STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555703	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Post Acute	523 Hayes Lane 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on observation, interview and record review, the facility failed to promote and enhance the sense of well-being for two residents (Resident 1 and Resident 6) of four sampled residents when facility staff did not verify Resident 1 and Resident 6 wore their own clothing. This failure resulted in Resident 1 showing up to a family party during the holidays wearing women ' s clothes and Resident 6 feeling disrespected and sad. Findings: A review of Resident 1 ' s admission record indicated he was admitted in 3/8/23 with diagnoses which included dementia (a group of conditions that cause loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/11/24, indicated he had severe memory impairment. A review of Resident 3 ' s admission record indicated he was admitted in 10/8/24 with diagnoses which included amyloidosis (a rare, inherited disorder characterized by the accumulation of abnormal proteins in the nerves, leading to progressive nerve damage). A review of an MDS, dated [DATE], indicated he had no memory impairment. A review of Resident 5 ' s admission record indicated he was admitted in 3/22/20 with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke) affecting the right dominant side. A review of an MDS, dated [DATE], indicated he had moderate memory impairment. A review of Resident 6 ' s admission record indicated he was admitted in 1/7/25 with diagnoses which included atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and rapidly). A review of an MDS, dated [DATE], indicated he had severe memory impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/5/25 at 10:05 a.m., Family Member XX stated Resident 1 was picked up from the facility by another family member to spend Christmas with the family in 2024 and arrived to the celebration wearing women ' s pants. Family Member XX stated Resident 1 was unaware he was not wearing his own clothing because of his dementia. Family Member XX stated Resident 1 had been observed in previous occasions wearing clothing that did not belong to him. Family Member XX gave the Surveyor permission to check Resident 1 ' s clothing in his closet. During an interview and concurrent observation on 3/5/25 at 10:45 a.m., Housekeeper A stated housekeeping personnel were responsible for putting away resident clothing in their closets based on the label printed on each garment, which indicated the name of the resident. Housekeeper A also stated housekeeping or laundry personnel were responsible for labeling residents ' clothes with their name for identification purposes. Resident 1 ' s closet was found to store a sweater labeled with another resident ' s name. This observation was confirmed by Housekeeper A. During an interview on 3/5/25 at 11:40 a.m., Resident 3 stated he had observed Resident 5 wearing Resident 6 ' s shirt, which had the design of a famous football team. Resident 3 stated he knew this information because Resident 6 used to be his roommate, and he had witnessed when his family had brought this shirt to him, as Resident 6 was a fan of the football team. During a concurrent observation and interview on 3/5/25 at 12:05 p.m., Resident 5 was observed in the dining room wearing a shirt adorned with a famous football team ' s logo. Resident 5 stated he had purchased it at a thrift store for two dollars. The Surveyor observed the shirt was labeled with Resident 6 ' s name, in clear black handwritten letters. During a concurrent interview and observation on 3/5/25 at 12:20 p.m., CNA B confirmed the shirt Resident 5 was wearing did not belong to him and acknowledged he had not checked the label written on the shirt prior to dressing Resident 6 that morning. During an interview on 3/5/25 at 12:33 p.m., the Director of Nursing (DON) stated CNAs were supposed to check residents ' clothing to ensure the clothing belonged to them, prior to assisting them with dressing. During an interview on 3/5/25 at 3:45 p.m., Resident 6 stated he had seen other residents wear his clothing. Resident 6 stated he felt disrespected and sad when other residents wore his clothing, because they were gifted by his sister, so they were very special to him. During a review of the facility ' s policy titled, Dignity, revised 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Residents ' private space and property are respected at all times. Based on observation, interview and record review, the facility failed to promote and enhance the sense of well-being for two residents (Resident 1 and Resident 6) of four sampled residents when facility staff did not verify Resident 1 and Resident 6 wore their own clothing. This failure resulted in Resident 1 showing up to a family party during the holidays wearing women's clothes and Resident 6 feeling disrespected and sad. