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	09/12/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete performance reviews (formal meetings where a supervisor evaluates an employee's job performance, providing feedback and setting goals for the future) for more than 12 months for three out of three randomly selected Certified Nursing Assistants (CNAs also known as nurse aides).This failure can prevent identification of skill gaps leading to decline in quality of care. Findings:During a concurrent interview and records review of competency evaluations of five randomly selected staff on 9/12/2025 at 11:18 AM, the DSD confirmed the most recent performance evaluations were more than a year ago as follows:1. CNA Q's last competency was on 4/2/23,2. CNA R's last competency was 4/1/23 3. CNA S' last competency was 4/1/23The DSD stated staff competency reviews should be conducted annually so that staff remain competent and able to provide proper care for the residents. During a review of the State Operations Manual (SOM) Appendix PP - Guidance to Surveyors for Long Term Care Facilities revision 232, Issued on 7/23/25, Code of Federal Regulations (CFR) Tag F730 S483.35(e)(7) for Regular in-service education, the CFR indicated, .The facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews.

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on interviews and record reviews, the facility failed to ensure sufficient staff members possessed the basic competencies and skills sets to meet the behavioral health needs of residents with mental disorders and those with a history of trauma and/or post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) as reflected in the facility assessment, when: 1. 12 Certified Nursing Assistants (CNAs - also known as nurse aides) did not receive training related to the care of residents with dementia (a progressive state of decline in mental abilities), 2. CNA D was allowed to start work without a competency check (a process that evaluates an individual's knowledge, skills, and abilities to perform a specific role or task effectively) completed, and3. 32 CNAs did not receive training related to the care of residents with a history of trauma and/or PTSD. These failures could result in an inability to provide quality care to residents with mental disorders and a history of trauma.Findings: During an interview on 9/11/2025 at 4:08 PM, the Director of Staff Development (DSD) stated she had been in her role since November of 2024 but did not know how many staff had completed mandatory Dementia trainings. The DSD stated she could not provide documentation that the Dementia training had been provided to and completed by staff. During continued interview on 9/11/2025 at 4:23 PM, the DSD stated staff are required to complete continuing education to ensure they are competent to do their job. During a concurrent interview and record review on 9/12/2025 at 10:08 AM, with the DSD, 12 CNA personnel folders (for CNA D, CNA E, CNA F, CNA G, CNA H, CNA I, CNA J, CNA K, CNA L, CNA M, CNA N, CNA O) did include a signed acknowledgement of dementia training being provided or completed. During a concurrent interview and record review on 9/12/2025 at 10:22 AM, CNA D's competency check list, dated 9/2/25, was reviewed. The DSD confirmed the competency check list was not marked/filled out to identify the specific competencies CNA D had satisfactorily passed or completed. The DSD confirmed that CNA D was working with residents of the facility. During a review of a facility record titled, Facility Inservice, on Dementia and PTSD: Managing difficult and challenging behaviors for CNAs, dated 6/19/25, indicated 29 of 61 CNAs signed and attended the training. No other in-service training on PTSD was provided for other staff. During a review of the facility assessment, updated and reviewed on January 2025, the assessment indicated the facility resident profile included residents with memory problems, PTSD, and dementia. The facility assessment also indicated the facility offered services and care for those with memory problems, and care of individuals with trauma/PTSD. Staff training and competencies included required in-services training for nursing aides on dementia management and competency training on caring for residents with mental and psychosocial disorders, as well as resident with a history of trauma and/or post-traumatic stress disorder. During a review of the resident matrix (a tool for nursing homes to document residents and their care needs), for dates 9/9-9/12/25, indicated the facility had a total of 96 residents, with 37 residents diagnosed with Alzheimer's (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline)/dementia and 7 residents with a history of PTSD/Trauma.