STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055734	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ukiah Post Acute	1349 South Dora St. Ukiah, CA 95482

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 three sampled residents reviewed from resident-to-resident abuse (Resident 2) by another resident (Resident 1). The facility failed to implement effective interventions after identifying an escalating pattern of accusations, threats, and aggressive behaviors directed by Resident 1 toward Resident 2.This finding resulted in Resident 1 striking Resident 2 in the arm on June 1, 2026. This finding had the potential to result in physical and psychosocial harm to Resident 2.A review of Resident 1's admission record (facility demographic) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included vascular parkinsonism (a neurological disorder affecting movement) and major depression. A review of Resident 1's Minimum Data Set (MDS), a federally required resident assessment, dated 5/04/26 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool), score of 15, indicating Resident 1 was cognitively intact.A review of Resident 2's admission record (facility demographic) indicated he was admitted to the facility on [DATE] with medical diagnoses which included chronic obstructive pulmonary disease (a chronic lung disease that causes airflow blockage and difficulty breathing), peripheral vascular disease (a circulatory disorder that reduces blood flow to the arms and legs), major depression (a mood disorder characterized by persistent feelings of sadness, hopelessness, or loss of interest), anxiety disorder (a mental health condition characterized by excessive worry, fear, or nervousness), and schizophrenia (a psychiatric disorder that may affect a person's thinking, perception, emotions, and behavior). Resident 2's most recent MDS dated [DATE] documented a BIMS score of 7, which indicated his cognition was moderately impaired.A review of Resident 1's nursing progress note dated 5/25/26 at 1:58 p.m. indicated Resident 1 accused Resident 2 of stealing soft drinks from him. The progress note documented staff investigated the allegation and later located the soft drinks in Resident 1's room. According to the progress notes, despite the allegation being determined unfounded, Resident 1 continued accusing Resident 2 of stealing from him.A review of physician orders dated 5/25/26 at 1:31 p.m. and behavioral monitoring records dated 5/25/26 at 1:31 p.m. revealed that on 5/25/26, the facility initiated behavior monitoring every shift for accusations that residents or staff were stealing Resident 1's belongings. Nursing documentation from 5/25/26 through 5/29/26 reflected ongoing accusations, fixation on theft, redirection by staff, and continued monitoring.A review of a nursing progress note dated 5/30/26 at 5 p.m. indicated Resident 1 verbally threatened to fight Resident 2 and raised his fist toward Resident 2 while accusing him of stealing soft drinks. The note documented management and the physician were notified.During an interview on 6/09/26 at 2:02 p.m., the Director of Nursing stated that following the 5/30/26 incident, the physician ordered Resident 1 and Resident 2 be kept apart. The Director of Nursing showed surveyor a social media communication between facility leadership and nursing staff documenting awareness of the escalating conflict and directing staff to monitor the residents and keep them separated.A review of the facility's Five-Day Report dated 6/01/26 indicated that at approximately 3:20 p.m., Resident 1 again confronted Resident 2 regarding alleged stolen soft drinks. The report documented Licensed Nurse A observed Resident 1's wheelchair positioned extremely (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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	close to Resident 2's wheelchair and intervened to separate the residents. The report documented that although staff did not directly witness physical contact, Resident 2 reported that Resident 1 struck him in the arm.During an interview on 6/09/26 at 11:40 a.m., Licensed Nurse A stated Resident 2 reported on 6/01/26 that Resident 1 had struck him in the arm. Licensed Nurse A further stated staff had been aware of the ongoing conflict between the residents before the incident.During an interview on 6/09/26 at 12:51 p.m., the Social Services Director stated she re-interviewed Resident 2 following the surveyor interview. The Social Services Director stated Resident 2 reported Resident 1 struck him in the right upper arm and stated he was not injured.A review of the Interdisciplinary Team note dated 6/02/26 at 4 p.m. documented that Resident 2 reported being struck in the arm by Resident 1 during the June 1, 2026 incident.During an interview on 6/09/26 at 12:15 p.m., when asked whether he struck Resident 2 during the incident, Resident 1 stated, I tried.A review of the facility policy titled Abuse, Resident-to-Resident, Revised 11/2023, indicated the facility is responsible for protecting residents from harm, including abuse by other residents, and requires implementation of measures necessary to prevent additional incidents.A review of the facility policy titled Behavioral Health Services, dated 4/2019, indicated residents exhibiting behavioral concerns shall be assessed, monitored, care planned, and provided appropriate interventions to address identified behavioral needs.