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	03/11/2026

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	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 observation, interview, and record review, the facility failed to ensure two of six sampled residents (Resident 1 and Resident 2) were protected from abuse and remained free from abuse when:A physical altercation occurred between Resident 1 and Resident 2 during which Resident 2 hit Resident 1 on the face,72-hour monitoring was not completed for Resident 1 and Resident 2 following the change of condition (COC), and;Immediate corrective actions were not implemented.This failure presented a risk of harm to Resident 1 and may have resulted in additional abuse or complications affecting both Resident 1 and Resident 2 after their COC. Cross reference F689. A review of Resident 1's admission record indicated he was admitted to the facility in April 2020 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebrovascular disease (conditions that affect blood flow to the brain), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/23/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 12 which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a COC among the residents) form, dated 2/24/26, indicated Resident 1 and Resident 2 had been involved in a resident-to-resident altercation in the smoking section of the facility. The form indicated, . [Resident 2] then hit him [Resident 1] on the right side of his face. The form indicated no injuries were sustained. A review of Resident 1's progress notes, type, IDT (interdisciplinary team, typically includes the nursing leadership, social services, and medical records) NOTE, dated 2/25/26 at 8:43 a.m., indicated, IDT met to discuss [Resident 1's] involvement in incident with male peer [Resident 2].He [Resident 1] stated male peer [Resident 2] then hit him on the right side of the face.Male peer [Resident 2] reported that [Resident 1] first elbowed him. A review of Resident 2's admission record indicated he was admitted to the facility in February 2026 with medical diagnosis which included paranoid schizophrenia (a chronic mental disorder characterized by intense irrational delusions [false beliefs] and auditory hallucinations [hearing voices]), and systemic lupus erythematosus (a chronic autoimmune disease where the immune system attacks healthy tissue). A review of Resident 2's MDS dated [DATE], indicated his BIMS score was five which indicated his cognition was severely impaired. A review of Resident 2's SBAR form, dated 2/24/26, indicated, Aggressive behavior/punch another resident. A review of Resident 2's progress notes, type, Social Service Note, dated 2/24/26 at 3:07 p.m., indicated, [Resident 2] explains that the other male resident [Resident 1] elbowed him, and that is when [Resident 2] admitted ly hit patient [Resident 1] and states it was self-defense. A review of Resident 3's admission record indicated he was admitted to the facility in January 2025. A review of (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's MDS dated [DATE], indicated his BIMS score was 15, which indicated his cognition was intact. During an interview on 3/10/26 at 11:21 a.m., Resident 2 stated, Maybe, but I don't remember, when asked about the altercation between him and Resident 1. During an interview on 3/10/26 at 12:25 p.m., Resident 1 stated he was outside smoking and Resident 2 approached him and asked for a cigarette and lighter. Resident 1 stated he told Resident 2, no and then Resident 2 hit him on the right side of the face. Resident 1 stated the incident upset him and he wants Resident 2 to stay away from him. Resident 1 stated the incident was witnessed by Resident 3. During an interview on 3/10/26 at 1:24 p.m., Resident 3 stated he witnessed the altercation between Resident 1 and Resident 2. Resident 3 stated Resident 2 asked Resident 1 for a cigarette and lighter. Resident 3 stated Resident 1 said no to Resident 2 and Resident 1 swung up his arm towards Resident 2. Resident 3 stated Resident 2 then hit Resident 1 in the head. During an interview on 3/10/26 at 2:18 p.m., the Social Service Director (SSD) stated she completed follow-up interviews with Resident 1, Resident 2, and Resident 3 regarding the abuse allegation. SSD confirmed that the facility concluded a physical altercation occurred between Resident 1 and Resident 2. During an interview on 3/11/26 at 11:58 a.m., the Director of Nursing (DON) confirmed that the facility concluded physical contact occurred between Resident 1 and Resident 2. The DON verified that it is the facility's responsibility to keep residents free from abuse. The DON further stated staff were not prepared for the interaction that occurred between Resident 1 and Resident 2 in the smoking area. During an interview on 3/11/26 at 1:24 p.m., the Administrator (ADM) confirmed he completed the five-day follow-up investigation report of the abuse allegation between Resident 1 and Resident 2. The ADM confirmed that physical contact occurred between Resident 1 and Resident 2. 