STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055854	A. BUILDING _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA ROSA POST ACUTE	4650 HOEN AVENUE 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 The following reflects the findings of the California Department of Public Health during an Abbreviated Survey of Complaint Intakes CA00909586 and CA00913590. The inspection was limited to the specific Complaints, and does not represent the findings of a full inspection of the facility. The Department was able to substantiate a violation of the regulation(s). Two deficiencies were issued for Intakes CA00909586 and CA00913590.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the	F 576		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/16/24

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 by HFEN 41175 on 10/23/24

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F 576	Continued From page 1 resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a reliable communication channel to one of three sampled residents (Resident 1), when phone calls to the facility were not picked up in a timely manner. These multiple unanswered phone calls resulted in difficulties in establishing communication between Resident 1 and her family, causing frustration and distrust. Findings: During an interview on 8/29/24 at 10 a.m., Family Member (FM) stated phone calls to the facility were not always answered. FM stated she did not live in the area, and calling the facility was the only way to contact her mother, Resident 1. FM stated she tried to call the facility in the evenings after her work, and added it was very frustrating when she was unable to get ahold of any staff for	F 576		

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F 576	Continued From page 2	F 576		

any updates or to answer questions. FM stated one phone call was even picked up by "a very confused lady, most likely another resident there". FM stated it was pointless for the facility to post their phone number as their contact information, if no one would be answering the calls.

An internet search of the facility indicated a publicly listed address and phone number. Calls were made to the facility on 9/1/24 at 6:30 a.m. and on 9/2/24 at 4:30 p.m. Neither of the calls were picked up.

During an interview on 8/29/24 at 4:30 p.m., Confidential Staff stated the facility's phone system was "pretty bad". Confidential Staff because the phone system was not provided by traditional landline companies, phone service was dependent on the strength of the Internet signal, which affected the calls' reliability and consistency. Confidential Staff stated not only were there previous issues with Internet signal in the neighborhood, but there were also areas in the facility where there was poor Internet reception, making phone calls impossible.

During an interview on 8/29/24 at 4:55 p.m., Licensed Staff B stated a receptionist sat by the front desk during the day and answered phone calls, and a cordless phone would be handed to the residents should a call come in for them. During the concurrent observation of the front desk, Licensed Staff B pointed to an empty phone charger on the desk and stated that was the "usual" location of the cordless phone used for the residents. Licensed Staff B stated he did not know where or who had the phone.

During an interview on 8/29/24 at 5:01 p.m., DON

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F 576	Continued From page 3 stated a receptionist worked during business hours (between 8 a.m. to 5 p.m.) during the weekdays (Monday to Friday), and part of her role was to answer the phones. DON stated the phones were answered by the staff afterhours. During a concurrent observation of the of the empty front desk, DON stated it was not unusual for the area to not be staffed at times, such as during meal service and med (medication) pass. DON stated the facility was aware of previous incidents where a resident with dementia picked up the front desk phone. DON proceeded to cross the front desk area, took a phone from the desk counter, and placed it behind the counter. DON stated expected the staff to keep the phones out of reach of the residents. DON stated she understood how frustrating unanswered phone calls could feel. DON stated the facility had no current policy on answering calls and/or assisting resident with calls.	F 576		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

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F 755	Continued From page 4 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed provide pharmaceutical services that meet the needs of the residents when one of four sampled residents (Resident 1) did not receive Lyrica (a medication used to treat It is used to treat painful nerve diseases) twice, over a seven-day period, contrary to the physician ' s orders. This failure was not in alignment with facility policy and procedures and resulted in Resident 1 to experience unrelieved pain which prompted her subsequent transfer to the emergency room. Findings: During an interview on 8/29/24 at 10 a.m., FM (Family Member stated Resident 1 was not given several doses of Lyrica. FM stated Resident 1 had been on Lyrica for a long time to control her pain and her suddenly missing several doses would increase her risk for withdrawal. FM stated	F 755		

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F 755	Continued From page 5	F 755		

Resident 1 ' s pain got "so severe" that she requested to be sent out to the emergency room.

Record review revealed Resident 1 was admitted to the facility with diagnoses including acute transverse myelitis (a neurological disorder that occurs when a section of the spinal cord is inflamed, causing pain, weakness, sensory problems, and dysfunction in the body) and an unspecified injury to the lumbar spinal cord (section of the spinal cord in the lower back).

A review of Resident 1 ' s "Medication Administration Records (MARs)", dated "AUG 2024", on 8/29/24 at 2:30 p.m., indicated an order for "Lyrica Capsule 75 MG Give 1 capsule by mouth two times a day for Chronic pain", with codes marked on the following scheduled doses: "8/2/24 0900 (9 a.m.) = 9, and 8/6/24 2100 (9 p.m.) = 9".
Further review of the MARs revealed a "Chart Codes/Follow Up Codes", indicating, "[9] = Other/See Nurses Notes".

During an interview on 8/29/24 at 4:11 p.m., Licensed Nurse A stated the pharmacy delivers medications daily to the facility three times a day. Licensed Nurse A stated in the event of a resident ' s medication supply running out, emergency kits could be accessed, but added, "not all medications are there." Licensed Nurse A stated part of a nurse ' s role was to pay attention to the residents ' medications, making sure there were enough doses. Licensed Nurse A stated the physician, and the pharmacy should be notified if a medication is unavailable, and request for a stat (immediate) medication delivery.

