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	04/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observations, interviews, and record review the facility failed to provide supervision and assistance during meals to prevent accidents for two of six sampled residents (Resident 1 and Resident 2), when staff allowed Resident 1 and Resident 2 to have access to their meal trays without the physician ordered 1:1 assistance. This failure resulted in unwitnessed choking and death for Resident 1 and placed Resident 2 at risk for aspiration (the accidental breathing in of food, liquid, saliva, or vomit into the airways and lungs instead of swallowing it down the food pipe (esophagus) to the stomach) while eating.On 4/16/26, the Department received a complaint from a Family Member (FM) alleging Resident 1 passed away on 3/11/26 after choking on food and being left unattended in the room with access to the breakfast tray. The FM reported speaking with the Medical Director (MD) on 3/11/26, who stated Resident 1 had orders for 1:1 assistance, while on 3/12/26 the Administrator stated the Speech Language Pathologist (SLP) had lifted the 1:1 order two days before the resident's death.During a phone interview on 4/20/26 at 4:25 p.m., with the FM, the FM stated Resident 1 had a known history of dysphagia, three prior strokes, dementia, and required strict 1:1 feeding assistance at home due to difficulty swallowing and a tendency to take large bites. The FM stated she informed the facility of these needs upon Resident 1's admission and observed during visits that Resident 1 continued to require close feeding assistance. The FM reiterated that on the morning of 3/11/26, the MD called and informed her Resident 1 had died and stated Resident 1 was found in bed and appeared to have choked on food. The MD again told the FM Resident 1 had physician prescribed 1:1 feeding orders and stated the event should not have happened, but did not know how Resident 1 got his hands on the food. The FM confirmed on 3/12/26, the Administrator called her and told her the SLP had discontinued the 1:1 order two days prior to the incident.A review of Resident 1's admission record, dated 1/9/26, indicated Resident 1 was admitted to the facility with multiple diagnoses including dementia (a progressive state of decline in mental abilities) and oropharyngeal dysphagia (a condition where the muscles in the mouth and throat do not work well, making it hard to start a swallow and causing food or liquid to enter the airway instead of the stomach).A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/13/26, indicated Cognitive Loss/Dementia and swallowing concerns were present.A review of Resident 1's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgment status), dated 1/14/26, showed a score of 00 (BIMS has a possible score range of 0-15, with lower scores indicating more severe cognitive impairment, a score of 00 reflects significant impairment in memory, attention, and orientation).During an interview on 4/21/26 at 9:55 a.m. with Licensed Nurse A (LN A), LN A stated based on the active orders in Resident 1's chart, [Name] (Resident 1) should have had someone with him during breakfast (on 3/11/26), as Resident 1 had an active order for 1:1 assistance with meals. LN A confirmed she was the nurse responsible for Resident 1 on 3/11/26 and reported that when she entered Resident 1's room at approximately 8:10 a.m., no nursing staff were present with the resident despite the 1:1 requirement. LN A stated she found the resident upright in bed, unresponsive, without respirations or a carotid pulse (pulse in the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055268	A. Building B. Wing	04/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	neck, just below the jawline), with scrambled eggs visible in the oral cavity, which she removed during her airway assessment. LN A stated she immediately requested assistance, verified Resident 1 was Full Code, initiated CPR, and directed 911 to be called.During an interview on 4/21/26 at 12:52 p.m. with the SLP, the SLP stated she did not discontinue Resident 1's physician ordered 1:1 Feeding Assistance with meals.During an interview on 4/21/26 at 2:45 p.m. with the Director of Staff Development (DSD), the DSD stated, Resident 1 should have had someone with him to help with feeding the morning of 3/11/26.During an interview on 4/29/26 at 4:21 p.m. with LN D, LN D stated a 1:1 feeding assistance order means a nursing staff member must always stay with the resident during meals.During an interview on 4/29/26 at 4:29 p.m., the MD confirmed Resident 1 had an active 1:1 feeding assistance order on 3/11/26. The MD stated a 1:1 feeding assistance order requires nursing staff to remain with the resident during the meal especially when the order is written for aspiration^risk supervision.During a review of Resident 1's Speech Therapy Evaluation titled Medicare SLP Evaluation & Plan of Treatment, dated 1/12/26, Resident 1 was documented to have poor safety awareness, impulsive intake behaviors, impaired cognition limiting the ability to follow swallowing strategies, and ongoing aspiration risk, with SLP noting the need for supervision during oral