basket

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the California Department of Public Health (CDPH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/24/19-09/27/19 Total facility census: 52 Sample Size: 18	F 000	RECEIVED MAY 04 2020 CDPH L&C Santa Rosa D.O. COPY	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to conduct a thorough investigation regarding a significant resident injury. The facility failed to document an investigation into the cause of a spiral tibia-fibula fracture for one of 18 sampled residents (Resident (R) R22).	F 607	F 607 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) Corrective action for residents found to have been affected by this deficiency: The IDT reviewed the medical record for Resident 22 as well as the documentation of the completed investigation. Resident 22 was interviewed as well as Resident 22's roommate. The care plan for Resident 22 was reviewed and updated. No additional corrective actions were needed for resident 22. 10/18/19 Corrective action for residents that may be affected by this deficiency: All resident injuries in past 12 months were reviewed to ensure a thorough investigation 10/18/19	10/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 04/30/20

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.

POC accepted. Notified Craig Fowler, Operational Manager and Eneolina DeLaCruz, DON on 5/14/2020 2:30pm. CW HFEMI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 1 Findings include: Review of the facility's policy titled, "Policy and Procedure - Administration -Resident Rights-Abuse and Neglect" policy, dated 11/28/17, documented: "Identification ...understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include ...extensive injuries ..."The investigation will include the following: . . .An interview with the person reporting the incident. An interview with the resident. Interviews with any witnesses to the incident. A review of the resident's medical record. The investigation, and the results of the investigation, will be documented ... To assist the facility's staff members in recognizing incidents of possible abuse, neglect ...the following definitions are provided ...Adverse Event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury or risk thereof ..." Review of R22's "Admissions Record," located under the "Profile" tab of her Electronic Health Record (EHR) documented she was admitted to the facility on 05/27/16, with diagnoses at the time of a closed fracture to the lower left tibia, dementia without behavioral disturbances, and osteoporosis (Disease in which bones become weak and are more likely to break. Without prevention or treatment, osteoporosis can progress without pain or symptoms until a bone break fractures).	F 607	was completed. No other residents were affected. **Measures that will be put into place to ensure that this deficiency does not recur:** The IDT will review all resident injuries on a daily basis. Any significant resident injuries of unknown cause or etiology will be referred to the Abuse Prevention Coordinator for a thorough investigation and documentation of such will be filed appropriately and documented on the Incident Log as appropriate. All staff were inserviced by the Director of Staff Development on 10/22/19 regarding the facility policy and procedure "Abuse: Prevention of and Prohibition Against" **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Incident Log will be brought to the QA&A committee on a monthly basis and any significant resident injuries of unknown cause or etiology will be reviewed by the committee to ensure that a thorough investigation was completed per policy. If the committee determines that a thorough investigation was not completed for any significant resident injuries, further interventions will be implemented as necessary.	10/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 2 R22's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/27/19, documented a Brief Interview of Mental Status (BIMS) of 2, indicating severely impaired cognition, and she required extensive assistance of 2 persons for transfers. Review of the Change of Condition entry in R22's "Interdisciplinary Team (IDT) Notes," dated 04/22/19 at 04:07 PM, documented symptoms of a "skin wound or ulcer." The "comments" area of the entry documented, "At [approximately 3:30 PM] was called to Pts [Patient's] room per CNA [Certified Nursing Assistant.] Per CNA she sat Pt up on side of bed to get her into her wheelchair. As she stood her up Pt started yelling and the CNA looked down there was blood on the floor. This writer noted blood squirting out for [sic] sock. Direct pressure applied. Wound measurement 13 [centimeters long] X [times] 2.5 w [wide] .4 depth. Pressure dressing applied, wrapped with Kerlix and support by splint...unable to obtain [vital signs] due to screaming, thrashing, and pushing at staff ..." The note documented R22 was sent to the Emergency Department ED) via ambulance at 04:10 PM. Review of the hospital History and Physical (H&P), dated 04/23/19, provided by the facility's Administrator on 09/27/19 at 08:44 AM, documented the resident was brought to the ED by Emergency Medical Services (EMS) as a "trauma alert" with "an open fracture." The H&P documented findings