2. A review of Resident 1 and Resident 2's progress notes, type, eINTERACT SBAR Summary for Providers, dated 2/24/26 indicated the resident-to-resident altercation occurred during the day shift (AM). A review of Resident 1's progress notes, type Nurse's Note, indicated his COC was monitored on: 2/24/26 during evening (PM) and night (NOC) shift, 2/25/26 and 2/26/26 during AM, PM, and NOC shift, and; There was no evidence that 72-hour (hr.) monitoring post COC was completed on 2/27/26 during AM, PM, and NOC shift. A review of Resident 2's progress notes, type, Nurse's Note, indicated his COC was monitored on: 2/24/26 during PM and NOC shift,2/25/26 during AM and PM shift, with no evidence that 72 hr. monitoring was completed during NOC shift, 2/26/26 during AM shift, with no evidence that 72 hr. monitoring was completed during PM and NOC shift, and;There was no evidence that 72 hr. monitoring post COC was completed on 2/27/26 during AM, PM, and NOC shift. During an interview on 3/10/26 at 4:15 p.m., Licensed Nurse 1 (LN 1) stated nurse staff were expected to evaluate a resident's COC for three days and document every shift [AM, PM, and NOC] with a progress note that summarized the resident's COC and any changes noted. LN 1 stated in the first 72 hr. post COC it was important to assess if changes to the resident, such as further decline or change in psychosis (a mental health condition that involves a mix of cognitive, emotional and behavioral changes), required attention and if changes to care required adjustment. During an interview on 3/11/26 at 11:36 a.m., LN 2 stated any COC required 72 hr. monitoring every shift by nurse staff. LN 2 stated that 72 hr. monitoring was expected to be documented under progress notes as a nursing note. LN 2 stated it was important to monitor the resident for changes the first 72 hrs. post COC because that was the time frame most changes commonly occurred. LN 2 stated it was especially important to conduct 72 hr. monitoring to any residents involved in an abuse allegation to ensure their safety. During a concurrent interview and record review on 3/11/26 at 11:58 a.m., the DON stated she expected 72 hr. monitoring to be completed after a COC. The DON further expected 72 hr. monitoring to be documented every AM, PM and NOC shift by nurse staff. The DON reviewed Resident 1's SBAR dated 2/24/26. The DON confirmed Resident 1's 72 hr. monitoring status post COC was not completed on 2/27/26 for AM, PM, and NOC shifts. The DON reviewed Resident 2's SBAR dated 2/24/26. The DON confirmed Resident 2's 72 hr. monitoring status post COC was not completed on 2/25/26 for NOC shift, and on 2/26/26 for PM and NOC shift, and no 72 hr. monitoring was documented on 2/27/26 for AM, PM, and NOC (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shifts. The DON stated it was important to monitor them [residents] for changes because the chance of changes occurring usually happened within that first 72 hr. period. 3. A review of the facility submitted SOC 341 (the official California Department of Social Services document used by mandated reporters to report suspected elder or dependent adult abuse) form, dated 2/24/26, indicated the altercation between Resident 1 and Resident 2 occurred on 2/24/26 at approximately 12:30 p.m.A review of Resident 2' s care plan initiated on 2/25/26 indicated, [Resident 2] got involved with incident with male peer and hit male peer on right side of face. [Staff were expected to] .continue to monitor smoking area. A review of Resident 2's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/24/26 at 4:04 p.m., indicated, Level of Assistance [check marked as] Independent/supervision not required.IDT [interdisciplinary team] Decision [check marked as] May smoke without supervision. During a concurrent observation and interview on 3/10/26 at 10:45 a.m. in the outdoor smoking area, Resident 2 was observed smoking without supervision. The DON stated Resident 2 did not require supervision and confirmed he was currently unsupervised. During an interview on 3/10/26 at 11:21 a.m., Resident 2 stated he could go outside and smoke on his own. During an observation on 3/10/26 at 12 p.m., Resident 2 was sitting in his wheelchair, unattended in the smoking area. During an interview on 3/10/26 at 1:24 p.m., Resident 3 stated there was a period after the altercation when more staff were outside to supervise but that only happened for, about a day only. Resident 3 further stated, The facility doesn't stick to the rules like they should. During an interview on 3/10/26 at 1:41 p.m., the Activities Director (AD) stated she was made aware of the resident-to-resident altercation that occurred between Resident 1 and Resident 2. The AD stated she was told to supervise the two of them [Resident 1 and Resident 2] when they were outside smoking. The AD further stated, We don't have the manpower to always be outside to supervise the smoking outside of smoking times. The AD stated that staff could not prevent the residents from going outside to smoke outside of the smoking times. During an interview on 3/11/26 at 11:36 a.m., LN 2 stated she was made aware of the resident-to-resident altercation that occurred between