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: A review of Resident 1's admission record indicated he was admitted in 3/8/23 with diagnoses which included dementia (a group of conditions that cause loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/11/24, indicated he had severe memory impairment. A review of Resident 3's admission record indicated he was admitted in 10/8/24 with diagnoses which included amyloidosis (a rare, inherited disorder characterized by the accumulation of abnormal proteins in the nerves, leading to progressive nerve damage). A review of an MDS, dated [DATE], indicated he had no memory impairment. A review of Resident 5's admission record indicated he was admitted in 3/22/20 with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke) affecting the right dominant side. A review of an MDS, dated [DATE], indicated he had moderate memory impairment. A review of Resident 6's admission record indicated he was admitted in 1/7/25 with diagnoses which included atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and rapidly). A review of an MDS, dated [DATE], indicated he had severe memory impairment. During a phone interview on 3/5/25 at 10:05 a.m., Family Member XX stated Resident 1 was picked up from the facility by another family member to spend Christmas with the family in 2024 and arrived to the celebration wearing women's pants. Family Member XX stated Resident 1 was unaware he was not wearing his own clothing because of his dementia. Family Member XX stated Resident 1 had been observed in previous occasions wearing clothing that did not belong to him. Family Member XX gave the Surveyor permission to check Resident 1's clothing in his closet. During an interview and concurrent observation on 3/5/25 at 10:45 a.m., Housekeeper A stated housekeeping personnel were responsible for putting away resident clothing in their closets based on the label printed on each garment, which indicated the name of the resident. Housekeeper A also stated housekeeping or laundry personnel were responsible for labeling residents' clothes with their name for identification purposes. Resident 1's closet was found to store a sweater labeled with another resident's name. This observation was confirmed by Housekeeper A. During an interview on 3/5/25 at 11:40 a.m., Resident 3 stated he had observed Resident 5 wearing Resident 6's shirt, which had the design of a famous football team. Resident 3 stated he knew this information because Resident 6 used to be his roommate, and he had witnessed when his family had brought this shirt to him, as Resident 6 was a fan of the football team. During a concurrent observation and interview on 3/5/25 at 12:05 p.m., Resident 5 was observed in the dining room wearing a shirt adorned with a famous football team's logo. Resident 5 stated he had purchased it at a thrift store for two dollars. The Surveyor observed the shirt was labeled with Resident 6's name, in clear black handwritten letters. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 3/5/25 at 12:20 p.m., CNA B confirmed the shirt Resident 5 was wearing did not belong to him and acknowledged he had not checked the label written on the shirt prior to dressing Resident 6 that morning. During an interview on 3/5/25 at 12:33 p.m., the Director of Nursing (DON) stated CNAs were supposed to check residents' clothing to ensure the clothing belonged to them, prior to assisting them with dressing. During an interview on 3/5/25 at 3:45 p.m., Resident 6 stated he had seen other residents wear his clothing. Resident 6 stated he felt disrespected and sad when other residents wore his clothing, because they were gifted by his sister, so they were very special to him. During a review of the facility's policy titled, Dignity, revised 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Residents' private space and property are respected at all times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure three residents (Resident 1, Resident 2 and Resident 4) of four sampled residents who lost personal items at the facility had their items located, replaced or reimbursed. These failures had the potential to result in feelings of frustration, loss of control, and uncertainty, which could have affected the residents ' comfort at the facility. Findings: A review of Resident 1 ' s admission record indicated admission to the facility on [DATE] with diagnoses which included dementia (a group of conditions that cause loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/11/24, indicated Resident 1 had severe memory impairment. A review of Resident 2 ' s admission record indicated admission to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic disease characterized by high levels of blood sugar). A review of an MDS, dated [DATE], indicated Resident 2 had no memory impairment. A review of Resident 