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	07/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to ensure the provision of a sanitary environment that would prevent the development and transmission of infections for one out of four residents (Resident 2) when:1. Resident 2's foley catheter (FC, a hollow tube inserted into the bladder to drain or collect urine also known as a urinary catheter) bag (a drainage bag connected to the FC) was touching the floor.2. Staff did not wear a gown, in accordance with enhanced barrier precautions (EBP, an infection control intervention, that involves the use of gowns and gloves during high-contact care activities to reduce the transmission of Multidrug-Resistant Organisms [MDRO, microorganisms (germs), that are resistant to one or more antibiotics]) while handling Resident 2's FC.These failures had the potential to cause and spread infections among residents and staff. Findings:1. During a concurrent observation and interview on 7/15/25 at 1:44 p.m. Unlicensed Staff A verified Resident 2's FC drainage bag was touching the floor. Unlicensed Staff A stated the FC drainage bag should not be touching the floor, for infection control purposes, as Resident 2 could get sick with an infection.During an interview on 7/15/25 at 1:58 p.m., Licensed Nurse (LN) B stated FC drainage bags should not touch the floor because the floor was dirty. LN B further explained, bacteria (germs) could contaminate the FC drainage bag and Resident 2 could end up with an infection.During an interview on 7/15/25 at 2:30 p.m., the Director of Nursing (DON) stated the FC drainage bag should not touch the floor, for infection control, as it increases the risk of a resident acquiring an infection.A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised 8/2022, the P&P indicated, . be sure the catheter tubing and drainage bag are kept off the floor.2. During a concurrent observation and interview on 7/15/25 at 1:53 p.m., outside Resident 2's door a poster indicated Resident 2 was on EBP. Unlicensed Staff A was observed handling Resident 2's FC drainage bag while not wearing a gown. Unlicensed Staff A verified Resident 2 was on EBP and that she had not followed the EBP when she had not worn a gown when she handled Resident 2's FC drainage bag. Unlicensed Staff A acknowledged EBP was expected to be followed to prevent spreading infections to other residents.During an interview on 7/15/25 at 1:58 p.m., LN B stated residents who had a FC were placed on EBP, and all staff were expected to follow the EBP when caring for these residents. LN B stated anytime a staff touched a residents' FC, staff must wear gloves and a gown to prevent cross contamination (transfer of germs from one place to another with harmful effect) and infection. During a concurrent interview and record review on 7/15/25 at 2:45 p.m., with the DON, the Centers for Disease Control (CDC, the national public health agency of the United States) EBP poster was reviewed, the DON verified Resident 2 had a foley catheter and was on EBP. The DON verified the facility followed the CDC's EBP guidelines which indicated when staff handled a resident's FC, they should wear gloves and gown. The DON stated it was important to follow EBP to prevent or reduce the spread of infections.A review of the CDC document titled Enhanced Barrier Precaution, undated, indicated, . everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and gowns for the following high contact resident care activities.device care or use:.urinary catheter.

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
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interviews and record review, the facility failed to ensure a call light (a communication tool used in healthcare settings to allow patients/residents to request assistance from staff) was provided to one out of three sampled residents (Resident 2) when the call light was not within Resident 2's reach.This failure could result in late provision of care, unmet needs and increases the risk of accidents.Findings:During a concurrent observation and interview on 7/15/25 at 1:38 p.m., Resident 2's call light was tangled with a red string by the wall and near the foot of his bed. Resident 2 stated when he needed help he would use his call light but added, it was not where he could reach as it was too far [away].During a concurrent observation and interview on 7/15/25 at 1:44 p.m., in Resident 2's room, Unlicensed Staff A verified Resident 2's call light was tangled with red string by the wall, near the foot of his bed, and was not within Resident 2's reach. Unlicensed Staff A stated Resident 2's call light should be within his reach so he could ask for assistance when he needed it. Unlicensed Staff A verified Resident 2's call light had a clip to ensure it could be clipped on his clothes or pillowcase to ensure the call light was within his reach. During an interview on 7/15/25 at 1:58 p.m. Licensed Nurse (LN) B stated residents' call light should be clipped to their clothing and be within residents' reach at all times. LN B stated residents used the call light to alert staff when they need assistance. LN B stated if a resident could not reach his call light easily, then it was a safety issue, as it could lead to unmet needs, and accidents. During an interview on 7/15/25 at 2:30 p.m., the Director of Nursing (DON) stated residents' call light should be within residents' reach at all times. The DON verified it was the facility's policy to place the call light within reach of the resident. A review of the facility's policy and procedure (P&P), titled Call light, revised 6/26/2024, the P&P indicated, .place the call light within reach of the resident .