

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555836	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Arbol Healthcare Center of Santa Rosa		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Fountaingrove Parkway Santa Rosa, CA 95403	
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 - Few	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** Based on observation, interview, and record review, the facility failed to provide care that respected resident dignity for one out of 13 sampled residents (Resident 34) when: 1. Staff did not close Resident 34's privacy curtain and door when performing a COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) and influenza (a respiratory infection caused by influenza virus) swab on Resident 34.2. Staff did not knock on Resident 34's room prior to entering. These failures had the potential for improper care to the residents. Findings:1. During a review of Resident 34's admission RECORD (AR), dated 9/16/2025, the admission record indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (a condition where blood flow to the brain is interrupted), apraxia (a disorder that affects speech) and aphasia (a disorder that affects the ability to understand language). During a concurrent observation and interview on 9/15/2025 at 4:03 p.m. with the Registered Nurse (RN) 1, outside of Resident 34's room, Resident 34 was lying in the bed, and was visible from the hallway. Resident 34's privacy curtain was not closed, and the door was wide open. RN 1 was observed swabbing Resident 34's nostrils. RN 1 stated the nostril swabs were to obtain COVID-19 and influenza samples. During a concurrent observation and interview on 9/15/2025 at 4:08 p.m. with Resident 34, in Resident 34's room, Resident 34 had difficulty forming words and was unable to move her right side of the body. Resident 34 was asked if it bothered her when RN 1 swabbed her nostrils without closing her privacy curtains, and Resident 34 nodded her head up & down with facial grimacing (a distorted facial expression that typically conveys pain or discomfort). During an interview on 9/15/2025 at 4:12 p.m. with RN 1, RN 1 stated I am only on call. I'm off shift right now, and walked away from this surveyor. During an interview on 9/18/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated all staff must close residents' privacy curtain when performing nostrils swab testing to protect their privacy and maintain their dignity. During a review of facility's policy and procedure (P&P) titled, Quality of Life - Dignity, [undated], the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .2. During a review of Resident 34's admission RECORD, dated 9/16/2025, the admission record indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (a condition where blood flow to the brain is interrupted, causing damage to brain tissue), apraxia (a disorder that affects speech) and aphasia (a disorder that affects the ability to understand language). During an observation on 9/15/2025 at 4:08 p.m. in Resident 34's room, the Registered Nurse (RN 1) entered Resident 34's room without knocking, no communication with Resident 34, picked up her things and left the room. During an interview on 9/15/2025 at 4:12 p.m. with RN 1, RN 1 stated I am only on call. I'm off shift right now, and walked away from this surveyor. During an interview on 9/18/2025 at 11:00 a.m. with the Director of Nursing (DON), the DON stated all staff must knock and ask permission before entering any of the residents' rooms. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Dignity, [undated], the P&P indicated, Each resident shall be cared for (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering residents' rooms .		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure a physician obtained informed consents (a process in which residents are given important information of the possible risk and benefits of the use of psychotropic medications-drug affecting mental state) for one of thirteen sampled residents (Resident 38) when Resident 38 received Trazodone HCl (an antidepressant medication) and Escitalopram Oxalate (antidepressant medication) without an informed consent. This failure had the potential in Resident 38 receiving psychotropic medications without being fully informed of the risk and benefits of the medication being administered. Findings: During a concurrent interview and record review on 9/17/25 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 38's physician orders were reviewed. The orders included Trazadone and Escitalopram Oxalate. LVN 1 stated there was no consent obtained for both medications and that it was the licensed nurse's responsibility to ensure the consent was obtained. During an interview on 9/17/2025 at 2:17 p.m. with Minimum Data Set Nurse (MDSN), MDSN stated a consent for Escitalopram and Oxalate Trazodone HCl needed to be obtained. During a concurrent interview and record review on 9/18/25 at 11:20 a.m. with the Director of Nursing (DON) the facility policy and procedure titled Informed Consent Policy dated 01/2024 was reviewed. The policy indicated .It is the policy of this Facility to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs, physical restraints and medical devices which may lead to the inability to regain use of a body function after prolonged use . The DON stated it was the nurse's responsibility to ensure the informed consent was signed. The DON stated the purpose of the consent was to ensure the resident or family know the risk and benefits.