STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055268	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sonoma Post Acute	678 2nd Street West Sonoma, CA 95476

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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review the facility failed to ensure criminal background checks were completed prior to direct resident care employment for one of three direct care staff (Certified Nurse Assistant 1 [CNA 1]) when CNA 1's criminal background check was completed nine months after he was hired. This failure had the potential to result in resident abuse, neglect and/or mistreatment by hiring staff with possible criminal records.A review of the facility's document titled, General Orientation List, dated 1/17/23, indicated CNA 1's date of hire was 1/17/23. A review of an undated facility document titled, Background Report, indicated a background report was conducted on 10/16/23 for CNA 1 by the facility. During an interview on 7/30/25 at 3:32 p.m., the Director of Staff Development (DSD) verified CNA 1's date of hire was 1/17/23. The DSD confirmed CNA 1's background check was ordered after the employee was hired and began to work directly with residents in the facility. The DSD further stated, I don't have a good answer for you. Usually, I don't let anyone get an offer letter or start orientation until it [background check] is complete.A review of the facility's policy and procedure titled, Background Screening Investigations, dated 2019, indicated, Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were met for one of five sampled residents (Resident 1) when supervisory staff did not provide oversight and follow-up after Resident 1 did not receive any showers or baths for seventeen days.This failure had the potential to increase Resident 1's susceptibility to infections, skin problems, and negatively impact his mental health and activities of daily living (ADL, activities such as bathing, dressing and toileting a person performs daily).A review of Resident 1's admission record indicated he was admitted to the facility in May 2025 with medical diagnosis which included vertebrogenic low back pain (chronic low back pain originating from the vertebral endplates, the surfaces of the vertebrae that meet the intervertebral discs in the spine), absence of left leg above the knee, schizophrenia (a mental illness that is characterized by disturbances in thought), depression (depression (a mental health condition characterized by symptoms like sadness, loss of interest and low energy) and PTSD (Post traumatic stress disorder- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 5/23/25 indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 12, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). In addition, this document indicated Resident 1 had impairment on one side of his lower extremity (hip, knee, ankle & foot) and required substantial/maximal assistance (helper does more than half the effort) with showers and baths. Resident 1's MDS also indicated Resident 1 was wheelchair dependent for ambulation.A review of Resident 1's care plan report, initiated date 5/16/25, indicated, Skin: [Resident 1] is at risk for skin breakdown related to impaired mobility.[staff were expected to] Keep skin clean and dry to the extent possible.A review of Resident 1's care plan report, initiated date 5/17/25, indicated, Mood: [Resident 1] At risk for decreased psychosocial well-being and adjustment issues, emotional distress.[staff were expected to] Encourage participation in ADL's.A review of Resident 1's progress notes, type SBAR [Situation, Background, Assessment, and Recommendation] Summary for Providers, dated 7/03/25 at 10:12 p.m., indicated, Patient [Resident 1] c/o [complain of] pain to R [right] forearm, area assessed and observed to have redden protruding pimple with white head. Slight swelling with firm induration (hardening of tissue) peri pimple and tender to touch observed.A review of Resident 1's progress notes, type Skin/Wound Note, dated 7/7/25 at 2:13 p.m., indicated, This pimple area ruptured now presenting as a abscess. The area is open very bright red with yellow thin pus draining on dressing.with increased swelling forearm to down to hand.now order to start po (by mouth) ATB (antibiotics- a medication used to treat infections).A review of the facility's document titled Shower Schedule, dated 7/16/25, indicated Resident 1 was scheduled to shower on Wednesdays and Saturdays.A review of a facility document titled, Documentation Survey Report v2, for Resident 1 dated 6/1/25-6/30/25, indicated a shower or bath was given on 6/1/25, 6/3/25, 6/12/25, 6/23/25, and 6/26/25. This document indicated Resident 1 refused a shower/bath on 6/30/25. The remaining dates were documented as no (not scheduled for this shift).A review of a facility document titled, Documentation Survey Report v2, for Resident 1 dated 7/1/25-7/31/25, indicated a shower/bath was given on 7/13/25. This document indicated Resident 1 refused a shower/bath on 7/10/25 and was unavailable on 7/3/25, and 7/11/25. The remaining dates were documented as no (not scheduled for this shift).During an interview on 7/31/25 at 1:30 p.m., Certified Nurse Assistant 2 (CNA 2) stated when she offered showers to Resident 1 he would tell her Later. CNA 2 further stated, I will follow up with the resident, but he will continue to say Later and then it's another shift and I did not get to it. During an interview on 7/31/25 at 2:30 p.m., Resident 1 stated, It's been a few weeks since I've taken one [a shower], yesterday was the first time in two weeks. Resident 1 further stated, Since the incident [a reported allegation of abuse that occurred in the shower room between himself and a direct care staff member], I'm just not comfortable with it.During an interview and concurrent record review on 8/1/25 at 10:55 p.m., the Director of Nursing (DON) stated the Director of Staff Development (DSD) was responsible for overseeing and auditing (examine) shower check offs. The DON further stated, If showers have not been given, the DSD should interview the nurse and the resident about it. The DON reviewed Resident 1's Documentation Survey Report v2, dated 6/1/25-6/30/25, and verified, based on the documentation, Resident 1 did not receive a shower or bath between the dates of 6/4-6/11 [indicating eight days without bathing], and 6/13-6/22 [indicating ten days without bathing]. The DON reviewed Resident 1's