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	04/14/2026

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident 1) of three sampled residents was free from physical abuse when Resident 2 struck the back of Resident 1's head and forcefully shook Resident 1's wheelchair.This failure placed Resident 1 at risk for actual and potential physical and psychosocial harm.A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of Wernicke's Encephalopathy (a medical condition caused by a severe deficiency of thiamine (Vitamin B1) which is liked with alcohol abuse. A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction (stroke) and Hemiplegia (paralysis on one side of the body) affecting the left side. A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/17/26, indicated Resident 1's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 14 of 15 which indicated intact cognition.A review of Resident 2's Situation, Background, Assessment and Recommendation (SBAR- a structured, standardized format for concise communication in healthcare which is designed to enhance patient safety and team communication) documentation, described Resident 2's previous physical altercations with other residents as follows:On 6/10/25 at 6:51 p.m., indicated, resident to resident physical incident where one resident's hand made contact with another resident's face after getting upset after hearing the resident cussing.On 10/2/25 at 9:34 p.m., indicated staff heard yelling coming from Resident 2 ?s room. Resident 2's roommate reported incident of resident-to-resident altercation with physical contact.On 3/21/26 at 7:10 a.m., indicated Resident 1 informed his nurse that he was hit by [Resident 2] on the right side of his head.A review of Resident 2's care plan, dated 6/10/25 and updated on 3/21/26, indicated Resident 2 was involved in a resident physical incident. A goal was for Resident 2 to have no further episodes of verbal or physical altercation with another resident. To meet this goal, the staff would administer Resident 2's medications, keep other residents away from Resident 2 until aggressive behavior resolved, monitor target behaviors and redirect, and intervene before agitation escalated.A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/17/26, indicated Resident 1's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 14 of 15 which indicated intact cognition.A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/19/26, indicated Resident 2's BIMS score of 13 of 15 which indicated intact cognition. During an interview in Resident 1's room on 4/14/26 at 11 a.m., Resident 1 stated Resident 2 was in the bed closest to the room's entrance/exit door of the threeˆbedroom room. Resident 1 reported that as he was passing by Resident 2's bed, Resident 2 attempted to punch him but missed. Resident 1 continued toward his bed which was the farthest from Resident 2's bed. Resident 2 then got out of bed, pushed Resident 1-who was in his wheelchair-across the room toward the window by Resident 2's bed, and whacked him on the back of the head. Resident 1 stated he then wheeled himself into the hallway, followed by (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2. Resident 2 began forcefully shaking Resident 1's wheelchair, prompting Resident 1 to call for help from Certified Nursing Assistant 1 (CNA 1).During an interview in the MDS office, on 4/14/26, at 11:43 a.m., CNA 1 stated he was in the hallway of the facility when he heard someone calling his name urgently. CNA 1 looked over and witnessed Resident 2 forcefully shaking the back of Resident 1's wheelchair. CNA 1 stated Resident 1 appeared scared while Resident 2 appeared angry about something. CNA 1 stated he was familiar with both residents, and that Resident 2 had been known to be aggressive on occasion.A review of facility policy titled Abuse, Neglect and Exploitation, dated 12/2022, indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.The facility will implement policies and procedures to prevent and prohibit all types of abuse.that achieves.the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed nurses did not revise a care plan for one resident (Resident 2) of two sampled residents after Resident 2 was involved in a physical altercation with another resident.This failure decreased the facility's potential to implement interventions to prevent further physical harm among residents.Findings:A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of Wernicke's Encephalopathy (a medical condition caused by a severe deficiency of thiamine (Vitamin B1) which is liked with alcohol abuse. A review of Resident 2's Situation, Background, Assessment and Recommendation (SBAR- a structured, standardized format for concise communication in healthcare which is designed to enhance patient safety and team communication) documentation, described Resident 2's previous physical altercations with other residents as follows:On 6/10/25 at 6:51 p.m., indicated, resident to resident physical incident where one resident's hand made contact with another resident's face after getting upset after hearing the resident cussing.On 10/2/25 at 9:34 p.m., indicated staff heard yelling coming from Resident 2 ?s room. Resident 2's roommate reported incident of resident-to-resident altercation with physical contact.On 3/21/26 at 7:10 a.m., indicated Resident 1 informed his nurse that he was hit by [Resident 2] on the right side of his head.A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/19/26, indicated Resident 2's BIMS score of 13 of 15 which indicated intact cognition.In an interview on 4/14/26 at 1:16pm, the Director of Nursing (DON) acknowledged Resident 2 had a history of physical and verbal abuse. The DON also acknowledged Resident 2's care plan did not include Resident 2's involvement in a physical altercation which occurred on 10/2/25. The DON stated the resident's care plan is supposed to reflect new interventions with every additional incident in hopes of preventing future incidents.A review of the facility's policy and procedure titled Abuse, Neglect and Exploitation dated December 2022 indicated, The facility will make efforts to ensure all residents are protected from physical and psychological harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to.Revision of the resident's care plan if the resident's [NAME], nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.