

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2025
NAME OF PROVIDER OR SUPPLIER  Santa Rosa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  4650 Hoen Avenue Santa Rosa, CA 95405	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46132</p> <p>Based on interviews and record reviews, the facility failed to implement their abuse policy, for one resident out of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> <li>1. Resident 1 made an abuse allegation on 3/26/25 but the facility did not report the allegation within two hours to the State (licensing agency), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and law enforcement, and</li> <li>2. six out of six facility staff did not know the expectation to report any allegation of abuse within two hours to the State, the Ombudsman, and the law enforcement.</li> </ol> <p>These failures could put the resident ' s safety at risk due to delayed intervention.</p> <p>Findings:</p> <p>During an interview on 4/9/25 at 9:45 a.m., Licensed Nurse A (LN A) stated abuse allegations should be reported to the State, Ombudsman and the Police (law enforcement), within 24 hours if there was no injury but within 2 hours if there was injury. LN A stated that late reporting of abuse might put residents at risk for abuse to continue and could put the residents at risk for emotional distress.</p> <p>During an interview on 4/9/25 at 10:40 a.m., LN B stated the staff follow the facility ' s policy on abuse reporting time frames and added, the facility ' s policy was to report abuse allegation within 24 hours if there was no injury and within 2 hours if there was injury. LN B stated not reporting an abuse allegation timely could put the patient safety at risk and could put the resident at risk for feeling fearful and distrustful of staff.</p> <p>During a concurrent interview and record review on 4/9/25 at 10:48 a.m., with the Social Services Assistant (SSA), the initial report of abuse, dated 3/27/25, was reviewed. The Social Services Assistant (SSA) verified the facility learned about the abuse allegation on 3/26/25 but did not make the report to the State, the Ombudsman and law enforcement until 3/27/25. The SSA stated she did not know the time frame for reporting abuse allegations.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/9/25 at 10:57 a.m., the Director of Staff Development (DSD) stated the staff follow the facility ' s policy on abuse reporting time frames. The DSD stated the facility ' s policy was to report abuse allegations to the Ombudsman, the State and law enforcement within 2 hours if there was injury but within 24 hours if there was no injury. The DSD stated not reporting an abuse allegation immediately could result to continued harm and delayed intervention.</p> <p>During a concurrent interview and record review on 4/9/25 at 11:12 a.m., with the administrator (Admin), the initial report of abuse, dated 3/27/25, was reviewed. The Admin verified the facility learned about the abuse allegation on 3/26/25 but did not report it to the Ombudsman, the State and law enforcement until 3/27/25. The Admin stated the facility follows the facility ' s abuse policy on reporting abuse allegations and added, abuse allegations should be reported within 24 hours if there was no injury and within 2 hours if there was an injury.</p> <p>During an interview on 4/9/25 at 11:15 a.m., the Director of Nursing (DON) stated the facility follows it ' s abuse policy reporting time frame. The DON stated the facility ' s abuse policy indicated abuse allegations should be reported to the State, Ombudsman and law enforcement within 2 hours if there was an injury and within 24 hours if there was no injury. The DON stated not reporting the abuse allegation timely could put the resident ' s safety at risk.</p> <p>A review of the facility ' s policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/2022, the P&amp;P indicated, . if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . immediately is defined as within 2 hours of an allegation involving abuse .</p> <p>Based on interviews and record reviews, the facility failed to implement their abuse policy, for one resident out of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> <li>1. Resident 1 made an abuse allegation on 3/26/25 but the facility did not report the allegation within two hours to the State (licensing agency), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and law enforcement, and</li> <li>2. six out of six facility staff did not know the expectation to report any allegation of abuse within two hours to the State, the Ombudsman, and the law enforcement.</li> </ol> <p>These failures could put the resident's safety at risk due to delayed intervention.</p> <p>Findings:</p> <p>During an interview on 4/9/25 at 9:45 a.m., Licensed Nurse A (LN A) stated abuse allegations should be reported to the State, Ombudsman and the Police (law enforcement), within 24 hours if there was no injury but within 2 hours if there was injury. LN A stated that late reporting of abuse might put residents at risk for abuse to continue and could put the residents at risk for emotional distress.</p> <p>(continued on next page)</p>		

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