intake.During a review of Resident 1's care plan titled, Care Plan Report, with entries initiated on 1/11/26 and revised on 3/12/26, the plan included *** Nursing - 1:1 ASSISTANCE @ MEALS *** and Whole pills w/ apple Sauce 1 pill at a time, identifying Resident 1 as requiring continuous assistance at meals.During a review of Resident 1's physician orders, titled Order Summary Report, covering 01/09/26 through 3/11/26, the record listed Resident 1 had an active, Prescriber Written order for Nursing - 1:1 Feeding Assistance with Meals.During a review of Resident 1's progress notes, titled Progress Notes *NEW*, dated 3/11/26, entry created by LN A at 3:43 p.m., LN A recorded at 07:47 a.m. a Certified Nursing Assistant (CNA) was notified to assist Resident 1 with breakfast. At approximately 8:10 a.m., Resident 1 was found by LN A sitting upright in bed, unresponsive, pale, and without respirations or carotid pulse (pulse in the neck, just below the jawline). Resident 1 did not respond to verbal or painful stimuli. LN A immediately requested assistance and verified the resident's Physician Orders for Life-Sustaining Treatment (POLST) indicating Full Code status. Cardiopulmonary resuscitation (CPR) was initiated at 8:11 a.m. LN C was performing chest compressions. LN D applied the Automated External Defibrillator (AED) and analysis showed a non^shockable rhythm. During airway assessment by LN E, visible food material was noted in the oral cavity and removed. LN A contacted Emergency Medical Services (EMS) at 8:12 a.m. while CPR continued. CPR continued until EMS arrived at approximately 8:16 a.m. and assumed care. Resuscitative efforts continued under EMS direction. Despite all interventions, the resident was pronounced deceased by EMS at 8:44 a.m.During a review of documentation received from the Sonoma County Sheriff's Office, titled Death Investigation Report and reflecting scene observations from 3/11/26, the cause of death for Resident 1 was listed as ASPHYXIA (a dangerous condition where the body does not get enough oxygen), due to OBSTRUCTION OF AIRWAY BY FOOD BOLUS (when a lump of food gets stuck in the throat and blocks the breathing tube, making it hard or impossible to breathe), and the manner of death was Accident. The report also stated that during the morning of 3/11/26, the coroner investigator saw scrambled eggs on the sheets and pillow near the headboard of Resident 1's bed, eggs in the suction device container, and eggs on the floor near the resident's head inside the room.A review of Resident 2's admission record dated 4/17/26, indicated Resident 2 was admitted to the facility with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and oropharyngeal dysphagia. Resident 2 was admitted with a tube feeding (when a person gets liquid food through a small tube that goes into their stomach or intestine because they cannot eat safely by mouth) in place.During an observation on 4/22/26 at 12:29 p.m., Resident 2 was in his room sitting upright in bed eating a pureed lunch (pureed ham steak, pureed pan seared potatoes, and pureed seasoned fresh broccoli) without nursing staff present to provide the physician (continued on next page)

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	04/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	ordered 1:1 supervision.During a concurrent observation and interview on 4/22/26 at 12:35 p.m., the surveyor was already in Resident 2's room when Licensed Nurse B entered. LN B stated Resident 2 should not have been left alone with the meal tray. LN B further stated either a licensed nurse, or a CNA was expected to remain with Resident 2 during meals because oral intake had only recently begun on 4/20/26 to transition him off tube feedings, which Resident 2 was still receiving. LN B remained in the room and provided continuous supervision until Resident 2 finished eating.During a review of Resident 2's dietary orders dated 4/20/26, Resident 2 was ordered a pureed diet and mildly thick liquids. The physician order required Resident 2 to take small bites and sips, use a chinˆdown posture when swallowing, and have 1:1 supervision during all eating to prevent choking.During a review of Resident 2's Speech Therapy Evaluation titled Medicare SLP Evaluation & Plan of Treatment, dated 4/20/26, Resident 2 was only allowed to try small amounts of food or liquid with staff help. The review showed Resident 2 needed 1:1 supervision any time food or liquid was given because of severe swallowing problems and silent aspiration (when food, liquid, or saliva goes down and into the airway and toward the lungs - without the person coughing, choking, or showing any obvious signs) in the past.During a review of Resident 2's care plan titled, Care Plan Report, printed 4/22/26, the care plan included instructions for Resident 2 to have 1:1 supervision during all eating trials. The care plan included goals to keep Resident 2 free from aspiration.During a review of the facility policy titled Assistance with Meals Policy, revised March 2022, the policy stipulated, .Facility staff will serve resident trays and will help residents who require assistance with eating., and .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity.