STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056120	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Bay Post Acute	300 Douglas Street 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38322 Based on interview and record review the facility failed to adequately staff the Noc shift (10:30 p.m. to 6:30 a.m.) when the registry nurses scheduled to work Noc shift did not report to work three nights in a row. This failure resulted in three nurses working a triple shift (three consecutive 8-hour shifts) for those three days, potentially putting residents at risk of medication errors or delay in care when nurses caring for the residents are too fatigued to accurately follow physician orders or provide care. Findings: During a record review and concurrent interview on 4/3/24 at 3:22 p.m., facility staffing assignment sheet for 3/17/24 revealed Licensed Nurse E worked AM shift (6:30 a.m. to 3:30 p.m.), PM shift (3:30 p.m. to 11:30 p.m.), and Noc shift. Review of staffing assignment sheet for 3/18/24 revealed Licensed Nurse F worked AM shift, PM shift, and Noc shift. Director of Nursing (DON) verified Licensed Nurses E and F worked 24-hours straight on those two days. DON stated Licensed Nurse G also worked 24 hours on 3/19/24. DON stated the nurses all worked double shifts (16 hours) and then the Noc nurse did not show, so the nurses stayed to cover the Noc shift. DON stated she did not know about it until after it happened. She stated she came into work early on 3/18/24 to check in with the Noc shift staff and was surprised to see Licensed Nurse E was still there. DON stated the staff tried to reach her to let her know the registry nurse that was scheduled did not report to work, but she had her phone on sleep mode, so it did not ring. DON stated she worked with Staffing Coordinator and told her this could not happen again. DON stated then it happened again (3/18/24). DON stated the staff tried again to call her, but her phone did not ring. DON stated Staffing Coordinator called the registry on 3/19/24 and they promised the nurse scheduled that night would show, but then it happened a third time (3/19/24). When queried, DON stated working for 24 hours straight was not safe, especially for nurses, You get tired. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/24 at 11 a.m., Licensed Nurse E verified that on 3/17/24 he worked a 24-hour shift. He stated that he clocked into work at about 6:40 a.m. and clocked out at about 7:10 a.m. the next day on Monday. Licensed Nurse E stated he was scheduled to work a double shift due to short staffing, then unfortunately the nurse who was supposed to work Noc did not show. Licensed Nurse E stated he tried to contact the scheduler, and no one answered, and he tried to call other colleagues to see if they could come, but no one could come in. Licensed Nurse E stated, I couldn't leave my colleague with over 90 patients alone, so I decided to stay. When queried, Licensed Nurse E stated the nurses were not supposed to put themselves in that position where they were compromised and might make errors. He stated he was not allowed to work 24 hours straight because it was not safe to staff or patients. During an interview on 4/17/24 at 11:18 a.m., Licensed Nurse G verified he worked a 24-hour shift last month. He stated he did not want to leave his patients and leave the other nurse by herself. Licensed Nurse G stated a registry nurse was supposed to come but did not come. Licensed Nurse G stated he came in at 6 a.m. and clocked out at 7 a.m. the next day. He stated it was unexpected but felt he was able to do it to help out. Licensed Nurse G stated he was not allowed to work 24 hours straight. He stated it was not safe for one's health or for the patients. He stated nurses had to read the medication, give the right medication, you might make a mistake. Licensed Nurse G stated he did not talk to anyone (facility leadership) about working the triple shift. During an interview on 4/17/24 at 1:32 p.m., Staffing Coordinator stated she recalled that on 3/17/24 she went to bed at 8 p.m. to wake up early, so when the staff texted her at 10 p.m. (to tell her the registry nurse was not coming) she was asleep already. Staffing Coordinator stated that when she found out in the morning that the registry nurse did not report to work, she called the registry right away to tell them, This is unacceptable. Staffing Coordinator stated the registry always gave her a back-up (staff), but she could only access that information in the portal from the office. She had no access to the portal at home. When asked how she responded the second time the registry nurse did not report to work, Staffing Coordinator stated she called the registry and told them they needed to replace staff right away when they could not come in for their shift. When asked if anyone called to verify the nurse showed up for Noc shift that second night, Staffing Coordinator stated, No. Staffing Coordinator stated that when the registry nurse that was scheduled did not show on the third night, the nurse was a no call no show (did not report to work and did not call to explain why). Staffing Coordinator stated that when she found out, she told the registry she did not want that nurse back, she needed