STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555209	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adventist Health Sonora - D/P Snf	179 South Fairview Lane Sonora, CA 95370

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to protect the resident's right to be free from physical abuse for one of two sampled residents (Resident 2) when Resident 1 struck Resident 2 in the face with a fist on 1/8/26. This failure resulted in Resident 2 suffering pain from a bleeding split lip and ongoing fear and anxiety that Resident 1 might hit Resident 2 again. A review of Resident 1's clinical record titled, Resident Face Sheet (a document used in healthcare settings to compile essential information about a resident, facilitating effective care and communication among healthcare professionals), dated 10/21/25, indicated that Resident 1 was admitted to the facility with a diagnosis that included but was not limited to vascular dementia (a progressive state of decline in mental abilities).A review of Resident 1's Brief Interview for Mental Status, (BIMS is a 0-15-point assessment used in long-term care to measure cognitive function, specifically focusing on short-term memory, orientation, and recall. The BIMS score indicates a person's cognitive level: 13-15 cognitively intact, 8-12 moderate cognitive impairment and 0-7 severe cognitive impairment. A score of 99 indicates the resident was unable to complete the test.) dated 12/30/25, indicated Resident 1 had a BIMS score of 99. A review of Resident 2's clinical record titled, Resident Face Sheet, dated 10/21/25, indicated that Resident 2 was admitted to the facility with a diagnosis that included but was not limited to depression (a mood disorder causing persistent sadness and loss of interest in activities that can interfere with daily life), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of fear, dread, and uneasiness).A review of Resident 2's BIMS, dated 10/27/25, indicated that Resident 2's BIMS score was coded as 03 (Resident 2 was severely cognitively impaired).A review of Resident 1's Physician Order Report, dated 9/28/25, indicated Resident 1 had been receiving Seroquel (quetiapine - an antipsychotic medication used to treat mental health disorders) 50mg (milligram, unit of measurement) one tablet three times a day for vascular dementia and was monitored every shift for the behaviors of aggression and wandering (traveling from place to place without purpose).A review of Resident 1's progress notes titled, CPC [Care Planning Conference], dated 1/7/26 indicated a care conference was held and indicated that resident would become aggressive with staff when they would attempt to provide stand by assistance when Resident 1 was walking. The note did not indicate that resident 1 had episodes of aggression towards other residents.A review of Resident 1's progress notes titled, PHYSICAL ABUSE TOWARD PEER RESIDENT, dated 1/8/26 at 3:00 PM, indicated, .[Resident 1] was sitting on the chair by the nursing station.got up to her feet and went to peer resident [Resident 2] that was sitting at the nursing station as well [Resident 1] approached [Resident 2], stood in front of [Resident 2] and then unexpectedly hit [Resident 2] in [Resident 2] face with her fist. [Resident 1] kept yelling out loud 'She is the devil' multiple times, and to the nurse 'You are nice to her, but she is the devil!' . A review of Resident 1's progress notes titled, PHYSICAL ABUSE TOWARD PEER RESIDENT, dated 1/8/26 at 3:05 PM, indicated, (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Initially resident [Resident 1] was quietly repeating her statement that victim [Resident 2] is the devil but later calmed down and was crying.A review of Resident 1's clinical record note titled Interdisciplinary Note, dated 1/9/26, indicated .IDT recommends continuing to provide spatial separation between resident [Name] and victim, encouraging family visits and calls as this seems to calm resident down, continue to use 1:1 sitter as staffing allows .consulting with MD for any further recommendations in which MD ordered: [labs] CBC [complete blood count], CMP [comprehensive metabolic panel], UA [urinalysis], Lorazepam (an antianxiety medication used to treat mental health disorders)] 0.5mg po Q6 hrs [hours] PRN [as needed] aggressive behavior/anxiety x 14 days . A review of Resident 2's progress notes titled, VICTIM OF PHISICAL ABUSE, dated 1/8/26, indicated, .Resident [2] became a victim of physical abuse from peer resident [Resident 1]. This was unprovoked and unexpected. Resident [2] was sitting in a chair close to the nursing station after talking to her daughter on the phone when peer resident [Resident 1] got up from her chair and stood up before her [Resident 2] and using fist hit her in the face at the left corner of her mouth area [sic] Attacking person [Resident 1] kept yelling 'She is the devil! multiple times [sic], I'm sick of it!, I live with the devil for 1 week!' . Victim resident [Resident 2] appeared to be shocked, quiet, her facial expression showed disbelief. When asked what happened, [Resident 2] stated that she got hit in the face and she pointed to the left