Resident 1 and Resident 2. LN 2 stated after the incident, staff were expected to supervise them [Resident 1 and Resident 2] when smoking. LN 2 further stated, Especially since they [Resident 1 and Resident 2] had an altercation while smoking outside. During a concurrent interview and record review on 3/11/26 at 11:58 a.m., the DON reviewed Resident 2's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/24/26 at 4:04 p.m. and confirmed the smoking assessment was completed after the abuse allegation. The DON further confirmed Resident 2's smoking assessment conflicted with the recent abuse allegation and the immediate action of the facility's 5-day summary investigation report. The DON agreed that Resident 2's smoking assessment required reconsideration, and it was not appropriate for Resident 2 to be unsupervised when smoking. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicated, Residents have a right to be free from abuse.Protect residents from abuse.by anyone including.other residents.Ensure adequate staffing and oversight.Protect resident from any further harm during investigations. A review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 2021, indicated, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A review of the facility's document titled, FACILITY REPORTED INCIDENT - 5-DAY FOLLOW-UP INVESTIGATION REPORT, conducted by the facility in response to the alleged resident-to-resident altercation on 2/24/26, indicated, Upon discovery of the allegation, the facility immediately implemented the following protective interventions: COC monitoring initiated.Increased staff supervision in the smoking area.Care plans updated to include.supervised smoking times.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe smoking environment for six out of six sample residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) when:The outside environment accessible to residents was not free from hazards and the door to the maintenance shed was left open and unattended,Adequate supervision was not provided in the smoking section and safe measures were not monitored for the extinguishing of cigarettes, andSmoking care plans were not initiated for Resident 4 and Resident 6.These deficiencies increased the risk of fire hazards and resident exposure to hazardous materials. Additionally, insufficient supervision led to an incident of resident-to-resident abuse and raised other safety concerns such as limited access to assistance, burns, fires, falls, wandering, elopement, exposure to or acquisition of external resources (including contraband), and trespassing. These failures also resulted in unmet care needs and inadequate care planning. Please refer to F600 for further information.Resident 1 A review of Resident 1's admission record indicated he was admitted to the facility in April 2020 with medical diagnosis which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebrovascular disease (conditions that affect blood flow to the brain), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/23/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 12 which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 1's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/24/26 at 3:55 p.m., indicated, Level of Assistance [check marked as] Independent/supervision not required.IDT [interdisciplinary team] Decision [check marked as] May smoke without supervision. A review of a facility policy and procedure (P&P) titled, Smoking Policy- Resident, indicated Resident 1 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 1 on 5/12/22. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 1 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 1 signed and dated the contract on 5/12/22. Resident 2 A review of Resident 2's admission record indicated he was admitted to the facility in February 2026 with medical diagnosis which included paranoid schizophrenia (a chronic mental disorder characterized by intense irrational delusions [false beliefs] and auditory hallucinations [hearing voices]), and systemic lupus erythematosus (a chronic autoimmune disease where the immune system attacks healthy tissue). A review of Resident 2's MDS dated [DATE], indicated his BIMS score was five which indicated his cognition was severely impaired. A review of Resident 2's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/24/26 at 4:04 p.m., indicated, Level of Assistance [check marked as] Independent/supervision not required.IDT Decision [check marked as] May smoke without supervision. A review of a facility P&P titled, Smoking Policy- Resident, indicated Resident 2 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 2's conservator (a court ordered, designated person who manages the financial affairs or personal care of an adult who cannot handle their own responsibilities) on 2/19/26. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 2 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 2's conservator signed and dated the contract on 2/19/2026. Resident 3 A review of Resident 3's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission record indicated he was admitted to the facility in January 2025 with medical diagnosis which included primary osteoarthritis (a chronic degenerative [progressive and irreversible] joint disease) of the right ankle and foot, and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). A review of Resident 3's MDS dated [DATE] indicated his BIMS score was 15 which indicated his cognition was intact. A review of Resident 3's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/11/26 at 12:12 p.m., indicated, Level of Assistance [check marked as] Independent/supervision not required.IDT Decision [check marked as] May smoke without supervision. A review of a facility P&P titled, Smoking Policy- Resident, indicated Resident 3 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 3 on 8/07/25. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 3 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 3 signed and dated the contract on 8/07/25. Resident 4 A review of Resident 4's admission record indicated he was admitted to the facility in October 2025 with medical diagnosis which included COPD, and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). A review of Resident 4's MDS dated [DATE], indicated his BIMS score was 11 which indicated his cognition was moderately impaired. A review of Resident 4's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 1/30/26 at 5:16 p.m., indicated, Level of Assistance [check marked as] Supervision required.IDT Decision [check marked as] May smoke with supervision. A review of a facility P&P titled, Smoking Policy- Resident, indicated Resident 4 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 4 on 10/26/25. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 4 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 4 signed and dated the contract on 10/26/25. Resident 5 A review of Resident 5's admission record indicated he was admitted to the facility in July 2025 with medical diagnosis which included displaced intertrochanteric fracture of right femur (a serious hip fracture involving the pelvis and thigh bone), and history of falling. A review of Resident 5's MDS dated [DATE], indicated his BIMS score was 11 which indicated his cognition was moderately impaired. A review of Resident 5's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 2/03/26 at 9:08 a.m., indicated, Level of Assistance [check marked as] Supervision required.IDT Decision [check marked as] May smoke with supervision. A review of a facility P&P titled, Smoking Policy- Resident, indicated Resident 5 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 5's responsible party (RP) on 7/31/25. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 5 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 5's RP signed and dated the contract on 7/31/25. Resident 6 A review of Resident 6's admission record indicated she was admitted to the facility in December 2025 with medical diagnosis which included Colles fracture of left radius (a fracture of the wrist) and repeated falls. A review of Resident 6's MDS dated [DATE], indicated her BIMS score was 15 which indicated her cognition was intact. A review of Resident 6's document titled, NURSING- SMOKING OBSERVATION/ASSESSMENT V2.0, dated 12/22/26 at 2:15 p.m., indicated, Level of Assistance [check marked as] Independent/supervision not required.IDT Decision [check marked as] May smoke without supervision. A review of a facility P&P titled, Smoking Policy- Resident, indicated Resident 6 understood the rules and regulations of smoking at the facility. The P&P was signed and dated by Resident 6 on 1/13/26. A review of a facility document titled, RESIDENT SMOKING CONTRACT, indicated Resident 6 acknowledged the smoking rules and agreed to follow and abide by the smoking contract. Resident 6 signed and dated the contract on 1/13/26. 1. During an observation on 3/10/26 at 10:45 a.m., the smoking area was located outside at the back of the facility. The smoking area was observed to be a covered, shaded space that measured approximately 10 feet (ft- a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unit of measure) by 10 ft with no marked parameter and open to the back parking lot. The smoking section contained one table, one wooden chair, one standing cigarette butt receptacle, and one carpet mat measuring approximately 3 ft x 4 ft. During an observation on 3/10/26 at 11:18 a.m., in and around the smoking area, numerous cigarette butts were scattered on the ground under the shade structure. Approximately 10 - 12 ft past the shade structure appeared to be a maintenance shed. Observed between the maintenance shed and the smoking section were approximately 10 empty to full card board boxes [scattered], a tarped card board box on a pallet, a large table covered with a tarp with broken furniture pieces, pallets, empty boxes, and random articles of debris on top, and wood pallets, wood slabs, and a plastic crate with two spray bottles and one plastic bottle that appeared to contain cleaning solution, and more debris under the table. The area also contained two overfilled garbage bins, one with bagged garbage, and one with broken down cardboard boxes, a rusty shovel, and a flat screen