During an interview and concurrent review of

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F 755	Continued From page 6 Resident 1 ' s MARs on 8/29/24 at 4:16 p.m., Director of Nursing (DON) confirmed Resident 1 ' s Lyrica doses on the morning of 8/2/24 and the evening of 8/6/24 were marked "9". DON stated Resident 1 did not received her Lyrica doses on said dates. DON stated the morning shift nurse should have realized there were no more Lyrica left in Resident 1 ' s supply after giving the last unit that morning and should have notified the physician to review the order. DON confirmed there was no documentation showing any interventions done by the nurse to ensure the next Lyrica doses were available. DON stated had the nurse notified the physician and had the order reviewed, the pharmacy would have been able to deliver Patient 1 ' s Lyrica, in time for the next schedule. DON stated stopping Lyrica abruptly could potentially result in residents to feel pain and anxiety, among other withdrawal symptoms. A review of the facility policy titled, "Administering Medications", dated "April 2019", indicated, "Policy Statement: Medications are administered in a safe and timely manner, and as prescribed... "	F 755		

Event ID: ZCYU11

SANTA ROSA
POST ACUTE

Santa Rosa Post Acute

Plan of Correction

Complaints CA 00909586 and CA00913590

F 576– Right to Forms of Communication w/Privacy

What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice?

Resident 1 no longer resides in the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.

During the department head meeting on 10-14-24, the Administrator spoke about how any resident can be affected by this deficient practice. The Administrator said that every staff member is responsible for answering the phones. The receptionist is usually at her desk, but especially if she is not, the staff members must work together to answer the phone calls to ensure family members, vendors, hospitals etc. are answering their concerns.

Immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.

Santa Rosa Post Acute reached out to our IT team on 10-9-24 and spoke to them about our phone issues and how some phones are not working. The IT guy was able come to our facility that same day to fix the phones that were not working, ensured all the phones had their volume on, and made sure the phones were not on "Do Not Disturb".

We also have a cell phone at the front desk that residents can use in private if they need to.

The Administrator gave an in-service training **(1st attachment)** to all staff on 10-14-24 to talk about how though it is the receptionist's main job to answer phones, it is every employee's responsibility to answer the phones. The Administrator trained the staff on how to use the phones and ensured that there is a list of phone numbers (extensions) next to or near each phone so that staff members know who to transfer a call to. The staff understood the importance of answering the phones and understood the Administrator's expectations.

Event ID: ZCYU11

SANTA ROSA
POST ACUTE

A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained.

Since this is such a critical issue, the Administrator will mention this topic every day for one month (and as needed thereafter) during our morning meeting to ensure that any issues are being monitored and any problems are resolved immediately. The Administrator and Maintenance Director will be the main people responsible for monitoring the phone system and staff will also report any issues to them as needed. This topic of the phones will also be discussed during our quarterly QAPI meeting and as needed.

Dates when corrective action will be completed.

The corrective action will be completed by 10-14-24.

End of POC for Tag F 576

Event ID: ZCYU11

SANTA ROSA
POST ACUTE

F 755– Pharmacy Services/Procedures/Pharmacist/Records

What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice?

Resident 1 no longer resides in the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.

A facility wide audit was conducted on 10-10-2024 by the nursing and medical records departments to identify any resident who had missed any dose of medications. The results of the audit 2 whose medications were not administered. The physician(s) of the identified residents were notified, and the pharmacist was told to expedite the provision of unavailable medications.

Immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.

An in-service training **(2nd attachment)** to licensed nurses was initiated on 10-11-2024 by the Director of Nurses and/or designee regarding the following topics:

1) The importance of ensuring medications is available by ordering at least 7 days prior to the last stock of medication dose.
2) The steps necessary when medications are unavailable which includes but not limited to
   2.1 retrieving the dose from the pharmaceutical emergency kit when available
   2.2 informing the physician that medications are unavailable and request orders for the next course of action
   2.3 notifying the pharmacy about missing medication and requesting to expedite the delivery of the medication.
3) To notify the Director of Nurses when pharmacy has not delivered the medication stock prior to the next medication dose.

On a daily basis, the Director of Nurses will track the number of medications that have not been reordered by the nursing staff nor been delivered by the pharmacy. The nursing staff who are responsible for reordering will be counselled immediately and the Director of Nurses will escalate the concern directly to the pharmacy manager for immediate resolution.

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SANTA ROSA
POST ACUTE

In addition, Omnicare Pharmacy will activate the Omnicell (machine that dispenses medications including controlled substances) on 10-23-2024. The Omnicell will carry a broader spectrum of medications than the previous E-Kits including Lyrica 50 mg & Lyrica 75 mg. Training to access the Omnicell was completed **(3rd attachment)** on 10/15/24 by pharmacy technician.

A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained.

The facility pharmacist will review resident records for medications that were not reordered timely nor delivered immediately and report results of the review to the Director of Nurses and/or Administrator monthly during his/her monthly pharmacy visits.

The Pharmacist will report any ongoing concerns to the Quality Assessment and Assurance (QA&A) committee quarterly to ensure processes remain in compliance.

Dates when corrective action will be completed.

The facility will achieve full compliance by 10-23-24.

End of POC for Tag F 755

Administrator's Signature: _____

Date of Submission: 10-16-24