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored in a safe and sanitary manner for a census of 98 residents who received food prepared from the kitchen, when:1. Four containers of spices past their use-by date labels were found available for use on the kitchen shelf;2. Staff cleaning dishes touched cleaned dishes with dirty gloves;3. Dish machine sanitizing solution was not at the required concentration levels.These failures decreased the facility's potential to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.Findings:1. During a concurrent observation and interview on 9/9/25 at 11:17 a.m. with the [NAME] (CK 1) in the kitchen, four containers of spices were observed on the kitchen shelf past use by dates (Ground Nutmeg with use-by date of 7/27/25, Rubbed Sage with use-by date of 7/5/25, Ground [NAME] with use-by date of 7/5/25, and Poultry Seasoning with use by-date of 8/24/25). CK 1 confirmed that the spices had expired. During an interview on 9/11/25 at 2:54 p.m. with Registered Dietitian (RD 1), RD 1 confirmed that spices should not be stored in the kitchen past their use-by date and should be discarded. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised November 2022, the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. 2. During a concurrent observation and interview on 9/11/25 at 9:39 a.m. with Dietary Supervisor (DS) near the kitchen's dishwashing area. Dietary Aide (DA 1) was observed using the dish machine to wash the dishes. DA 1 assembled, touched, and prepared dirty dishes on one side of the machine. When the dish machine cycle was over, DA 1 used the same gloves to push clean dishes over to the clean side of the machine. DS confirmed the observation and stated that DA 1 needed to perform hand hygiene before moving to the clean side or touching clean dishes. 3. During a concurrent observation and interview on 9/11/25 at 10:19 a.m. with DS in the kitchen. The Dish Machine was observed in active use and connected to a chlorine container stored at the bottom. DS performed a sanitizing chemical test by using chlorine test strips. DS dipped the test strip in the solution at the bottom of the dish machine and compared it to the indicator on the test strip container. The test strip did not change color [indicating that the sanitizing chemical was not present at detectable levels]. A sign posted on the wall indicated that the solution must be at 100 ppm [parts per million, unit of concentration]. DS stated that the solution was not at the correct concentration.During an interview on 9/11/25 at 2:54 p.m. with the RD 1, RD 1 confirmed that staff should perform hand hygiene when moving from dirty to clean dishes. RD 1 further stated that staff should test the dish machine sanitizing solution, and she expected it to be at appropriate concentrations to sanitize the dishes. A review of the facility's policy and procedure (P&P) titled, Dishwashing Machine Use, dated 07/2018, the P&P indicated, Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine. Wash hands before handling clean dishes. Dishwashing machine chemical sanitizer concentrations and contact times will be as follows. Chlorine 50-100ppm 10 seconds.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews and record reviews, the facility failed to ensure they had an effective pest control program for all residents of the facility when there were flies inside the facility.This failure put the residents at risk for the possible spread of infections.Based on observation, interviews and record reviews, the facility failed to ensure they had an effective pest control program for all residents of the facility when there were flies inside the facility.This failure put the residents at risk for the possible spread of infections.Findings:During an interview on 09/09/2025 at 12:07 PM, Resident 82 had a fly hovering around her food but landed on her blanket. Resident 82 stated there had been a lot of flies in the facility which upset her because she thought flies were unsanitary, especially when they land on food. Resident 82 stated whatever the facility was doing to eliminate the flies were not effective. During an observation on 9/9/25 at 2:36 P.M., 2 flies were flying around Resident 73 and both ultimately landed on his blanket.During an interview on 09/09/2025 PM at 2:49 P.M., there were 3 flies noted hovering