television leaning against the shed. Dry leaves and fallen tree twigs and debris covered the surrounding, unpaved ground. One of the four observed shed doors adjacent to the smoking area was found open and unattended. The room accessible through this door contained maintenance supplies, tools, chemical solutions, aerosols, documentation, broken equipment, and several glass fluorescent tube lights. The inside of the maintenance shed was also in disarray. The back room had no clear walking path and was cluttered with approximately 14 cardboard boxes of glass fluorescent tube lights and approximately six of those boxes were left open. During a concurrent interview and observation on 3/10/26 at 11:38 a.m., Resident 4 was seated in his wheelchair and smoking outside just past the exit/entrance door to the smoking area. Resident 4 confirmed that there were cigarette butts all over the ground. Resident 4 further stated that not everyone put their cigarettes out in the ashtray (cigarette butt receptacle). Resident 4 looked towards the maintenance shed and stated, Yeah, there is a bunch of junk back there. During a concurrent interview and observation at 3/10/26 at 11:43 a.m., Certified Nurse Assistant 1 (CNA 1) observed the smoking section and stated, There are boxes everywhere. It looks like trash. CNA 1 confirmed there was a rug on the ground under the shade structure and that cigarette butts were everywhere on the ground. CNA 1 further stated, That can be a fire hazard- it's not safe. During a concurrent interview and observation on 3/10/26 at 11:51 a.m. outside the facility with the Activities Director (AD), she stated the shed behind the smoking section was for maintenance and housekeeping. AD confirmed there were cardboard boxes and various items left outside of the shed and close to the designated smoking area. During a concurrent interview and observation on 3/10/26 at 11:55 a.m. outside with Life Safety/Housekeeping Director (HD), he confirmed the smoking area was in close vicinity to the housekeeping and maintenance shed. The HD also confirmed there were empty and full cardboard boxes left outside, dry wood pallets, and random debris in the surrounding area. Subsequently, the door to the maintenance shed was left open, and the HD confirmed the front door to the maintenance shed should be closed and locked for resident safety. The HD further confirmed that the maintenance shed was hazardous. The HD confirmed that aerosol items (pressurized propellants like butane, isobutane, or propane [all three are liquified gases], along with flammable active ingredients; they pose significant fire hazards), notably two cans of [brand name of aerosol spray] and four cans of [brand names of aerosol sprays], were stored inside the maintenance shed by the entrance. The HD stated the protocol was for flammable items to be kept in the back of the shop [maintenance shed]. The HD opened the locked housekeeping shed [directly attached to the left side of the maintenance shed] which housed several cleaning solutions and boxes of hand sanitizer containing ethyl alcohol [ethyl alcohol is known to be highly flammable and poses a significant fire risk]. The HD further acknowledged the two garbage bins outside and confirmed the two bins were overflowing. The HD stated, It's [the garbage bins] a hazard for infection control reasons. It can draw insects and animals, and they should be dumped. The HD verified that cigarette butts were scattered on the ground. The HD further stated a resident (no name mentioned) dumped the ashtray. During an observation on 3/10/26 at 12:25 p.m., outside in the smoking area, Resident 5 was overheard telling the AD, Wow, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they finally swept out here! During an interview on 3/10/26 at 1:24 p.m., Resident 3 stated the condition of the smoking area was dirty. Resident 3 stated today was the second time they [facility staff] swept the ground in weeks. Resident 3 further stated, They only swept it today because you are here. Resident 3 stated that Resident 2 made it worse because he shook the cigarette butts out of the ashtray. Resident 3 further stated, But it's always a mess out there, and confirmed that the cigarette butts on the ground bothered him. Resident 3 stated, It's terrible! Resident 3 further stated that other residents threw their cigarette butts on the ground and it could be a fire hazard. Resident 3 stated, It [smoking area and surrounding area] kind of looks like a dump yard. During an interview on 3/10/26 at 2:07 p.m., the HD stated the floor technician, housekeeping or his assistant were responsible for cleaning and maintaining the smoking and surrounding area once a week. The HD stated his expectation was that the leaf blower be used, rocks removed from the area, and that trash was collected and disposed of properly. The HD stated there was no log to document when and who completed these tasks. During an interview on 3/10/26 at 2:50 p.m., Resident 5 stated the outside smoking area looked like a storage area. Resident 5 stated, It's a mess, but I've learned to live with it. Resident 5 further stated