of, "Comminuted, displaced open fractures of the distal left tibia and fibula with surrounding soft tissue swelling and edema ..." The hospital's 04/27/19 "Discharge Summary" documented the resident was noted upon	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 3 admission to have a "large skin tear to her left shin and apparent arterial spurting ...postoperatively she developed an acute blood loss anemia and was transfused with 2 units of packed red blood cells ..." During an interview on 09/26/19 at 11:23 AM, the Director of Nursing (DON) was asked for the facility's investigation regarding the incident. The DON stated the facility did not have an investigation or incident report of the event, or any documentation other than the Change of Condition note above. On 09/26/19 at 11:42AM, the Administrator and DON were interviewed. The Administrator stated they had not completed a formal investigation "because the CNA's story made sense, in terms of the nature of the injury." The Administrator stated he had not suspected abuse or neglect, "based on my knowledge of the staff and the CNA involved." When asked whether the resident's injuries would be considered as "extensive" and/or "adverse event" based on the definitions in the facility's abuse and neglect policy, the Administrator stated, "Not necessarily." The Administrator stated he remembered talking to all the staff working that day, and thought maybe he had made some notes in "bits and pieces of paper," but had moved offices since the time of the event and had been unable to locate them. On 09/27/19 at 08:44 AM, the Administrator provided a Manilla file folder with several hand-written pages of notes, which he stated he "miraculously" found that morning. The first page was labeled," Incident on 4/22/19 With.[R22]." The pages documented the location of each staff member on duty on 04/22/19 when the fractures	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 4 took place, and how they became aware of the incident. The file did not include statements from R22, other residents in the facility at the time, or a review of the R22's medical record.	F 607		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to	F 657	F 657 **Care Plan Timing Revision CFR(s): 483.21(b)(2)(i)-(iii)** **Corrective action for residents found to have been affected by this deficiency:** The care plan for Resident 22 was reviewed by the Director of Nursing and has verified that it reflects their current ADL needs. 10/18/19 **Corrective action for residents that may be affected by this deficiency:** The Director of Nursing conducted a facility wide audit on 10/18/19 to identify any care plans for residents that have not been reviewed after an MDS assessment. 10/18/19 All care plans for current residents were reviewed and revised as appropriate for all current residents to reflect current ADL needs. 10/18/19 **Measures that will be put into place to ensure that this deficiency does not recur:** MDS nurse was educated by the Director of Nursing on 10/18/19 to review and revise the care plan after an assessment as appropriate and ensure that it is documented when a revision is not appropriate. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 update the care plan of one of 18 sampled residents (Resident (R) 22): R22's care plan was not updated after an assessment showed she required two-person assistance for transfers, rather than one person. Failure to update the care plan resulted in staff performing a one-person transfer which caused a comminuted, displaced open fractures of the distal left tibia and fibula fracture with surrounding soft tissue swelling and edema as well a large skin tear to the resident's left shin. Postoperatively, the resident developed an acute blood loss anemia and was transfused with two units of packed red blood cells. Findings include: Review of R22's "Admissions Record," located under the "Profile" tab of her Electronic Health Record (EHR) documented she was admitted to the facility on 05/27/16, with diagnoses at the time of a closed fracture to the lower left tibia, dementia without behavioral disturbances, and osteoporosis (Disease in which bones become weak and are more likely to break. Without prevention or treatment, osteoporosis can progress without pain or symptoms until a bone break fractures). A review of the "Physical Therapy Discharge Summary" for R22, dated 07/02/18, documented she required "Minimum Assistance of 1" for transfers when discharged from therapy that date. R22's Annual "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 11/27/18 documented R22 had a Brief Interview of Mental Status (BIMS) score of two out of 15, indicating severely impaired cognition, and required extensive assistance of one person	F 657	MDS nurse will review and revise care plans as appropriate after completion of all MDS assessments. The IDT will ensure that the care plan has been reviewed and revised as appropriate during quarterly and annual care conferences for all residents and ensure that the care plan matches the current ADL needs of the residents. CNA staff were educated by the Director of Staff Development to communicate changes in functional status or level of assistance needed to nursing and therapy for appropriate follow-up. A representative from therapy will attend the weekly RNA meetings and when RNA notes a change in functional status or level of assistance needed, therapy will assess the patient to determine the need for changes to their plan of care and will communicate these to nursing to review and revise the care plan as appropriate. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** An audit will be performed by the Director of Nursing on a monthly basis for 3 months and then quarterly thereafter to ensure care plans are being reviewed and revised as appropriate after an MDS assessment and that the care plan matches the ADL needs of the residents. Any trends will be brought to	11/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 for transfers. R22's Quarterly "MDS" assessment, with an ARD of 02/27/19, documented a BIMS of two out of 15, indicating severely impaired cognition, and she required extensive assistance of two persons for transfers. There were no care plan updates noted as a result of this MDS assessment Review of R22's care plan, provided by the Director of Nursing (DON) on 09/27/19 at 8:44 AM, documented a focus area of, "ADL [Activities of Daily Living] self-care performance deficit [related to history] of [left] femur and tibia fracture, requiring assistance, weakness, diagnosis of dementia and anemia." The intervention for transfers documented, "Requires extensive assistance of one staff participation with transferring." Both the focus area and the intervention were created on 12/31/17 and revised on 06/20/18. No further revisions to the care plan were noted prior to after the MDS Assessment dated 02/27/19. Review of R22's Interdisciplinary (IDT) Progress Notes revealed Restorative Nursing Assistant (RNA)1 made weekly entries from 02/15/19 to 04/05/19 indicating R22 was having increasing difficulty with transfers, standing, and ambulation. Review of R22 IDT note, dated 04/05/19 at 11:41 AM, the Director of Staff Development (DSD), who oversaw the RNA program, documented " ...therapy screen/eval [evaluation] is recommended in order to reassess current level of functioning ..." R22's record did not contain further entries from either nursing or therapy that such an evaluation took place, or any adjustments were made to her care plan.	F 657	QA&A meeting for further interventions as needed. The Director of Staff Development will monitor to ensure the care plan has been reviewed and revised as appropriate for all residents on RNA caseload who have been referred to therapy after a noted change in functional status or level of assistance needed. Any trends will be brought to QA&A meeting for further interventions as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 RNA1 documented on 04/12/19 and 04/19/19 that R22 continued to have difficulty with transfers, ambulation, and standing. Review of the Change of Condition entry in R22's IDT notes, dated 04/22/19 at 04:07 PM, documented symptoms of a "skin wound or ulcer." The "comments" area of the entry documented, "At [approximately 3:30 PM] was called to Pts [Patient's] room per CNA [Certified Nursing Assistant.] Per CNA she sat Pt up on side of bed to get her into her wheelchair. As she stood her up Pt started yelling and the CNA looked down there was blood on the floor. This writer noted blood squirting out for [sic] sock. Direct pressure applied. Wound measurement 13 [centimeters long] X [times] 2.5 w [wide] .4 depth. Pressure dressing applied, wrapped with Kerlix and support by splint ...unable to obtain [vital signs] due to screaming, thrashing, and pushing at staff ..." The note documented R22 was sent to the Emergency Department via ambulance at 04:10 PM. Review of the hospital History and Physical (H&P), dated 04/23/19, provided by the facility's Administrator on 09/27/19 at 08:44 AM, documented the resident was brought to the Emergency Department (ED) by Emergency Medical Services (EMS) as a "trauma alert" with "an open fracture." The H&P documented findings of, "Comminuted, displaced open fractures of the distal left tibia and fibula with surrounding soft tissue swelling and edema ..." The hospital's 04/27/19 "Discharge Summary" documented the resident was noted upon admission to have a "large skin tear to her left shin and apparent arterial spurting	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1200 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 ...postoperatively she developed an acute blood loss anemia and was transfused with 2 units of packed red blood cells ..." The hospital's 04/27/19 "Discharge Summary" also indicated, "irrigation debridement to open left tibia/fibula fracture, intramedullary nailing of the left tibia, closure of 15-centimeter traumatic wound of the left leg." On 09/26/19 at 10:36 AM, the MDS nurse reviewed the 11/27/18 and 02/27/19 MDS. She stated she was not aware there had been a decline in the resident's transfer status from an MDS perspective until today, and it was up to the nurses on the floor or other nurse managers to update care plans. During an interview on 09/26/19 at 11:42 AM, the Director of Nursing (DON)DON stated that if the MDS nurse had evaluated R22 to require two-person assistance for transfers, then it would be the MDS nurse's responsibility to update the care plan accordingly. The DON stated she had not been made aware R22's transfer status had changed prior to the 04/22/19 incident, so did not know if a care plan update was warranted. Review of the facility's policy titled "Nursing Administration Care Planning," dated June 2018, documented, " ...A comprehensive care plan is developed within 7 days of the completion of the Resident Minimum Data Set (MDS) ...the care plan is developed by the IDT which includes ...Licensed nursing staff ...physical, occupational, or speech therapies ...Director of Nursing services ...nursing assistants responsible for resident care ..." The policy did not specify when care plan revisions should be made, or who was responsible to make them.