

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 01/09/2026
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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare, food under sanitary conditions and in accordance with professional standards for a census of 92 when shelf surfaces in the walk-in refrigerator were observed to be discolored with rust-colored markings, indicating deterioration and potential contamination risk. This failure had the potential to contribute to the spread of foodborne illnesses among a vulnerable resident population. Findings: During the initial kitchen tour on 1/6/26 at 8:48 a.m. multiple shelves inside the walk-in refrigerator were observed with dark brown and/or rust colored markings. During a concurrent observation and interview on 1/8/26 at 8:35 a.m., with the Dietary Manager (DM), the DM observed these same walk-in refrigerator shelves and described the shelves as, Very rusty and need to be replaced. The DM also acknowledged the rusted surfaces could not be sanitized. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P stipulated, all shelves shall be free from corrosions.		

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to protect resident health information for a census of 92 when meal tickets were disposed of in the facility's regular trash. This failure decreased the facility's potential to protect and safeguard resident confidentiality and personal privacy. Findings: During a concurrent observation and interview on 1/8/26 at 8:28 a.m. with the Dietary Aide (DA), in the kitchen dishwashing area, the DA was observed removing trays from the soiled tray carts to prepare them to be washed. The DA sorted the tray contents and threw residents' meal tickets into the garbage can along with scraps of food. The DA stated residents' meal tickets were thrown into the garbage with food scraps. An observation of the contents of the garbage can included 4 meal tickets. During an interview on 1/8/26 at 8:47 a.m. with the Dietary Manager (DM), the DM stated the meal tickets were thrown into the regular trash. The DM agreed the residents' name, room number, diet order, allergies, and likes and dislikes were visibly clear to read on the meal tickets. During an interview on 1/9/26 at 10:00 a.m. with the Director of Nursing (DON), the DON stated any information with residents' identifiers was not to be disposed of in the regular trash. The DON confirmed residents' meal tickets contained the resident's name, room number, diet order and texture, food likes and dislikes, and food allergies which were part of the residents' health information; therefore, it should have been disposed of in a locked confidential information bin for shredding. During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, revised 2/21, the P&P indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interviews and record reviews, the facility failed to ensure the accuracy of assessments for four out of four sampled residents for Preadmission Screening and Resident Review level 1 (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care), when Residents: 5, 58, 72 and 55's PASARR did not indicate their diagnosed serious mental illness (MI, disorders that affect your mood, thinking and behavior). This failure could result in residents not being accurately identified with MI, missing further evaluation, and not receiving care/services in setting most appropriate to their needs. Findings: A review of Resident 58's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 1/31/25 with a diagnosis of major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health condition characterized by persistent, excessive worry or fear in situations that aren't threatening, interfering with daily life) and Post Traumatic disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). A review of Resident 58's PASARR dated 10/23/2024 did not indicate Resident 58 had a diagnosis of major depression, anxiety disorder or PTSD. A review of Resident 5's face sheet indicated an admission date of 3/2025 a diagnosis of major depression, anxiety disorder and PTSD. A review of Resident 5's PASARR dated 12/19/25 did not indicate Resident 5 had a diagnosis of major depression, anxiety disorder or PTSD. A review of Resident 72's face sheet indicated an admission date of 9/2024 with a diagnosis of Depression and Schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 72's PASARR dated 9/20/24 did not indicate Resident 72 had a diagnosis of Depression or Schizophrenia. A review of Resident 55's admission record indicated he was last admitted in 9/25 with the diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 55's PASARR, dated 9/17/25, indicated he did not have a serious mental illness and was not referred for a PASARR Level II. During an interview on 1/8/26 at 1:15 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC reviewed the PASARR for Resident 55, agreed it was incorrect, and stated Resident 55 should have been flagged to have a PASARR II (an in-depth, mandatory evaluation for nursing facility applicants suspected of having serious mental illness) completed. During a concurrent interview and record review with the MDSC on 01/09/2026, Residents 58, 5 and 72's face sheet and PASARR were reviewed. The MDSC verified Resident 58's face sheet indicated a diagnosis of major depression, anxiety disorder and PTSD however, Resident 58's PASARR dated 10/23/2024 did not indicate these diagnoses. The MDSC verified Resident 5's face sheet indicated diagnosis of major depression, anxiety disorder and PTSD however, Resident 5's PASARR dated 12/19/25 did not indicate these diagnoses. The MDSC verified Resident 72's face sheet indicated a diagnosis of Schizophrenia and Depression