mouth region.cold compress was applied to left corner of her mouth, it was slightly swollen and bruised, observed small dots, light smear of blood on the washcloth.A review of Resident 2's Physician Order Report, dated 1/8/26, indicated Ice pack to lips/face for 20 mins TID PRN for swelling, Three Times A Day .A review of Resident 2's clinical record titled NEUROLOGICAL EXAMINATION RECORD, dated 1/8/26 through 1/12/26, indicated that Resident 2 was placed on neurological checks (rapid, focused assessments of brain and nervous system function, often performed hourly in critical care to detect acute changes).During a concurrent interview and record review on 1/16/26 at 3:45 PM with the Licensed Nurse (LN) 1, LN 1 stated, .that particular day [1/8/26] was a bad day for [Resident 1] and [Resident 1] was very suspicious and paranoid. LN 1 further stated that Resident 1 had not been physically aggressive with other residents prior to the altercation with Resident 2 so they [the staff] were all very surprised when Resident 1 hit Resident 2.During an interview on 1/20/26 at 12:02 PM with LN 2, LN 2 stated that she heard a noise and saw Resident 1 on her knee and in front of Resident 2 and Resident 2 had her hand to her mouth. LN 2 stated as Resident 1 was removed from the situation, Resident 1 yelled that Resident 2 was the devil. LN 2 further stated that when she assessed Resident 2's mouth, her upper lip was cut and bleeding. During a joint interview on 1/23/26 at 10:49 AM with Resident 2 and a Russian speaking staff member assisting with translation, Resident 2 stated that Resident 1 had come up to her and hit her in the face, which injured her lip Resident 2 pointed to the upper left part of her lip. Resident 2 stated, [Resident 1] hit her like a man, she injured my lip, and there was blood and yes it was painful. Resident 2 further stated that she was afraid when she was hit in the face by Resident 1 because she did not understand how or why Resident 1 had hit her. Resident 2 further stated that she was still nervous and scared that Resident 1 would hit her again. During a concurrent interview and record review on 1/23/26 at 11:42 AM with the Director of Nurses (DON), Resident 1 and Resident 2's Physician Order Report, dated 12/23/25 through 1/23/26 were reviewed. The DON stated that she was not aware that Resident 2 had ongoing feelings of anxiety and fear related to the altercation that occurred with Resident 1 on 1/8/26.The DON confirmed that Resident 1 was not referred to the facility's psychiatric service provider following the altercation on 1/8/26 with Resident 2 for any medication evaluations or adjustments. The DON confirmed that Resident 1 was receiving Seroquel for aggressive behaviors. The DON further stated that Resident 2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was also not referred for psychiatric service for post resident to resident altercation on 1/8/26 because the facility was unaware that Resident 2 had ongoing emotional distress over the resident-to-resident altercation with Resident 1. The DON further stated that the altercation between Resident 1 and Resident 2 was abuse and an injury to Resident 2 had occurred because of Resident 1's aggression. During a concurrent interview and record review on 2/3/26 at 2:44 PM with the DON and the Practice Administrator, the DON stated that after the altercation was reviewed with Resident 2's physician on 1/8/26, the facility initiated neuro checks (rapid, focused assessments of brain and nervous system function, often performed hourly in critical care to detect acute changes) for Resident 2 that continued until 1/12/26. The DON stated that Resident 1 struck Resident 2 in the face and the neuro checks were necessary to monitor Resident 2 for changes in vital signs (measurable indicators of basic body functions-body temperature, pulse rate, respiration rate and blood pressure) and neurological status. Review of Resident 1's clinical record titled Monitor Administration History, dated 1/7/26 through 1/12/26, with the DON and the Practice Administrator, confirmed that Resident 1 had aggressive behaviors during that period as follows: 1/7 - 2 on AM shift, 1/8 - 4 on AM shift and 1 on NOC shift, 1/9 - 2 on NOC shift, 1/10 - 1 on NOC shift, and 1/12 - 15 on NOC shift, but the documentation did not distinguish whether the aggression was directed at staff and/or other residents nor did it indicate what type of aggression occurred.During a concurrent interview and review of the facility's Policy and Procedure titled, POLICY: ABUSE AND NEGLECT PREVENTION AND INVESTIGATION, dated 5/7/25,the P&P indicated .The resident has the right to be free from verbal, sexual, physical, and mental abuse.Abuse means the willful infliction of injury.with resulting harm, pain, or mental anguish.Physical Abuse includes hitting.abuse or neglect of resident by anyone; including.other residents.is not condoned by the facility. The DON stated that by the policy definition of abuse the Resident-to-Resident altercation that occurred on 1/8/26 between Resident 1 and Resident 2 was considered physical abuse, and that Resident 2 was physically abused by Resident 1.