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide adequate assistance to prevent a resident from injury for one of 21 sampled residents (Resident (R) 22). R22 sustained a comminuted, displaced open fractures of the distal left tibia and fibula fracture with surrounding soft tissue swelling and edema as well a large skin tear to the resident's left shin. Postoperatively, the resident developed an acute blood loss anemia and was transfused with two units of packed red blood cells. Findings include: Review of R22's "Admissions Record," located under the "Profile" tab of her Electronic Health Record (EHR) documented she was admitted to the facility on 05/27/16, with diagnoses at the time of a closed fracture to the lower left tibia, dementia without behavioral disturbances, and osteoporosis (Disease in which bones become weak and are more likely to break. Without prevention or treatment, osteoporosis can progress without pain or symptoms until a bone	F 689	F 689 **Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)** **Corrective action for residents found to have been affected by this deficiency:** Resident 22's care plan has been reviewed and updated to reflect current ADL needs including transferring. All licensed staff were educated on the appropriate level of assistance needed for Resident 22 based on their current ADL needs. **Corrective action for residents that may be affected by this deficiency:** All residents have the potential to be affected. No other residents were affected. **Measures that will be put into place to ensure that this deficiency does not recur:** All nursing and therapy staff were educated on 10/22/19 by the Director of Staff Development on the importance of providing adequate assistance to residents in order to prevent the potential for injury.	10/18/19 10/22/19 10/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 breaks fractures). A "Physical Therapy Discharge Summary" for R22, dated 07/02/18, documented she required "Minimum Assistance of 1" for transfers when discharged from therapy that date. R22's Annual "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 11/27/18 documented R22 had a Brief Interview of Mental Status (BIMS) score of 2, indicating severely impaired cognition, and required extensive assistance of one person for transfers. R22's Quarterly MDS assessment with an ARD of 02/27/19 documented a BIMS of 2, indicating severely impaired cognition, and she required extensive assistance of two persons for transfers. There were no care plan updates noted as a result of this MDS assessment Review of R22's care plan, provided by the Director of Nursing (DON) on 09/27/19 at 8:44 AM, documented a focus area of, "ADL [Activities of Daily Living] self-care performance deficit [related to history] of [left] femur and tibia fracture, requiring assistance, weakness, diagnosis of dementia and anemia." The intervention for transfers documented, "Requires extensive assistance of one staff participation with transferring." Both the focus area and the intervention were created on 12/31/17 and revised on 06/20/18. No further revisions were noted prior to 04/22/19. Review of R22's Interdisciplinary Progress Notes (IDT notes), dated 01/25/19 at 11:39 AM, located under the "Prog Notes" tab of her EHR,	F 689	CNA staff were educated by the Director of Staff Development to communicate changes in functional status or level of assistance needed to nursing and therapy for appropriate follow-up. A facility wide audit was conducted by Director of Staff Development to identify all residents who require 2 person assist with transfers. This list of residents will be provided to nursing and CNA staff and updated as needed when a change in the level of assistance required has been identified. Changes in residents' level of functioning will be identified through daily shift to shift reporting and nursing huddle, daily change of condition review by the IDT, RNA weekly meeting, and Rehab Screening on a quarterly basis and as needed after a change of condition. Any changes in residents' current level of functioning identified will be referred to therapy for assessment. If therapy identifies a change in the level of assistance required they will notify nursing staff and the changes will be communicated through daily nursing huddle and shift to shift reporting. The care plan will be revised to reflect the current level of assistance required. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:**	11/20/19 11/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 documented an entry from Restorative Nursing Assistant (RNA) 1. The entry documented, " ...RNA was able to stand [R22] with an FWW [front-wheeled walker] and maximum assistance but [R22] was unable to take a step. Nursing and PT [Physical Therapy] notified ..." Entries with this same information were documented on 02/01/19 at 11:46 AM and 02/08/19 at 12:24 PM. No documentation of an evaluation from PT or nursing regarding these changes was found in R22's record following these entries. A 02/12/19 quarterly "Rehabilitation Services Rehabilitation Tool," located under the "Assessments" tab of R22's EHR, completed by Occupational Therapy, documented the resident had experienced no changes in her transfer status over the past quarter, and a statement that, "Nursing reports no functional decline." On 02/15/19 at 01:35 PM, R22's IDT notes contained an entry from RNA1 which documented, " ...She [R22] requires extensive assistance X [times] 2 to stand and is unable to take a step with FWW. Nursing and PT notified ..." This same information was documented in RNA entries on 02/22/19 at 11:09 AM and 02/28/19 at 9:34 AM. No documentation of an evaluation from PT or nursing regarding these changes was found in R22's record following these entries. R22's "Weekly Nursing Summary" forms, located under the "Assessments" tab of her EHR, documented the facility was providing one-person assistance for transfers between 02/25/19 and 04/14/19. Review of R22's "IDT Notes," dated 03/08/19 at	F 689	During the weekly RNA meeting for the next 3 months and then quarterly thereafter the Director of Staff Development will review all residents and their current level of assistance needed for transfers and will provide an updated list to nursing and CNA staff. The Director of Nursing will perform an audit of all rehab screening assessments monthly for 3 months and quarterly thereafter to ensure the care plan matches the current ADL needs as identified in the assessment. Any trending issues will be reported to the QA&A committee for further discussion and interventions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 01:18 PM, contained an entry from RNA1 which documented, " ...RNAs are unable to ambulate with [R22] d/t [due to] decline in sit-stands and transfers. Nursing and PT notified ..." This same information was documented in an RNA entry on 03/15/19 at 12:11 PM. No documentation of an evaluation from PT or nursing regarding these changes was found in R22's record following these entries. R22's "IDT Notes," dated 03/22/19 at 11:53 PM, contained an entry from RNA1 which documented, "RNAS are unable to ambulate with [R22] d/t decline in standing and transfers. RNAs provide maximum assist for stand-pivot transfer from bed to wheelchair. Nursing and skilled therapy notified of decline ..." Similar entries were documented on 03/29/19 at 04:38 PM and 04/05/19 at 11:23 AM. No documentation of an evaluation from PT or nursing regarding these changes was found in R22's record following these entries. On 04/05/19 at 11:41 AM, the Director of Staff Development (DSD), who oversaw the RNA program, documented an IDT note which read, " ...therapy screen/eval [evaluation] is recommended in order to reassess current level of functioning ..." R22's record did not contain further entries from either nursing or therapy that such an evaluation took place, or any adjustments were made to her care plan. On 04/12/19 at 07:50 AM, R22's IDT notes contained an entry from RNA1 which documented, " ...[R22] did not participate in ambulation d/t decline in transfers and standing tolerance. Nursing and skilled therapy aware." A similar entry was made on 04/19/19 at 12:37 PM.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1260 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 No documentation of an evaluation from PT or nursing regarding these changes was found in R22's record following these entries. The facility failed to further evaluate the decline in R22's transfer status identified in the 02/27/19 MDS, or the RNA notes that indicated she required more assistance with transfers. Review of R22's "ADL Task Sheet," provided by the DON on 09/27/19 and identified as the facility's documentation for the assistance actually provided to a resident, documented that between 03/22/19 and 04/22/19, R 22 was transferred 14 times with the assistance of one person, and only three times with the assistance of two persons. The DON reiterated that the facility had no documentation to suggest R22 had been having difficulty with a one-person transfer prior to her fractures on 04/22/19. Review of the Change of Condition entry in R22's IDT notes, dated 04/22/19 at 04:07 PM, documented symptoms of a "skin wound or ulcer." The "comments" area of the entry documented, "At [approximately 3:30 PM] was called to Pts [Patient's] room per CNA [Certified Nursing Assistant.] Per CNA she sat Pt up on side of bed to get her into her wheelchair. As she stood her up Pt started yelling and the CNA looked down there was blood on the floor. This writer noted blood squirting out for [sic] sock. Direct pressure applied. Wound measurement 13 [centimeters long] X [times] 2.5 w [wide] .4 depth. Pressure dressing applied, wrapped with Kerlix and support by splint ...unable to obtain [vital signs] due to screaming, thrashing, and pushing at staff ..." The note documented R22 was sent to the ED via ambulance at 04:10 PM.