

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Park View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3751 Montgomery Dr 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 - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, including a Santa [NAME] Police Department Detective interview, and facility record reviews, the facility failed to protect one resident (Resident 1) of a census of 115 and sample of 77 interviewable residents, to be free from sexual abuse, when Licensed Staff B witnessed Unlicensed Staff A touching his exposed penis against Resident 1's naked body during care. This failure to protect Resident 1 from Unlicensed Staff A resulted in Resident 1 stating she told Unlicensed Staff A to stop, and it made her feel uncomfortable, and would make a reasonable person, who suffered from sexual assault by a facility staff member, to experience fear, guilt, shame, isolation, dehumanization and humiliation as a result of the sexual abuse. A review of Resident 1's medical record document titled Face Sheet, indicated she was admitted [DATE] with diagnoses including Parkinson's Disease (A chronic, progressive brain disorder affecting chemicals in the brain, leading to impaired muscle control) with Dyskinesia (involuntary movements), with fluctuations of Dyskinesia, Dysphonia (a voice disorder characterized by hoarseness, raspiness, breathiness, or strain), and muscle weakness. A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/11/25, indicated Resident 1 had no memory impairment and unclear speech. The MDS indicated Resident 1 had a BIMS (Brief Interview for Mental Status) score of 13 (13-15 indicate intact cognition, 8-12 suggest moderate impairment, and 0-7 signify severe impairment). During an interview with the Administrator on 1/27/26 at 9:15 a.m., he stated he was informed by his Business Officer Manager (BOM) that Licensed Nurse B walked into Resident's 1's room on 12/29/25 and witnessed Unlicensed Staff A standing behind Resident 1 with his penis own in his hand. The Administrator stated Licensed Nurse B immediately escorted Unlicensed Staff A to meet with the Business Officer Manager. During an interview with Resident 1 on 1/27/26 at 10:30 a.m., in the Administrator's office, Resident 1 was observed sitting in a specialty wheelchair, with her arms and legs contracted up to her chest. Her voice was very quiet. She answered in few words. Resident 1 remembered Unlicensed Staff A. When she was asked if he was inappropriate, she responded Yes. When asked if he did things she did not want him to she stated, It did happen. When asked if he put two - three fingers in her body when he was cleaning her, she stated, It did happen. When asked if he put his penis in her vagina she stated, More than once. She stated she would say No to him. During an interview on 1/27/26 at 11:48 a.m. the Business Operation Manager stated on 12/29/25 around 4 p.m., Licensed Nurse B came into the office with Unlicensed Staff A and stated she had observed Unlicensed Staff A in Resident 1's bedroom, standing beside Resident 1 with his penis exposed, in his hand. The Business Operation Manager stated he asked Unlicensed Staff A if it was true if he had his penis exposed in Resident 1's room and Unlicensed Staff A responded, I don't know and stated whatever she [Licensed Nurse B] said. The Business Operation Manager stated Unlicensed Staff A never denied the allegation. The Business Operation Manager stated he interviewed Licensed Staff B and she stated when she walked into Resident 1's</p> <p>(continued on next page)</p>		

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 - Actual harm Residents Affected - Few	<p>room she observed Resident 1 lying on her back, in her bed, with her limbs contracted towards her leaning to her right side. During an interview on 1/27/26 at 1:35 p.m., Licensed Staff B stated on 12/29/25 between 4 p.m. and 5 p.m. she walked into Resident 1's room and saw Resident 1 lying on her bed with her legs contracted and Unlicensed Staff A had his penis out and touching her [Resident 1's] butt area. She stated Resident 1 was positioned on the right side of the bed, facing the door, with her buttocks on the edge of the left side of the bed, where Unlicensed Staff A was standing. She stated she observed Unlicensed Staff A with his pants were pulled down in the front. She stated, He was holding his penis in his left hand, and his right hand was on Resident 1's left buttock, and his penis was pressed against her left buttock at the gluteal fold (the horizontal skin crease separating the lower buttock from the upper thigh). During an interview on 1/27/26 at 1:50 p.m., Charge Nurse C stated on 12/29/25 after 5 p.m., Licensed Nurse B told her she had seen Unlicensed Staff A touch Resident 1 with his exposed penis. Charge Nurse C went with Licensed Nurse B to Resident 1's room and asked her if she was okay. Charge Nurse C stated Resident 1 stated Boundaries were crossed with the unlicensed staff who had been with her. She stated she spoke with Resident 1 later during the shift, and she stated Unlicensed Staff A had crossed boundaries when he changed her brief. She stated Resident 1 stated sometimes he would push his fingers on her anus and he was rough. She stated Resident 1 felt he lingered too long in her room during personal care. During an interview with the Police Detective on 1/29/26 at 2:32 p.m., he stated Resident 1 indicated during his interviews with her on 12/29/25 and 12/30/25, that Unlicensed Staff A had touched her with his penis, had inserted his penis into her vagina, and had inserted two or three fingers into her vagina on multiple occasions. He stated when he interviewed Unlicensed Staff A he admitted he touched Resident 1 inappropriately with his penis and his fingers on multiple occasions. During a review of a facility Policy and Procedure titled Resident Abuse Prevention Policy, revised 9/19/25, it stipulated The purpose of this policy is to affirm the facility's commitment to preventing any form of resident abuse. The facility maintains a zero-tolerance stance toward any form of resident abuse.</p>		