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	12/03/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36790 Based on Interview and Record Review the Facility failed to allow residents, who were smokers at time of their admission, the right to self-determination when the facility made the decision to enforce the Smoking Policy without considering the rights of the residents to choose their schedules. Residents, who were smokers, were not allowed input about the changes in the Policy including the timing of smoking breaks. Residents were not given guidance for managing the restrictions nor alternatives to smoking. This change in Policy infringed on the rights of the Residents who smoked, and affected nine of the thirteen residents, who identified as smokers in the facility, among them Resident 3, Resident 11, Resident 2, Resident 7, and Resident 12. Findings: During an interview on 10/29/24 at 2:30 p.m., Resident 3 stated she did not want to quit smoking and this change in policy infringed on her rights as a Resident. Resident 3 stated it was not right to change the door code to the exit by station 2, preventing her from exiting. Resident 3 stated she would like to exit to get fresh air, not just to smoke. Resident 3 stated it's my freedom, I'm a resident and this is one rule I do not want. During a review of Resident 3's clinical record, the admission record documented Resident 3 was admitted [DATE]. Resident 3's Smoking-Safety Screen, dated 8/14/24 assessed Resident 3's ability to smoke safely. The assessment determined that Resident 3 was safe to smoke with supervision. During an interview on 10/29/24 at 2:55 p.m., Resident 11 stated that she remembered that a brief mention about the smoking policy was made at a Resident Council meeting (A meeting for Residents to discuss ideas or problems concerning the facility.) Resident 11 stated the director (Activities Coordinator who assists with the meetings) handed out copies of the policy but Resident 11 did not have a copy now. Resident 11 stated she did not like the policy because she would like to go out to smoke in the evening to have a quiet place while her roommates were being changed by the CNAs. During a review of Resident 11's clinical record, the admission record documented Resident 11 was admitted [DATE]. Resident 11's Smoking-Safety Screen, dated 8/14/24 assessed Resident 11's ability to smoke safely. The assessment determined that Resident 11 was safe to smoke with supervision. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/24 at 3:30 p.m., Resident 2 stated she uses a vape pen to meet her needs for nicotine. Resident 2 stated she does not need a lighter or match to use her pen. She stated she would like to use it on her schedule and not be limited to the smoking policy scheduled times. Resident 2 stated she resented being yelled at for using her vape pen other than at the smoking times. During a review of Resident 2's clinical record, the admission record documented Resident 2 was admitted [DATE]. Resident 11's Smoking-Safety Screen, dated 8/14/24 assessed Resident 2's ability to smoke safely. The assessment determined that Resident 2 was safe to smoke without supervision. During an interview on 12/3/24 at 3:30 p.m., Resident 7 stated he did not plan to quit smoking. He stated it is his right to continue smoking. Resident 7 stated we were allowed to smoke when we wanted and to have more than 2 cigarettes at a time, but we had to go to the outdoor smoking area. Resident 7 stated he gets accused of breaking the policy whether they see him outside with or without his cigarettes. During a review of Resident 7's clinical record, the admission record documented Resident 7 was admitted [DATE]. Resident 7's Smoking-Safety Screen, dated 8/14/24 assessed Resident 7's ability to smoke safely. The assessment determined that Resident 7 was safe to smoke without supervision. During an interview on 12/3/24 at 3:30 p.m., Resident 12 stated he was aware of the smoking policy. Resident 12 stated the schedule would be better for him if there was an evening smoke break after dinner. During a review of Resident 12's clinical record, the admission record documented Resident 12 was admitted [DATE]. Resident 12's Smoking-Safety Screen, dated 8/14/24 assessed Resident 12's ability to smoke safely. The assessment determined that Resident 12 was safe to smoke with supervision. During an interview on 10/29/24 at 3 p.m., Licensed Staff A stated we started enforcing the smoking policy recently, but the Residents do not like this because they did not have to follow the policy in the past. During an interview on 12/3/24 at 3:55 pm., Unlicensed Staff B stated the facility had not been enforcing the smoking policy in the past. Unlicensed Staff B stated they do not like and have been non-compliant with the enforcement of the smoking policy. She has been told by residents it is their right to smoke and their right to keep the cigarettes that they purchased. During a review of the Resident Council minutes dated 7/30/24, the following was documented to be part of the discussion. Resident Council were encouraged to follow smoking protocol. This was under the section Administration. Fourteen residents were listed as present on 7/30/24. Five of these residents were on the list of smokers from the facility dated 10/22/24. During an interview on 10/29/24 at 10:00 a.m., Administrator stated we had concern about the safety of the facility related to the residents who smoke. Administrator stated management attended the Resident Council meeting and informed the residents smoking will only be tolerated under supervision and at set times.