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 Review of the hospital History and Physical (H&P), dated 04/23/19, provided by the facility's Administrator on 09/27/19 at 08:44 AM, documented the resident was brought to the Emergency Department (ED) by Emergency Medical Services (EMS) as a "trauma alert" with "an open fracture." The H&P documented findings of, "Comminuted, displaced open fractures of the distal left tibia and fibula with surrounding soft tissue swelling and edema ..." The hospital's 04/27/19 "Discharge Summary" documented the resident was noted upon admission to have a "large skin tear to her left shin and apparent arterial spurting ...postoperatively she developed an acute blood loss anemia and was transfused with 2 units of packed red blood cells ..." Review of the X-ray report dated 05/07/19, which was completed in conjunction with an orthopedic follow-up appointment indicated, "Undisplaced spiral fracture of the shaft of tibia." Observation on 09/26/19 at 08:15 AM, revealed R22 was observed lying in bed, dressed and wearing sunglasses. She was reading the facility's activities newsletter. When asked about her fracture in April, R22 stated she had no recollection of the event, and ended the interview by stating she was preparing for a business meeting later in the day. There was a poster-sized dry erase board on the wall to the left of her bed, with the day, date, name of her nurse and CNA, her current diet, and instructions to use a two-person mechanical lift transfer written on it.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 During an interview on 09/26/19 at 08:26 AM, Licensed Vocational Nurse (LVN) 1, who had been the nurse caring for R22 at the time of the event, LVN1 reviewed the progress note she had written that day and stated per her recollection the injury occurred while the resident was being transferred from the bed to the wheelchair. LVN1 stated there was only one CNA in the room at the time of the event, and it was appropriate for staff to transfer R22 with just one-person assistance. LVN1 stated there was a dry erase board in each resident's room with instructions as to how much help a resident needed, and R22's board had directed one-person assistance for transfers prior to the injury. LVN1 stated while she was unsure who was responsible to update the information on the dry erase board, or when it was updated, she presumed the information written on it was correct and if staff were following those instructions, they were providing appropriate care. LVN1 was unaware of any other documentation that R22 needed two-person assistance for transfers. LVN1 stated the CNA involved in the transfer no longer worked at the facility. During an interview on 09/26/19 at 09:00 AM, CNA2 stated there was a dry erase board in every resident's room with diet and care information on it CNA2 stated used this a guide if she was taking care of an unfamiliar resident. She stated she presumed the transfer information was placed on the dry erase board by PT and was accurate. Interview on 09/26/19 at 09:06 AM, with the Director of Rehab (DOR) revealed he was familiar with R22 and was working as the DOR when she fractured her leg. The DOR described the fracture as "spontaneous" which he defined	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 as not resulting from a fall but occurring during a transfer. The DOR stated he understood, from the verbal report he received from nursing following the incident, that staff were using a two-person stand-pivot transfer at the time which would have been appropriate for the resident. When asked to review the 02/12/19 "Quarterly Therapy Screen" and 02/27/19 MDS, the DOR stated, "She must have had a significant decline in her function," and he should have been notified. The DOR stated the Quarterly Therapy Screen involved talking to the nursing staff to determine if there had been any changes and would involve a "hand's on" transfer or observation of a transfer if possible. The DOR stated he could not tell from reviewing the therapy screen document if an observation or transfer with therapy had taken place when the document was completed. The DOR stated he met with the DSD and RNAs weekly to discuss any residents who were experiencing any decline but did not recall discussing R22 prior to her fracture. The DOR reviewed his documentation and stated he had not been notified of a change in R22's ability to transfer either by the MDS nurse or the DSD. The DOR stated had he known, therapy would have conducted a second screening or evaluation for R22. Follow up interview on 09/26/19 at 09:46 AM, the DOR stated the dry erase boards in resident rooms were not for staff to use as they provided cares, but an "encouragement" for the residents to see how much gain they had made by working with therapy. The DOR stated, staff should refer to resident care plans for guidance to care for residents. The DOR stated the therapy department "tried" to keep the information on the dry erase boards accurate, but there was no	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 formal process and "it doesn't always get done, especially once a resident is off therapy." Interview on 09/26/19 at 10:06 AM, RNA1 