reliable nurses. When asked if staff were allowed to work 24 hours straight, Staffing Coordinator stated she was not sure. During an interview on 4/17/24 at 1:45 p.m., Staff H stated Licensed Nurse G worked a 24-hour shift on 3/19/24. Staff H verified this happened three nights in a row where the registry nurses scheduled to work did not show up for their shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/24 at 2:38 p.m., Licensed Nurse F stated she was a treatment nurse. Licensed Nurse F stated she recalled that on 3/18/24 she came in at 8 a.m., then one nurse called out (sick) so she ended up passing medications to residents instead of starting the wound treatments. She stated she did the treatments in the afternoon, but then they got a phone call around 11:30 p.m. that the registry nurse was not coming in for the Noc shift. Licensed Nurse F stated three of the nurses were working double shifts that day, so she stayed to cover the registry nurse that called out. When queried, Licensed Nurse F stated she did not want to drive home in the morning, so her son picked her up and she slept almost all day. She stated she was not allowed to work 24 hours straight, but she did not want to leave her coworker by herself, and she did not want to leave her patients without a nurse. When asked about the safety of working a 24-hour shift, Licensed Nurse F stated, I don't think it's safe because we're human. It was a hard choice. She stated it was hard to be awake during the night, and if you're not careful you can do med (medication) errors. Licensed Nurse F stated when she realized she had to stay and work through the night, she called the person who does the schedule, but she did not answer. She stated she also texted both DON and Administrator around midnight that she was going to stay but got no response to her texts. During an interview on 4/17/24 at 1:09 p.m., Medical Director stated she was not aware that three nurses had worked 24-hour shifts in March. When asked about the safety of nurses working 24-hour shifts, Medical Director stated it was not safe because nurses did med pass, and they had to take care of people. She stated that if the nurses were too sleepy to work, their response time would be slow. She stated it put the nurses at risk of falling asleep without knowing it. Medical Director stated people did not fall asleep while they were driving because they decided to take a nap, they fell asleep without knowing it. She stated that could happen when a nurse was sitting in a chair at a computer, which would result in a delay in care. When asked if a root cause analysis should be done, Medical Director stated, Yes, always do a root cause analysis. There has to be improvement. During an interview on 4/30/24 at 1:43 p.m., Administrator stated he had heard that a nurse had worked a 24-hour shift but was not aware it had happened three days in a row. When queried, Administrator stated the DON should have come in and worked the shift. Administrator stated a root cause analysis of the nurses working 24-hour shifts had not been done and did not know how a root cause analysis would be part of this occurrence. Review of Licensed Nurse E's time sheet for 3/17/24 indicated he clocked in at 6:37 a.m. and clocked out at 7:17 a.m. on 3/18/24, for a total shift of 24 hours and 40 minutes with 30-minute breaks at 6:25 p.m. and 3 a.m. Review of Licensed Nurse F's time sheet for 3/18/24 indicated she clocked in at 8:16 a.m. and clocked out at 8:30 a.m. on 3/19/24, for a total shift of 24 hours and 14 minutes with 30-minute breaks at 12 p.m., 7:39 p.m., and 2:57 a.m. Review of Licensed Nurse G's time sheet for 3/19/24 indicated he clocked in at 6:06 a.m. and clocked out at 7 a.m. on 3/20/24, for a total shift of 24 hours and 54 minutes with 30-minute breaks at 10:12 a.m. and 7 p.m. Review of facility staffing assignment sheet dated 3/19/24 indicated Licensed Nurse G was scheduled for AM shift and PM shift. The Noc shift assignment sheet had one of the Noc shift nurse's name crossed out with Licensed Nurse G's name written to the side. Review of facility policy Staffing, Sufficient and Competent Nursing, revised 8/2022, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and facility assessment.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38322 Based on observation, interview, and record review, the facility failed to maintain a sanitary environment for food storage and preparation when the kitchen where the residents' food was stored and prepared was found to be infested with rats. This failure resulted in 90 out of 90 residents being served food that had been prepared in a kitchen contaminated with rat droppings and urine. On 4/3/24 at 11:06 a.m., due to the facility's failure to maintain sanitary conditions in the kitchen for food storage and preparation, Administrator and Director of Nursing (DON) were verbally notified of the Immediate Jeopardy. The Health Facilities Evaluator Nurse informed Administrator and DON of the surveyor's findings that rat droppings and gnawed food in the kitchen indicated a rat infestation and residents could not be served food from the kitchen. Lunchtime was in one hour and resident needed a meal to be served from an alternative source. Immediate Jeopardy is a situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident (State Operations Manual, Appendix Q). On 4/11/24 at 12:56 p.m., the facility presented a corrective plan of action, including but not limited to: 1) discarded all contaminated food, 2) food for residents to be prepared off site and delivered to the facility, 3) pest control service every three days and increased rat bait stations until no more activity, 4) hired additional pest control company for rat exclusion work. On 4/15/24 at 4:05 p.m., the removal of Immediate Jeopardy occurred in the presence of Administrator after interviews, observations, and record review confirmed the facility implemented the corrective plan of action. The facility kitchen remained closed for all food preparation and distribution at the time of the exit conference. Findings: During an observation and concurrent interview on 4/3/24 at 9:36 a.m. in the facility kitchen, kitchen staff were preparing food. When queried, [NAME] A stated the dietary manager was out of the country for the past month. Several dark brown droppings were under the ware washing area (area of the kitchen for rinsing and washing pots, pans, and dishes). When queried, Director of Nursing (DON) stated they were droppings. More droppings were under the two-compartment sink, the steam table (appliance used to keep food warm while it is being plated for residents' meals), under the ice machine, and in the dry storage area under shelves of food and on food. Dietary Aide B stated the droppings were rat poop. She stated she had been seeing the droppings in the kitchen for two months. In the dry storage area, multiple food items had been gnawed on, including bananas, a loaf of wheat bread, and a bag of spaghetti. DON verified the food items had been gnawed on and she saw the droppings on the food. DON stated that at a recent stand-up meeting someone had mentioned that they had had to throw away food from the kitchen. On returning to the kitchen from the dry storage area, Dietary Aide B was noted to be preparing sandwiches with wheat bread. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 4/3/24 at 9:58 a.m., Administrator stated the pest control company had been out to the facility numerous times for reports of rodents in the kitchen. Administrator stated the last time the pest control company was on site was last week. When asked the last time he had been in the kitchen to check for signs of rodents, Administrator stated last week. During a record review and concurrent interview on 4/3/24 at 10:05 a.m., Maintenance Director stated he had been getting complaints of rats in the kitchen for two weeks. When asked how he responded to the complaints, he stated he put poison baits in the kitchen under the dishwasher because they had a nest in the wall under there. He stated he opened the wall behind the dishwashing area and put poison in the nest. He also put steel wool and spray foam in the holes where they were coming in, but he had noticed this morning they were gnawing on the foam. Maintenance Director stated he did see the droppings under the ware washing area this morning. When asked if he told anyone, he said he told the dietary aide. When asked if he called the pest control company, Maintenance Director stated, No, not yet. Review of the pest control visit documentation revealed they had not been to the facility since 3/19/24. Maintenance Director stated he had received complaints from the kitchen staff that there were droppings or gnawed food every day since 3/19/24. The 3/19/24 pest control report indicated a rat was removed from the premises. During an observation on 4/3/24 at 10:20 a.m., Maintenance Director indicated the patched wall where he had found the rats' nest just outside the staff breakroom door. An area approximately 2 feet wide and 1.5 feet high just above the floor was patched over with spackle. On the other side of the wall was the ware washing area of the kitchen. During an interview on 4/3/24 at 11:20 a.m., Infection Preventionist (IP) stated the last time she was in the kitchen was to observe the maintenance staff perform the ice machine cleaning process. IP stated she was not doing a kitchen inspection at that time. IP stated she did rounds twice a month in the kitchen. She stated she had not gotten any complaints of rats from kitchen staff, but she heard they recently caught one. When asked about potential harm to residents with a rat infestation in the kitchen, IP stated rats carried disease, and verified residents could be exposed. IP was shown a photo this surveyor took of the rat droppings in the kitchen. IP verified the kitchen staff cleaned the kitchen every evening, so the droppings were from rats in the kitchen last night. During a phone interview on 4/3/24 at 11:30 a.m., the pest control company's customer service stated that during the last six months the facility had called in reports of rat activity in the kitchen on 11/27/23, 12/19/23, 2/20/24, 2/28/24, 2/29/24, 3/8/24, and 3/19/24. During an interview on 4/3/24 at 11:30 a.m., [NAME] C stated he had been noticing gnawed food in dry storage for two months. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 4/3/24 at 12:47 p.m., Pest Control Service Specialist was on site and stated that he was assigned this account at the beginning of March 2024. He stated he was last at the facility on 3/19/24 for an extra service request to remove a trapped rat. He stated he did not look in dry storage or under the dishwasher or sink during that visit. He stated he did look in dry storage during his visit on 3/8/24 and saw rat droppings at the time. When asked how he responded to finding rat droppings in dry storage, Pest Control Service Specialist stated he told the staff to clean them up. He stated that today (4/3/24) he found a hole and saw droppings under the dishwasher, he found holes on either side of the kitchen back door, he saw droppings in dry storage and gnawed food. Pest Control Service Specialist verified there had been rats in the facility kitchen. Pest Control Service Specialist stated he set additional traps in the kitchen and the facility would now be on escalation which means visits every three days. He stated to get off escalation the facility would have to have three visits with no catches and his manager must do a final walk-through. Pest Control Service Specialist stated he did not know if the facility had been on escalation before since he was new to the account, but the facility had not been on escalation since he was assigned at the beginning of March 2024. During an observation and concurrent interview on 4/3/24 at 1:10 p.m., County Health Inspector (CHI) D arrived at the facility and inspected the kitchen. CHI D verified the presence of rat droppings and gnawed food in the kitchen, including a bag of hamburger buns, a box of creamy wheat, a bag of corn meal, a bag of pancake mix, a bag of raisin bran cereal, and a box of salt. A tray of coffee mugs, boxes of food, and canned goods also had rat droppings on them. A white cardboard box on a shelf in dry storage had a yellowish dried liquid stain on the top that CHI D stated was likely rat urine. During an interview on 4/3/24 at 1:39 p.m., Registered Dietitian (RD) stated she did kitchen inspections twice a month. RD denied seeing any signs of rat activity or staff reporting rat activity to her. During an interview on 4/3/24 at 2:13 p.m., CHI D stated that due to the rat infestation, the facility kitchen could not be used to prepare or distribute food, and food for the residents needed to be obtained from an outside source until further notice. During a record review on 4/4/24 at 8 a.m., CHI D's emailed report of the facility's inspection titled, Permanent Food Facility Inspection Report, dated 4/3/24, indicated, Placard Status: Red - closed; suspension of permit to operate. The report further indicated major violations cited included rodents inside the facility, contaminated and adulterated food, food contact surfaces not cleaned and sanitized as required, and improper hot and cold holding temperatures for food. During an observation and concurrent interview on 4/6/24 at 5:14 p.m., County Health Inspector (CHI) J arrived at the facility and inspected the kitchen. CHI J verified water damaged wall under the ware washing station had been repaired with spray foam and wood and could be chewed through by rats. CHI J pointed out dried, grayish rat droppings on the floor behind the supports holding the ware washing station. CHI J stated the area behind the oven repaired with plaster could also be chewed through by rats. More dried, grayish rat droppings noted on the floor behind the cook line. CHI J verified the droppings looked old and had been there for some time. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 4/10/24 at 2:30 p.m., Dietary Manager stated he just got back from a month-long vacation. Dietary Manager denied any knowledge of the calls to the pest control company since November 2024. He stated that all he knew was the pest control guy came and put down the traps prior to his vacaton. When queried, Dietary Manager stated if the kitchen staff saw any signs of rodents while he was on vacation, they should have reported it to Administrator and cleaned it up. During an interview on 4/25/24 at 1:13 p.m., RD stated she did not know who had oversight of the kitchen while Dietary Manager was away for a month. During an interview on 4/30/24 at 10:50 a.m., Administrator stated that while Dietary Manager was away RD had oversight of the kitchen. Review of facility policy Food Receiving and Storage, revised 11/2022, indicated, Non-refrigerated foods . are stored in a designated 'dry storage' unit which is temperature and humidity controlled, free of insects and rodents and kept clean. Review of facility policy Food Preparation and Service, revised 11/2022, indicated, Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Review of the Food and Drug Administration (FDA) Food Code, last revised 2022, Chapter 6: Physical Facilities indicated, 6-202.16 Exterior Walls and Roofs, Protective Barrier. Perimeter walls and roofs of a FOOD ESTABLISHMENT shall effectively protect the establishment from the weather and the entry of insects, rodents, and other animals. 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; Pf and (D) Eliminating harborage conditions.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 38322 Based on observation interview and record review the facility failed to store garbage in a manner that made it inaccessible to pests. This failure potentially contributed to a rat infestation in the kitchen. Finding: During an observation on 4/3/24 at 9:34 a.m., a dumpster on the side of the facility, approximately 20 feet from the kitchen door, had the lid propped open with a long stick. The facility's dumpster area was surrounded by extensive overgrowth of English ivy. A photo of the dumpster was obtained. During a phone interview on 4/3/24 at 11:20 a.m., the pest control company's customer service stated that during the last six months the facility had called in reports of rat activity in the kitchen on 11/27/23, 12/19/23, 2/20/24, 2/28/24, 2/29/24, 3/8/24, and 3/19/24. During an interview on 4/3/24 at 11:30 a.m., [NAME] C stated he had been noticing gnawed food in dry storage for two months. During an interview on 4/3/24 at 12:47 p.m., Pest Control Service Specialist D was on site and stated that he was assigned this account at the beginning of March 2024. He stated he was last at the facility on 3/19/24 for an extra service request to remove a trapped rat. He stated he looked in dry storage during his visit on 3/8/24 and saw rat droppings at the time. He stated that today (4/3/24) he found a hole and saw droppings under the dishwasher, he found holes on either side of the kitchen back door, he saw droppings in dry storage and gnawed food. Pest Control Service Specialist D verified there had been rats in the facility kitchen. During an observation on 4/4/24 at 11:39 a.m., the dumpster on the side of the facility outside the kitchen door was propped open with a long stick and piled high with clear bags full of used Styrofoam food containers. During an observation and concurrent interview on 4/6/24 at 5:40 p.m. with Registered Dietitian, a staff member put a clear garbage bag of Styrofoam food containers in the dumpster and pushed the lid down, but the lid popped back up approximately 6 to 8 inches because the dumpster was so full of garbage. Ivy was still surrounding the dumpster area. Registered Dietitian verified the need to cut back the ivy to prevent rats. During an interview on 4/10/24 at 2:30 p.m., Dietary Manager was shown the photos of the facility's dumpster taken on 4/3/24 and 4/4/24. Dietary Manager verified the dumpster should not be propped open. When queried, Dietary Manager stated the reason the dumpster should not be open was to keep rodents out. Review of the Food and Drug Administration (FDA) Food Code, last revised 2022, Chapter 5: Water, Plumbing and Waste, subsection 5-5 Refuse, Returnables, and Recyclables revealed, (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5-501.110 Storing Refuse, Recyclables, and Returnables. REFUSE, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: . (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT. 5-502.11 Frequency. REFUSE, recyclables, and returnables shall be removed from the PREMISES at a frequency that will minimize the development of objectionable odors and other conditions that attract or harbor insects and rodents.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38322 Based on observation, interview, and record review, the facility administrator failed to 1. Follow up on reports of rats in the facility kitchen to ensure the pest control company was controlling the rats, 2. Follow up on letters from the county health department requesting a plan to address code compliance issues in the kitchen (dating back to 8/2023), and 3. Ensure the staffing agency sent nurses to cover shifts as agreed upon. These failures resulted in the facility's kitchen closing for several weeks requiring food to be obtained from an outside source for the residents, and also resulted in nurses working 24-shifts to cover for registry nurses who did not report to work. Findings: 1. During an observation and concurrent interview on 4/3/24 at 9:36 a.m. in the facility kitchen, kitchen staff were preparing food. Several dark brown droppings were under the ware washing area (area of the kitchen for rinsing and washing pots, pans, and dishes). More droppings were under the two-compartment sink, the steam table (appliance used to keep food warm while it is being plated for residents' meals), under the ice machine, and in the dry storage area under shelves of food and on food. Dietary Aide B stated the droppings were rat poop. She stated she had been seeing the droppings in the kitchen for two months. In the dry storage area, multiple food items had been gnawed on, including bananas, a loaf of wheat bread, and a bag of spaghetti. During an interview on 4/3/24 at 9:58 a.m., Administrator stated he knew about the rat problem in the kitchen, and he had had pest control come out numerous times to address it. Administrator stated the last time pest control was at the facility was a week ago. When queried, Administrator stated that the last time he had checked the kitchen to see if the pest control company's efforts to control the rats were effective was one week ago. During a record review and concurrent interview on 4/3/24 at 10:05 a.m., Maintenance Director stated he had been getting complaints of rats in the kitchen for two weeks. Review of the pest control visit documentation revealed they had not been to the facility since 3/19/24 (15 days earlier). Maintenance Director stated he had received complaints from the kitchen staff that there were droppings or gnawed food every day since 3/19/24. The 3/19/24 pest control report indicated that during the visit a rat was removed from the facility. During a phone interview on 4/3/24 at 11:30 a.m., the pest control company's customer service stated that during the last six months the facility had called in reports of rat activity in the kitchen on 11/27/23, 12/19/23, 2/20/24, 2/28/24, 2/29/24, 3/8/24, and 3/19/24. During an interview on 4/30/24 at 10:50 a.m., Administrator stated he had ultimate oversight of the pest control program. Administrator stated he did not know about the five calls to the pest control company reporting rodent activity in February and March. Administrator stated he did not have a copy of the contract with the pest control company and had just requested one from the company. (continued on next page)

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	056120	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Bay Post Acute	300 Douglas Street Petaluma, CA 94952

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility job description, Administrator, signed by Administrator on 1/4/21, under section Essential Job Functions indicated, Ensure that the facility is maintaining all policies and procedures through regular inspections and walkthroughs; urgently develop action plans to correct any deficiencies. 2. During a record review on 4/4/24 at 8 a.m., County Health Inspector (CHI) D's emailed report of the facility's kitchen inspection titled, Permanent Food Facility Inspection Report, dated 4/3/24, indicated, Placard Status: Red - closed; suspension of permit to operate. The report further indicated major violations cited included rodents inside the facility, contaminated and adulterated food, food contact surfaces not cleaned and sanitized as required, and improper hot and cold holding temperatures for food. During a review of an email on 4/5/24 at 5:22 p.m., CHI D indicated the facility's kitchen permit would remain suspended until the facility worked with a licensed contractor to address code compliance issues detailed in an 8/9/23 county inspection report and a plan review correction letter sent on 12/4/23, and the county health department had completed an on-site visit to verify the work. During an observation and concurrent interview on 4/6/24 at 5:14 p.m., CHI J arrived at the facility and inspected the kitchen. CHI J verified water damage under the ware washing station had been repaired with spray foam and wood. CHI J stated the repair was not up to code because the foam and wood were not smooth, cleanable surfaces and could be chewed through by rats. CHI J stated the area behind the oven that had been repaired with plaster was also not up to code and could be chewed through by rats. CHI J pointed out the kitchen floor was so damaged that it was not cleanable. CHI J stated the facility had been notified last year that there were code compliance issues in the kitchen, but the county health department had not received a response from the facility. During an interview on 4/30/24 at 10:50 p.m., Administrator stated that after the change of ownership finally went through, the county health department came to inspect the facility kitchen in August 2023 because new owenership required a new permit (to operate the kitchen). Administrator stated the facility was given a conditional permit and the county wanted a bunch of stuff including architectural plans for a three-compartment sink. Administrator stated, They (the architectural plans) didn't get done. Review of facility job description, Administrator, signed by Administrator on 1/4/21, under section General Purpose indicated, Responsible for the day-to-day functions of the facility, ensuring compliance in accordance with local, state, federal regulations and guidelines. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a record review and concurrent interview on 4/3/24 at 3:22 p.m. with Director of Nursing (DON), review of facility staffing assignment sheet for 3/17/24 revealed Licensed Nurse E worked AM shift (6:30 a.m. to 3:30 p.m.), PM shift (3:30 p.m. to 11:30 p.m.), and Noc shift (11:30 p.m. to 6:30 a.m.). Review of staffing assignment sheet for 3/18/24 revealed Licensed Nurse F worked AM shift, PM shift, and Noc shift. DON verified Licensed Nurse E and Licensed Nurse F worked 24-hours straight on those two days. DON stated Licensed Nurse G also worked 24-hours on 3/19/24. DON stated the three nurses all worked double shifts (16 hours) and then the Noc nurse did not show, so the nurses stayed to cover the shift. DON stated the staff tried to reach her on 3/17/24 to let her know the registry nurse that was scheduled did not report to work, but she had her phone on sleep mode, so it did not ring. DON stated she worked with Staffing Coordinator and told her this could not happen again. DON stated then it happened again the next night (3/18/24). DON stated the staff tried again to call her, but her phone did not ring. DON stated Staffing Coordinator called the registry and they promised the nurse scheduled that night would show, but then it happened a third time 3/19/24 (the registry Noc nurse did not show). When