over Resident 73, 2 had landed on his blanket and 1 landed on his LAL control unit. Resident 73 stated there were lots of flies in the facility and they irritate him especially when they land on his food. During an interview on 09/09/2025 at 2:51 PM, Resident 45 noted there was a fly buzzing around him. Resident 45 stated he noticed there were more flies these past few days. Resident 45 stated it was gross when the flies touch their food and stated it was very unsanitary. Resident 45 stated he thinks the facility could be better in flies in the facility. During an interview on 09/11/2025 at 9:38 AM, the Infection Preventionist (IP) stated she had heard reports of flies in the facility. The IP stated it was not acceptable to have flies in the facility as they can contaminate food when they land on it. The IP stated flies were not supposed to be in the facility as it was an infection control issue and could get the resident's sick.During an interview on 09/11/2025 at 11:48 AM, Licensed Nurse (LN) C stated had witnessed flies in the facility. LN C stated it was the facility's responsibility to ensure there were no flies in the facility as they put the residents at risk of getting sick.During an interview on 09/12/2025 at 8:20 AM, the Maintenance Director (Maint Dir) stated he had received reports that flies were seen in the facility. The Maint Dir stated flies should not be in the facility because it could make the residents sick. The MD stated one of the recommendations from the facility's pest exterminator was to have a blowing fan on the doors that would push out flies when they try to enter the facility. The Maint Dir acknowledged the facility has not implemented the pest exterminator's recommendation. During an interview on 09/12/2025 at 10:11 AM, the Minimum Data Set coordinator (MDSC) stated it was the facility's responsibility to ensure there were no flies inside the facility. The MDSC stated having flies inside the facilities could be an indication the facility's pest control management was ineffective. During an interview on 09/12/2025 at 1:18 PM, LN C stated having flies inside the facility indicate the facility's pest control system was ineffective.A review of the facility's policy and procedure (P&P) titled Pest Control, revised 5/2008, the P&P indicated, .our facility should maintain an effective pest control program.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record reviews, the facility failed to ensure a written summary of the baseline care plan (BCP, a document created within 48 hours of a resident's admission, outlining the initial care needed, focusing on basic needs and resident-specific information) was provided to the resident and/or the responsible party (RP, a person who is designated in making decisions about health care and financial matters) for two out of five sampled residents (Residents 31 and Resident 82) when no documented evidence that the BCP summary was provided.This failure could compromise residents' safety, hinder effective communication, and could lead to adverse events, especially during the critical initial days of admission.Findings: A review of Resident 31's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 7/2025 with a diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and muscle weakness.A review of Resident 31s Baseline Care Plan Person-Centered Care Planning form-V3, dated 7/24/25, did not indicate the printed BCP summary was provided to the resident or the RP.A review of Resident 82's face sheet indicated an admission date of 3/2024 with a diagnosis of Multiple Sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and muscle weakness.A review of Resident 31s Baseline Care Plan Person-Centered Care Planning form-V3, dated 3/5/24, did not indicate the printed BCP summary was provided to the resident or the RP.During a concurrent interview and record review on 09/11/2025 at 11:08 AM, Residents 31's and Resident 82's BCP Person-Centered Care Planning form-V3 was reviewed with the Social Services Director (SSD). The SSD stated she was part of the team that creates a BCP along with nursing and rehabilitation services. The SSD verified that based on Residents 31's and Resident 82's BCP Person-Centered Care Planning form-V3 documentation, there was no indication the BCP summary was provided to the resident and or the RP. The SSD stated BCP summary should be given to the residents and or the RP. The SSD stated it was important that residents and or the RP were aware of what care they will be receiving at the facility.During a concurrent