS device to Resident 1 ' s left ankle. During an interview on 1/17/25 at 4:15 p.m., Licensed Staff B stated she had just come on shift and was unaware Resident 1 was wearing a WMS device. Licensed Staff B stated the nurses test the alarm by taking the resident to the front door and maintenance monitored the function of the WMS system. During an interview on 1/21/25 at 1:48 p.m., the Maintenance Supervisor (MS) stated the facility ' s WMS was outdated and had been updating the system, but the update had been canceled. The MS stated he tested the WMS front door alarm on a weekly basis but did not change the batteries to the WMS device and did not know who changed them. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Arbol Residences of Santa Rosa		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 Fountaingrove Parkway Santa Rosa, CA 95403	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/21/25 at 2:30 p.m., the two facility exit doors (one in the back of the facility and one on the side of the facility) did not have WMS alarms to alert staff when a resident was exiting the building. Review of Resident 1 ' s elopement evaluation conducted on 1/22/25, indicated, .Has the Resident verbally expressed the desire to go home .[answer checked] No .Is the wandering behavior a pattern, goal-directed (i. e. confused, moves with purpose .) [answer checked] No .Has the Resident been recently .readmitted (within the past 30 days) and is not accepting the situation .[answer checked] No . Further review of this document indicated the options in section Clinical Suggestions were not chosen at all. In an interview and concurrent record review with the Infection Preventionist on 2/10/25 at 3:10 p.m., the IP verified all monitoring in January 2025 for Resident 1 was documented on her TAR. The IP also confirmed the clinical suggestions section of Resident 1 ' s elopement evaluation form dated 1/22/25 was incomplete. The IP stated it should have been completed. A review of Resident 1 ' s TAR dated January 2025 indicated Resident 1 had an order for licensed staff to, . Check placement, functioning and integrity on left ankle .every shift for 30 Days- Start Date 1/22/25 at [7 a.m.] . In an interview on 2/12/25 at 11:33 a.m., the IP confirmed there was no documented evidence visual checks were done on 1/14/25 and 1/15/25 for Resident 1. The IP also verified the facility did not have a policy and procedure for the use of the WMS and stated the facility should have one. The IP further stated the facility is working on getting a policy written.

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F 0727

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.

38335

Based on interview, and facility record review, the facility failed to have a Registered Nurse (RN) performing the function of the Director of Nursing (DON) on a full-time basis to provide oversight and guidance on the provision of care provided by nursing staff. This failure prevented the facility from having the required management, to adequately assess and meet the needs of residents in a timely manner and had the potential to negatively impact the quality of care delivered by licensed and non-licensed nursing staff to residents.

Findings:

During an interview on 1/17/25 at 12:35 p.m., Licensed Staff A stated there was no DON at the facility and there has not been a DON since November. Licensed Staff A stated the facility was advertising for a DON, but currently, there were no candidates.

During an interview on 1/17/ 25 at 12:45 p.m., the Infection Preventionist (IP) stated the previous DON left at the end of November 2024. The IP also stated she currently occupied the full-time IP role and the interim DON role, until a permanent DON is hired. The IP confirmed she was a Licensed Vocational Nurse (LVN).

During an interview on 1/21/ 25 at 3:30 p.m., the Administrator stated the DON left on 11/27/24 and the facility has been advertising for a new DON, but at-the-moment there were no candidates. When asked who was in charge, she stated the IP was the interim DON until a full-time DON could be hired. The Administrator stated RNs were scheduled on all work shifts, but none wanted the DON position.

Review of the facility ' s job description titled Director of Nursing revised on 1/2/20 indicated, Qualifications . Registered nurse with a current license in community's state .B.S. [Bachelor of Science] Degree in nursing .

Based on interview, and facility record review, the facility failed to have a Registered Nurse (RN) performing the function of the Director of Nursing (DON) on a full-time basis to provide oversight and guidance on the provision of care provided by nursing staff. This failure prevented the facility from having the required management, to adequately assess and meet the needs of residents in a timely manner and had the potential to negatively impact the quality of care delivered by licensed and non-licensed nursing staff to residents.

Findings:

During an interview on 1/17/25 at 12:35 p.m., Licensed Staff A stated there was no DON at the facility and there has not been a DON since November. Licensed Staff A stated the facility was advertising for a DON, but currently, there were no candidates.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/17/ 25 at 12:45 p.m., the Infection Preventionist (IP) stated the previous DON left at the end of November 2024. The IP also stated she currently occupied the full-time IP role and the interim DON role, until a permanent DON is hired. The IP confirmed she was a Licensed Vocational Nurse (LVN). During an interview on 1/21/ 25 at 3:30 p.m., the Administrator stated the DON left on 11/27/24 and the facility has been advertising for a new DON, but at-the-moment there were no candidates. When asked who was in charge, she stated the IP was the interim DON until a full-time DON could be hired. The Administrator stated RNs were scheduled on all work shifts, but none wanted the DON position. Review of the facility's job description titled Director of Nursing revised on 1/2/20 indicated, Qualifications . Registered nurse with a current license in community's state .B.S. [Bachelor of Science] Degree in nursing .

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F 0838

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.

38335

Based on interview and record review, the facility failed to ensure a facility-wide assessment (a review of a facility's infrastructure, resident population, and services to determine needed resources to provide care) was available, current, and complete. This deficient practice decreased the facility ' s potential to safely admit residents and ensure their care needs were met.

Findings:

During an interview on 1/17/24 at 1:58 p.m., a copy of the facility assessment was requested from the Director of Staff Development (DSD). The DSD stated the facility assessment was not available and was locked in the Administrator ' s office.

