STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056072	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Petaluma Post-Acute Rehabilitation	1115 B Street 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35314 Based on observation, interview, record review, facility policy review, the facility failed to complete an assessment to determine if a resident was able to self-administer their medication(s) for 1 (Resident #52) of 18 sampled residents. Findings included: A facility policy titled, Self-Administration of Medications, revised 12/2022, indicated, 1. As part of their overall evaluation, the staff will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff will perform a more specific skill assessment, including (but not limited to) the residents a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. An Admission Record revealed the facility admitted Resident # 52 on 11/13/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of intracapsular fracture of the right femur. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #52's care plan included a focus area initiated 11/13/2024, that indicated the resident had alteration in comfort due to pain. Interventions directed staff to administer prescribed pain medication. Resident #52's Admission / Readmission Screen and Baseline Care Plan, dated 11/13/2024, indicated the resident did not request to self-administer medication(s). Resident #52's Medication Review Report, for the timeframe 12/13/2024 - 01/13/2025, revealed an order dated 12/12/2024, for Biofreeze professional external gel 5%, apply to neck topically every six hours as needed for pain management. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/16/2024 at 2:06 PM, Resident #52 removed Biofreeze (a pain relief gel) from their bedside table and stated they spoke with someone who agreed to allow them to keep the medication at their bedside. Resident #52 stated the medication was used for their neck pain. During an interview on 12/18/2024 at 8:04 AM, Registered Nurse (RN) #2 acknowledged Resident #52 kept Biofreeze medication at their bedside. RN #2 stated she did not know if a self-administration of medication assessment had been completed. During an interview on 12/18/2024 at 1:37 PM, the Director of Nursing (DON) stated she was not aware Resident #52 had medication at their bedside. The DON stated Resident #52 had not been assessed to keep the Biofreeze at their bedside. According to the DON, the nurse should not have given the medication to the resident to keep at their bedside as the interdisciplinary team had not met to discuss if the resident was safe and able to self-administer the medication.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35314 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore a gown and gloves when they provided incontinence care to 2 (Resident #34 and Resident #66) of 18 sampled residents. Findings included: A facility policy titled Enhanced Barrier Precautions, effective 08/06/2024, revealed, Enhanced Barrier Precautions (EBP) - used in conjunction with the standard precautions and expand the use of PPE [personal protective equipment] to donning of gown and gloves during high-contact resident care activities and in situations of expected exposure to blood, body fluids, skin breakdown, or mucous membranes that provide opportunities for transfer of MDROs [multidrug-resistant organisms] to staff hands and clothing to reduce transmission. The policy specified, 4. Facility staff shall perform hand hygiene and in cases when standard precautions may not be sufficient, will don gown and gloves before performing high-contact resident care activities. The list below is not all-inclusive, and activities requiring EBP are on a case by case basis as determined by the facility * Device care or use: PICC/MID [peripherally inserted central catheter/midline] line, urinary catheter, feeding tube, tracheostomy/ventilator * Wound care on chronic wounds requiring a dressing * Bathing/showering * Dressing and/or Transferring where contact with bodily fluids is likely * Providing hygiene where standard precautions may not be sufficient * Changing soiled linens * Changing briefs or assisting with toileting. 1. An Admission Record revealed the facility admitted Resident #66 on 11/07/2024.According to the Admission Record, the resident had a medical history that included a diagnosis of retention of urine. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2024, revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #66 was dependent on staff for lower and upper body dressing. The MDS indicated the resident was dependent on staff for toileting hygiene and had an indwelling catheter. Resident #66's care plan included a focus area initiated 12/02/2024, that indicated the resident had an activity of daily living self-care performance deficient related to impaired mobility, weakness, deconditioned, and multiple medical problems. During an observation on 12/17/2024 at 2:01 PM, Certified Nurse Aide (CNA) #3 and CNA #4 assisted Resident #66 with repositioning. CNA #3 and CNA #4 wore gloves and no gowns. CNA #3 handed CNA #4 the resident's urinary catheter bag and assisted the resident to turn in bed. CNA #3 was also noted to hold the resident's urinary catheter bag and adjusted the resident's catheter tubing. During an interview on 12/17/2024 at 2:02 PM, CNA #3 stated she did not wear a gown because she did not empty the resident's urinary catheter bag. According to CNA #3, she only needed to wear a gown when she emptied the resident's urinary catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 2:13 PM, CNA #4 stated she did not wear a gown when she assisted CNA #3 to reposition Resident #66. Per CNA #4, she only needed to wear a gown when she emptied the resident's urinary catheter bag. During an interview on 12/18/2024 at 8:20 AM, the Infection Preventionist stated staff should use personal protective equipment for high contact activities for residents on enhanced barrier precautions. 51749 2. An Admission Record revealed the facility admitted Resident #34 on 02/25/2019. According to the Admission Record, the resident had a medical history that included diagnoses of chronic kidney disease and retention of urine. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance with toileting hygiene, was frequently incontinent of bowel, and had an indwelling catheter. Resident #34's care plan included a focus area initiated 11/14/2024, that indicated the resident was at high risk for developing complications to include a urinary tract infection due to the presence of a catheter related to obstructive uropathy. During an observation on 12/17/2024 at 2:22 PM, Certified Nurse Aide #5 did not wear a gown when she provided incontinence care to Resident #34. During an interview on 12/18/2024 at 8:20 AM, the Infection Preventionist stated staff should use personal protective equipment for high contact activities for residents on enhanced barrier precautions.