

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Petaluma Post-Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1115 B Street Petaluma, CA 94952	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of two residents (Resident 36 and Resident 92) had access to devices needed for sensory impairment when, 1. Resident 36 reported broken glasses, needed for distance, on admission, and the glasses remained unaddressed a month later. And, 2. Resident 92 reported needing hearing aids to hear people clearly, on admission, and Social Services did not respond to his request. This failure affected both residents' ability to actively engage in their care, their overall functionality, and their sense of well-being. Findings: 1. A review of Resident 36's clinical record indicated she was admitted in 11/2025, with a diagnosis of a fracture of her left patella and a large contusion over her left eye after a fall. A review of Resident 36's inventory of personal effects, dated 11/18/25, indicated she reported that glasses were broken. A review of Resident 36's MDS (MDS-A resident assessment tool), dated 11/22/25, indicated no cognitive impairment and that vision was adequate (meaning she could read fine print). A review of Social Services initial assessment, dated 11/25/25, indicated she did not require a vision referral. A review of Resident 36's Care Plan indicated the Activities Assistant identified a vision deficit and need for glasses, on 11/28/25. A care plan further indicated Resident 36 was a high falls risk. During a concurrent interview and observation on 12/16/25 at 9:30 a.m., with Resident 36 in her room, her glasses were visualized, and the right lens was completely shattered. Resident 36 stated she had told staff but could not remember who, and needed glasses for distance, watching TV, driving, and having her glasses would help with physical therapy and walking. Resident 36 stated, I really don't want to fall again. During an interview on 12/18/25 at 2:41 p.m., with the Social Services Director (SSD), the SSD stated the broken glasses were reported on admission, but she did not think it was urgent. The SSD further stated she understood how it would affect Resident 36's functionality and could cause her anxiety about falling again as well as her readiness for discharge. 2. A review of Resident 92's clinical record indicated he was admitted in 12/2025, with a diagnosis of surgical aftercare following surgery on the digestive system. A review of Nursing Progress Notes, dated 12/10/25 at 03:29 p.m., indicated Resident 92 reported he lost his hearing aids during his transfer from the hospital. The note further indicated the nurse would endorse this with Social Services. A review of an MDS, dated [DATE], indicated Resident 92 had minimal cognitive impairment, and he had moderate difficulty hearing (meaning speaker had to increase volume and speak distinctly). A review of Resident 92's initial Social Services assessment, dated 12/15/25, indicated Resident 92 did not need a hearing amplifier or a hearing referral. During an interview on 12/15/25 at 12:38 p.m., with Resident 92 in his room, Resident 92 reported he did not have his hearing aids and needed them; he reported it to someone but not sure who. Resident 92 stated he could hear if it was up close, but it made communication difficult and he must ask people to repeat themselves frequently. During an interview on 12/18/25 at 10:56 a.m., with the SSD, the SSD stated she could not find a note about Resident 92's hearing aids and there may have been some confusion. During a subsequent interview at 11:26 a.m., the SSD stated nothing had been done about the missing hearing aids. At 2:49 p.m., the SSD stated residents and staff reported concerns verbally to herself and to her partner but there could be a better way to record or document these concerns, so they do not get missed or delayed. During an (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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 12/19/25 at 9:22 a.m. with the Director of Nursing (DON), DON stated nursing or SSD should do a sensory assessment for quality of life and if a resident brings the need to our attention her expectation would be to get started on it right away. A review of a facility policy titled, Sensory Impairments-Clinical Protocol, revised 3/2021, indicated staff would identify individuals with sensory impairment. identify the cause.order appropriate consultations when necessary.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure safe medication labeling and storage practices were followed when, 1. A loose Lantus Solostar Insulin Pen (A disposable prefilled injection device for long-acting insulin administration for diabetic residents) was found in the medication refrigerator with no label, no resident name, no instructions, no open date. And, 2. Medication tablets and pills intended for wasting, were collected and filled in an unlabeled urine specimen cup that was stored inside a medication cart. These failures had the potential to contribute to unsafe medication use and administration and medication diversion. Findings: 1. During a concurrent observation and interview on 12/17/25 at 1:05 p.m., in the main medication room with the Nurse Manager (NM), a loose unlabeled Lantus Solostar Insulin Pen was found in the medication refrigerator. The NM stated he did not know why it was not labeled or which resident it was for. The NM further stated, if the medication was not labeled it could be used for the wrong resident. During an interview on 12/19/25 at 9:22 a.m., with the Director of Nursing (DON), the DON stated all medications should be labeled with the resident name, date of birth, directions, expiration date and open date. The DON further stated this did not meet her expectations, and the medication would be unusable as they did not know who it belonged to. A review of a facility policy titled, Medication ordering and receiving from Pharmacy, dated 04/2014, indicated each prescription label should include resident name, specific directions for use, medication name, medication strength, prescribers name, date dispensed, quantity of medication, expiration date, name address and telephone number of the pharmacy, and prescription number. 