interview and record review on 09/11/2025 at 11:30 AM, Residents 31 and 82s BCP Person-Centered Care Planning form-V3 was reviewed with the Minimum Data Set Coordinator (MDSC) A. The MDSC A verified the BCP summary was not provided to Residents 31 and 82 nor to their RPs. The MDSC A stated it was important to provide the BCP summary to RP and the residents per facility policy so they know the residents' plan of care that they were going to be receiving at the facility, to provide safe care and prevent miscommunication.A review of the facility's policy and procedure (P&P) titled Care Plans-Baseline, revised 3/2022, the P&P indicated, . resident and or representative are provided a written summary of the baseline care plan.provision of the summary to the resident and or resident representative is documented in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure one out of twenty sampled residents (Resident 28) was provided the Restorative Nursing Assistant Program (RNA-P, a program which provides exercise and a range of motion activities to the residents), when Resident 28's physician's orders, person-centered care plan, and resident's choice to participate in the RNA-P was not being followed.This failure had the potential to result in Resident 28's decline in physical abilities and decreased muscle strength.Findings:A review of Resident 28's admission record indicated he was originally admitted to the facility in November 2023 with diagnoses including lung disease and the absence of right leg, below the knee. A review of Resident 28's Minimum Data Set (MDS- a federally mandated assessment tool), dated 8/22/25, indicated Resident 28 had an ability to express ideas and wants.A review of Resident 28's Care Plan Report, dated 12/8/23 with no resolved date, titled Restorative Nursing- Range of Motion indicated, RNA PROGRAM FOR AROM [active range of motion] BUE [bilateral upper extremity] RESISTIVE EXERCISE 3x15 for each exercise. Encourage to engage in UE [upper extremity] exercises for bicep/triceps curls, chest press, and overhead press as tolerance. May also engage in omnicycle [exercise equipment] for BUE at level 1-2 for approx. [approximately] 15 minutes. MWF [Mondays, Wednesdays, and Fridays]. A review of Resident 28's Order Summary Report, for active orders, indicated RNA PROGRAM FOR AROM BUE RESISTIVE EXERCISE 3x15 for each exercise. Encourage to engage in UE exercises for bicep/triceps curls, chest press, and overhead press as tolerance. May also engage in omnicycle for BUE at level 1-2 for approx. 15 minutes. every day shift every Mon, Wed, Fri.A review of Resident 28's Nursing - RNA Weekly Summary/Restorative Progress Notes, dated 7/20/25, the Restorative Nursing Assistant (RNA) documented we just see him twice this week, resident do bicycle and no complain of pain. During an observation and interview on 9/9/25 at 4 p.m., with Resident 28 in his room, Resident 28 voiced concerns that he was no longer getting RNA-P. He stated he does not know why it stopped; he was going three days a week and was doing well. Resident 28 said he liked going to the activity outings and wanted to be strong enough to participate. During a concurrent interview and record review on 9/12/25 at 10:40 a.m., with Director of Staff Development (DSD), DSD stated she is responsible for the RNA-P, and for scheduling the RNA staff meetings to review the residents' progression. DSD said meetings had not been scheduled in a while. DSD presented a spreadsheet named RNA Program - January 2025, with 32 residents listed, including Resident 28, for Active and Passive ROM [range of motion] for BLE [bilateral lower extremity] and BUE, scheduled for Mondays, Wednesdays, and Fridays. DSD said this was an old list and acknowledged she did not have current spreadsheets, or meeting notes. The DSD confirmed there was no physician's order to discontinue Resident 28's RNA-P. DSD stated it was important to have an accurate rehabilitation treatment care plan for residents to maintain their level of mobility. During a concurrent interview and record review on 9/12/25 at 2 p.m., with Director of Nursing (DON) and RNA, DON and RNA acknowledged Resident 28 had not been evaluated since 7/20/25, and meetings had not been scheduled. They both confirmed Resident 28 started the RNA-P in December 2023, and there were no physician's orders to end the program. DON and RNA stated the RNA-P was important to prevent decline, continue mobilization, and prevent contractures (a condition in which muscles and tissues become abnormally tight, restricting movement. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, revised July 2017, the P&P stipulated, Residents will receive restorative nursing care.to help promote optimal safety and independence.Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. 4. The resident.will be included in determining goals and the plan of care. 5. Restorative goals may include,.maintaining or strengthening his/her physiological and psychological resources; c. maintaining his/her dignity, independence and self-esteem; and d. participating in the development and implementation of his/her plan of care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interviews and record reviews, the facility failed to ensure adequate pain relief for one out of 20 sampled residents (Resident 45), when using a numeric pain rating scale where 0 as no pain, 1 to 3 as mild pain, 4 to 6 as moderate pain, and 7 to 10 as severe pain, Resident 45 complained of moderate to severe pain daily.This failure resulted in Resident 45 feeling frustrated and complaining of lack of quality of life.Findings:A review of Resident 45's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in June 2025 with a diagnosis of fracture of unspecified part of neck of left femur (a break in the part of the left thigh bone just below the hip joint) and pain due to internal orthopedic prosthetic devices (an artificial replacement part for the body), implants (devices or tissues that are placed inside or in the body) and grafts (skin or bone cut from one part of a person's body or other source and used to repair a damaged part).A review of Resident 45's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 7/31/25, indicated Resident 45 had intact cognition (a person has healthy mental functions, including sufficient judgment, memory, planning, and problem-solving abilities to manage daily life). A review of Resident 45's Nursing Pain Observation Assessment, dated 6/3/25, indicated Resident 45 experienced frequent aching, stabbing pain on his hips and pain that affects his sleep, rest, social activities, physical activities and mobility.A review of Resident 45's Physician Order Summary (a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive), for active order as of 9/11/25, indicated Resident 45 was receiving: Acetaminophen (a medication that can be used to treat pain) 325 milligram (mg, a unit of measurement) 2 tablets by mouth (po) every 6 hours as needed (prn) for mild pain, and hydromorphone hydrochloride HCL(a medication used to treat pain) 2 mg 1 tablet po every 4 hours prn for moderate to severe pain (5-10).A review of Resident 45's Electronic Medication Administration Record (EMAR, a digital system used to track and document the administration of medications, ensuring accuracy and timeliness in medication delivery) for 8/2025 indicated: Resident 45 received hydromorphone HCL daily, as often as 5 times a day, Resident 45 reported experiencing severe pain on 8/1/25, 8/4/25, 8/5/25, 8/9/25, 8/10/25, 8/11/25, 8/12/25, 8/13/25, 8/14/25, 8/16/25, 8/17/25, 8/22/25, 8/23/25, 8/24/25, 8/28/25, 8/29/25 and 8/31/25. Resident 45 reported on 8/22/25 a pain level of 8 out of 10 and the hydromorphone HCL was ineffective, however, there was no indication an alternative medication was provided to Resident 45 for pain relief. Resident 45 reported on 8/7/25, 8/23/25, and 8/31/25 severe pain but was administered acetaminophen (ordered for mild pain)A review of Resident 45's EMAR, for 9/2025, indicated: Resident 45 continued to receive hydromorphone HCL daily, as often 5 times a day, and Resident 45 continued to report experiencing severe pain on 9/3/25, 9/4/25, 9/5/25, 9/7/25 9/9/25 and 9/10/25.A review of Resident 45's care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) titled discomfort due to: status post [s/p, after] left hip arthroplasty [surgical reconstruction or replacement of a joint] with surgical wound to left thigh. dated 6/4/2025 it further indicated to notify physician if resident experiences unmanageable or intolerable pain.During a concurrent observation and interview on 09/09/2025 at 2:51 PM, Resident 45 was lying awake in bed, brows furrowed. Resident 45 stated he had pain at his hip. Resident 45 stated his current pain level was 7 but creeping up to an 8. Resident 45 stated the nurse already knew he was in pain, but he needed to wait for about 1 1/2 hours before staff could give his hydromorphone HCL because it was not time yet. Resident 45 stated this was how it was all the time. Resident 45 stated he was in pain daily and some nurses