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NAME OF PROVIDER OR SUPPLIER North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36790 Based on interview and record review the Facility failed to follow transfer and discharge requirements when nine of thirteen residents, who at the time they were admitted to the facility, identified as smokers, were given a Notice of Transfer and Discharge for endangering the health of safety of individuals in the facility, all on 10/23/24. The facility did not have appropriate documentation to support that the residents were noncompliant with the smoking policy or that their smoking behavior was a safety risk for the other residents at the facility. The failure to identify and document in each of the nine residents records the behavior that caused the need for the facility to initiate a resident discharge could result in unfair and unsafe discharges. Findings: During a review of Resident 2's clinical record, the admission record documented Resident 2 was admitted [DATE]. Resident 2's Smoking-Safety Screen, dated 8/14/24 assessed Resident 2's ability to smoke safely. The assessment determined that Resident 2 was safe to smoke without supervision. Resident 2's Progress Notes had an entry by social services, dated 10/24/24 at 18:23 p.m., revealed the following Late Note for 10/23/24 (resident 2) was given a 30 day notice of discharge due to none compliance with the smoking policy, she had been given a policy and schedule time of smoking before she believes that because what she uses vaping it does not apply to her, she was educated that smoking is smoking. Documentation to show she was given the policy prior was not in Resident 2's electronic medical record. Documentation to show non-compliance was not provided by staff. During a review of Resident 3's clinical record, the admission record documented Resident 3 was admitted [DATE]. Resident 3's Smoking-Safety Screen, dated 8/14/24 assessed Resident 3's ability to smoke safely. The assessment determined that Resident 3 was safe to smoke with supervision. Resident 3's Progress Notes had an entry by social services, dated 10/24/24 at 18:41 p.m., revealed the following Late Note for 10/23/24 (resident 3) was given a 30-day notice of discharge due to none compliance with the smoking policy, she had been given a policy and schedule time of smoking before she refused to sign the notice. Documentation to show she was given the policy prior was not in Resident 3's electronic medical record. The following progress note was written after the 30-day discharge notice was given. Progress notes by Licensed Staff written 10/23/24 at 23:44 (11:42 p.m.,) noted pt were outside by station 2 exit door smoking. Told her smoking time is over it was past 8 pm pt ignored writer. During an interview on 10/29/24 at 2:30 p.m., Resident 3 felt it unfair that 10 of the smokers were given the Notice of Discharge on the same day. During a review of Resident 4's clinical record, the admission record documented Resident 4 was admitted [DATE]. Resident 4's Smoking-Safety Screen, dated 10/3/24 assessed Resident 4's ability to smoke safely. The assessment determined that Resident 4 was safe to smoke without supervision. Resident 4's Progress Notes had an entry by social services, dated 10/24/24 at 17:56 p.m., documenting Resident 4 was given a 30-day discharge notice for noncompliance with the smoking policy. Documentation to show non-compliance was not provided by staff. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's clinical record, the admission record documented Resident 5 was admitted [DATE]. Resident 5's Smoking-Safety Screen, dated 8/14/24 assessed Resident 5's ability to smoke safely. The assessment determined that Resident 5 was safe to smoke with supervision. Resident 5's Progress Notes had an entry by social services, dated 10/24/24 at 18:45 p.m., revealing the following Late Note for 10/23/24 (resident 5) was given a 30-day notice of discharge due to none compliance with the smoking policy, he had been given a policy and schedule time of smoking before. Documentation to show he was given the policy prior was not in Resident 5's electronic medical record. Documentation to show non-compliance was not provided by staff. During a review of Resident 7's clinical record, the admission record documented Resident 7 was admitted [DATE]. Resident 7's Smoking-Safety Screen, dated 8/14/24 assessed Resident 7's ability to smoke safely. The assessment determined that Resident 7 was safe to smoke without supervision. Resident 7's Progress Notes had an entry by social services, dated 10/24/24 at 18:36 p.m., revealing the following Late Note for 10/23/24 (resident 7) was given a 30-day notice of discharge due to none compliance with the smoking policy, he had been given a policy and schedule time of smoking before he became angry and belligerent with this writer and refused to sign notice of transfer. Documentation to show he was given the policy prior was not in Resident 7's electronic medical record. Documentation to show non-compliance was not provided by staff. During a review of Resident 9's