2. During an observation on 12/17/25 at 8:53 a.m., of a medication administration in Hall C with Medication Cart C, Licensed Nurse 2 (LN2) spilled a med cup with two medications inside and proceeded to waste the two medications into a urine specimen cup filled with loose meds and stored in the medication cart drawer. During an interview on 12/17/25 at 9:05 a.m., with LN 2, LN 2 stated the urine cup was for non-controlled medications intended for destruction and acknowledged the cup was full. LN 2 further stated it was emptied at some point, but she was unsure of when and by whom. During a concurrent observation and interview on 12/17/25 at 10:45 a.m., in Hall C, Medication Cart C was surveyed with LN 2. The urine cup full of loose medications to be destroyed was still in cart. LN 2 stated she was not sure if this followed facility policy, but to destroy medications she would take them to the main medication room, crush them, and put them in the incinerator bin, if it was a controlled medication, do the same process with another nurse to witness and co-sign. LN 2 stated, having loose medications in carts presented a risk of potential access by residents and other facility staff. During a concurrent observation and interview on 12/17/25 at 11:10 a.m., in Hall D with Medication Cart D and Licensed Nurse 3 (LN 3), no urine specimen cup with loose medications was seen. LN 3 stated she would destroy medications as soon as possible and that it was not policy to keep a urine cup full of meds in the cart. During an interview on 12/17/25 at 11:42 a.m., with Licensed Nurse 1 (LN1), LN 1 stated to destroy non-controlled medication she would take it to the med room and dispose of it in the incinerator bin, and that she did not think it was policy to keep loose medications in a urine cup in the med cart. LN 1 further stated the policy was to not have any loose medications in the carts. During an interview on 12/17/25 at 1:05 p.m., with the Nurse Manager (NM), the NM stated all non-controlled meds should be destroyed by end of shift, and if there is a urine cup holding loose medications in the cart, it should not be full and should have been emptied. During an interview on 12/19/25 at 9:22 a.m., with the DON, the DON stated she did not feel it was best practice to keep a urine specimen cup full of loose medications to be wasted in the cart. This Surveyor requested a more specific policy for medication wasting during administration. The DON could not provide such a policy. A review of facility policy titled, Disposal of Medications and Medication Related Supplies, revised 10/2025, indicated that non-controlled medications shall be disposed in the proper waste container in the medication room.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control procedures were followed for two of two Residents (Resident 62 and Resident 64), when Licensed Nurse 1(LN 1) did not disinfect the blood pressure cuff between use on these residents.This failure had the potential to spread infection between residents.Findings:During an observation on 12/17/25 at 8:09 a.m., in Hall A, LN1 checked the blood pressure of Resident 64 and did not disinfect the blood pressure cuff afterwards.During an observation on 12/17/25 at 8:26 a.m., in Hall A, LN1 proceeded to check the blood pressure of Resident 62 and did not disinfect the blood pressure cuff prior to using.During an interview on 12/17/25 at 8:43 a.m., with LN 1, LN1 stated she should have cleaned the blood pressure cuff between residents to stop the spread of germs from resident to resident.During an interview on 12/17/25 at 1:36 p.m., with the Infection Preventionist (IP), the IP stated all vitals equipment should be cleaned at the start of the shift and between residents always, all multi-use equipment should follow this standard to protect residents against infection.During an interview on 12/19/25 at 9:22 a.m., with the Director of Nursing (DON), the DON stated it was her expectation that all reusable equipment be cleaned between residents, and all staff should follow the infection control program.A review of a facility policy titled, Cleaning and Disinfecting Non-Critical Resident Care Items, revised 6/2021, indicated non-critical reusable items are disinfected between residents and as needed.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility failed to ensure the Ombudsman (A government official who advocates for residents directly with the facility to resolve concerns and complaints) was notified, when one Resident (Sampled Resident #83) was transferred to the hospital. This failure had the potential to deny protection to Resident #83 from being inappropriately transferred or discharged and to have access to an advocate who could inform them of their options and rights. Findings: During a concurrent interview with the Nurse Manager (NM) on 12/17/2025 at 11:47 AM, the NM stated, when a resident was going to be transferred the expectation for nurses was to call the physician, notify family, get paperwork ready and to complete a hand-off report to the accepting facility. The NM did not state the expectation was to also notify the facility Ombudsman. During an interview and concurrent record review with the Director of Nursing (DON) at 11:47 AM, she stated Resident #83 was sent to the hospital for shortness of breath on 10/20/2025. She stated Resident #83 was admitted to the hospital, and the physician and Resident #83's husband were notified. She stated she could not find documentation the Ombudsman was notified of the transfer. The DON stated the, Ombudsman was not notified. During an interview and concurrent record review with Social Services (SS) on 12/17/25 at 11:55 AM, she stated a Notice Of Transfer document was completed in the electronic medical record and was automatically emailed to the Ombudsman. She stated the facility Policy & Procedure supported this practice. She attempted to find a copy of the notification to the Ombudsman in the medical record and then in a binder where she kept copies of all the notifications. She stated the notification to the Ombudsman was not done and indicated, We missed it. SS stated they did not complete the notice to the Ombudsman for this discharge and transfer for Resident #83. She stated it was, Supposed to be done, and it was not done, and they did not follow the facility Policy & Procedure. During an interview on 12/17/2025 at 12:40 PM, with the Director of Nursing (DON) and Administrator (ADM), they stated they tried to locate the notice to the Ombudsman for Resident #83's transfer to the hospital. The Administrator stated, anytime a resident left the facility, The Ombudsman SHALL be notified. She stated the Ombudsman was not notified for Resident #83 and it was supposed to have been completed. The Policy and Procedure for Transfer Notification to the Ombudsman was requested and not received by the end of Survey.		