

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555703	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Ridgeway Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure an abuse allegation between Residents 1 and 2 was reported to the state licensing/certification agency (the state) within 2 hours. This failure could put the residents at significant risk for continued harm, which could lead to severe physical and psychological trauma. Findings: A review of Resident 1's face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 12/2017 with a diagnosis of Schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 6/27/25, score was 10 indicating Resident 1 had moderately impaired thinking and memory. A review of Resident 2's face sheet indicated an admission date in 9/2023 with a diagnosis of Dementia (a progressive state of decline in mental abilities) and Major Depressive disorder. A review of Resident 2s BIMS, dated 6/18/25, score was 10 indicating Resident 2 had moderately impaired thinking and memory. A review of the SOC 341 form (written report used by mandated reporters when abuse or neglect of an elder (65+) or dependent adult (18-64 with disabilities) is suspected), dated 7/31/25, indicated, . at around 5:10 AM. Resident states that he does not know why roommate hit him. and roommate just punched him in the face. resident hit roommate on the right temple. roommate retaliated by hitting resident back on the nose. The fax confirmation sheet indicated the SOC 341 form was sent to the state licensing/certification agency on 7/31/25 at 8:50 a.m. During an interview on 8/20/25 at 2:14 p.m., the Minimum Data Set coordinator (MDSC) stated abuse allegations should be reported to the state within 2 hours of discovery. MDSC stated if the abuse allegation was not reported to the state within 2 hours, residents' safety could be at risk. During an interview on 8/20/25 at 3:27 p.m., the Director of Staff Development (DSD) stated that abuse allegations should be reported to the state within 2 hours of discovery. The DSD stated if not reported to the state immediately, within 2 hours, resident could be at risk for continued abuse. During a concurrent interview and record review on 12/16/25 at 11:41 a.m., with the Director of Nursing (DON), the SOC 341, sent to the state on 7/31/25 at 8:50 a.m., was reviewed. The DON verified the facility was aware of the abuse allegation on 7/31/25 at 5:10 a.m. The DON stated that abuse allegations should be reported to the state within 2 hours of discovery. The DON verified that this abuse allegation was reported late to the state. A review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, revised 9/2022, the P&P indicated, . the administrator or the individual making the allegation immediately reports his or her suspicions to the following persons or agencies: state licensing/certification agency responsible for surveying/licensing the facility, local state ombudsman, law enforcement official. immediately is defined as within 2 hours of an allegation involving abuse or result in serious bodily injury.</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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the Long Term Care Ombudsman (ombudsman, an advocate for residents of nursing homes, board and care centers, and assisted living facilities) for one out of two sampled residents (Resident 3) when Resident 3 was discharged from the facility and admitted to the hospital on [DATE] and again on 8/12/25. This failure put Resident 3 at risk for unsafe discharge. Findings: During an interview on 8/20/25 at 2:14 p.m., the Minimum Data Set coordinator (MDSC) stated the Ombudsman needs to be notified when a resident was sent or discharged to the hospital. The MDSC stated this was the residents' right and for their safety. During an interview on 8/20/25 3:27 p.m., the Director of Staff Development (DSD) stated the facility should notify the Ombudsman when residents are discharged to home or transferred to the hospital. The DSD stated if the Ombudsman was not notified of a discharge or transfer, it could leave the resident vulnerable to an unsafe discharge. During a concurrent interview and record review on 12/16/25 at 11:41 a.m. with the Director of nursing (DON), Resident 3's admission/discharge census record was reviewed. The DON verified Resident 3 was transferred to the hospital on 7/15/25 and 8/12/25. The DON stated the facility should notify the Ombudsman of discharges and transfers to the hospital per the facility policy. The DON stated the person responsible for notifying the Ombudsman of discharges and transfers was the Social Services Director (SSD). The DON stated if the Ombudsman was not notified of discharge or transfer to the hospital, residents would be at risk for unsafe discharge. During an interview on 12/16/25 at 12:40 p.m., the SSD stated it was their responsibility to notify the Ombudsman of a resident transfer or discharge. The SSD stated she did not have any documentation that indicated the Ombudsman was notified of Resident 3's transfers to the hospital on 7/15/25 or 8/12/25. A review of the facility's policy and procedure (P&P) titled Transfer and Discharge Notices, revised 3/2025, the P&P indicated, . notice of transfer and discharge (emergency): notice of transfer is provided to the resident and responsible party (RP) as soon as possible before the transfer and to the long term care (LTC) ombudsman when practicable (in a monthly list that includes all notices.) A review of the All Facilities Letter (AFL) 25-17 dated 5/28/25, indicated, before the SNF (Skilled Nursing Facility) transfers or discharges the resident, the SNF must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman.</p>		