however, Resident 72's PASARR dated 9/20/24 did not indicate these diagnoses. MDSC verified Residents 58, 5 and 72's level 1 PASARR 1 was inaccurate as it did not accurately capture Residents 58, 5 and 72's diagnosis of serious mental illness. The MDSC stated it was important to ensure the information on the PASARR accurately reflects the residents' mental and psychological status to ensure appropriate placement and receive the appropriate care/ treatment they need. During an interview on 01/09/2026 at 09:40 p.m., the Director of Nursing (DON) stated it was important that the PASARR was accurate to ensure residents with MI get the necessary support they need and to prevent inappropriate placement. The DON stated he recognized their deficient practice and will ensure that PASARR will contain accurate information moving forward. During an interview on 1/9/26 at 10:00 a.m. with the Director of Nursing (DON), the DON stated PASARR screenings should be reviewed for accuracy, corrected if an error is found, and a referral for a PASARR Level II screening if necessary. A review of the facility's policy and procedure (P&P) titled, PASARR, dated 2/25, the P&P stipulated, the facility coordinates assessments with the PASARR program under Medicaid to ensure the most suitable setting for individuals with qualifying conditions.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record reviews, the facility failed to ensure the baseline care plan (BCP, a document created within 48 hours of a resident's admission to a nursing home, outlining the initial care needed to ensure residents safety and well-being, focusing on basic needs and resident-specific information) for four out of four sampled residents (Residents 5, 58, 72 and 106) were completed within 48 hours of admission. This failure could result in residents' delayed or inconsistent care and increased vulnerability to immediate harm. Findings: A review of Resident 58's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date of 1/31/25 with a diagnosis of major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health condition characterized by persistent, excessive worry or fear in situations that aren't threatening, interfering with daily life) and Post Traumatic disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). A review of Resident 58's BCP with an admission date of 1/31/25 did not indicate it was completed within 48 hours of admission. A review of Resident 5's face sheet indicated an admission date of 3/2025 with a diagnosis of major depression, anxiety disorder and PTSD. A review of Resident 5's BCP with an admission date of 3/25/25 did not indicate it was completed within 48 hours of admission. A review of Resident 72's face sheet indicated an admission date of 9/2024 with a diagnosis of Depression and Schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 72's BCP with an admission date of 9/20/24 did not indicate it was completed within 48 hours of admission. A review of Resident 106's face sheet indicated an admission date in 12/2025 with a diagnosis of Hypertension (HTN, high blood pressure) and Acute Kidney Injury (AKI, a sudden decrease in kidney function that develops within seven days). A review of Resident 106's BCP with an admission date of 12/19/25 indicated it was completed on 12/22/25. During a concurrent interview and record review on 01/09/2026 at 08:37 a.m., the Minimum Data Set coordinator (MDSC) verified the BCP for Resident 106 with an admission date of 12/19/25 was late when it was completed on 12/22/25. The MDSC verified the BCP for Residents 5, 58 and 72 did not indicate it was completed within 48 hours of admission. The MDSC stated the facility policy was to complete the BCP within 48 hours of admission. The MDSC stated not completing the BCP within 48 hours of admission meant the facility policy was not followed and could put the residents at risk for receiving unsafe care. During an interview on 01/09/2026 at 10:31 a.m., the Director of Nursing (DON) stated BCP were expected to be completed within 48 hours of admission per facility policy. The DON stated if a BCP was not completed within 48 hours of admission, it meant the facility policy was not followed and it could compromise residents' safety and quality of life. The DON stated he recognized the deficient practice and will strive to complete the BCP within 48 hours upon admission moving forward. A review of the facility's policy and procedure (P&P) titled Care Plan-Baseline, undated, the P&P indicated a baseline plan of care should be developed for each resident within 48 hours of admission.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician within 24 hours of a significant change in condition for one of one sampled resident with a change in condition (Resident 33), when nursing staff identified ongoing confusion, urinary frequency, and symptoms consistent with a urinary tract infection (UTI- an infection in the bladder/urinary tract).This failure resulted in delayed medical evaluation and treatment of Resident 33's UTI.Findings:A review of Resident 33's admission record indicated she was admitted in 6/2021 with the diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). A review of Resident 33's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare professionals when there is a change of condition among the residents), dated 12/19/25, indicated, .[Patient 33] experienced confusion for past 2 days, [Patient 33] has been urinating more frequently[Patient 33] increased confusion.Needs more assistance with ADLs [Activities of Daily Living].Reported to Primary Care Clinician.12/19/2025 10:55A review of Resident 33's progress note, dated 12/19/25 at 10:07 p.m., indicated Nursing staff was monitoring resident's increased confusion, frequent urination, and painful urination. There was no documentation that the physician was notified. A review of Resident 33's care plan focused .at risk for impaired cognitive function., initiated 6/8/21 and revised 3/4/22, indicated interventions staff to implement included, .monitor/document/report [as needed] any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.During an interview on 1/7/26 at 3:19 p.m. with licensed nurse (LN C), LN C stated she was aware of the residents' confusion and urinary symptoms and recalled monitoring the resident. LN C stated she notified Resident 33' primary physician via text message, which she identified as the normal method of physician communication at the facility. However, LN 3 was unable to show documentation on the electronic tablet verifying that the physician was notified prior to 12/19/25.During an interview on 1/7/26 at 11:44 a.m. with Residents 33's responsible party (RP - healthcare decision maker). The RP stated on 12/22/25, she found Resident 33 not dressed appropriately for the day, wearing shorts without underwear, and with a wet bed. The RP stated that due to the Resident 33's past history of UTI's, she took the resident to the hospital. The RP reported Resident 33 was admitted with a diagnosis of a UTI.During an interview on 01/09/26 at 11:00 a.m., with the Director of Nursing (DON), the DON stated he expected nursing staff to notify the physician when a change of condition occurred and for the physician to respond in a timely manner. The DON further stated that if the physician did not respond, nursing staff were expected to follow up and document the communication in the electronic health record. The DON acknowledged there was no documentation that the physician was notified or that a physician response occurred for Resident 33. The DON stated this situation did not meet his expectations for managing and communicating a change in condition.During a review of the facility policy titled Change in a Resident's Condition or Status, revised 2/21, indicated, Our facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition.notifications will be made within twenty-four (24) hours of a change occurring.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure three of 22 sampled residents (Resident 21, Resident 31, and Resident 54) were provided a comfortable and homelike environment when: 1. Resident 21's ceiling had an area in mid-repair state; and 2. Resident 31 and Resident 54's walls showed significant surface deterioration, cracking, and extensive paint peeling. These failures had the potential to negatively impact the residents' comfort and create an environment that was not homelike. Findings: 1. During a concurrent observation and interview on 1/6/26 at 9:28 a.m. in Resident 21's room, the ceiling was observed to have an unfinished repair characterized by a large, rectangular beige patch, approximately 2 feet by 3 feet in size, surrounded by several areas of fresh, un-sanded white plaster. Resident 21 stated the repair was due to a leak in the ceiling. During an interview on 1/7/26 at 12:46 p.m., with the Maintenance Supervisor (MS), the MS stated he did not know when staff completed the repair. The MS added that the issue had been present since he started working at the facility approximately one year ago. 2. During an observation on 1/6/26 at 10:21 a.m., in Resident 31's room, the wall next to Resident 31's bed was observed to be dirty with food debris and with the top layer of yellow paint curling and falling off in large flakes and a deep, straight vertical crack approximately 3 feet long extended down the corner where the two walls meet, exposing peeling paint and plaster. During an observation on 1/6/26 at 12:29 p.m. in Resident 54's room, the wall next to Resident 54's bed was observed with the top layer of yellow paint curling and falling off in large flakes and a deep, straight vertical crack approximately 2 feet long extended down the corner where the two walls meet, exposing peeling paint and plaster. During an interview on 1/6/26 at 12:48 p.m. with Licensed Nurse (LN) 4, LN 4 stated the walls in Resident 31's room and Resident 54's room were in need of repair due to the paint chipping. LN 4 stated the condition of the walls did not present a homelike environment. During an interview on 1/9/26 at 10:00 a.m. with the Director of Nursing, the DON agreed peeling paint, dirt and gashes on the walls, and unfinished repairs do not present a homelike environment. The DON also stated repairs should not take as long as a year to be completed. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, undated, the P&P stipulated, residents are provided with a clean and homelike environment.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to ensure an abuse allegation of misappropriation of property (when someone in a position of trust steals, misuses, or benefits personally from assets belonging to another) for one out of two sampled resident (Resident 106) when the allegation was not reported to the state licensing agency and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) within 2 hours. This failure could put Resident 106 at risk for continued financial and emotional distress. Findings: A review of Resident 106's face sheet (frontpage of the chart that contains a summary of basic information about the resident) indicated an admission date in 12/2025. A review of Resident 106's inventory of personal effects, dated 12/19/25, indicated Resident 106 had a black wallet. A review of a promissory note dated 12/23/25, signed by both Resident 106 and the Social Services Director (SSD), indicated Resident 106 had 3 bank cards. A review of Social Services