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	02/06/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect one resident (Resident 1) of two sampled residents from physical abuse when Resident 2 bit Resident 1 on the hand.This failure decreased the facility's potential to ensure residents did not experience abuse.Findings:A review of Resident 1's admission record indicated admission to the facility in November 2025 with diagnoses which included diabetes mellitus, difficulty walking, and morbid obesity. A review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 12/30/25 indicated a Brief Interview for Mental Status (BIMS) score of 15 which indicated no memory impairment.A review of Resident 2's admission record indicated admission to the facility in December 2025 with diagnoses which included vascular dementia and anxiety disorder. A review of Resident 2's MDS dated [DATE] indicated a BIMS score of 1 which indicated severe memory impairment.A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR) communication form dated 1/13/26 indicated, [Resident 1 has] bite on the hand by another Res. [Resident 2] .[Resident 1] had a Res. [Resident 2] wander into his room, [Resident 2] was confused/angry .[Resident 2] bit [Resident 1] on the hand .A review of Resident 1's care plan initiated on 1/14/26 indicated, .1/13/26 [Resident 1] has impaired skin integrity as evidenced by a human bite to his R [right] hand and is at risk for: Pain or discomfort, infection .In an interview on 2/6/26 at 1:12 p.m., Licensed Nurse 1 (LN 1) stated she was in the hallway on 1/13/26 when she noticed Resident 2 walking in the hallway in disarray. LN 1 called for a Certified Nurse Assistant (CNA) to help Resident 2 back to his room. The CNA was assisting another resident at the time when LN 1 heard Resident 1 call out, He bit me. LN 1 then ran to Resident 1's room and escorted Resident 2 out of the room and found a CNA to help Resident 2 to his room. When LN 1 returned to Resident 1's bedside and conducted an assessment, she observed obvious bite marks with droplets of blood. LN1 then cleaned the wound, wrapped it loosely, and reassured Resident 1 until he felt comfortable.In an interview on 2/6/26 at 3:40 p.m., Resident 1 stated he was in bed with his head down and feet up when Resident 2 charged toward him and said, I'm going to kill you and I hate you then punched him and bit him.A review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 indicated, Resident have the right to be free from abuse .

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