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	04/28/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 31424 Based on interview and record review, the facility failed to implement its abuse policy when Certified Nursing Assistant B (CNA B) was allowed to return to work after a physical and sexual abuse allegation was made against him, and prior to the facility completing their abuse investigation. This failure caused Resident 1 to feel unsafe, and potentially placed other residents, who were cared for by CNA B, at risk of abuse. Findings: During an interview on 4/25/25 at 2:50 p.m., the Administrator stated Resident 1 had reported that CNA B had pushed her and had jumped on her roommate. The Administrator stated the facility's investigation into the incident was in process (not finished). The Administrator stated Resident 1's roommate (Resident 2) screamed when CNAs provided ADL (Activities of Daily Living; care such as eating, dressing, bathing, and toileting) care and Resident 1 may have inferred she was being abused. When asked how Resident 1 and Resident 2 were being protected during the investigation, Administrator stated he had immediately suspended CNA B. Review of Resident 1's MDS (Minimum Data Set - a federally mandated resident assessment tool) dated 2/10/25, her BIMS (Brief Interview for Mental Status; an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was 13 (cognitively intact). During an interview on 4/25/25 at 3:15 p.m., Resident 1 stated the previous night (4/24/25), CNA B had not fed Resident 2 (the roommate) her meal; she stated CNA B also pushed her (Resident 1) shoulder. Resident 1 stated two months earlier, CNA B was on top of Resident 2 on the bed; she stated the curtains were pulled around the bed but she could see through an opening in the material. Resident 1 stated if CNA B returned to the facility, she would not feel safe. During an interview on 4/25/25 at 4:20 p.m., the Social Worker (SW) stated Resident 1 reported to them that she was giving Resident 2 a sandwich, but CNA B took it away and pushed her. The SW also stated Resident 1 had alleged staff had grabbed Resident 2, threw her on the bed, men had sex with Resident 2, and she heard Resident 2 screaming. SW stated the facility suspended CNA B. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056120	A. Building B. Wing	04/28/2025

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/25 at 3:10 p.m., Resident 1 stated she had seen CNA B in the building over the weekend (4/26-4/27/25) but he was not taking care of the three women in her room. When asked if she felt safe, Resident 1 stated, hell no! Review of CNA B's Employee Timesheet (dated 04/16/2025 - 04/30/2025) indicated on, Sat [Saturday] 04/26/2025, CNA B worked from approximately 2:23 p.m. to 11:07 p.m. and Sun [Sunday] 04/27/2025, CNA B worked from approximately 2:29 p.m. to 11:04 p.m. During an interview on 4/28/25 at 3:50 p.m., the Administrator stated the abuse investigation was not yet completed but CNA B had returned to work over the weekend. The Administrator stated staff could return to work prior to the facility abuse investigation's completion as long as there was no truth to the allegation. A review of facility's document title, Summary-Staff-to-Resident Allegation, sent to the California Department of Public Health on 4/30/25, indicated the investigation continued through 4/30/25. Review of facility policy titled, Alleged or Suspected Abuse and Crime Reporting, subtitled, 7. Protection, dated 2/21/2025, indicated, To protect residents . from harm or retaliation during an investigation, the facility shall: .Suspend staff member(s) believed to be involved, pending the outcome of an investigation .