when it was raining outside, residents did not go where they should and they just threw their cigarette butts on the floor. During an interview on 3/11/26 at 1:24 p.m., the Administrator (ADM) stated his expectation for the upkeep of the facility grounds and the facility was to maintain it in a way that was presentable, safe, and functionable. The ADM stated once a day a housekeeper was expected to go outside and check for debris and miscellaneous items. The ADM stated he expected areas to be maintained and free of hazards. The ADM was offered to review the photographs taken of the outside grounds upon the abbreviated survey entrance, and he declined. The ADM further stated, No, I believe you. The ADM stated that the back area by the maintenance shed and smoking section could be a hazard if it caught on fire. 2a. A review of Resident 2's progress notes, type, Social Service Note, dated 2/24/26 at 3:07 p.m., indicated, [Resident 2] was outside in the smoking area. [Resident 2] explains that the other male resident [Resident 1] elbowed him, and that is when [Resident 2] admitted ly hit patient [Resident 1] and states it was self-defense. A review of Resident 2's progress notes, type IDT (interdisciplinary team, typically includes the nursing leadership, social services, and medical records) NOTE, dated 2/25/26 at 8:13 a.m., indicated, IDT met to discuss [Resident 2] involvement in incident with male peer [Resident 1] .Will.continue to monitor residents when smoking. A review of Resident 2' s care plan initiated on 2/25/26 indicated, [Resident 2] got involved with incident with male peer [Resident 1] and hit male peer [Resident 1] on right side of face. [Staff were expected to] .continue to monitor smoking area. A review of Resident 1' s care plan initiated on 2/25/26 indicated, [Resident 1] got involved with incident with male peer [Resident 2] stating that the male peer [Resident 2] hit him on right side of face. [Staff were expected to] .continue to monitor smoking area. During an observation and concurrent interview with the DON on 3/10/26 at 10:45 a.m., Resident 2 and Resident 3 were observed sitting in their wheelchairs smoking unsupervised in the smoking area. Resident 3 was smoking in the parking lot past the first row of cars. Resident 2 was smoking under the shaded area of the smoking area. The Director of Nursing (DON) stated Resident 2 and Resident 3 did not require supervision, and she confirmed they were currently unsupervised. During a concurrent interview and observation on 3/10/26 at 11:21 a.m. with Resident 2, he stated he could go outside and smoke on his own. Resident 2 was observed with two small holes in the front of his coat. Resident 2 stated the holes were from a burning cigarette. Resident 2 stated he did not remember when it happened. Resident 2 further stated, It went out on its own. Resident 2 verified he was alone when it happened. During an observation on 3/10/26 at 12 p.m., Resident 2 was sitting in his wheelchair, unsupervised in the smoking section. During an interview on 3/10/26 at 1:24 p.m., Resident 3 stated there was a period after the altercation [between Resident 1 and Resident 2] when more staff were outside to supervise but that only happened for about a day only. Resident 3 further stated, The facility doesn't stick to the rules like they should. 2b. During a concurrent observation and interview on 3/10/26 at 11:38 a.m., Resident 4 (continued on next page)

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	055854	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Post Acute	4650 Hoen Avenue Santa Rosa, CA 95405

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was smoking outside unsupervised, seated in his wheelchair just past the exit/entrance door to the smoking section. Resident 4's legs were both wrapped in kerlix gauze (100% woven cotton; should be kept away from open flames and sparks) from the ankles to the knees. Resident 4 stated he can keep his own cigarettes and lighter, and that he can go outside to smoke anytime he wanted unsupervised. Resident 4 stated that he was upset, and further stated, A CNA brought me outside to smoke and left me in the sun. I'm wearing a jacket and it's hot out here! I need help and this is where he left me. Resident 4 stated that since his legs have been wrapped, he can't help himself and required assistance. Resident 4 was observed putting his lit cigarette out with his right-hand fingers and put the cigarette butt in the pocket of his coat. Resident 4 stated he will put the cigarette out with his hand if he is not by the ashtray, or he will flick it. Resident 4 asked for assistance to turn his wheelchair and to open the door since he was unattended and could not do it independently. 