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

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555836	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbol Healthcare Center of Santa Rosa	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility placed the life of one of three sampled residents (Resident 1) in danger when the facility discharged her from the facility when her insurance coverage ended. The facility did so fully aware Resident 1's family could not provide care at home, and without an appropriate discharge plan, transfer documentation, or follow-up aftercare. In addition, the facility physician discharge orders for Physical therapy (PT, the practice of improving mobility and flexibility through a variety of exercises and other treatments), Occupational Therapy (OT, a therapy that uses everyday life activities to promote health, well-being, and the ability to participate in important activities) and Registered Nursing Services, dated 11/28/25, were not followed.As a result, Resident 1 was immediately hospitalized after discharge from the facility, with a post-surgical abdominal wound dehiscence (when a surgical incision splits open again requiring prompt medical attention) requiring immediate surgery. A review of Resident 1's facility admission Record (Facility demographic), indicated Resident 1 was admitted to the facility on [DATE] with multiple diagnoses which included disruption or dehiscence of closure of internal operation (surgical) wound of abdominal wall, end stage renal disease (when kidneys lose almost all function, requiring dialysis or transplant), and cognitive communication deficit (a difficulty in expressing or understanding messages due to impaired thinking skills like attention, memory, problem-solving, or organization).A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), dated 11/28/25, indicated Resident 1had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 which indicated Resident 1 was cognitively intact (A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). The MDS also indicated Resident 1 used a wheelchair, required substantial/maximum assistance for toileting, showering, dressing, bed mobility, and transfers. In addition, the MDS indicated Resident 1 received hemodialysis (a life-sustaining treatment that acts as an artificial kidney, filtering waste, toxins, and extra fluid from the blood when kidneys fail), speech therapy, occupational therapy, and physical therapy while in the facility. The MDS also indicated Resident 1 had a recent surgery requiring active Skilled Nursing Facility (SNF) care.A review of Resident 1's facility document titled, Care Plan Report, initiated on 11/18/25 indicated interventions for safe discharge included, make arrangements with required community resources to support independence post-discharge for [Resident 1's] preferred home care, PT, OT, MD [Medical Doctor], Wound Nurse.make arrangements with required community resources to support independence post-discharge.A review of Resident 1's facility document titled, Order Summary Report, dated 12/04/25, indicated Resident 1 was prescribed wound Vacuum-Assisted Closure (VAC therapy- a special foam dressing, tubing, and a portable pump to create gentle suction on a wound, removing fluid, reducing swelling, and promoting the growth of new tissue for faster healing) care and to, apply black foam on top of wound bed and cover with vac tape. Set wound vac to 125 mmHg [meters of mercury, a unit used to measure pressure] continuous pressure.A review of Resident 1's wound care note titled, SNF Wound Care @ [at] [Facility name], dated 11/24/25, indicated Resident 1's abdominal wound measured 14.0 cm (centimeters-a unit of measure) x 10.0 cm x UTD [unmeasurable] after debridement (a medical procedure to remove dead, damaged, or infected tissue), with light serosanguineous drainage (a normal, watery, pale pink or reddish fluid from a healing wound, a mix of clear serum and a small amount of blood, indicating healthy healing).A review of Resident 1's facility Progress Notes, dated 11/25/25, indicated Social Services Director (SSD) presented Resident 1 and spouse (FM) with a Notice of Medicare Non-Coverage (NOMNC-a form Medicare providers must give beneficiaries when their Medicare-covered services are ending, informing them of their right to appeal the decision) on 11/27/25 for impending discharge on [DATE]. This note indicated when FM received this form, he stated, if she [Resident 1] discharges on 11/28/25 I will be bringing her straight back to the hospital and that's that.A review of Resident 1's facility document titled, Notice of Transfer or Discharge, dated 11/28/25, indicated Resident 1 was notified on 11/28/25 about impending discharge home on that same date. According to this document, the facility determined the reason for discharge was, The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer require services provided by this facility. The form was signed by the SSD.A review of Resident 1's facility Progress Notes, dated 11/28/25, indicated SSD documented, this writer was approached by residents' [Resident 1's] spouse, resident and resident's spouse requesting transportation to be arranged for discharge, this writer arranged transportation for resident to discharge to home During a phone interview