administered acetaminophen when he was experiencing moderate to severe pain. Resident 45 acknowledged he took the acetaminophen knowing it wouldn't work but he was desperate for some sort of pain relief. Resident 45 stated being in pain and waiting for pain medication was cruel but he could not do anything. Resident 45 stated he had requested the nurse to contact the doctor to let him (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know the pain regimen was ineffective, but nothing ever changed. Resident 45 acknowledged his realistic goal was to have mild pain but added, having unrelieved moderate to severe pain was very frustrating, negatively affected his mood and his desire to go out and socialize, and negatively affected his quality of life. During a concurrent interview and record review on 09/12/2025 at 08:45 AM, Resident 45's 8/2025 and 9/2025 EMARs were reviewed with the Minimum Data Set coordinator (MDSC). The MDSC confirmed the facility defined mild pain as pain level of 1 to 3, moderate for pain level of 4 to 6 and severe pain for pain level of 7 to10. The MDSC verified that based on 8/2025 EMAR, acetaminophen was only ordered prn for mild pain. The MDSC verified based on 8/2025 EMAR, Resident 45 received acetaminophen PRN despite complaint of severe pain on these dates: 8/7/25, 8/23/25 and 8/31/25. The MDSC stated it was not acceptable to administer acetaminophen for moderate to severe pain because it would be ineffective. The MDSC verified that based on 8/2025 and 9/2025 EMAR, Resident 45 was receiving the prn hydromorphone HCL daily 4 times sometimes as much as 5 times a day and had been complaining of moderate to severe pain almost daily. The MDSC stated based on the 8/2025 and 9/2025 EMAR and Resident 45 daily complaints of moderate to severe pain, the current pain regimen was ineffective since Resident 45's pain was not adequately controlled.During a telephone interview on 09/12/2025 at 11:07 AM, the pharmacist (RPh) stated it was not appropriate to administer acetaminophen for moderate to severe pain, as the physician's order was to give it only for mild pain. The Rph stated per her records, she could see Resident 45 had been receiving the prn order for the hydromorphone HCL everyday as much as 4 to 5 times daily. The Rph stated she would recommend Resident 45's physician reevaluate Resident 45's pain management regimen to make changes to better manage Resident 45's pain. The Rph stated ineffective pain management could result in more severe pain and affect Resident 45's quality of life. During a concurrent interview and record review on 09/12/2025 at 1:18 PM, Resident 45's 8/2025 and 9/2025 EMAR were reviewed with Licensed Nurse (LN) C. LN C stated she was familiar with Residents 45's care and his complaints of pain. LN C stated she even administered hydromorphone HCL to Resident 45 as a preventative measure because she knew Resident 45 would have pain later and the pain would be harder to control then but Resident 45 remains in pain. LN C verified Resident 45 complained of moderate pain to severe pain daily and that Resident 45 received hydromorphone HCL daily, as often five times daily. LN C stated the frequency of Resident 45 receiving the hydromorphone suggested his current pain regimen was ineffective and that Resident 45 pain was not adequately controlled. LN C stated she had never had the physician reviewed Resident 45's EMAR to see if changes in pain regimen need to be made. During a concurrent interview and record review on 09/12/2025 at 1:37 PM, the 8/2025 and 9/2025 Resident 45s EMAR were reviewed with Resident 45's physician. Resident 45's physician stated the EMARs might indicate Resident 45's pain was not adequately controlled by the current pain regimen. Resident 45's physician stated the nurses had never sent him a copy of Resident 45's EMARs, had not discussed with him the frequency of Resident 45's hydromorphone HCL use, nor Resident 45's goal in pain relief.A review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, revised 10/2022, the P&P indicated, .the pain management is based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and resident choices related to pain management.pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals.pain management is a multidisciplinary care process that includes the following: modifying approaches as necessary.review the medication administration record to determine how often the individual request and receives prn pain medication and to what extent the administered medication relieve the resident's pain.

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	09/12/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews and record review, the facility failed to ensure one resident out of 20 sampled residents (Resident 87) was provided with a safe and sanitary environment when the commode (portable toilet designed for individuals with limited mobility) was covered with a blanket.This failure has the potential to spread germs and cause illness among residents.Findings:A review of Resident 87's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date to the facility in July 2025 with a diagnoses of muscle weakness and difficulty walking.During a concurrent observation and interview on 09/09/2025 at 12:34 PM, in Resident 87's room, a commode was covered with a blanket. Resident 87 stated staff have used a blanket to cover the commode for about two months.During a concurrent observation and interview on 09/09/2025 at 1:18 PM, Licensed Nurse (LN) C verified Resident 87's commode bucket was covered with a blanket. LN C verified the commode had always been covered that way. LN C stated it was not acceptable, and it was the facility's responsibility to ensure commode was covered with the appropriate lid. LN C stated covering the commode bucket with a blanket was unhygienic and unsanitary. During an interview on 09/11/2025 at 11:57 AM, the Infection Preventionist (IP) it was not acceptable to cover the commode with a blanket as it was an infection control issue. The IP stated cloth traps and harbor bacteria, so it becomes a contaminated surface, and could increase the risk of spreading germs and bacteria that could make the resident sick.A review of the facility's policy and procedure (P&P) titled Policies and Practices-Infection Control, revised 9/2023, indicated, .this facility's infection control practices are intended to help support a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infection.

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	055854	A. Building B. Wing	09/12/2025

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Santa Rosa Post Acute	4650 Hoen Avenue Santa Rosa, CA 95405

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interviews and record reviews, the facility failed to ensure the call light (a communication tool used in healthcare settings to allow patients to request assistance from staff) was within reach for one out of five sampled residents (Resident 102), when her call light was found coiled around her lower bed post away from her reach.This failure put Resident 102 at risk for delayed provision of care and accidents.Findings:A review of Resident 102's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission to the facility in April 2020 with a diagnosis of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).During a concurrent observation and interview on 09/09/2025 at 11:47 AM, in Resident 102's room, Resident 102's stated she had been using the pressure pad to call for help and no staff responded because she believed it was not working. Resident 102 stated earlier in the morning her normal call light had been changed to the pressure pad call button. Resident 102 stated it was very frustrating to have a call light that was not working because the call light was the way to call staff when help was needed. During a concurrent observation and interview on 09/09/2025 at 12:08 AM, Licensed Nurse (LN) C verified Resident 102's pressure pad call button was not working but pointed out there was a call button that was working, however, it was coiled on the lower bed post which was too far for Resident 102 to reach. LN C stated a call light must always be in working condition and must always be within a resident's reach. LN C stated not having a working call light and not having a call light within reach put the residents' safety at risk as it placed them at high risk for accidents.During an interview on 09/12/2025 at10:35 AM, the Director of Staff Development (DSD) stated call lights were meant to be used by the resident to call the staff's attention if they needed help. The DSD stated that a call light wrapped on the lower bed post was unacceptable and was not within a residents' reach. The DSD stated if the call light wasn't within residents' they might fall or have an accident when they tried to get up on their own.A review of the facility's policy and procedure (P&P) titled Answering Call lights, undated, indicated, .when resident is in bed or confined in a chair be sure the call light is within easy reach of the resident.

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	055854	A. Building B. Wing	09/12/2025

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Santa Rosa Post Acute	4650 Hoen Avenue Santa Rosa, CA 95405

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain the kitchen's drain in working order when the sewage drainpipe was observed disconnected and leaking outside the kitchen. This decreased the facility's potential to maintain sewer lines in proper working order and containment.Findings:During a concurrent observation and interview on 9/9/25 at 11:27 a.m. with the Maintenance Director (Maint Dir) outside the kitchen near the wall corresponding to the kitchen's food preparation sink. A black plastic sewer pipe was observed coming off the wall down to the top of the ground. The pipe was observed disconnected at one of the joints with light-colored solid particles scattered in the direction of the slope of the ground from the pipe's opening. Maint Dir confirmed that the pipe is not supposed to be disconnected. During an interview on 9/12/25 at 1:47 p.m. with the Dietary Supervisor (DS), DS acknowledged that a leaky drainpipe could attract pests, and it should have been fixed. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, revised December 2009, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.