2c. During an observation on 3/10/26 at 12:25 p.m., Resident 1 was smoking in the smoking section in attendance of the AD. Resident 1 was observed with what appeared to be a plastic cup holder attached to his wheelchair near his thigh. Resident 1 flicked his cigarette into the attached plastic cup holder. The inside of the plastic cup holder was coated with ash. During an observation on 3/10/26 at 2 p.m. in the activities room, Resident 1 was observed with two cigarette butts inside the plastic cup holder attached to his wheelchair. During an interview on 3/10/26 at 11:43 a.m., CNA 1 stated there were set smoking times and supervision was provided by the activities department. CNA 1 stated that supervision should be provided to all residents who wanted to smoke and that residents should not be by themselves while smoking. During an interview on 3/10/26 at 11:50 a.m., the DON stated some residents did not require supervision to smoke. The DON further stated, There are independent smokers and they will not follow the smoking schedule. The DON stated it was facility policy that they [residents who smoke] adhered to smoking times. During an interview on 3/10/26 at 11:51 a.m., the AD stated smoking times with supervision were 9 a.m., 11 a.m., 2 p.m., and 4:30 p.m. The AD further stated there are not enough staff to always supervise smoking times. During an interview on 3/10/26 at 1:41 p.m., the AD stated that Resident 1 and Resident 2 were unsupervised when the resident-to-resident altercation between them occurred. The AD stated she was told to supervise the two of them [Resident 1 and Resident 2] when they were outside smoking. The AD further stated, We don't have the manpower to always be outside to supervise the smoking outside of smoking times. The AD stated that staff could not prevent the residents from going outside to smoke outside of the smoking times. The AD stated to her knowledge, Resident 1 had a cup holder attached to his wheelchair. The AD further stated, He should not be putting cigarettes out in the cup holder because it's plastic. It could be flammable, and he could burn himself. During an interview on 3/11/26 at 11:36 a.m., LN 2 stated she was made aware of the resident-to-resident incident that occurred between Resident 1 and Resident 2. LN 2 stated after the incident, staff were expected to supervise them [Resident 1 and Resident 2] when smoking. LN 2 further stated, Especially since they [Resident 1 and Resident 2] had an altercation while smoking outside. During a concurrent interview, and record review on 3/11/26 at 11:58 a.m., with the DON, safety concerns were discussed and the DON stated that staff were not prepared for the interaction that occurred between Resident 1 and Resident 2 in the smoking area. The DON further stated, Everything we do can have safety concerns. The DON stated if a resident could not wheel himself back into the facility, then the resident should not be outside unsupervised. When asked how unsupervised residents accessed assistance when outside, the DON stated residents could yell for help. No other examples were provided by the DON. The DON stated, Residents who require supervision, they have to be supervised by staff. The DON further stated some residents were self-determined and they did what they wanted. The DON confirmed that the facility smoking rules were not enforced. The facility documents that pertained to the residents' smoking contracts, smoking policy, and zero tolerance were concurrently reviewed and conclusively the documents indicated that the residents agreed to smoking during the set smoking times. The DON confirmed that was the expectation. The DON stated after hours, residents were not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allowed to go outside to smoke but they did. The DON confirmed that residents who smoked went outside at any hour of the night. The DON verified and addressed that some safety concerns included residents obtaining contraband or prohibited items, risk for fires, and falls. The DON stated she was not aware that Resident 1 utilized his cup holder attached to his wheelchair as an ashtray. The DON confirmed it was not allowed, and stated, Well, it can be a fire hazard. The DON confirmed that supervision was required for Resident 4 while smoking. The DON stated Resident 4 was not ambulatory and required assistance to get back into the building. The DON confirmed that Resident 4 should not have been left outside unsupervised. The DON further confirmed that it was not safe to extinguish cigarettes with the fingers and it was not appropriate to put cigarette butts inside pockets of clothing. The DON stated that practice could harm the residents, and it was a fire hazard. 3. A review of Resident 4's care plan report indicated no evidence that a smoking care plan was initiated. A review of Resident 6's care plan report indicated that a smoking care plan was initiated on 3/10/26 [during the abbreviated survey]. The care plan indicated, Smoking: [Resident 4] is a smoker and is at risk for smoking related injury r/t [related to] .noncompliance with smoking times. There was no evidence that a smoking care plan was initiated prior to the abbreviated survey. During an interview on 3/10/26 at 11:51 a.m., the AD stated per policy, if the residents were independent and did not require supervision, they could smoke unsupervised as long as it was care planned. During an interview on 3/11/26 at 11:36 a.m., LN 2 stated care plans planned the care for the residents. LN 2 stated care plans