STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055854	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Post Acute	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39621 Based on interview and record review, the facility failed to implement its abuse and change of condition policy for two residents (Resident 1 and Resident 2) of four sampled residents when the facility staff did not: Notify the residents' family representatives and physicians, Document an Interdisciplinary Team (IDT- a multidisciplinary team who ensures a comprehensive and coordinated approach to patient care) note, and Initiate care plans to provide person-centered care for both residents for an allegation of resident-to-resident abuse. This failure decreased the facility's potential to prevent recurrence of abuse between Resident 1 and Resident 2. Findings: A review of a investigation summary report sent to the California Department of Public Health (CDPH) on 4/14/25 indicated, On 4/9/25, the [Resident 1] reported to the staff that her roommate [Resident 2], came to her bed around midnight, tore the blankets off the bed, began commanding that she go to the bathroom, and then struck her on the face and chest several times. During an interview on 4/25/25 at 9:10 a.m., the Administrator stated the permanent Director of Nursing (DON) was on leave and not currently working at the facility. A review of an electronic-mail sent to the Surveyor on 4/25/25 at 12:41 p.m. from the Director of Medical Records (DMR) indicated there was no documented evidence of family representative notifications, physician notifications, Special Incident Reports (SIR- a form that documents critical and unexpected events that could impact a patient's health or safety), or IDT notes found in Resident 1 or Resident 2's charts regarding the allegation of abuse on that was reported on 4/9/25. During an interview on 4/25/25 at 2:40 p.m., the Director of Staff Development (DSD) stated licensed staff were expected to notify residents' representatives and physicians of resident-to-resident abuse allegations. The DSD also stated staff were also required to complete a SIR of the allegation and document an IDT note in each residents' chart. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/25/25 at 2:48 p.m., Licensed Staff A (LS A) stated Resident 1 notified her of the resident-to-resident abuse allegation on 4/9/25 at around 6 a.m. LS A stated she wrote a nursing progress note about it but did not complete a SIR. LS A stated she was unsure if she had notified the residents' family members or the physician of the allegation. LS A stated Resident 1 was moved to another room after the allegation. During an interview on 4/25/25 at 2:58 p.m., the DMR acknowledged there were no care plans in Resident 1 and Resident 2's medical charts regarding the abuse allegation reported on 4/09/25. During a phone interview on 4/28/25 at 9:22 a.m., the DSD stated care plans were expected to be initiated after an abuse allegation for the residents involved. During a phone interview on 5/7/25 at 2:15 p.m., the DSD stated Charge Nurses were responsible for notifying the residents' representatives and physicians about any allegations of abuse when they were notified. The DSD also stated licensed nurses were expected to monitor residents involved in the alleged abuse for 72 hours and document their assessments in the residents' charts. The DSD further stated care plans regarding abuse allegations were expected to be initiated by the IDT. During a review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/22, indicated, .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies .The resident's representative .The resident's attending physician; and .The facility medical director .The administrator is responsible for keeping the resident and his/her representative .informed of the progress of the investigation. Record review of the facility's policy titled, Change in a Resident's Condition or Status, revised 2/21 indicated, .The nurse will notify the resident's attending physician or physician on call when there has been an .incident involving the resident .A ' significant change' of condition is a major decline .in the resident's status that .requires interdisciplinary review and/or revision to the care plan .Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR [Situation, Background, Assessment, Recommendation] Communication Form .Unless otherwise instructed by the resident, a nurse will notify the resident's representative when .there is a significant change in the resident's physical, mental, or psychosocial status .there is a need to change the resident's room assignment.

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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 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. 39621 Based on interview and record review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for two residents (Resident 1 & Resident 2) of four sampled residents when an allegation of resident-to-resident abuse was reported to the California Department of Public Health (Department) five days later. This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety. Findings: A review of a facility document dated and received by the Department on 4/14/25, indicated an allegation of suspected dependent adult/elder abuse had been made on 4/09/25 related to a resident-to-resident altercation between Resident 1 and Resident 2. During an interview on 4/25/25 at 11:28 a.m., the Administrator stated the facility had mistakenly sent the five-day abuse investigation summary to the Department since the facility was not required to report abuse at all when the residents involved had dementia (memory loss), and the incident had not resulted in serious bodily injury. The Administrator confirmed the allegation on 4/9/25 had not been reported to the Department until 4/14/25. A review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/22, indicated, All reports of resident abuse .are reported to local, state, and federal agencies .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .'Immediately' is defined as .within two hours of an allegation involving abuse.