stated R22 had been having a decline in her abilities to transfer for "weeks to months" prior to her fracture, which RNA1 documented in R22's IDT notes and discussed verbally in a weekly meeting with the DSD and DOR. RNA1 stated she was told to continue to encourage R22 to participate in her Restorative Nursing program, and presumed either the DSD or DOR had done "some kind of evaluation." On 09/26/19 at 10:25 AM, R22's Medical Doctor, who was also the facility's Medical Director (MD) stated R22 had fairly advanced dementia, and while he had never done a "formal diagnostic work-up" he presumed she had osteoporosis based on her age and history of fractures prior to the fractures in April. The MD stated the fractures in April were the result of her tibia and fibula "twisting against each other" as her foot was stationary during a stand-pivot transfer. The MD stated the choice to use one or two people to transfer R22 at that time would have been based on the facility's assessment of the resident's abilities. On 09/26/19 at 10:36 AM, the MDS nurse reviewed the 11/27/18 and 02/27/19 MDS. She stated she was not aware there had been a decline in the resident's transfer status from an MDS perspective until today, and it was up to the nurses on the floor or other nurse managers to update care plans. The MDS nurse reviewed the RNA documentation leading up to the 02/27/19 MDS and stated the DSD should have notified the DOR of those changes, but only notify MDS "if	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 needed." On 09/26/19 at 11:42 AM, the DON, DOR and Administrator were interviewed. The DON reviewed the documentation in R22's record and stated based on the care plan and weekly nursing summaries, it was appropriate for staff to use one person to transfer R22. The DON had not been aware of the RNA documentation but did not think it was relevant to the incident with the fracture because other staff were able to transfer R22 with just one person. The DON stated that if the MDS nurse had evaluated that R22 required 2-person assistance for transfers, then it would be the MDS nurse's responsibility to update the care plan accordingly. The DOR agreed that the MDS nurse should update the care plans for resident transfer status if that status changed after a resident was discharged from therapy. The DOR and DON stated interdisciplinary communication in the facility was customarily verbal communication, and the follow-up to changes such as the ones noted in RNA1's documentation for R22 would not be necessarily documented anywhere. The DON stated she had been in the facility at the time of the incident and had assisted to evaluate R22 and prepare her for EMS transport. The DON and Administrator stated they had no concerns that anything "inappropriate" had occurred during R22's transfer and such fractures were "not unexpected" for this resident. During the above interview, the Administrator provided the facility's care plan and shift-to-shift communication policies. The Administrator stated the facility followed the shift-to-shift report policy for interdisciplinary communication regarding resident status.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 Review of the facility's policy titled, "Nursing Administration Care Planning" policy, dated June 2018, documented, " ...A comprehensive care plan is developed within 7 days of the completion of the Resident Minimum Data Set (MDS) ...the care plan is developed by the IDT which includes ...Licensed nursing staff ...physical, occupational, or speech therapies ...Director of Nursing services ...nursing assistants responsible for resident care ..." The policy did not specify when care plan revisions should be made, or who was responsible to make them. Follow up interview on 09/27/19 at 08:44 AM, with the Administrator, DON, and DOR the Administrator stated after reviewing the facility's documentation, he felt a one-person transfer at the time R22 sustained her fractures was appropriate, and the facility was not responsible for the outcome. The facility's policy titled, "Transfer and Movement of Residents," dated July 2017 and provided by the Administrator on 09/27/19 at 08:44 AM, documented, "Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan." Review of the facility's policy titled, "Nursing Administration Shift-to-Shift Report," dated June 2018, documented, " ...all nursing personnel participate in shift to shift, peer to peer, and interdisciplinary team communication ...walking rounds, Huddles, and shift to shift reporting may commence in the beginning of each shift, during the shift, or at the end of the shift ..." The policy	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1260 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 did not specify whether or where this communication was documented.	F 689		