provided information about resident monitoring and the plan of action. LN 2 provided an example and stated that a resident should be assessed if he/she was safe to use and keep a lighter. LN 2 stated if the resident dropped the lighter and another resident found it and was confused; it could be a safety issue. LN 2 further stated, This is why care plans are important. During a concurrent interview and record review on 3/11/26 at 11:58 a.m., the DON reviewed Resident 4's care plan report and confirmed his smoking status was not care planned. The DON stated, Without the care plan, staff don't know that he [Resident 4] is a smoker and that he needs supervision to go outside. The DON further stated the purpose of the care plans was, So staff are aware of residents needs and plan of care. The DON confirmed that she expected a resident's smoking status to be care planned within seven days of admission. The DON further stated a resident's care plan was a growing document throughout the resident's admission. The DON reviewed Resident 6's care plan report and confirmed her smoking status was not care planned within seven days of admission. A review of the facility's P&P titled, Safety and Supervision of Residents, revised in 2017, indicated, Our facility strives to make the environment as free from accident hazards as possible.Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Safety risks and environmental hazards are identified on an ongoing basis.Resident supervision is a core component of the system approach to safety. A review of the facility's P&P titled, Maintenance Service, revised in 2009, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable condition.Functions of the maintenance personnel include.maintaining the building in good repair and free from hazards.maintaining the grounds.in good order.Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. A review of the undated facility's document titled, Job Description: Maintenance Director, indicated, The primary purpose of your job position it to.assure that our facility is maintained in a safe and comfortable manner.Inspect storage rooms, workrooms, utility/janitorial closets, etc., for upkeep.Supervise safety and fire protection and prevention programs by inspecting work areas . A review of the undated facility's document titled, Job Description: Housekeeper Prepared, indicated, Define the roles and responsibilities of the Housekeeper.the purpose is to maintain a safe, orderly, and clean environment free of obstacles.Maintain all public and common areas. A review of the undated facility's document titled, [Name of company] Safety Data Sheet Spectrum Advance Hand Sanitizer Gel, indicated, FLAMMABLE LIQUIDS.and vapor.Keep away from heat/sparks/open flames.No smoking. A review of the facility's P&P titled, Smoking Policy-Residents, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised in 2023, indicated, This facility.maintains safe resident smoking practices.Any resident with smoking privileges requiring monitoring shall have the supervision of a staff member, family member, visitor, or volunteer worker while smoking.Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco. expect under supervision.residents who are currently allowed to smoke will be provided an area to smoke which maintains the quality of life and safety for smoking residents. A review of the undated facility's P&P that was provided to, signed and dated by the smoking residents, titled, Smoking Policy-Residents, indicated, Any smoking related privileges, restrictions, and concerns [for example, need for close monitoring] shall be noted on the care plan.Smoking times will be 9:00 AM, 11:00 AM, 2:00 PM and 5:00 PM.Residents with smoking privileges may not have or keep any smoking articles.outside of designated smoking times.By signing this agreement, I understand the rules and regulations of smoking at [name of facility]. If I violate these rules and regulations, I will not be privileged to smoke on the facility premises. A review of an undated facility document titled, RESIDENT SMOKING CONTRACT, indicated, I agree to the designated smoking times as stated in the Smoking Policy.I understand if I violate this contract, I forfeit my privilege to smoke and my actions could result in discharge from the facility. A review of an undated facility document titled, CURRENT SMOKERS ROSTER, indicated, Location: Smoking area is in back parking lot in designated smoking area .Supervised smoking times: 9 A.M., 11 A.M., 2 P.M., 4:30 P.M. A review of the facility's P&P titled, Care Plans, Comprehensive Person Centered, revised in 2022, indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment, and no more than 21 days after admission.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.reflects currently recognized standards of practice for problem areas.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. A review of the undated facility's document titled, Job Description: Registered Nurse (RN), indicated, Participate in the development of a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care.Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs.