

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Sonoma Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one of five sampled residents (Resident 1) from abuse when Resident 2 punched Resident 1 in the face and chest while he was in his bed. This failure caused Resident 1's lip to bleed and redness to his chest when Resident 1, who was bed-bound, was unable to get away from Resident 2 when he approached him and began to punch him with his fist. Review of a document from the county sheriff's department titled, Incident/Investigation Report, dated 6/16/26 at 8:13 p.m., indicated an officer responded to a report of an assault that had occurred between two residents who were roommates. The report indicated, The victim was punched twice, once in the chest and once in the lip causing a minor laceration to his lower lip. The report further indicated the offender was Resident 2, the victim was Resident 1, and the reportee was Licensed Nurse (LN) C. During an observation and concurrent interview on 6/24/26 at 2:30 p.m., Resident 2 was seated on the couch in a common area with his head in his hands and his eyes closed. When this surveyor greeted Resident 2 and introduced herself, Resident 2 opened his eyes and responded with nonsensical statements and was not able to give any meaningful answers to questions. During an observation and concurrent interview on 6/24/26 at 2:52 p.m., Resident 1 was seated in a wheelchair. Resident 1 stated with difficulty due to his aphasia (impaired ability to speak) that he needed to talk to this surveyor. Resident 1 took his right fist and moved it quickly toward his mouth and then pointed at his mouth. When asked if he had been punched in the mouth, Resident 1 nodded yes. Resident 1 was not able to state the name of who punched him. Resident 1 stated he needed help to get out of the facility. During an interview on 6/25/26 at 2:05 p.m., LN A stated she was regularly assigned to care for Resident 2. LN A stated Resident 2 had aggressive behaviors. LN A stated Resident 2 had recently lashed out and tried to hit the PM shift nurse when he tried to give Resident 2 his pills. LN A stated Resident 2 had angry outbursts at staff, he called her names, yelled at other residents, and he recently punched Resident 1. During an interview on 6/25/26 at 2:10 p.m., Certified Nursing Assistant (CNA) B stated he regularly was assigned to care for Resident 2. CNA B stated Resident 2 had aggressive behaviors such as getting upset during care and yelling, Leave me alone! Don't touch me! CNA B stated he had to have another CNA with him to help during care, such as brief changes, due to Resident 2's aggression. During an interview on 6/25/26 at 2:43 p.m., LN C verified she responded to the incident on 6/16/26 between Resident 1 and Resident 2. LN C stated that around 7:30 p.m., CNA D and CNA E heard yelling in Resident 1 and 2's room. LN C stated CNA D entered the room and saw Resident 2 standing very close to Resident 1. LN C stated CNA D redirected Resident 2 out of the room and LN C did a thorough assessment of Resident 1. LN C stated she noted Resident 2's lower lip was bleeding and he had redness to his right chest. LN C stated Resident 1 told her he was punched by Resident 2. LN C stated she called the administrator, law enforcement, and sent the required form to the long-term care ombudsman. LN C stated Resident 2 was not able to recall that he had punched Resident 1. LN C stated Resident 2 had had behavior like this before. During an interview on 6/25/26 at 3 p.m., CNA E stated she recalled the incident between Residents 1 and 2 on 6/16/26. CNA E stated her coworker CNA D was assigned to care for Residents 1 and 2 that (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
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evening. CNA E stated she was in a room down the hall when she heard yelling and CNA D came and got her and took her to the room where Residents 1 and 2 resided. CNA E verified Residents 1 and 2 were roommates. CNA E stated Resident 2 was already walking towards the nurses' station by this time. CNA E stated she tried to talk to Resident 1, he was having a hard time saying what he wanted to say, but he kept saying, He punched me, he punched me. CNA E stated she put on gloves and looked at the inside of Resident 1's lower lip which looked like he had been punched. CNA E stated she also noted redness on Resident 1's chest and asked him if Resident 2 had punched him in his chest, too, and Resident 1 responded, Yes. CNA E stated she reported this to LN C at the nurses' station. CNA E stated Resident 1 did not have any injuries at the beginning of her shift. CNA E stated Resident 1 was in his bed laying down at the time of the incident. CNA E stated Resident 1 could not get up on his own so he could not get away from the situation. CNA E stated Resident 2 had aggressive behaviors, such as if he heard something he did not like he would start yelling and cussing, and he also would get in people's faces. During a phone interview on 6/25/26 at 3:08 p.m., CNA D stated she recalled that on the evening of 6/16/26 she saw Resident 2 walk into his room and close the door behind him. CNA D stated that about 10 seconds later she could hear Resident 2 yelling at Resident 1, she heard Resident 2 call Resident 1 an asshole and a bitch, so she walked in and separated them. CNA D stated she told