STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056476	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Post Acute	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F689Based on interviews and record reviews, the facility failed to report Resident 1's elopement to the California Department of Public Health (CDPH). During the incident, the resident suffered a left knee laceration but was unable to explain how it occurred.This failure had the potential to put the resident's safety at risk and delay the investigation of CDPH. On 5/28/26 at 12:10 p.m., an unannounced visit was conducted at the facility to investigate a complaint. During a review of Resident 1's Departmental Notes indicated that the resident was discovered missing on 5/25/26 at approximately 5:00 a.m. and was later located at the 7-Eleven store across the street from the nursing home at 5:30 a.m. During an interview on 5/28/26 at 1:44 p.m. with Registered Nurse (RN) 1, RN1 stated on 5/25/26 at 5:00 a.m., the facility staff was unaware that the resident had left the building and explained that the front lobby door automatically allowed anyone inside to exit. RN1 also added, the resident was found at 5:30 a.m. by Certified Nursing Assistant (CNA 1) in the 7-eleven store across the street and when he assessed the resident, the resident had a left knee skin laceration and was unable to explain how he obtained the laceration.A review of Resident 1's Face sheet indicated that the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, muscle weakness and cognitive communication deficit (cerebral infarction is medical term for stroke meaning when blood flow to the brain is stopped causing brain injury, cognitive communication deficit means someone struggles to communicate effectively, because their brain has trouble processing or organizing information. It affects a person's ability to pay attention, remember details, reason, and understand social cues).During a review of Resident 1's MDS (an assessment tool) dated 5/8/26 under Section C, it indicated Resident 1's cognition was severely impaired. During an interview on 5/28/26 at 4:07 p.m. with the Director of Nursing (DON), the DON stated that Resident 1's elopement incident should have been reported to the department. During an interview on 5/28/26 at 4:43 p.m. with the Administrator (Adm), ADM stated Resident 1 eloped on 5/25/26 and stated the incident of elopement was not reported to the department.During a review of the facility's policy and procedure (P&P) titled, Accidents and incidents investigating and reporting, dated 2001, the P&P indicated, Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F609Based on interview and record review, the facility failed to provide adequate supervision when Resident 1 eloped from the facility.This failure had the potential to put the resident's safety at risk. A review of Resident 1's Departmental Notes indicated that the resident was discovered missing on 5/25/26 at approximately 5:00 a.m. and was later located at the 7-Eleven store across the street from the nursing home at 5:30 a.m.During an interview with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 5/25/26 at 5:00 a.m., Resident 1 was missing from the facility. CNA 1 stated the resident was last seen lying in bed in his room at approximately 4:30 a.m. CNA 1 further stated that at 5:30 a.m., she found the resident inside the 7-Eleven store across the street from the facility sitting in a wheelchair and Resident 1 told CNA 1 he wanted to go home.A review of Resident 1's Face sheet indicated that the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, muscle weakness and cognitive communication deficit (cerebral infarction is medical term for stroke meaning when blood flow to the brain is stopped causing brain injury, cognitive communication deficit means someone struggles to communicate effectively, because their brain has trouble processing or organizing information. It affects a person's ability to pay attention, remember details, reason, and understand social cues). A review of Resident 1's MDS (an assessment tool) dated 5/8/26 under Section C, it indicated Resident 1's cognition was severely impaired. The MDS Section GG titled, Functional Abilities indicated, Resident 1 only needed supervision or touching assistance from a helper to ambulate. The MDS also indicated that the resident only needed supervision or touching assistance from a helper when wheeling himself with a manual wheelchair to a distance of at least 50 feet and partial assistance from a helper when wheeling himself to a distance of at least 150 feet.During an observation on 5/28/26 at 2:15 p.m., Resident 1 was observed to be sitting in his wheelchair and was independently propelling himself down the hallway where he was residing.During a review of Resident 1's nursing progress note dated 1/6/26, it indicated that the resident attempted to stand from wheelchair stated, .I want to go home. leave me alone, I want to go home.During a review of Resident 1's nursing progress note dated 4/14/26, Resident 1 stood up from wheelchair and said he wanted to walk so he could go home. During an interview on 5/28/26 at 3:04 p.m. with Responsible Party (RP), RP stated on 5/4/26, the facility informed her that Resident 1 fell in the hallway where the resident lived. RP also stated she was worried about the resident wandering around the building and potentially getting out of the facility.During a review of Resident 1's SBAR (SBAR stands for Situation, Background, Assessment and Recommendation, a standardized communication tool used in healthcare to share information quickly and clearly) dated 5/4/26, it indicated the resident had a fall in another hallway from where the resident's room was located. During an interview on 5/28/26 at 1:44 p.m. with Registered Nurse (RN)1, RN 1 stated on 5/25/26 at 5:00 a.m., the facility staff was unaware that the resident had left the building and explained that the front lobby door automatically allowed anyone inside to exit. Stated the resident was found at 5:30 a.m. by CNA 1 in the 7-eleven store across the street and when he assessed the resident, the resident had a left knee skin laceration and was unable to explain how he obtained the laceration. RN 1 also stated that Resident 1 was observed wandering throughout the facility frequently.During an interview on 5/28/26 at 4:07 p.m. with the Director of Nursing (DON), the DON stated the facility did not expect that the resident would go out of the facility.During an interview on 5/28/26 at 4:43 p.m. with the Administrator (Adm), ADM stated Resident 1 eloped on 5/25/26 and stated the incident of elopement was not reported to the department.During a review of the facility's policy and procedure (P&P) titled, Leave of Absence Without Notice(LAWN), dated 1/16/26, the P&P indicated, Policy: The interdisciplinary team members (IDT) are recommended to evaluate if a resident is deemed at risk of leaving the facility without notice and identify resident-specific measures in a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	least restrictive environment. Definitions. Elopement occurs when a resident leaves the premises or a safe area without notice/authorization.