

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/17/2026
NAME OF PROVIDER OR SUPPLIER  Rosewood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1911 Oak Park Boulevard Pleasant Hill, CA 94523	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to protect one of four sampled residents (Resident 1) from physical abuse when Resident 2 hit Resident 1 on the left side of his face. This failure resulted in Resident 1 having pain, swelling and redness near the left eye. During a record review of Resident 1's admission record, the record indicated Resident 1 was admitted to the facility on [DATE]. The record indicated Resident 1 had diagnoses which included dementia (a loss of brain function affecting memory, thinking, language, judgment, or behavior). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment tool used in identifying problems to be addressed in plan of care), dated 1/14/26, the record indicated Resident 1 was rarely/ never understood, had a memory problem, and never/rarely made decisions regarding tasks of daily life. The assessment indicated Resident 1 used a wheelchair and was able to wheel/propel himself independently. During a record review of Resident 2's admission record, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included anxiety (a feeling of fear, dread, and uneasiness that acts as a natural reaction to stress) and aphasia (disorder that lessens ability in speaking, understanding, reading or writing). During a record review of Resident 2's MDS assessment dated [DATE], the assessment indicated Resident 2's Brief Interview for Mental Status (BIMS, short-term memory screening tool) score was zero (0) out of 15, indicating severe loss of ability with memory and thinking. During an observation on 2/17/26 at 10:48 a.m. Resident 1 was wheeling himself along the hallway in the facility. During an observation on 2/17/26 at 10:52 a.m. Resident 2 was sitting in his wheelchair inside his room. Resident 2 stated Please! Please! with a loud, high tone of voice, while shaking his head left to right, when asked about any memory regarding the incident between him and Resident 1. During a phone interview on 2/17/26 at 12:05 p.m. with Restorative Nurse Assistant (RNA), RNA 1 stated on 1/15/26, at around 10:30 a.m., while he was with another resident, he heard someone yelling. RNA 1 stated he rushed to Resident 2's room. RNA 1 stated he saw Resident 1 and Resident 2, both were sitting in their wheelchairs in Resident 2's room. RNA 1 stated he saw Resident 2 swinging his arm and hitting Resident 1 on the left side of his face. RNA 1 stated he had to separate both residents. During a record review of Resident 1's progress notes dated 1/15/26, Registered Nurse (RN 1) documented, resident had physical altercation with another resident. It was reported that [Resident 1] was struck on his left eye by [Resident 2] .[Resident 1] with mild pain to [left] eye and surrounding outer area. Area with redness and mild swelling .cool compress provided to area .Tylenol (medication for pain) was provided for pain . During a record review of Resident 2's progress notes dated 1/15/26. RN 1 documented, resident [Resident 2] physically struck another resident [Resident 1] in the L (left) eye. [Resident 2] refused to speak with staff about incident . [Resident 2] was angry . During an interview on 2/17/26 at 1:01 p.m. Licensed Vocational Nurse (LVN 1) stated Resident 1 was wheelchair bound and goes around the facility by himself. LVN 1 stated</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  056476	Facility ID:  056476  If continuation sheet Page 1 of 2

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1 was confused and would go inside other resident's rooms. During an interview with Registered Nurse (RN 1) on 2/17/26 at 2:27 p.m. RN 1 stated she was on duty on the day of the incident. RN 1 stated the abuse incident between Resident 1 and Resident 2 could have been avoided by ensuring that Resident 1 was kept in line of sight. RN 1 also stated that it was even more important to protect residents with severe cognitive impairment (difficulty with thinking, memory, and understanding, preventing them from living independently) from abuse, as they are the vulnerable population (people who are easily harmed physically and emotionally). During a review of facility's Policy and Procedure (P&amp;P) titled, Abuse Prohibition dated 10/25/24, P&amp;P indicated, Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Physical abuse includes hitting, slapping, pinching, kicking, etc.</p>		