queried, DON stated working for 24 hours straight was not safe, especially for nurses, You get tired. During an interview on 4/17/24 at 1:09 p.m., Medical Director stated she was not aware that three nurses had worked 24-hour shifts in March. When asked about the safety of nurses working 24-hour shifts, Medical Director stated it was not safe because nurses did med (medication) pass, and they had to take care of people. She stated that if the nurses were too sleepy to work, their response time would be slow. She stated it put the nurses at risk of falling asleep without knowing it. Medical Director stated people did not fall asleep while they were driving because they decided to take a nap, they fell asleep without knowing it. She stated that could happen when a nurse was sitting in a chair at a computer, which would result in a delay in care. During an interview on 4/17/24 at 2:38 p.m., Licensed Nurse F stated she was a treatment nurse. Licensed Nurse F stated that on 3/18/24 she came in at 8 a.m., then they got a phone call around 11:30 p.m. that the registry nurse was not coming in for the Noc shift. Licensed Nurse F stated when she realized she had to stay and work through the night, she called the person who does the schedule, but she did not answer. Licensed Nurse F stated she also texted both DON and Administrator around midnight that she was going to stay but got no response to her texts. During an interview on 4/30/24 at 2:45 p.m., Administrator stated he he did not review the contract for the staffing registry and he was not involved in the facility's response to this staffing agency's failure to send staff to cover these three shifts. Administrator stated the DON and the staffing coordinator were self-sufficient. Review of facility job description, Administrator, signed by Administrator on 1/4/21, under section Essential Job Functions indicated, Assume the administrative authority, responsibility, and accountability of directing the activities, programs, and operations of the facility. Ensure that the facility is properly staffed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when signs of a rat infestation in the kitchen were not adequately addressed. This resulted in rats contaminating the residents' food and the kitchen where food was prepared. Findings: During an observation and concurrent interview on 4/3/24 at 9:36 a.m. in the facility kitchen, kitchen staff were preparing food. When queried, [NAME] A stated the dietary manager was in [NAME] for the past month. Several dark brown droppings were under the ware washing area (area of the kitchen for rinsing and washing pots, pans, and dishes). When queried, Director of Nursing (DON) stated they were droppings. More droppings were under the two-compartment sink, the steam table (appliance used to keep food warm while it is being plated for residents' meals), under the ice machine, and in the dry storage area under shelves of food and on food. Dietary Aide B stated the droppings were rat poop. She stated she had been seeing the droppings in the kitchen for two months. In the dry storage area, multiple food items had been gnawed on, including bananas, a loaf of wheat bread, and a bag of spaghetti. DON verified the food items had been gnawed on and she saw the droppings on the food. DON stated that at a recent stand-up meeting someone had mentioned that they had had to throw away food from the kitchen. On returning to the kitchen from the dry storage area, Dietary Aide B was noted to be preparing sandwiches with wheat bread. During an interview on 4/3/24 at 9:58 a.m., Administrator stated the pest control company had been out to the facility numerous times for reports of rodents in the kitchen. Administrator stated the last time the pest control company was on site was last week. When asked the last time he had been in the kitchen to check for signs of rodents, Administrator stated last week. During a record review and concurrent interview on 4/3/24 at 10:05 a.m., Maintenance Director stated he had been getting complaints of rats in the kitchen for two weeks. When asked how he responded to the complaints, he stated he put poison baits in the kitchen under the dishwasher because they had a nest in the wall under there. He stated he opened the wall behind the dishwashing area and put poison in the nest. He also put steel wool and spray foam in the holes where they were coming in, but he had noticed this morning they were gnawing on the foam. Maintenance Director stated he did see the droppings under the dishwasher this morning. When asked if he told anyone, he said he told the dietary aide. When asked if he called the pest control company, Maintenance Director stated, No, not yet. Review of the pest control visit documentation revealed they had not been to the facility since 3/19/24. Maintenance Director stated he had received complaints from the kitchen staff that there were droppings or gnawed food every day since 3/19/24. The 3/19/24 pest control report indicated a rat was removed from the premises. During an observation on 4/3/24 at 10:20 a.m., Maintenance Director indicated the patched wall where he had found the rats' nest just outside the staff breakroom door. An area approximately 2 feet wide and 1.5 feet high just above the floor was patched over with spackle. On the other side of the wall was the ware washing area of the kitchen. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/3/24 at 11:20 a.m., Infection Preventionist (IP) stated the last time she was in the kitchen was to observe the maintenance staff perform the ice machine cleaning process. IP stated she was not doing a kitchen inspection at that time. IP stated she did rounds twice a month in the kitchen. She stated she had not gotten any complaints of rats from kitchen staff, but she heard they recently caught one. When asked about potential harm to residents with a rat infestation in the kitchen, IP stated rats carried disease, and verified residents could be exposed. IP was shown a photo this surveyor took of the rat droppings in the kitchen. IP verified the kitchen staff cleaned the kitchen every evening, so the droppings were from rats in the kitchen last night. During a phone interview on 4/3/24 at 11:30 a.m., the pest control company's customer service stated that during the last six months the facility had called in reports of rat activity in the kitchen on 11/27/23, 12/19/23, 2/20/24, 2/28/24, 2/29/24, 3/8/24, and 3/19/24. During an interview on 4/3/24 at 11:30 a.m., [NAME] C stated he had been noticing gnawed food in dry storage for two months. During an interview on 4/3/24 at 12:47 p.m., Pest Control Service Specialist was on site and stated that he was assigned this account at the beginning of March 2024. He stated he was last at the facility on 3/19/24 for an extra service request to remove a trapped rat. He stated he did not look in dry storage or under the dishwasher or sink during that visit. He stated he did look in dry storage during his visit on 3/8/24 and saw rat droppings at the time. When asked how he responded to finding rat droppings in dry storage, Pest Control Service Specialist stated he told the staff to clean them up. He stated that today (4/3/24) he found a hole and saw droppings under the dishwasher, he found holes on either side of the kitchen back door, he saw droppings in dry storage and gnawed food. Pest Control Service Specialist verified there had been rats in the facility kitchen. Pest Control Service Specialist stated he set additional traps in the kitchen and the facility would now be on escalation which means visits every three days. He stated to get off escalation the facility would have to have three visits with no catches and his manager must do a final walk-through. Pest Control Service Specialist stated he did not know if the facility had been on escalation before since he was new to the account, but the facility had not been on escalation since he was assigned at the beginning of March 2024. During an observation and concurrent interview on 4/3/24 at 1:10 p.m., County Health Inspector (CHI) D arrived at the facility and inspected the kitchen. CHI D verified the presence of rat droppings and gnawed food in the kitchen, including a bag of hamburger buns, a box of creamy wheat, a bag of corn meal, a bag of pancake mix, a bag of raisin bran cereal, and a box of salt. A tray of coffee mugs, boxes of food, and canned goods also had rat droppings on them. A white cardboard box on a shelf in dry storage had a yellowish dried liquid stain on the top that CHI D stated was likely rat urine. During an interview on 4/3/24 at 2:13 p.m., CHI D stated that due to the rat infestation, the facility kitchen could not be used to prepare or distribute food, and food for the residents needed to be obtained from an outside source until further notice. During a record review on 4/4/24 at 8 a.m., CHI D's emailed report of the facility's inspection titled, Permanent Food Facility Inspection Report, dated 4/3/24, indicated, Placard Status: Red - closed; suspension of permit to operate. The report further indicated major violations cited included rodents inside the facility, contaminated and adulterated food, and food contact surfaces not cleaned and sanitized as required. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and concurrent interview on 4/6/24 at 5:14 p.m., County Health Inspector (CHI) J arrived at the facility and inspected the kitchen. CHI J verified water damage under the ware washing station had been repaired with spray foam and wood and could be chewed through by rats. CHI J pointed out dried, grayish rat droppings on the floor behind the supports holding the ware washing station. CHI J stated the area behind the oven repaired with plaster could also be chewed through by rats. More dried, grayish rat droppings noted on the floor behind the cook line. CHI J verified the droppings looked old and had been there for some time. During an interview on 4/10/24 at 2:30 p.m., Dietary Manager stated he just got back from a month-long vacation. Dietary Manager denied any knowledge of the calls to the pest control company since November. He stated that all he knew was the pest control guy came and put down the traps. When queried, Dietary Manager stated if the kitchen staff saw any signs of rodents while he was on vacation, they should have reported it to Administrator and cleaned it up. Review of facility policy Pest Control, last revised 5/2008, indicated, Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.