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	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Bay Post Acute	300 Douglas 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36790 Based on interviews and record reviews, the facility failed to implement the interventions to reduce the risk of elopement (leaving the facility without knowledge of the staff) for one of one sampled resident (Resident 1), who left the facility, undetected, and was found on a busy street. A bystander stayed with him until the emergency responders arrived. This failure had the potential to result in serious injuries, including bruises, lacerations, head injury and broken bones. Findings: During a review of Resident 1's Admission Record, printed 9/16/24, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and was readmitted to the facility on [DATE]. This record indicated Resident 1's most recent hospital stay was 4/26/24 to 7/24/24. Resident 1's principal diagnosis was Unspecified dementia, unspecified severity, with other behavioral disturbance (impaired memory and judgement). During a review of Resident 1's medical records, on 9/16/24, a SBAR (Situation, Background, Assessment, and Request) Communication Form and Progress Note, dated 4/24/24, documented the following: Situation, Resident 1 was, having episodes of wanting to leave, and he gets angry, upset and physically aggressive. Background documented his diagnosis of dementia, and he was very impulsive and hard to be re-directed (to change his focus). The request made was to transfer Resident 1 to an acute care hospital. During a review of Resident 1's medical records, on 9/16/24, Resident 1's Admission Record indicated the date of readmission as 7/24/24. Resident 1's Wandering Risk Scale (to assess risk of elopement) was done on 7/24/24. Resident 1 was found to be a High Risk to Wander. Resident 1's score was 17, and the scale's scoring showed 11 and above was a High Risk to Wander. During a review of Resident 1's medical records, on 9/16/24, Resident 1's Care Plan documented the Problem: Resident has impaired cognitive function with a goal that resident will be able to communicate basic needs on a daily basis through the review date. This was initiated on 7/30/24. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24, an On-Line Health Facility Complaint from the Ombudsman reported, Resident walked out of the facility and didn't know where he was. A mile away from North Bay, He was ringing door bells and North Bay didn't know that [Resident 1's name] was missing. Safe Team was called and returned [Resident 1's name] to the facility. North Bay has not reported this incident to the Ombudsman. The compliant indicated the event occurred on 8/19/24. During a review of Resident 1's medical records, one, Progress Note, documented the event. The Social Services staff documented to the Progress Notes on 8/19/24 at 6:41 p.m. Resident was not seen in facility staff went out looking for him shortly after the safe team brought resident back they drop him off they left without given [sic] any report to staff resident said he was looking for cigarettes. Wife is aware . During an Interview on 9/16/24 at 2:50 p.m., the Licensed Nurse (Registry Staff) who was assigned Resident 1 on 8/19/24, was called. The Licensed Nurse stated she did not remember one of her residents Eloping on the day she worked for the facility. The Licensed Nurse stated she did remember hearing that a resident had left and came back. She recalled a resident telling staff he did want to stay at the facility but does not remember which resident. During a review of Resident 1's medical records, a Wandering Risk scale was done 8/19/24. An order by the doctor to monitor and use the wander guard system (a bracelet for residents to wear which sets off the alarm at exit doors) was made 8/19/24. Resident 1's Care Plan was updated on 8/19/24, with the Problem: Resident is an elopement risk/wanderer, and the goal was, Resident will not leave facility unattended. Interventions included monitoring for wandering, provide structured activities and Wander Alert on Left Wrist. During a review of Resident 1's medical records, Resident 1's Medication Administration Record for 8/2024, had the following order, dated 8/19/24. Monitor wander guard placement every shift. The documentation for nursing to indicate this was done started 8/19/24, on the evening shift. During an interview on 9/13/24 at 4 p.m., the Administrator stated he was aware Resident 1 had eloped. The Administrator stated Resident 1 had been wearing a wander guard since the event. The Administrator stated the facility hired a receptionist to help monitor the entry and hired other staff. An in-service on Prevention of Elopement was conducted. During an interview on 9/16/24 at 4 p.m., the Administrator stated the facility was aware Resident 1 was an elopement risk and had expected nursing to write the care plan and implement measures to prevent elopement. The Administrator stated he investigated the event and learned the care plan and measures to reduce the risk for elopement had not been initiated. During a review of the facility's Elopement Prevention Policy, dated 8/2024, the policy indicated, It is our policy to identify residents at risk and intervene accordingly, and to establish a plan of care when risk factors are present .Upon admission, residents who are cognitively impaired and independently mobile .and/or have a history of wandering or elopement will have elopement risk evaluation completed. Residents found at risk are to have the care plan written to address this risk. (continued on next page)

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