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	09/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse within the mandated timeframe for one resident (Resident 2) of two sampled residents when the facility submitted notification to the California Department of Public Health (CDPH) on 8/25/25 when the allegation of abuse was reported to a nurse on 8/24/25.This failure decreased the facility's potential to protect residents.Findings:A review of Resident 2's admission record indicated admission to the facility on 7/17/25 with diagnoses which included dementia (a progressive state of decline in mental abilities), mild cognitive impairment of unknown cause, and a need for assistance with personal care.A review of Resident 2's Minimum Data Set (an assessment tool) dated 7/20/25 indicated a Brief Interview for Mental Status (BIMS, a screening tool used to monitor cognitive function (the mental processes our brain uses to perceive, learn, remember, and reason)) score of 11 which indicated moderate cognition.A review of Resident 2's progress note dated 8/24/25 at 5:25 p.m. indicated, Resident's daughter .reported to desk nurse that [Resident 2] stated that she was 'slapped two times' .During the skin assessment, the resident stated that she was 'slapped twice on the face, 3 weeks ago'. A review of a fax confirmation receipt of an SOC 341 (a state form used in California for mandated reporters to report suspected elder and dependent adult abuse or neglect) sent to CDPH from the facility regarding Resident 2's allegation of abuse was received on 8/25/25 at 10:15 a.m.In an interview on 9/9/25 at 12:58 p.m. , the Administrator (ADM) stated he was the Abuse Coordinator and acknowledged allegations of abuse were to be reported to CDPH within 2 hours. The ADM stated he had faxed the SOC 341 to CDPH again on 8/25/25 when he realized it had not been confirmed as received on 8/24/25. The ADM also stated he called CDPH and left a message notifying the Department of Resident 2's allegation of abuse.A review of CDPH's voice message log on 9/9/25 at 3:55 p.m. showed no evidence that a call was received from the facility on 8/24/25. A review of CDPH's fax log confirmed a document regarding Resident 2's allegation of abuse was received from the facility on 8/25/25.A review of the facility's policy and procedure titled Elder/Dependent Adult Abuse revised 5/31/19 indicated, All alleged violations of abuse .the mandated reporter shall .Make phone report immediately .(no later than (2) two hours) to the .licensing agencies of .obtaining knowledge of, or suspecting abuse .Fax within (2) two hours .written report (SOC 341) to .the licensing agency.

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