STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055919	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Valley Post-Acute Rehab	1035 Gravenstein Hwy South Sebastopol, CA 95472

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on interview and record review, the facility failed to honor a resident's desire to go outdoors when one of two sampled residents, Resident 1, was asked repeatedly by multiple staff members to go inside to his room where he was in isolation for COVID-19. This failure potentially resulted in an escalation of Resident 1's anxiety prompting a call to the police and Resident 1's subsequent arrest. Finding: On 3/25/25, the Department received a report from the facility that on 3/24/25 at approximately 11:30 a.m., [Resident 1] became agitated in his covid isolation room. He exited the room using his walker without shoes or a mask on and went to exit the facility, to get fresh air and sun. As he approached the exit of the facility, the [facility] receptionist let him know he was not wearing the proper PPE (personal protective equipment) and was supposed to stay in his isolation room. Once inside, Resident 1 became significantly more agitated, 911 was called, police arrived, and after he became physical with one of the police officer, Resident 1 was arrested and escorted to the county jail. During a record review on 4/22/25 at 2:45 p.m., Resident 1's face sheet revealed an admitted [DATE] with multiple diagnoses including prostate cancer, anxiety disorder, difficulty in walking, and depression. Resident 1's face sheet also indicated he was his own responsible party. Review of Resident 1's MDS (minimum data set, an assessment tool) dated 2/23/25 indicated he had a BIMS score of 13 (Brief Interview for Mental Status, a score of 13 indicates intact cognition) and he had exhibited no behaviors in the past five days such as physical or verbal aggression or resisting care. (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
	055919	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Valley Post-Acute Rehab	1035 Gravenstein Hwy South Sebastopol, CA 95472

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 1:25 p.m. with Director of Nursing (DON) and Administrator, DON stated that on 3/24/25 Resident 1 was in isolation because he had tested positive for COVID-19. DON stated Resident 1 had four days left of isolation. DON stated Resident 1had a roommate who was getting a therapy session that day (3/24/25) and Resident 1 had gotten tired of the therapy staff talking to his roommate. DON stated Resident 1 left his room and went outside. Administrator stated staff were trying to ask Resident 1 not to go out, he had no shoes and no mask on. Administrator stated two nurses went outside with Resident 1 because he was unsteady on his feet. Administrator stated DON and a nurse tried to calm Resident 1, but Resident 1 would not calm down, Resident 1 said he was tired of being on isolation. Administrator stated Infection Prevention Nurse (IPN) called 911. Administrator stated that while the police were here, Resident 1 got so worked up contact was made, Resident 1 was arrested for resisting arrest and assault on a police officer. When queried, DON stated that even though Resident 1 was already outside, Resident 1 could not remain outside because he was COVID-positive and was on isolation. During an interview on 4/22/25 at 1:51 p.m., IPN stated that on 3/24/25 someone came and told her that Resident 1 had left his room and she went outside to talk to Resident 1. IPN stated he was in the front of the building without shoes or a mask, just his walker. IPN stated Resident 1 was angry and he stated he felt hot. IPN stated she asked Resident 1 to go back to his room to talk, which he did. IPN stated that when they got to his room, Resident 1 told her the air purifier in his room was too noisy, the room was hot, and he said he wanted to get away from you f---ing people. IPN stated she told Resident 1 she would get him a fan, and Resident 1 asked for lorazepam (an antianxiety medication) which Resident 1's nurse, Licensed Staff B, gave to him. IPN stated that while she got the fan, Resident 1 left his room again. IPN stated Licensed Nurse C approached her and told her, We need to 5150 (an involuntary psychiatric hold) him. IPN stated DON told staff to call 911, which they did. IPN stated she spoke to the dispatcher and explained Resident 1's situation and told them a peace officer would be good to de-escalate Resident 1. IPN stated an officer came and talked to Resident 1 in the dining room. IPN stated the officer started yelling and shuffling around, and then called for backup and a second officer came. IPN stated the two officers tried to restrain Resident 1 and Resident 1 hit one of the officers. IPN stated the police escorted Resident 1 out and put him in the police car. IPN denied any visitors or residents were out in the front of the building during the time of this incident. When queried, IPN stated Resident 1 was never aggressive prior to this incident. IPN stated Resident 1 would let his needs be known, and he would let staff know if he was anxious, which was handled with lorazepam, and then she would talk to him about how he was doing. When queried, IPN stated any time a resident was on isolation the resident could be outside safely with PPE and the resident could take their mask off when outside to get fresh air. IPN stated she had not in-serviced the staff on how to let someone on isolation go outside safely. During an interview on 4/22/25 at 2:08 p.m., Receptionist A stated that on 3/24/25 Resident 1 was agitated, he was unmasked and COVID- positive. Receptionist A stated that when Resident 1 headed towards the door, he (Receptionist A) tried to approach Resident 1, but he bashed me with his walker. I got out of the way, and I got help from other staff members. Receptionist A stated Resident 1 said, F--- you. I'm going outside, I'm getting the f--- out of here, and Resident 1 went outside. Receptionist A stated, It happens (resident aggression towards staff), it's not the first time. I just roll with it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055919	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Valley Post-Acute Rehab	1035 Gravenstein Hwy South Sebastopol, CA 95472

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 2:27 p.m., Licensed Nurse B verified he was Resident 1's nurse the day he went to jail. Licensed Nurse B stated Resident 1 was on isolation for COVID, and it was reported to him that Resident 1 was out of his room going to the main door to go out. Licensed Nurse B stated IPN guided Resident 1 back to his room. Licensed Nurse B stated Resident 1 was very anxious, Resident 1 was verbalizing that he was feeling isolated, and he was anxious and confused about what was going on. Licensed Nurse B stated he administered lorazepam to Resident 1 for his anxiety and then after that Resident 1 attempted again to get out of the room. Licensed Nurse B stated he was following Resident 1, letting him know he was on isolation, and he has to go back to the room. Licensed Nurse B stated Resident 1 went to the dining room and he and DON and were watching Resident 1 at that time. Licensed Nurse B stated Resident 1 was aggressive in the dining room, he put his leg on a box, and he was trying to grab something, and we were trying to get it away from him because we thought he might throw it. Licensed Nurse B stated Resident 1 was very anxious. When queried, Licensed Nurse B stated that was his first day working with Resident 1 and he did not know the plan for Resident 1's anxiety except to give the lorazepam as needed. When queried, Licensed Nurse B stated that what Resident 1 needed in that moment was to get out of the room. Licensed Nurse B stated Resident 1 could not be out of his room at that time because he was on isolation, so his (Licensed Nurse B's) understanding was that all activities, therapy, and visitation happened in his room. During a phone interview on 4/22/25 at 4:15 p.m., Licensed Nurse C stated that on 3/24/25 Resident 1 had COVID, no mask, no shoes, and no socks and had gone outside. Licensed Nurse C stated he tried to get Resident 1 to come inside, but Resident 1 was saying, I want to go, this is like a jail. Licensed Nurse C denied anyone else was outside at the time, except maybe staff. During an interview on 4/23/25 at 1:24 p.m., Social Services Director (SSD) stated Resident 1 did not have aggressive behaviors prior to 3/24/25, just frustrated behaviors. SSD stated Resident 1 found out about his cancer diagnosis just before he got here, he lost his ability to live independently and found out he was not going to be able to go home to the same situation, he lost his apartment, and then he got the COVID diagnosis, which delayed his transfer out, and all that compounding was a lot for him. During an interview on 4/24/25 at 3:32 p.m., Administrator stated yes, Resident 1 could absolutely go outside as long as he followed protocol for infection control. Administrator verified someone could have brought Resident 1 a chair and his shoes. During a record review on 4/23/25 at 4:05 p.m., Resident 1's medication administration record for March 2025 indicated Resident 1 had a physician order for lorazepam 0.5 mg (milligrams) every six hours as needed for anxiety and Licensed Nurse B documented a dose given to Resident 1 on 3/24/25 at 11:41 a.m. Review of Resident 1's nurse progress notes indicated a note written by IPN dated 3/20/25 at 11:51 a.m., Resident tested positive for COVID 19 on 3/20/2025. He presents with a low grade fever and overall feeling of weakness. No other documentation of COVID symptoms was noted. Review of Resident 1's vital signs (blood pressure, pulse, respiratory rate, and temperature) revealed no fever after 3/20/25. Review of facility policy Resident Self Determination and Participation, last revised 8/2022, indicated, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life.