F 920 SS=E	Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sufficient dining space to allow residents to enter and leave the dining room without disturbing other residents. This impacted six Residents (R (R) 3, R20, R21, R24, 28, and R98) of 18 sampled residents, and created the potential that a resident could not remove themselves from the dining room or be removed in the event of an emergency. Findings include: Observation of the lunch meal on 09/24/19 at 12:22 PM revealed a horseshoe-shaped table in an alcove in the back of the facility's dining room. The circular opening at the center of the table was against the east wall, with the edges of the	F 920	F 920 **Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4)** **Corrective action for residents found to have been affected by this deficiency:** Residents 3, 20, 21, 24, 28, and 98 were affected. The rack of chairs were removed from the dining room on 9/25/19 and returned to their normal storage location in the outside storage container. Upon assessment, it was determined that there was sufficient dining space to allow residents to enter and leave the dining room without disturbing other residents. — 9/25/19 **Corrective action for residents that may be affected by this deficiency:** No other residents were affected. The dining room configuration was reviewed by the Dining Committee on 10/22/19 and updated to ensure sufficient space to allow residents to enter and leave without disturbing other residents. — 10/22/19 **Measures that will be put into place to ensure that this deficiency does not recur:**	10/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 920	Continued From page 21 perimeter of the table along a wall to the north and south. Four residents (R3, R21, R24, and R98) were sitting along the perimeter of the table with R24 along the south side of the table. There was a metal rack containing approximately 15 metal folding chairs behind R24, between him and the wall. There were two square tables arranged at a diagonal behind R21 and R98, with R3 along the north wall. Restorative Nursing Assistant (RNA) 2 was sitting in the circular opening of the horseshoe table assisting all four residents. There was no room for either R24 or R3 to be removed from the dining room should they request to leave or require emergency evacuation, without R21 or R98 moving first. During an interview on 09/24/19 at 03:18 PM, RNA2 stated the configuration observed in the dining room observed during the lunch meal that day was customary for the dining room, and he had never considered how residents could be removed without moving other residents. RNA2 stated there was always staff in the dining room who could help move residents out of the way if needed. Additional Observation on 09/25/19 at 12:24 PM, revealed the same table configuration was observed during the noon meal. R24 was sitting along the north side of the horseshoe table when the Activities Director (AD) brought R21 into the dining room in her wheelchair. The AD placed R21 on the south side of the horseshoe table. The metal rack with folding chairs made it difficult to place R21 in this position, and the AD had to lift the rear wheels of R21's wheelchair several times while pivoting the wheelchair into its position. Each time the AD lifted and pivoted the wheelchair, R21's wheelchair bumped the rack of	F 920	The Dining Committee will continue to review the dining room configuration on a weekly basis and will make changes to the configuration as needed. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Dining Committee will report during QA&A meeting any changes made or needed to the dining room configuration. Any issues identified will be discussed by the QA&A committee and further interventions will be implemented as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 920	Continued From page 22 chairs, jarring R21 slightly. R98 and R3 were then brought into the dining room and placed at the remaining two spaces at the horseshoe table. Same observation, continued. After the four residents were seated at the horseshoe table, eight residents were placed at the two square tables at a diagonal to the horseshoe table. R20 and R28 were the final two residents placed at these tables, with the backs of their wheelchairs only inches from one another. As staff began to serve meal trays to the residents at the horseshoe table, staff had to lift the meal trays directly over the heads of R20 and R28, turns sideways, and shimmy to get through to the horseshoe table. As RNA2 tried to fit through this small space, he knocked his walkie talkie off his waistband. None of the residents at the horseshoe table, R20 or R28, would have been able to leave the dining room without disturbing other residents. During an interview on 09/27/19 at 10:12 AM, the Administrator stated the facility had not identified this as a problem with the crowded configuration in the dining room, and no one had reported to him that crowding in the dining room was a problem. On 09/27/19 at 12:30 PM, the Administrator stated he had looked at the dining configuration when lunch was served that day. He stated that the facility had recently admitted new residents who required assistance to eat their meals, which had resulted in more residents being seated at the identified tables. The Administrator stated he was not aware of a specific policy regarding this issue. The Administrator stated the facility would address the crowded dining situation.	F 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056364	A. BUILDING _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERFIELD HEALTH CARE CENTER	1280 SUMMERFIELD RD SANTA ROSA, CA 95405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE