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	05/02/2025

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 - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43238 Based on interview and record review, the facility failed to protect a census of 94 residents from sexual abuse when the facility allowed an alleged perpetrator, Certified Nursing Assistant 1 (CNA 1), to enter the facility on 4/4/25 after conducting an incomplete investigation per facility policy for a census of 94 residents. This failure granted CNA 1 access to Resident 1 and had the potential to place Resident 1 and other residents at risk for further harm. Cross-reference F610. Findings A review of an admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of cardiomegaly (a condition when the heart becomes larger than normal) and dementia (a progressive state of mental decline). A review of Resident 1's progress note dated 4/4/25 at 9:38 p.m. indicated, Spoke to this [Resident 1] at approximately 12:40 p.m. today due to .reporting to a CNA that [Resident 1] experienced sexual abuse at the facility .This [Resident 1] reported that a male cleaned her in her room after a bowel movement .He then took the [Resident 1] to the shower room where he provided a shower .The [Resident 1] states that it was in her room that the male exposed himself to her and asked her to touch him . A review of CNA 1's time sheet dated 4/1/25 to 4/8/25, indicated CNA 1 clocked in for work on 4/4/25 at 3:31 p.m. and clocked out for the shift at 6:07 p.m. During an interview on 4/9/25 at 1:29 p.m., the Director of Nursing (DON) stated she became aware of the sexual abuse allegation against CNA 1 at approximately 12:30 p.m. on 4/4/25. The DON stated was able to identify the alleged abuser based on Resident 1's description of him. The DON then questioned other female residents in the same hallway as Resident 1's room and altered CNA 1's schedule to exclude Resident 1. The DON interviewed CNA 1 about the alleged incident after he clocked in for his shift on the afternoon of 4/4/25 at 4 p.m. The DON stated CNA 1 admitted to providing Resident 1 showers three times per week but documented them under another CNA's name. The DON then placed CNA 1 on suspension following her interview with him on 4/4/25. During an interview on 4/14/25 at 1:16 p.m., the Director of Staff Development (DSD) stated she was also made aware of the sexual abuse allegation at approximately 12:30 p.m. on 4/4/25. (continued on next page)

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 - Many	A review of facility policy titled Abuse Prevention Program , dated 2001, indicated, Our residents have the right to be free from abuse .This includes but is not limited to freedom from .sexual .abuse. As part of the resident abuse prevention, the administration will .protect residents during abuse investigations. A review of facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating , dated 2001, indicated, The administrator ensures that the resident .are protected from retaliation or reprisal by the alleged perpetrator.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43238 Based on interview and record review, the facility failed to thoroughly investigate an allegation of sexual abuse for one resident (Resident 1) of eight sampled residents when Resident 1 alleged a male Certified Nursing Assistant (CNA) matching the identity of CNA 1 exposed himself to Resident 1 and forced Resident 1 to touch his genitals. This failure decreased the facility's potential to protect Resident 1 and a facility census of 94 residents at the facility from harm. Findings: A review of CNA 1's employee file indicated he was hired at the facility on 8/31/21. A review of Resident 1's admission record indicated admission to the facility on [DATE] with a diagnosis of cardiomegaly (a condition when the heart becomes larger than normal), dementia (a progressive state of mental decline), delirium due to known physiological condition, adult failure to thrive (a condition where older adults experience a significant decline in their overall health and well-being, often due to a combination of physical, psychological, and social factors), and the need for assistance with personal care. A review of Resident 1's Minimum Data Set (MDS-an assessment tool), dated 3/3/25, indicated Resident 1: - had a Brief Interview for Mental Status (BIMS-an assessment tool) score of 11, which indicated moderate cognitive (relating to processes of thinking and reasoning) impairment, - had no signs and symptoms of delirium (a disturbed state of mind characterized by symptoms such as confusion, disorientation, agitation, and hallucinations (a mental state in which a person's senses makes them believe a situation is real but it is not), - required substantial assistance (the helper does more than half the effort) from staff to shower/bathe. A review of Resident 1's untitled facility documents referred to by nursing staff as shower sheets (documentation of residents' skin conditions during showers), dated 2/27/25, 3/10/25, 3/27/25 and 4/3/25 indicated a wet signature (a handwritten signature made with ink on a physical document) by CNA 1 which indicated he provided Resident 1 showers. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility document faxed to the California Department of Public Health (CDPH) on 4/4/25 at 3:18 p.m., indicated, DSD [Director of Staff Development] approached [Resident 2] at approximately 12:30 p.m DSD asked [Resident 2] to bring her to the allegedly abused resident .