During an interview on 1/21/24 at 10:25 a.m., the Infection Preventionist (IP) (who was also the interim Director of Nursing (DON)) stated she could not find the facility assessment. The IP stated she was putting one together over the weekend and what she had was incomplete. A review of the of the document provided to the surveyor on 1/21/24 did not follow the facility ' s policy and procedure for conducting, reviewing, and updating the facility assessment.

During an interview on 1/21/24 at 3:30 p.m., the Administrator verified they could not find the facility assessment.

During a review of the facility ' s Policy and Procedure titled Facility Assessment, revised October 2018 indicated, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents day-to-day .The team responsible for conducting, reviewing and updating the facility assessment includes the following .The Administrator .A representative of the governing body .The medical director .The director of nursing services .

Based on interview and record review, the facility failed to ensure a facility-wide assessment (a review of a facility's infrastructure, resident population, and services to determine needed resources to provide care) was available, current, and complete. This deficient practice decreased the facility's potential to safely admit residents and ensure their care needs were met.

Findings:

During an interview on 1/17/24 at 1:58 p.m., a copy of the facility assessment was requested from the Director of Staff Development (DSD). The DSD stated the facility assessment was not available and was locked in the Administrator's office.

During an interview on 1/21/24 at 10:25 a.m., the Infection Preventionist (IP) (who was also the interim Director of Nursing (DON)) stated she could not find the facility assessment. The IP stated she was putting one together over the weekend and what she had was incomplete. A review of the of the document provided to the surveyor on 1/21/24 did not follow the facility's policy and procedure for conducting, reviewing, and updating the facility assessment.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/21/24 at 3:30 p.m., the Administrator verified they could not find the facility assessment. During a review of the facility's Policy and Procedure titled Facility Assessment, revised October 2018 indicated, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents day-to-day .The team responsible for conducting, reviewing and updating the facility assessment includes the following .The Administrator .A representative of the governing body .The medical director .The director of nursing services .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38335 Based on observation, interview, and record review, the facility failed to ensure patient care equipment was functioning and maintained under sanitary conditions when oxygen therapy equipment provided to facility residents was dirty and not maintained. This failure decreased the facility ' s potential to prevent infections among respiratory compromised residents who used oxygen concentrators for medical treatments. Findings: During an interview on 1/21/25 at 1:48 p.m., the Maintenance Supervisor (MS) stated he checked the oxygen storage room periodically to ensure the oxygen tanks were secure. The MS also stated he did not have oversight nor did any maintenance on the oxygen concentrators and was unsure who maintained the oxygen concentrators. During an observation and current interview on 1/21/25 at 2:00 p.m., the Infection Preventionist (IP) stated she tracked all residents on respiratory therapy and any respiratory infections that occurred in the facility. The IP stated there were currently six residents on oxygen therapy who used oxygen concentrators provided by the facility. An observation of the oxygen storage room and concurrent interview on 1/21/25 at 2:15 p.m., showed multiple oxygen tanks were not secured or in a rack (unsecured oxygen tanks can be dangerous and cause serious injury or death by tipping over and shear the valve or a pressurized cylinder to explode from a mechanical failure). Three oxygen concentrators were observed to have dust covering the top and front of the oxygen concentrators. The sides of one concentrator had filters that were full of lint and debris. On one oxygen concentrator the last date of maintenance service performed was 3/25/20. The IP verified the concentrators were dirty and stated she did not know who was responsible for cleaning and maintaining the concentrators. IP stated she was in the process of establishing a clean and dirty location for the oxygen concentrators. During a continued interview on 1/21/25 at 2:30 p.m., the IP verified there was no maintenance contract for service of the oxygen concentrators. A request for a policy and procedure and instructions for use (IFU) for the maintenance of the oxygen concentrators was requested but not provided. A review of the manufactures instructions for use (IFU) for the oxygen concentrators, indicated, routine maintenance and cleaning of the oxygen concentrators following a preventative maintenance record. Based on observation, interview, and record review, the facility failed to ensure patient care equipment was functioning and maintained under sanitary conditions when oxygen therapy equipment provided to facility residents was dirty and not maintained. This failure decreased the facility's potential to prevent infections among respiratory compromised residents who used oxygen concentrators for medical treatments. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: During an interview on 1/21/25 at 1:48 p.m., the Maintenance Supervisor (MS) stated he checked the oxygen storage room periodically to ensure the oxygen tanks were secure. The MS also stated he did not have oversight nor did any maintenance on the oxygen concentrators and was unsure who maintained the oxygen concentrators. During an observation and current interview on 1/21/25 at 2:00 p.m., the Infection Preventionist (IP) stated she tracked all residents on respiratory therapy and any respiratory infections that occurred in the facility. The IP stated there were currently six residents on oxygen therapy who used oxygen concentrators provided by the facility. An observation of the oxygen storage room and concurrent interview on 1/21/25 at 2:15 p.m., showed multiple oxygen tanks were not secured or in a rack (unsecured oxygen tanks can be dangerous and cause serious injury or death by tipping over and shear the valve or a pressurized cylinder to explode from a mechanical failure). Three oxygen concentrators were observed to have dust covering the top and front of the oxygen concentrators. The sides of one concentrator had filters that were full of lint and debris. On one oxygen concentrator the last date of maintenance service performed was 3/25/20. The IP verified the concentrators were dirty and stated she did not know who was responsible for cleaning and maintaining the concentrators. IP stated she was in the process of establishing a clean and dirty location for the oxygen concentrators. During a continued interview on 1/21/25 at 2:30 p.m., the IP verified there was no maintenance contract for service of the oxygen concentrators. A request for a policy and procedure and instructions for use (IFU) for the maintenance of the oxygen concentrators was requested but not provided. A review of the manufactures instructions for use (IFU) for the oxygen concentrators, indicated, routine maintenance and cleaning of the oxygen concentrators following a preventative maintenance record.