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	10/22/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one resident (Resident 1) of two sampled residents was free from physical abuse when Resident 2 punched Resident 1 in the eye.This failure resulted in Resident 1 sustaining a bruise on the left eye.Findings:A review of Resident 2's admission record indicated admission to the facility on [DATE] with diagnosis which included Wernicke's Encephalopathy (a severe neurological disorder caused by a deficiency of Vitamin B1) and anxiety disorder (a mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life).A review of Resident 2's Minimum Data Set (MDS, an assessment tool) dated 8/19/25 indicated Resident 2 had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (the person thought and remembered well at the time of the assessment).A review of Resident 2's Psychotherapeutic Drug Summary dated 9/1/25 at 12:35 a.m. indicated Resident 2 was on four orders for psychotropic medications (medication that affect a person's mental state, emotions, and behavior) due to behaviors of angry outbursts and physical aggression. A review of Resident 1's admission record indicated admission to the facility on 8/29/25 with a diagnosis which included Alcoholic Cirrhosis of Liver without Ascites (a chronic liver disease caused by excessive alcohol consumption, leading to scarring and damage to the liver) and Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).A review of Resident 1's MDS dated [DATE] indicated Resident 1 had a BIMS score of 10 (which indicated the person had mild impairment in their thought and memory process at the time of the assessment).A review of Resident 2's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form and progress note, dated 10/2/25 at 9:34 p.m., indicated, [Resident 2] had physical altercation with [Resident 1].A review of Resident 1's SBAR Communication Form and progress note, dated 10/2/25 at 9:35 p.m. indicated, Situation.resident-to-resident altercation .During rounds at approx. 8pm resident heard yelling from room., then [Resident 1] reported incident.of resident-to-resident altercation with physical contact.A review of Resident 1's Skin Observation Tool dated 10/2/25 at 11:45 p.m. indicated, .Bruise noted under [Resident 1's] Left eye. This tool did not indicate Resident 1 had any other bruising to the body prior to 10/2/25.A review of Resident 2's nursing progress note dated 10/3/25 at 12:49 a.m. indicated, Resident on monitoring for Physical and Verbal aggression d/t [due to] resident to resident altercation.Resident left facility, taken by police at approx. [11:30 p.m.].A review of Resident 1's nursing progress note dated 10/6/25 at 2:19 p.m. indicated, .Resident on monitoring for emotional distress related to altercation (physical) with another resident resulting in violent behavior. Patient complains of tolerable pain over his left eye. Bluish discoloration around the eyes still noted. A review of Resident 1's nursing home visit by the physician dated 10/10/25 at 9:58 p.m. indicated, Chief complaint.Altercation.[Resident 1] had an altercation with [Resident 2], [Resident 2] end up punching patient in the face, leaving a left eye ecchymosis [bruise], [Resident 2] now in jail.Objective [Assessment].Left eyelid and periphery with ecchymosis.During an interview on 10/10/25 at 11:50 p.m., Case Manager B (CM B) stated she saw Resident 1 on 10/3/25 and Resident 1 told CM B that he asked Resident 2 to turn off the light and the conversation turned into a verbal argument then Resident 2 became physical.During a concurrent observation in Resident 1's room and interview on 10/10/25 at 12:49 p.m., Resident 1 was sitting up in bed with the blankets up around his face. Resident 1 refused to be interviewed and stated he wanted to be left alone.During a telephone interview on 10/13/25 at 1:56 p.m., Licensed Staff A (LS A) stated on 10/2/25 she heard yelling from Resident 1 and Resident 2's room and went to see what happened. When she entered the room, she saw Resident 1's meal tray on the floor. LS A stated she saw Resident 1 had bruising under his left eye and asked if he wanted to go to the emergency room. Resident 1 refused so LS A offered Resident 1 an ice pack for his left eye. LS A stated when the police arrived Resident 1 wanted to press charges and Resident 2 was arrested and taken by the police. LS A stated she asked Resident 1 what happened, and he stated, he asked Resident 2 to turn out the light and the conversation turned into an argument resulting in Resident 2 punching Resident 1 in the left eye. LS A stated Resident 2 had not returned to the facility and was waiting for a court hearing.A review of the facility's policy titled, Alleged or Suspected Abuse and Crime Reporting, dated 2/21/25, indicated, Each Resident has the right to be free from abuse.