

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 04/25/2025
NAME OF PROVIDER OR SUPPLIER North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>51218</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 1) of three sampled residents received care which met services provided to meet professional standards when nursing assessments related to changes in Resident 1's skin integrity (skin health) was not documented in Resident 1's medical record.</p> <p>This failure resulted in inaccurate assessment documentation which had the potential to prevent Resident 1's skin integrity from further impairment.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated admission to the facility in April 2024 with diagnosis of syncope (fainting or passing out) and collapse, muscle weakness, abnormalities of gait (a manner of walking) and mobility, presence of right and left artificial knee joint (knee replacement), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>A review of a Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/9/25, indicated Resident 1:</p> <p>No memory impairment,</p> <p>Risk of developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence),</p> <p>Impairment on one side lower extremity (hip, knee, ankle, foot),</p> <p>Substantial/maximal assistance (helper does more than half the effort) sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer,</p> <p>Unable to walk 10 feet,</p> <p>Wheelchair independent and,</p> <p>Always incontinent (lack of voluntary control over urination or defecation) of urinary and bowel.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's discontinued orders 3/25-4/25, indicated a phone order was received on 4/10/25 at 3:19 p.m., by License Nurse 1 (LN 1). The order summary indicated, LAL (low-air loss mattress [a medical-grade mattress designed to prevent and treat pressure injuries]) mattress.</p> <p>A review of Resident 1's discontinued orders 3/25-4/25, indicated a phone order was receive on 4/10/25 at 6:07 p.m., by LN 1. The order summary indicated, Apply barrier cream (skincare product designed to protect and support the skin's natural barrier function) to bilateral buttocks redness every shift.</p> <p>A review of Resident 1's shower sheet, dated 4/14/25, indicated two open areas on Resident 1's body map. One circle described open on Resident 1's coccyx (tailbone), and one circle described open on Resident 1's left buttocks. If new skin problem observed, was nurse notified? , indicated, Yes. Nurse intervention for new findings, indicated, No new findings. The shower sheet included Certified Nurse Assistant 1 (CNA 1) signature, and a Nurse signature.</p> <p>During an interview on 4/24/25 at 3:30 p.m., Resident 1 stated he received incontinence care at the facility. Resident 1 stated he can wait up to thirty minutes to be changed when wet or soiled. In regard to bed mobility, Resident 1 stated, I can participate a little bit, but it's getting harder.</p> <p>During a concurrent observation and interview on 4/24/25 at 3:41 p.m., CNA 1 stated, Oh yea, he (Resident 1) had a wound on his coccyx area before he went to the hospital. CNA 1 described the wound as a small opening, gesturing with her thumb and index finger by bringing them together with a gap approximately measuring 3 centimeters (cm, a unit of measure) in-between. Additionally, CNA 1 stated Resident 1 had redness on his bilateral buttocks. CNA 1 stated Resident 1 was treated with barrier cream to the wound and buttocks and was being repositioned. CNA 1 stated a LAL mattress was started this month.</p> <p>During an interview on 4/25/25 at 10:58 p.m., LN 1 stated changes in skin condition are reported to the Medical Director (MD), Director of Nursing (DON), nurses, and Wound Specialist (WS), as soon as they are discovered. LN 1 stated the WS will evaluate and give new orders. LN 1 stated WS notes are emailed to her, and she enters the WS notes into the resident's electronic record. LN 1 stated prior to Resident 1's recent admission to the hospital, Resident 1 had redness to the left buttocks and was treated with barrier cream. LN 1 stated a LAL mattress was ordered 4/10/25 to prevent skin injury.</p> <p>During an interview on 4/25/25 at 11:19 a.m., the CNA 2 stated, He (Resident 1) can't really help anymore with shifting in bed. He is a 2-person assist (a patient or resident requires two caregivers to safely assist with mobility, transfers, or other daily living activities) for incontinence care.</p> <p>During an interview on 4/25/25 at 11:37 p.m., the DON stated his expectations for reporting changes in skin condition is for staff to initiate a change in condition (COC) form, and notify the MD, and family if resident is not own representative. DON stated the treatment nurse, and the Director of Staff Development (DSD) are expected to review shower sheets daily. DON stated any changes in skin should be reported to the treatment nurse and charge nurse for assessment. DON stated alert charting for changes in skin is completed for two days, stating, The treatment nurse would continue to chart skin assessments. DON reviews the shower sheet dated 4/14/25, and stated it is not the CNA's scope of practice to assess wounds.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/25 at 1:50 p.m., the DON stated the shower sheet dated 4/14/25 was reported to a treatment nurse by CNA 1. The DON confirmed there is no documentation of the assessment, and stated, The only documentation we have is of the barrier cream and dressing.</p> <p>During an interview on 4/25/25 at 2:14 p.m., the DSD stated, The charge nurse or treatment nurse should be completing the assessment if changes to skin are reported. Changes should be documented in SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents). The DSD stated, CNA's are expected to document the location and a description of what they see on the body map of the shower sheet. The DSD confirms the interpretation of open on the body map would indicate the skin is no longer intact (not damaged, or impaired in any way).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention, Management and Documentation, dated 2024, the P&P indicated, Licensed nurses will conduct a pressure injury risk assessment .Whenever the resident's condition changes significantly Findings will be documented in the medical record.</p> <p>During a review of the facility's P&P titled, Skin Care, dated 2024, the P&P indicated, A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse .The assessment may also be performed after a change of condition or after any newly identified pressure injury .Documentation of skin assessment .Document observations (e.g. skin conditions .) .Document type of wound .Document wound (measurements, color .).</p> <p>During a review of the facility's P&P titled, Resident Showers, dated 2024, the P&P indicated, The CNA will assess the skin for any changes while performing bathing .</p>		