[Resident 1] began to explain that there is a male that is approximately 6 feet, Latin, dark, with black hair, and a muffled voice .The male told her that she needed a bath. The male got bath supplies and returned. After returning, the male cleaned her bowel movement with peri-wipes [disposable wipes designed to clean the area between the anus and the genitals] and cleaned her vagina. He then took her to the shower room, undressed her and gave her a shower with warm water .After returning to the room, the male exposed his chest then unzipped his pants, and asked [Resident 1] to touch him. [Resident 1] states that this occurred within the last month. [Resident 1] also states that she could point out this male because he looks exactly like an ex-boyfriend that she had [AGE] years ago .[Resident 1]'s diagnoses and chart were reviewed. Diagnoses include dementia, delirium, mild cognitive impairment. Review of the resident chart revealed that the resident has only had showers from female staff for the last 30 days. The facility's investigation points to no substantiated abuse. A review of Resident 1's document titled POC [Plan of Care] Response History printed on 4/4/25 at 8:59 p.m. indicated a shower/bath had been provided to Resident 1 by CNA 4 on 3/27/25 and 4/3/25. A review of Resident 1's progress note dated 4/4/25 at 9:38 p.m., indicated, .The facility did not find the abuse allegation substantiated following its investigation, including interviews of various residents. In an interview on 4/8/25 at 12:20 p.m., the Long-Term Care (LTC) Ombudsman stated she interviewed Resident 1 and Resident 2 and found their details of the incident matched. The LTC Ombudsman also stated she believed Resident 1 was a good witness for herself despite her diagnosis of dementia. A review of a facility document faxed to CDPH on 4/8/25 at 2:49 p.m. indicated, Subject: 5-day follow up investigation from reported abuse from 04-04-25 .The [Resident 1] reported a different version of the story to another resident on 04/03/25 .Other female residents were interviewed of the same hallway were interviewed to assess if they have ever been made to feel uncomfortable or if any staff members were inappropriate in anyway, including someone verbalized to them [sic]. Each female resident interviewed stated that there have been no inappropriate words or actions by male staff members directed at them or witnessed by them. The residents interviewed include [four residents which did not include Resident 1's roommate] .At this time the facility is concluding the investigation and does not find this allegation substantiated. The inconsistencies in the stories as well as the inability to find any female residents who could identify the CNA as a danger to any residents brought us to the conclusion that there was no harm committed .Facility Immediately intervened upon receiving report from the resident to ensure that she was safe .The incident was investigation and reported to CDPH, LTC Ombudsman, and .[the] Police Department. A review of the facility's census dated 4/9/25 at 8:28 a.m. indicated Resident 7's room was located next door to Resident 1 on the same hallway. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/9/25 at 12:01 p.m., CNA 2 stated Resident 1 told her she did not want CNA 1 caring for her because he was rude to her roommate. The CNA 2 stated Resident 1 had not used CNA 1's name, but had described him as, a big man. The CNA 2 then suggested the Surveyors interview three specific residents because they would have stories to tell them about CNA 1. The CNA 2 added when the Surveyor had been at the facility on 4/4/25 the staff who were working did not feel comfortable talking about CNA 1 because his wife (CNA 4) was working at the facility on the same shift. A review of Resident 7's MDS dated [DATE] indicated a BIMS score of 11 which indicated moderate cognitive impairment. In an interview on 4/9/25 at 1:04 p.m., Resident 7 stated she had been living in the facility for 2 years and 3 months. Resident 7 also stated, One guy [CNA 1] used to touch me on the leg. He used to give me showers, but I won't let him do that anymore. He touched my leg and said, ' Come on baby.' I told the Administrator [ADM] who asked me if I wanted him to get rid of him. He said he would call the police [but they] haven't come yet .Touching like rubbing. [He] almost touched my private parts, but I pushed his hand away and said, ' No.' In an interview on 4/9/25 at 1:29 p.m., the Director of Nursing (DON) stated she became aware of Resident 1's sexual abuse allegation against CNA 1 at approximately 12:30 p.m. on 4/4/25. The DON stated was able to identify the alleged abuser based on Resident 1's description of him. The DON then questioned other female residents in the same hallway as Resident 1's room and altered CNA 1's schedule to exclude Resident 1. The DON stated she had not found any other residents who complained or had issues with CNA 1's care. The DON interviewed CNA 1 about the alleged incident after he clocked in for his shift on the afternoon of 4/4/25 at 4 p.m. The DON stated CNA 1 admitted to providing Resident 1 showers three times per week but documented them under another CNA's name. The DON then placed CNA 1 on suspension following her interview with him on 4/4/25. The DON stated CNA 1 had been placed on suspension from 4/4/25 to 4/7/25. In an interview on 4/11/25 at 10:25 a.m., Resident 7 stated the incident with CNA 1 occurred around 3 weeks ago. Resident 7 stated, I didn't tell anyone [other staff] about it- only the guy in charge. Resident 7 confirmed the guy in charge was the [ADM]. Resident 7 added she told her nurse she did not want CNA 1 caring for her anymore. In an interview on 4/11/25 at 10:36 a.m., LN 3 stated, [Resident 7] mentioned a while ago, ' There was a guy that gave me a shower and he washed my vagina- really washed it. The LN 3 stated when she asked Resident 7 whether she felt it was sexual or made her feel uncomfortable, Resident 7 stated she did not know and asked if it was weird that his wife was in the room also. The LN 3 told Resident 7 it was not necessarily weird if the wife was trying to help. The LN 3 stated Resident 7 often made [NAME] comments about male genitals and if LN 3 felt it was misconduct of sexual connotation, the LN 3 would report it to the DON and refer to the facility's binder titled Mandated Reporting Binder. In an interview on 4/14/25 at 12:28 p.m., CNA 4 stated CNA 1 has always had a problem obtaining access to the facility's Electronic Documentation System (EDS). CNA 4 stated she and CNA 1 had started working at the facility as on-call or per diem (called to work when needed) staff. When CNA 4 and CNA 1 became full-time staff, CNA 1's inability to log into the EDS became a real problem. CNA 4 gave CNA 1 her password so CNA 1 could document under her name. CNA 4 stated CNA 1 had notified the DSD on several occasions about his inability to log into the EDS, but they never fixed it until now. CNA 4 stated, I know it was wrong, but [CNA 1] couldn't document so I did it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/14/25 at 1:16 p.m., the DSD acknowledged she was made aware of Resident 1's sexual abuse allegation against CNA 1 at approximately 12:30 p.m. on 4/4/25. The DSD stated she interviewed Resident 1 then reviewed Resident 1's shower documentation and did not see CNA 1 listed as a person who gave Resident 1 a shower/bath. The DSD then left the facility around 2 p.m. The DSD stated she returned to the facility around 6 p.m. after the DON informed her CNA 1 had stated he had given Resident 1 showers/baths and had been documenting under CNA 4's name. The DSD interviewed female residents whom CNA 1 would have showered. The DSD confirmed these female residents were not in CNA 1's old or new assignment. The DSD also stated she interviewed three staff members but was only able to name one of the staff members as she was unable to remember the names of the other two. The DSD acknowledged she had not included the staff interviews in her report because she did not think it mattered. The DSD left the facility again at 8:30 p.m. and considered the investigation concluded. The DSD stated Resident 1's story kept changing so the investigation concluded quickly. The DSD acknowledged she interviewed Resident 1 once and thought Resident 1 may have had a urinary tract infection, indicating Resident 1 may have a common side effect of confusion from it. The DSD stated she had been working at the facility for 4 months and had not been trained on how to investigate abuse allegations. The DSD further stated she did not follow the facility's Abuse Investigation Protocol. In an interview on 4/14/25 at 1:53 p.m., the Director of Nursing (DON) stated CNA 1 told her he did not usually touch female residents near their private parts or will have his wife accompany him when he provides a female resident a shower/bath. The DON further stated she had interviewed CNA 1 and one other male staff member who worked the same shift as CNA 1. The DON also stated, [It was] absolutely wrong [CNA 1] documented under [CNA 4's] name .I did not assist [the DSD] in the investigation, write up or conclusion. In an interview on 4/14/25 at 2:24 p.m., the ADM denied Resident 7's report of having been inappropriately touched by CNA 1. The ADM stated he would have reported it. The ADM confirmed he was the Abuse Coordinator and named the DON and DSD as his designees. The ADM further stated, If I am here, I will help [with the investigation]. The ADM acknowledged he had not gone to the facility on [DATE]. The ADM also acknowledged he had read the 5-day follow up investigation report but had not noticed it did not include any staff interviews. The ADM stated he did not, formally train anyone on the correct procedure for investigating abuse allegations . The ADM stated he could not confirm the investigation was thorough. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating , dated 2001, indicated, All reports of resident abuse .[are] thoroughly investigated by facility management. Findings of all investigations are documented and reported .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator .The administrator of the individual making the allegation immediately reports his or her suspicion .Upon receiving any allegations of abuse .the administrator is responsible for determining what actions .are needed for the protection of residents .The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation .The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated by the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The individual conducting the investigation as a minimum .interviews the resident's attending physician as needed to determine the resident's condition .interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .interviews the resident's roommate .interviews other residents to whom the accused employee provides care or services .reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly .The investigator consults daily with the administrator concerning the progress/findings of the investigation .