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to complete a Physician Orders for Life Sustaining Treatment (POLST- is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) for one of thirteen sampled residents (Residents 33). This deficient practice had the potential for Resident 33 to receive unnecessary care and/or treatment services against the resident's wishes. Findings: During an interview on 9/15/25 at 3:38 P.M. with Resident 33, Resident 33 stated that she would like a copy of the POLST but it was not given. During a concurrent interview and record Review on 9/17/25 at 11:28 A.M. with Licensed Vocational Nurse (LVN) 1, Resident 33's POLST was reviewed. LVN 1 stated the POLST was in the chart but was not completed. LVN 1 stated it was the nurse's responsibility to ensure that the POLST was completed. LVN 1 stated on 9/14/25, the progress note indicated a follow up would be done but no follow up was done. During a concurrent interview and record review on 9/18/25 at 11:17 A.M. with the Director of Nursing (DON) the facility policy and procedure titled Advanced Directive dated 12/2016 was reviewed. The policy indicated . Upon admission, the resident will be provided with written information concerning the right to refuse medical or surgical treatment and to formulate an advance directive if he or she chooses to do so . The DON stated the physician goes over the POLST with the resident and it was the nurse's responsibility to ensure it was completed.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written Notice of Medicare Provided Non-Coverage (NOMNC-a notice that informs the beneficiary about the impending end of coverage and their right to appeal the decision) for one of thirteen sampled residents (Resident 42) when Medicare coverage was terminated. This deficient practice resulted in not protecting Resident 42's right to appeal the termination of Medicare Part A and possibly denying Resident 42's needed services. Findings:During a review of Resident 42's Minimum Data Set (MDS- a report that helps the healthcare team plan the best treatment and services for a resident in a skilled nursing facility), the MDS indicated that Resident 42 was admitted to the facility on [DATE] with diagnoses that included sepsis (a severe life-threatening reaction to infection) and cancer. During a concurrent interview and record review on 9/16/2025 at 2:00 p.m. with Operations Manager (OM), OM reviewed the facility document titled, Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review which indicated Resident 42's Medicare Part A Skilled Services Episode start date was 9/13/2024 and the last covered day of Medicare Part A Service was on 3/3/2025. OM stated that a NOMNC was not provided to Resident 42 because the previous ownership [had] miscalculated days at SOC (start of care) on 11/23/2024 as previous days used [at] 49.when [it] should have been 47. OM indicated that because of the miscalculation of days previously used, the facility failed to ensure that Resident 42 received the required NOMNC timely. During a review of the facility's policy and procedure (P&P) titled, Medicare Denial Process Beneficiary Notices dated 11/27/2023, the P&P indicated, Medicare beneficiaries will be properly notified in accordance with the most current Centers for Medicare and Medicaid Services (CMS) Beneficiary Notice guidelines when it is determined that they do not meet the requirements for covered skilled services under the Medicare program. The use of notification form including the timing and instructions will be based on CMS guidelines on CMS/Medicare Beneficiary Notice Initiative (BNI- a program that makes skilled nursing facilities tell residents ahead of time when Medicare will stop paying for their care) .and will be used by the facility upon; a minimum of 2 days prior to the last Medicare Part A covered day. This includes the denial date, last covered day and first day of non-coverage, and the appropriate type of denial letter to be initiated based on the reason for denial.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview, and record review, the facility failed to maintain a safe and comfortable environment for three of 13 sampled residents (Resident 6, Resident 8 and Resident 18) when:1. Resident 6's inventory sheet was not updated and was inaccurately completed. This failure had the potential to result in Resident 16's belongings not being documented in the event of an alleged loss or theft.2. Fire alarm test was conducted without notification to Resident 8 and 18. This failure resulted in Resident 8 and 18 feeling startled.Findings:1.During an interview on 9/15/25 at 4:40 p.m. with Family (FM), FM stated that the facility had misplaced her dad's hearing aids and that she had to purchase a new set. FM stated she was unaware of the inventory log.During a concurrent interview and record review on 9/17/25 at 9:24 a.m. with Social Service Director (SSD), Resident 6's Inventory of Personal Effects (IPE) dated 8/27/25 was reviewed. The IPE indicated, one left hearing aid. SSD stated the inventory was not documented accurately since he had two hearing aids. SSD stated on 9/6/25 the daughter had purchased new pair of hearing aids which was not inventoried.During a concurrent interview and record review on 9/18/25 at 11:32 a.