Resident 2 to follow her out of the room and then she told CNA E to go check on Resident 1. CNA D stated CNA E told her that Resident 1 was bleeding and she was going to get the nurse. CNA D verified Resident 1 did not have any injuries before the incident occurred. CNA D stated Resident 2 had aggressive behaviors, and stated Resident 2 had grabbed her by her arm and tried to bite her when she was changing his brief. CNA D stated Resident 2 also called her an asshole when she tried to encourage him to eat, and he had grabbed the nurses' hands when they were providing care. CNA D stated Resident 2 generally stayed away from people when he was out of his room, but when he was in a room with people, that was when he targeted people. CNA D stated Resident 2 thought people were saying things about him that were not true, and all you have to do is look at him to get him riled up. CNA D stated Resident 2's new roommate told her yesterday (6/24/26) that he woke up and Resident 2 was staring at him watching him sleep, so he told Resident 2 to go away, and Resident 2 told him he was going to punch him in the face. Review of Resident 1's facesheet (demographics) indicated an admission date of 3/20/25, age of eighty years old, and multiple medical diagnoses including but not limited to amyotrophic lateral sclerosis (ALS, commonly known as Lou Gehrig's disease, destroys motor neurons in the brain and spinal cord, which causes muscles to weaken, twitch, and waste away, leading to loss of movement, speech, swallowing, and breathing) and left-sided paralysis following a stroke. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 6/11/26 indicated Resident 1 had a moderate cognitive impairment, had difficulty making himself understood when speaking, and needed extensive assistance from staff for most activities of daily living (eating, dressing, bathing, etc) and mobility. Review of Resident 2's facesheet indicated an admission date of 5/16/26, age of eighty-one years old, and multiple medical diagnoses including but not limited to metabolic encephalopathy (altered brain function caused by an underlying systemic, chemical, or organ problem rather than a direct brain injury) and dementia (a decline in cognitive abilities-such as memory, reasoning, and communication-that is severe enough to interfere with daily life). Review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a severe cognitive impairment and was able to walk at least 50 feet with supervision. Further review of Resident 2's MDS indicated that he had displayed verbal and physical behaviors that significantly interfered with his care and activities on one to three of the past seven days, and that the behaviors put others at risk of injury. Review of Resident 2's care plan indicated a focus area, dated 5/18/26, The resident has a behavior problem of being verbally and physically aggressive [related to] dementia. Resident peer to peer (aggressor) swiped right hand across another resident, with interventions that included, Intervene as necessary to protect the rights and safety of others. Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2021, indicated, Residents have the right to be free from abuse . This includes but is not limited to freedom from . physical abuse . The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse . by anyone including, but not necessarily limited to: . other residents .		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report to the Department an allegation of abuse. This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety. Review of a document from the county sheriff's department titled, Incident/Investigation Report, dated 6/16/26 at 8:13 p.m., indicated an officer responded to a report of an assault that had occurred between two residents who were roommates. The report indicated, The victim was punched twice, once in the chest and once in the lip causing a minor laceration to his lower lip. During a record review and concurrent interview on 6/24/26 at 3:20 p.m., the Administrator stated he was aware of the resident-to-resident incident that occurred on 6/16/26 but stated it was not reported to the Department because the resident who was the aggressor had dementia. The Administrator provided a flow sheet created by a long-term care ombudsman organization which indicated that in cases of alleged abuse where the aggressor had a dementia diagnosis, facility staff were only required to notify law enforcement and the ombudsman's office. The Administrator stated he was following the reporting guidance on the flow sheet he was given. During an interview on 6/25/26 at 2:43 p.m., Licensed Nurse (LN) C verified she responded to the resident-to-resident incident that occurred on 6/16/26. LN C stated she called the Administrator, who was the abuse coordinator, who advised her to call law enforcement to report the incident and send the form for abuse allegation reporting to the long-term care ombudsman. When queried, LN stated she was not sure when abuse allegations needed to be reported to the Department. Review of facility policy and procedure Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last revised 9/2022, indicated, All reports of resident abuse (including injuries of unknown origin) . are reported to local, state and federal agencies (as required by current regulations) . The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .		