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	09/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided by the facility met professional standards of practice for administering medications as ordered by the physician (MD) for three residents (Resident 1, Resident 2, and Resident 3) of three sampled residents when: 1. Resident 1 did not receive her heart failure medication, antidepressant medication, and ointment for skin redness;2. Resident 2 did not receive a dose of his anti-fungal powder; and,3. Resident 3 did not receive her medication to alleviate pain and itching and medication for her thyroid. These failures decreased the facility's potential to ensure residents received medications that prevented a decline in their health status or prolonged discomfort due to their health diagnoses. Findings:1. A review of Resident 1's admission record indicated she was admitted on [DATE] with a diagnosis of congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and adjustment disorder with depressed mood (a mental health condition characterized by significant and persistent feelings of sadness and hopelessness).A review of Resident 1's Medication Administration Record (MAR), dated August 2025, indicated the following MD orders:a. Sacubitril/Valsartan (medication used to treat heart failure), 24-26 milligrams (mg- a unit of measurement) tablet, one tablet by mouth two times a day for heart failure with a start date of 8/12/25 at 5 p.m. The MAR indicated Resident 1 had not been given the evening dose of the medication on 8/12/25 nor the morning and evening doses on 8/13/25 at 9 a.m. and 5 p.m.b. Sacubitril/Valsartan, 24-26 mg. tablet, one-half tablet by mouth two times a day for heart failure with a start date of 8/26/25 at 6 p.m. The MAR indicated Resident 1 had not been given the evening dose of the medication on 8/30/25 at 6 p.m. and 8/31/25 at 6 p.m.c. Trazadone (used to treat depression), 50 mg. tablet, two tablets by mouth, at bedtime for depression with a start date of 8/12/25 at 8 p.m. The MAR indicated Resident 1 had not been given the dose on 8/12/25 at 8 p.m.d. Menthol Zinc Oxide ointment 0.44 -20.6% (%- a unit of measurement), apply to effected area topically every 8 hours for redness of skin with a start date of 8/12/25 at 5 p.m. The MAR indicated Resident 1 had not been given the evening dose on 8/12/25 at 5 p.m. and the morning dose on 8/13/25 at 1 a.m.2. A review of Resident 2's admission record indicated he was admitted on [DATE] with the diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).A review of Resident 2's MAR, dated August 2025, indicated the following MD orders:a. Nystatin (anti-fungal) Powder, 100000 UNIT/Gram (UNIT/GM.- a unit of measurement), apply to groin topically every shift for moisture-associated skin damage (MASD) with a start date of 8/20/25 at 2:30 p. m. The MAR indicated Resident 2 had not been given the night shift dose (NOC) of the medication on 8/20/25. 3. A review of Resident 3's admission record indicated she was admitted on [DATE] with the diagnosis of a recurring dislocation of the left shoulder and psoriasis (a chronic skin condition characterized by itchy and sometimes painful red, scaly plaques that can appear anywhere on the body). A review of Resident 3's MAR, dated August 2025, indicated the following MD orders:a. Lidocaine (medication used to alleviate pain) external patch, 4%, apply to effected area topically one time a day for pain with a start date of 8/27/25 at 9 a.m. The MAR indicated Resident 3 had not been given the medication on 8/27/25 nor 8/28/25 at 9 a.m. b. Betamethasone Dipropionate external cream 0/05%, apply to affected area topically every 8 hours for psoriasis with a start date of 8/26/25 at 5 p.m. The MAR indicated Resident 3 had not been given the evening dose on 8/26/25 at 5 p.m., the morning and mid-day dose on both 8/27/25 and 8/28/25 at 1 a.m. and 9 a.m.c. Levothyroxine Sodium oral tablet, 50 micrograms (mcg. - a unit of measurement), give 50 mcg by mouth in the morning for hypothyroidism (when the thyroid gland is unable to meet the body's needs) with a start date of 8/31/25 at 6 a.m. The MAR indicated Resident 3 had not been given the medication on 8/31/25 at 6 a.m. During a concurrent interview and record review on 9/2/25 at 11:24 a.m., the Infection Preventionist (IP) reviewed Resident 1's, Resident 2's, and Resident 3's August 2025 MARs and confirmed all three residents had missed doses of their medications.During a second interview and concurrent record review on 9/2/25 at 12:10 p.m., the IP stated licensed nurses are expected to check the facility's emergency medication stock for the ordered medication. The licensed nurses are also expected to call the pharmacy to confirm a delivery date and time, then call the physician to notify him of the issue. The physician can then decide whether to order a substitute or confirm that the delay of medication administration is okay. Lastly, the licensed nurses are then expected to document what they did and any instructions they were given in the resident's chart. The IP also stated the pharmacy was located close by so most medications could be