4 ' s admission record indicated admission to the facility on [DATE] with diagnoses which included chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood). A review of an MDS, dated [DATE], indicated Resident 4 had no memory impairment. During a phone interview on 3/5/25 at 10:05 a.m., Family Member XX stated Resident 1 had lost his dentures at the facility approximately a year and a half prior ago and she had notified the Social Services Director 1 (SSD 1) about it. The Family Member XX also stated Resident 1's dentures had not been located, replaced, or reimbursed. Family Member XX also stated she had been bringing clothes for Resident 1 throughout his stay at the facility. Record review of Resident 1's weekly progress note dated 4/5/24 at 3:12 a.m., indicated Resident 1 had dentures. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Administrator (ADM) on 3/12/25 at 3:50 p.m., a social services note for Resident 1 dated 4/18/24 at 9:03 a.m., was reviewed. The note indicated the SSD 1, LM (Left message) for Daughter RP (Responsible Party), regarding missing dentures. The ADM acknowledged this note and stated he would expect to see a missing items report for Resident 1 ' s dentures based on this information. The ADM also reviewed Resident 1's facility document titled, INVENTORY OF PERSONNAL EFFECTS (Inventory sheet) dated 3/13/23. The inventory sheet indicated the clothing Resident 1 was admitted with, but did not include any additional items obtained by Resident 1 after his admission. A review of the inventory sheet indicated no documented evidence it had been updated since 3/13/23 and had not included Resident 1's RP's signature. The ADM acknowledged Resident 1's inventory sheet had not been updated to reflect additional clothing the RP had brought for Resident 1 nor had it been signed by the RP. The ADM stated Certified Nursing Assistants (CNAs), Licensed Nurses (LNs) and Department heads were responsible for updating the inventory sheet when the resident received additional items. The ADM stated the Resident or RP and a staff member were required to sign the inventory sheet. Further review of the inventory sheet indicated, .Update as needed throughout the resident's stay by using the space provided. During an interview on 3/5/25 at 11:50 a.m., Resident 2 stated he lost all the original clothing he was admitted with because he was not notified he had to label his clothing with his name for identification purposes upon admission. According to Resident 2, his clothes were never returned after they were taken by staff to the laundry. Resident 2 stated he tried to tell the housekeeping personnel to look for his clothes, but they did not speak English and could not understand his request. Resident 2 stated he also told other facility staff about his missing clothes but he could not remember their names. Resident 2 stated his clothes were never located, reimbursed, or replaced. During a concurrent interview and record review with Resident 2 on 3/12/25 at 3:02 p.m., the document titled, INVENTORY OF PERSONAL EFFECTS with his name on it was reviewed. This document indicated Resident 2 had the following items in his possession upon admission on 12/3/24, BLUE HOODY JACKET . BLUE SHORTS .PAIR OF GRAY SLIPPERS .BLUE SHIRT .GRAY BLACK JOGGER .SOCKS. Resident 2 stated he had lost all these items at the facility and had notified staff about it but received no resolution. Resident 2 stated the blue jacket was the most significant loss because it was given to him by his mother. During an interview on 3/5/25 at 11:20 a.m., Resident 4 stated she currently had three dresses that went missing at the facility. Resident 4 stated she reported two of the three missing dresses about six months ago to SSD 1, but the dresses had not been located, replaced, or reimbursed. Resident 4 also stated laundry staff regularly delivered clothes which did not belong to her every two or three days. Resident 4 stated she has to alert staff to take them back because they are someone else's. During a concurrent interview and record review with Resident 4 on 3/12/25 at 2:40 p.m., the document titled, INVENTORY OF PERSONAL EFFECTS, with her name on it was reviewed. This document indicated Resident 4 had several dresses in her possession on 2/3/23 including a, Raspberry/white polka dot dress . [and] Raspberry/pink flower dress. Resident 4 stated these were the dresses she lost about six months prior. Resident 4 stated she filled out a theft/loss report and provided it to SSD 1 to report her missing dresses. Resident 4 stated she was not given a copy of her signed missing items report. Resident 4 still had not received a resolution to her missing dresses. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/5/25 at 12:44 p.m., the Social Services Director 2 (SSD 2) stated she was recently notified of Resident 1 ' s missing dentures and was in the process of replacing them. The SSD 2 stated her employment as an SSD had just started a week prior, as the SSD 1 had left, and SSD 2 was promoted to the position. The SSD 2 stated the facility was supposed to replace or reimburse residents ' personal items lost at the facility. The SSD 2 stated there was only one missing items report on file and it belonged to Resident 1. The report titled Theft/Loss Report indicated Resident 1 lost two pairs of sweatpants on 7/13/23. The SSD 2 stated there was no documented evidence the facility reimbursed or replaced the items in the report. The SSD 2 stated she was unable to locate any other missing items reports. During an interview on 3/12/24 at 1:30 p.m., the Maintenance Director (MD) stated when residents reported missing items, he would try to locate the items first. If they were not found, the MD verbally notified SSD 1 but did not document this notification. During an interview on 3/12/25 at 2:06 p.m., Housekeeper A stated when residents reported missing items, she would first try to locate them. If they were not found, Housekeeper A verbally notified the MD. The Housekeeper A also stated she felt CNAs failed to bring resident clothing to the housekeeping department to be labeled which contributed to the missing clothing. Housekeeper A stated she received four bags of clothing to label for seven newly admitted residents in the last four weeks. A review of the facility's document titled Admission/Discharge To/From Report indicated seven new residents were admitted to the facility between 2/12/25 and 3/12/25. During an interview on 3/12/25 at 2:17 p.m., the CNA F stated when residents reported missing items, she would try to locate the items first. It they were not found, the CNA F verbally notified the MD. During an interview on 3/12/25 at 3:40 p.m., Licensed Staff G stated when residents reported missing items, he sent a communication message through the facility ' s electronic documentation system. All staff who had access to the system would receive the message and try to locate the missing items, but the message was not part of the residents' medical record. The Licensed Staff G stated there was no way to know if the SSD had read the communication messages he sent. The Licensed Staff G stated he had not documented residents ' reports of missing items in their progress notes. During a concurrent record review and interview with SSD 2 on 3/12/25 at 2:40 p.m., the file which contained missing items reports and grievances was reviewed. The last missing items report on file was dated April 2024. The last grievance on file was also dated April 2024. There were no missing items reports for Resident 2, Resident 4, or Resident 1's belongings. The SSD 2 confirmed the missing reports and grievance documents and who added, This is just ridiculous [regarding the lack of new or updated grievances of missing items reports since April 2024]. The SSD 2 stated she previously worked in the business office and did not know SSD 1 had not been filing or keeping records of the grievances. The SSD 2 also if residents filed grievances and the SSD 1 had not provided them with a copy of the grievance, then there was no way for residents to know if the information in the grievance was correct. A review of the Social Services Designee job description, signed by SSD 1 on 8/7/23, indicated, Essential Duties .Assist in inventory and tracking patient belongings .Coordinate response to reports of missing, lost or stolen belongings. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Lost and Found dated 1/2008, indicated, Our facility shall assist all personnel and residents in safe-guarding their personal property . Lost and found records will be maintained for one (1) year, then destroyed .Reports of misappropriation or mistreatment of resident property are immediately investigated. A review of the facility's policy titled Grievances/Complaints, Filing, last revised in 4/2017, indicated, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances .The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative .Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care . theft of property, or any other concerns .Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint .The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure three residents (Resident 1, Resident 2 and Resident 4) of four sampled residents who lost personal items at the facility had their items located, replaced or reimbursed. These failures had the potential to result in feelings of frustration, loss of control, and uncertainty, which could have affected the residents' comfort at the facility. Findings: A review of Resident 1's admission record indicated admission to the facility on [DATE] with diagnoses which included dementia (a group of conditions that cause loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 12/11/24, indicated Resident 1 had severe memory impairment. A review of Resident 2's admission record indicated admission to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a chronic disease characterized by high levels of blood sugar). A review of an MDS, dated [DATE], indicated Resident 2 had no memory impairment. A review of Resident 4's admission record indicated admission to the facility on [DATE] with diagnoses which included chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood). A review of an MDS, dated [DATE], indicated Resident 4 had no memory impairment. During a phone interview on 3/5/25 at 10:05 a.m., Family Member XX stated Resident 1 had lost his dentures at the facility approximately a year and a half prior ago and she had notified the Social Services Director 1 (SSD 1) about it. The Family Member XX also stated Resident 1's dentures had not been located, replaced, or reimbursed. Family Member XX also stated she had been bringing clothes for Resident 1 throughout his stay at the facility. Record review of Resident 1's weekly progress note dated 4/5/24 at 3:12 a.m., indicated Resident 1 had dentures. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Administrator (ADM) on 3/12/25 at 3:50 p.m., a social services note for Resident 1 dated 4/18/24 at 9:03 a.m., was reviewed. The note indicated the SSD 1, LM (Left message) for Daughter RP (Responsible Party), regarding missing dentures. The ADM acknowledged this note and stated he would expect to see a missing items report for Resident 1's dentures based on this information. The ADM also reviewed Resident 1's facility document titled, INVENTORY OF PERSONNAL EFFECTS (Inventory sheet) dated 3/13/23. The inventory sheet indicated the clothing Resident 1 was admitted with, but did not include any additional items obtained by Resident 1 after his admission. A review of the inventory sheet indicated no documented evidence it had been updated since 3/13/23 and had not included Resident 1's RP's signature. The ADM acknowledged Resident 1's inventory sheet had not been updated to reflect additional clothing the RP had brought for Resident 1 nor had it been signed by the RP. The ADM stated Certified Nursing Assistants (CNAs), Licensed Nurses (LNs) and Department heads were responsible for updating the inventory sheet when the resident received additional items. The ADM stated the Resident or RP and a staff member were required to sign the inventory sheet. Further review of the inventory sheet indicated, .Update as needed throughout the resident's stay by using the space provided. During an interview on 3/5/25 at 11:50 a.m., Resident 2 stated he lost all the original clothing he was admitted with because he was not notified he had to label his clothing with his name for identification purposes upon admission. According to Resident 2, his clothes were never returned after they were taken by staff to the laundry. Resident 2 stated he tried to tell the housekeeping personnel to look for his clothes, but they did not speak English and could not understand his request. Resident 2 stated he also told other facility staff about his missing clothes but he could not remember their names. Resident 2 stated his clothes were never located, reimbursed, or replaced. During a concurrent interview and record review with Resident 2 on 3/12/25 at 3:02 p.m., the document titled, INVENTORY OF PERSONAL EFFECTS with his name on it was reviewed. This document indicated Resident 2 had the following items in his possession upon admission on 12/3/24, BLUE HOODY JACKET . BLUE SHORTS .PAIR OF GRAY SLIPPERS .BLUE SHIRT .GRAY BLACK JOGGER .SOCKS. Resident 2 stated he had lost all these items at the facility and had notified staff about it but received no resolution. Resident 2 stated the blue jacket was the most significant loss because it was given to him by his mother. During an interview on 3/5/25 at 11:20 a.m., Resident 4 stated she currently had three dresses that went missing at the facility. Resident 4 stated she reported two of the three missing dresses about six months ago to SSD 1, but the dresses had not been located, replaced, or reimbursed. Resident 4 also stated laundry staff regularly delivered clothes which did not belong to her every two or three days. Resident 4 stated she has to alert staff to take them back because they are someone else's. During a concurrent interview and record review with Resident 4 on 3/12/25 at 2:40 p.m., the document titled, INVENTORY OF PERSONAL EFFECTS, with her name on it was reviewed. This document indicated Resident 4 had several dresses in her possession on 2/3/23 including a, Raspberry/white polka dot dress . [and] Raspberry/pink flower dress. Resident 4 stated these were the dresses she lost about six months prior. Resident 4 stated she filled out a theft/loss report and provided it to SSD 1 to report her missing dresses. Resident 4 stated she was not given a copy of her signed missing items report. Resident 4 still had not received a resolution to her missing dresses. (continued on next page)

