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	12/26/2025

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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 1) out of three sampled residents was free from a significant medication error when:Resident 1 did not have a person-centered care plan that included the administration of glucagon (emergency treatment to raise blood sugar levels) during a hypoglycemic episode (when a person's blood sugar level drops below 70 milligrams per deciliter (a unit of measurement)) nor one for Resident 1's risk for refractory hypoglycemia;Licensed Nurse 2 (LN 2) documented that insulin was administered at 11:30 a.m. when it was supposed to be given at 6:30 a.m.;The facility's glucometer had not been tracking accurate dates or times;LN 2 did not document Resident 1's blood glucose value of 434 mg/dl and did not notify the physician;LN 2 administered a total of 16 units of insulin to Resident 1 within 1 hour and 18 minutes;LN 2 did not use a Spanish language interpreter to communicate with Resident 1 when LN 2 administered insulin; and,LN 1 did not administer glucagon per the facility's protocol via intramuscular (into a large muscle) injection when Resident 1 became unresponsive with a blood glucose level of 50.This failure resulted in Resident 1 receiving life-threatening and invasive treatment at a local hospital emergency room.Findings:A review of Resident 1's admission record indicated admission to the facility on 4/23/25 with diagnoses of End Stage Renal Disease (ESRD- a condition in which kidneys are severely damaged and can no longer function on their own) with dependence on renal dialysis (a life-sustaining treatment that filters waste and excess fluid from the body when the kidneys fail) and Type 2 Diabetes Mellitus (DM- a chronic condition in which the body has difficulty in controlling blood sugar levels).A review of Resident 1's focused care plan, dated 4/23/25, for DM indicated Resident 1's goal was to be free of signs or symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) and to minimize the risk of DM. To assist Resident 1 to reach his goal, nursing staff were expected to: monitor for signs and symptoms of hypo/hyperglycemia; implement interventions to manage hypo/hyperglycemic events; and perform blood glucose checks as ordered. The care plan also indicated Resident 1 experienced a hypoglycemic event on 8/1/25 at which time Resident 1 was given glucagon, but the administration of glucagon was not included in the care plan as a nursing intervention. A further review of all of Resident 1's care plans dated 4/23/25 to 11/2/25 showed no documented evidence of a focused person-centered care plan that indicated he had refractory hypoglycemia.A review of Resident 1's weights and vitals summary indicated Resident 1's blood glucose level on 8/1/25 was 45 mg/dL.A review of Resident 1's Minimum Data Set (an assessment tool) dated 8/5/25 indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident 1 had moderate impairment to his ability to process knowledge and understanding.A review of MD orders dated 10/8/25 at 4:30 p.m., indicated the physician ordered [Brand name insulin lispro (a rapid acting insulin used to decreased high levels of blood glucose; it starts working within 5 minutes and its maximum effect occurs between 30 to 90 minutes)] Subcutaneous Solution Pen-injector [a pre-filled, disposable insulin pen which delivers insulin] 100 UNIT/ML [milliliter-a unit of measure] Inject as per sliding scale [a method of determining a dosage based on a person's current blood glucose level]: if 70 - 150 = 0. If BG [Blood Glucose] under 70, give 0 units, and initiate hypoglycemic protocol, recheck in 30 min [minutes] and notify MD [physician]; if [BG] 151- 200= [give] 2 [units of insulin]; 201- 250= 4; 251-200= 6; 301-350= 8; 351- 400= 10; 401+= 12.before meals and at bedtime for DM.A review of Resident 1's Medication Administration Record (MAR) dated November 2025 indicated on 11/2/25:-At 6:30 a.m. Resident 1's blood glucose level was 317 and he was given 8 units of insulin lispro.-At 11:30 a.m. Resident 1's blood glucose level was 317 and he was given 8 units of insulin lispro.A review of Resident 1's Location of Administration Report dated November 2025 indicated on 11/2/25 at 11:07 a.m. LN 2 administered insulin to Resident 1 at 11:07 a.m. when it was scheduled to be administered at 6:30 a.m. LN 2 also administered a second dose of insulin to Resident 1 at 12:25 p.m. resulting in Resident 1 receiving two doses of insulin within a time frame of 1 hour and 18 minutes.A review of Resident 1's facility document titled .Healthcare Providers-Return to Acute (Unplanned Discharge) dated 11/2/25 at 7:12 p.m., indicated, .Change of Condition.[Resident 1 is] insulin Dependent DM, Received insulin this AM [morning] with breakfast. Nursing team noted [Resident 1] to have AMS [Altered Mental Status]. BS [blood sugar] = 50. Unable to give oral dextrose [glucose gel- over the counter medication to rapidly treat low blood sugar].Intervention attempted: Called 911 for refractory hypoglycemia [a severe, prolonged low blood sugar state that resists standard treatments like consuming sugar; causes include extremely high insulin doses; unlike typical hypoglycemia that resolves quickly, refractory episodes can last for extended periods]