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled Resident's Personal Belongings-Personal Property dated 6/13/25 was reviewed. The P&P indicated .The resident's personal belongings and clothing shall be inventoried and documented upon admission and as needed as changes are made . The DON stated that it was the nurses and SSD responsibility to inventory personal belongings, to ensure safety and reimburse the resident in the event it gets lost or stolen.2.During an interview on 9/16/25 at 2:36 p.m. with Resident 18, Resident 18 stated a week ago the facility conducted a fire alarm test without informing her. Resident 18 stated the alarm startled her because she thought there was an actual fire.During an interview on 9/16/25 at 2:38 p.m. with Resident 8, Resident 8 stated the fire alarm was really loud and that she was unaware of the test. Resident 8 stated, The alarm startles you when you are sleeping.During a review of the facility Fire Safety Service Invoice (FSS) dated 9/9/25, the FSS indicated, three fire tests were conducted on 9/9/25 10:45 A.M., 5:15 P.M. and on 9/10/25 at 3:00 A.M.During an interview on 9/16/25 at 3:35 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated that there was a fire alarm test last week. CNA 1 stated she was notified about the fire alarm test but was not instructed to notify the residents.During a concurrent interview and record review on 9/18/25 at 11:21 a.m. with the DON, the facility P&P titled Testing of Fire Alarm System dated 05/2008 was reviewed. The P&P indicated .Notify all staff that the alarm is only a test . The DON stated residents should also be notified so they will not be startled and to keep them comfortable.During a review of the facility P&P titled, Quality of Life-Homelike Environment dated 05/2007, the P&P indicated, .Residents are provided with a safe, clean comfortable and homelike environment .comfortable noise levels .		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain professional standards when oxygen was administered to one of 13 sampled residents (Resident 35), without a physician's order. This failure had the potential to cause harm to the residents. Findings: During a review of Resident 35's admission Record, dated 9/16/2025, the admission record indicated, Resident 35 was admitted to the facility on [DATE] with diagnoses of emphysema (a disease where the air sacs in the lungs are damaged), respiratory failure with hypoxia (a condition where the lungs fail to provide enough oxygen), and dependence on supplemental oxygen (the need for supplemental oxygen therapy to maintain adequate oxygen levels in the body). During an observation on 9/16/2025 at 1:57 p.m. in Resident 35's room, Resident 35 was observed lying in bed while receiving four liters per minute continuous supplemental oxygen through nasal cannula (a thin, two-pronged plastic tube device that delivers supplemental oxygen from the oxygen tank to the nostrils). During a review of Resident 35's Order Summary Report, dated 9/16/2025, the order summary report indicated there was no physician order for oxygen for Resident 35. During an interview on 9/17/2025 at 2:00 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated there was no oxygen order from the physician. MDSN stated this must have been overlooked. During an interview on 9/18/2025 at 11:01 a.m. with the Medical Doctor (MD 1), MD 1 stated oxygen is considered a medication and oxygen administration must have a physician's order. MD 1 stated that oxygen administration without physician's order can harm residents with hypoxia (not enough oxygen in the body) or oxygen toxicity (too much oxygen in the body). During an interview on 9/18/2025 at 11:45 a.m. with the Director of Nursing (DON), the DON stated, I forgot to put the order in, I was busy with admission and did not enter her oxygen order. The DON added that the expectation was for all medications, including oxygen, to have a physician order, or it could harm the residents. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated October 2010, the P&P indicated, Guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that medications were stored securely and administered according to physician orders for one of 13 sampled residents (Resident 20) when staff left medication at Resident 20's bedside. This failure had the potential for misuse by the resident on unintended areas or for non-approved purposes. Findings: On 9/15/2025 at 3:50 p.m. a 30 milliliter (unit of measurement) medication cup with a white cream/ointment was observed on the shelf in Resident 20's room. The medication cup was not labeled. On 9/15/2025 at 3:56 p.m. during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, LVN 1 verified that Resident 20 did not have a physician order to keep any type of medication at bedside. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility dated April 2008, the P&P indicated, ID4: Bedside Medication Storage. A. A written order for the bedside storage of medication is present in the resident's medical record.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in safe and sanitary conditions in the food service department, when the dry storage area contained food items that were undated. This failure had the potential to expose residents to food contamination and food-borne illnesses (sickness by consuming contaminated food or drinks). Findings: During a concurrent observation and interview on 9/16/2025 at 2:00 p.m. with the Consultant Registered Dietitian (CRD), in the kitchen, there was a food container labeled Polenta with no expiration date. CRD stated the expectation was for staff to carefully inspect all food delivery, to label and to date food items. CRD further stated labeling and dating food items were necessary to prevent food-borne illnesses to the residents. During a review of the facility's policy and procedure (P&P) titled, GENERAL RECEIVING OF DELIVERY OF FOOD AND SUPPLIES, dated 2018, the P&P indicated, Label all items with the delivery date or a use-by-date .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain a safe and sanitary environment with an effective infection prevention and control program for two of 13 sampled resident's (Resident 33 and Resident 4) when: 1.Certified Nursing Assistant (CNA) 1 entered a coronavirus (COVID-19- a contagious serious respiratory infection transmitted from person to person) isolation room with a surgical mask.2. Enhanced Barrier Precautions (EBP, an infection control strategy in nursing homes that expands the use of Personal Protective Equipment (PPE), specifically gowns and gloves, for high-contact care activities to prevent the spread of multidrug-resistant organisms), was not followed for one of 13 sampled residents (Resident 4).These failures had the potential to place residents and staff at increased risk for infections. Findings: 1.During an observation on 9/16/25 at 3:28 P.M. near room [ROOM NUMBER], a red sign was posted which read Stop Special droplet/contact precautions. A three-compartment cart was located next to the door which contained Personal Protective Equipment (PPE-protective clothing to prevent infection). The room door was open and CNA 1 walked out of the room with a surgical face mask. During an interview on 9/16/25 at 3:29 P.M. with CNA 1, CNA 1 stated she was in the room giving Resident 33 a bath. CNA 1 stated she was wearing a surgical mask because wearing an N95 (mask approved to filter airborne particles) made it hard to breathe and fogged up her glasses. CNA 1 stated she was supposed to wear an N95 when in a droplet isolation room. During an interview on 9/17/2025 at 9:48 A.M. with Infection Preventionist (IP), IP stated the purpose of wearing the N95 was to prevent transmission of infection and source control. IP stated, Resident 33 was on isolation for COVID-19 and that staff should be wearing an N95 when entering the room. During a concurrent interview and record review on 9/18/25 at 11:18 A.M. with the Director of Nursing (DON), the facility policy and procedure titled COVID-19 Isolation Quarantine PPE Requirement dated 8/14/25 was reviewed. The policy indicated .To prevent the spread of COVID 19 and to protect Residents and Staff affected by the infectious disease. Staff need to wear .N95 respirator .when caring for symptomatic or confirmed COVID-19 positive residents on isolation . The DON stated staff should wear N95 in COVID-19 isolation for protection against the virus. 2. During a review of Resident 4's admission Record, dated 9/17/2025, the admission record indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis (MS, a chronic, autoimmune disease that affects the brain and spinal cord) and had a gastrostomy tube (a surgical procedure that creates an opening in the abdomen into the stomach). During an observation on 9/17/2025 at 8:49 a.m. outside Resident 4's room, an EBP poster was posted next to Resident 4's name. The EBP poster indicated staff must wear gloves and gown for high-contact resident care activities including Device care or use, feeding tube (flexible tube inserted directly into the stomach to deliver food). During a concurrent observation and interview on 9/17/2025 at 8:51 a.m. with Registered Nurse (RN) 3 in Resident 4's room, RN 3 was observed wearing gloves and disconnecting Resident 4's feeding tube from Resident 4's stomach. RN 3 stated, I just forgot to put the gown on and did not pay attention. RN 3 further stated, I should have worn it because Resident 4 is on EBP precautions. RN 3 stated, EBP precautions need to be followed to reduce risk of contamination to the residents. (continued on next page)		

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