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Ridgeway Post Acute	523 Hayes Lane Petaluma, CA 94952

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/5/25 at 12:44 p.m., the Social Services Director 2 (SSD 2) stated she was recently notified of Resident 1's missing dentures and was in the process of replacing them. The SSD 2 stated her employment as an SSD had just started a week prior, as the SSD 1 had left, and SSD 2 was promoted to the position. The SSD 2 stated the facility was supposed to replace or reimburse residents' personal items lost at the facility. The SSD 2 stated there was only one missing items report on file and it belonged to Resident 1. The report titled Theft/Loss Report indicated Resident 1 lost two pairs of sweatpants on 7/13/23. The SSD 2 stated there was no documented evidence the facility reimbursed or replaced the items in the report. The SSD 2 stated she was unable to locate any other missing items reports. During an interview on 3/12/24 at 1:30 p.m., the Maintenance Director (MD) stated when residents reported missing items, he would try to locate the items first. If they were not found, the MD verbally notified SSD 1 but did not document this notification. During an interview on 3/12/25 at 2:06 p.m., Housekeeper A stated when residents reported missing items, she would first try to locate them. If they were not found, Housekeeper A verbally notified the MD. The Housekeeper A also stated she felt CNAs failed to bring resident clothing to the housekeeping department to be labeled which contributed to the missing clothing. Housekeeper A stated she received four bags of clothing to label for seven newly admitted residents in the last four weeks. A review of the facility's document titled Admission/Discharge To/From Report indicated seven new residents were admitted to the facility between 2/12/25 and 3/12/25. During an interview on 3/12/25 at 2:17 p.m., the CNA F stated when residents reported missing items, she would try to locate the items first. It they were not found, the CNA F verbally notified the MD. During an interview on 3/12/25 at 3:40 p.m., Licensed Staff G stated when residents reported missing items, he sent a communication message through the facility's electronic documentation system. All staff who had access to the system would receive the message and try to locate the missing items, but the message was not part of the residents' medical record. The Licensed Staff G stated there was no way to know if the SSD had read the communication messages he sent. The Licensed Staff G stated he had not documented residents' reports of missing items in their progress notes. During a concurrent record review and interview with SSD 2 on 3/12/25 at 2:40 p.m., the file which contained missing items reports and grievances was reviewed. The last missing items report on file was dated April 2024. The last grievance on file was also dated April 2024. There were no missing items reports for Resident 2, Resident 4, or Resident 1's belongings. The SSD 2 confirmed the missing reports and grievance documents and who added, This is just ridiculous [regarding the lack of new or updated grievances of missing items reports since April 2024]. The SSD 2 stated she previously worked in the business office and did not know SSD 1 had not been filing or keeping records of the grievances. The SSD 2 also if residents filed grievances and the SSD 1 had not provided them with a copy of the grievance, then there was no way for residents to know if the information in the grievance was correct. A review of the Social Services Designee job description, signed by SSD 1 on 8/7/23, indicated, Essential Duties .Assist in inventory and tracking patient belongings .Coordinate response to reports of missing, lost or stolen belongings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555703	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Post Acute	523 Hayes Lane Petaluma, CA 94952

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Lost and Found dated 1/2008, indicated, Our facility shall assist all personnel and residents in safe-guarding their personal property . Lost and found records will be maintained for one (1) year, then destroyed .Reports of misappropriation or mistreatment of resident property are immediately investigated. A review of the facility's policy titled Grievances/Complaints, Filing, last revised in 4/2017, indicated, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances .The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative .Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care . theft of property, or any other concerns .Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint .The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.