clinical record, the admission record documented Resident 9 was admitted [DATE]. Resident 9's Smoking-Safety Screen, dated 8/14/24 assessed Resident 9's ability to smoke safely. The assessment determined that Resident 9 was safe to smoke with supervision. Resident 9's Progress Notes had an entry by social services, dated 10/24/24 at 18:10 p.m., documenting Resident 9 was given a 30-day discharge notice for noncompliance with the smoking policy. This note indicated that Resident 9 had a past incident of noncompliance, (date not included.) No other Documentation to show non-compliance was provided by staff. During a review of Resident 11's clinical record, the admission record documented Resident 11 was admitted [DATE]. Resident 11's Smoking-Safety Screen, dated 8/14/24 assessed Resident 11's ability to smoke safely. The assessment determined that Resident 11 was safe to smoke with supervision. Resident 11's Progress Notes had an entry by social services, dated 10/24/24 at 1846 p.m., revealed the following Late Note for 10/23/24 (resident 11) was given a 30-day notice of discharge due to none compliance with the smoking policy, she had been given a policy and schedule time of smoking before. Documentation to show she was given the policy prior was not in Resident 11's electronic medical record. Documentation to show non-compliance was not provided by staff. During an interview on 10/29/24 at 2:55 p.m., Resident 11 stated that she remembered that a brief mention about the smoking policy was made at a Resident Council meeting. Resident 11 stated the director handed out copies of the policy but does not have a copy now. Resident 11 thought they started enforcement about 3 weeks ago. Resident 11 stated she does not like the policy because she would go out to smoke in the evening if her roommates were having troubles. Resident 11 stated she did not have anywhere she could go to if discharged . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's clinical record, the admission record documented Resident 12 was admitted [DATE]. Resident 12's Smoking-Safety Screen, dated 8/14/24 assessed Resident 12's ability to smoke safely. The assessment determined that Resident 12 was safe to smoke with supervision. A social service progress note dated 9/26/24 at 14:53 documented This writer meet with resident today and provide him with a copy of smoking policy and smoking schedule and offer her the a patch if she wants, discus that if she dose not follow schedule will be given a 30 day notice to discharge per admiration. Resident refused to sign; she is always safe and leaving in a few das any way. Documentation to show non-compliance was not provided by staff. Resident 12's Progress Notes had an entry by social services, dated 10/24/24 at 18:21 p.m. , revealing the following Late Note for 10/23/24 (resident 12) was given a 30-day notice of discharge due to none compliance with the smoking policy, he had been given a policy and schedule time of smoking before. During a review of Resident 13's clinical record, the admission record documented Resident 13 was admitted /26/24. Resident 13's Smoking-Safety Screen, dated 8/14/24 assessed Resident 13's ability to smoke safely. The assessment determined that Resident 13 was safe to smoke with supervision. Resident 13's Progress Notes had an entry by social services, dated 10/24/24 at 18:07 p.m., revealing the following Late Note for 10/23/24 (resident 13) was given a 30-day notice of discharge due to none compliance with the smoking policy, she had been given a policy and schedule time of smoking before. He requested a nicotine patch will provide when available. Documentation to show he was given the policy prior was not in Resident 13's electronic medical record. Documentation to show non-compliance was not provided by staff. During an interview on 12/3/24 at 4:15 p.m., Social Services Director (SSD) stated she was directed to issue 30-day discharge or transfer notice to a list of residents because of non-compliance with the smoking policy. SSD confirmed the notice was given to each resident on the same day. SSD indicated staff had been monitoring the residents for compliance with the smoking policy for some time. During an interview on 12/3/24 at 4:05 p.m., Administrator stated the 30-day notice of transfer discharge was sent to the residence to encourage compliance with the smoking policy. Administrator indicated finding appropriate placement for these residents would be difficult to accomplish. During a review of the facilities policy and procedure titled, Transfer and Discharge Facility Initiated, dated 10/2022, indicated Once admitted to the facility, residents have the right to remain in the facility. Facility -initiated transfers and discharges, when necessary, must meet specific criteria . each resident will be permitted to remain in the facility and not be transferred or discharged unless . c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident and d. the health of individuals in the facility would otherwise be endangered . The policy also indicated that the grounds for transfer or discharge must be in the medical record.