Note dated 1/7/26 12:51 p.m. indicated Resident 106 reported that someone has taken his money, and his wallet was missing. During an interview on 01/07/2026 at 3:36 p.m., Resident 106 stated he had his wallet in his room. Resident 106 stated his wallet and bank cards were missing when his bank alerted him that his card was used for about \$6000 of unauthorized purchases since 1/4/26. Resident 106 stated he reported this incident to the Social Services Director (SSD) before lunch time on 1/7/26. During an interview on 01/08/2026 at 1:55 p.m., the administrator (admin) verified the facility was aware of Resident 106 allegation of misappropriation of funds but did not report the allegation to the state licensing agency or the ombudsman. During an interview on 01/08/2026 at 2:06 p.m., the Minimum Data Set coordinator (MDSC), stated if a resident was missing his wallet and there was unauthorized use of his bank card, these would be considered an allegation of financial abuse or misappropriation of property. The MDSC stated if a resident reported that his wallet was missing and his card had unauthorized charges while he was at the facility, this should have been reported to the ombudsman and the state licensing agency within 2 hours. The MDSC stated if this allegation was not reported to these agencies within the 2 hours' time frame per the facility policy, it could lead to potentially escalating abuse and might leave the residents vulnerable to further exploitation. During an interview on 01/08/2026 at 2:26 p.m., the Director of Nursing (DON) stated being aware of Resident 106's allegation of missing wallet and unauthorized charges on his bank card. The DON acknowledged the facility did not report this incident to the state or the ombudsman. During an interview on 01/08/2026 at 4:06 p.m., the Social Services Director (SSD) stated that on 1/7/26, before lunch, Resident 106 reported his wallet and money was missing. The SSD verified she had this conversation documented on 1/7/26. During an interview on 01/09/2026 at 09:15 a.m., Licensed Nurse (LN) E stated if a resident reported that his wallet was missing and there were unauthorized charges on his cards then this could be an allegation of abuse and should be reported to the state and the ombudsman per facility policy. LN E stated not reporting this allegation to the state and the ombudsman could result in continued abuse. A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/2022, the policy indicated .if a resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the admin and to the other officials according to the state law. the admin or the individual making the allegation immediately reports his or her suspicion to the following person or agency: the state licensing/certification agency responsible for surveying/licensing the facility, the state ombudsman. immediately is defined as within 2 hours of any allegation involving abuse or serious bodily injury.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews and record reviews the facility failed to deliver professional standards of quality for one of 22 sampled residents (Resident 7), when a physician order was not obtained prior to the application of bordered dressing (a multi-layered wound care product with a central absorbent pad and an adhesive border that secures it to the skin) on Resident 7's Deep Tissue Injuries (DTI, purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear)This failure could put the patient at risks for physical harm and worsening wound conditions.Findings:1.A review of Residents 7's Minimum Data Set assessment (MDS, a federally mandated resident assessment tool), dated 11/26/25, indicated Resident 7 had two deep tissue injuries (DTI, purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear).A review of Resident 7's physician order summary (POS, a healthcare professional's written instruction specifying the care, services, treatment and medications a patient should receive) of active orders, as of 1/9/26, indicated an order of may self-apply bordered dressing as needed (PRN) per patients' request for preventative treatment for wound care management with the start date of 1/7/26.A review of Resident 7's electronic treatment administration record (ETAR, a digital system used to track and document the administration of treatments), for 1/2026, did not indicate an order to apply bordered dressing for treatment.During a concurrent observation and interview on 01/07/2026 at 11:00 AM, Licensed Nurse (LN) B verified Resident 7 had two DTI's, one on each posterior (back) leg. LN B was seen with two bordered dressings. LN B stated she had used the bordered dressings to treat Resident 7's DTIs both in the past and on this date. LN B confirmed an order from the physician was required to use the border dressing on Resident 7's DTIs and acknowledged there was no such order.During an interview on 01/08/2026 at 10:42 AM, Resident 7 stated staff had been placing the bordered dressing on the DTIs on her legs and buttocks for a while now. Resident 7 stated that 1/7/26 was not the first time staff had used bordered dressing to cover her DTI's. During a concurrent interview and record review on 01/08/2026 at 10:57 AM, with the Minimum Data Set coordinator (MDSC) 2, Resident 7's POS was reviewed. The MDSC 2 verified the order for the bordered dressing was provided on 1/7/26 and there were no previous orders to apply the bordered dressing on Resident 7's DTI's in the past. MDSC 2 stated the application of bordered dressing need to have a physician order. The MDSC 2 stated physician's order must be followed by the nurses and deviations were not allowed. She stated applying a dressing without a physician's order was beyond a nurse's scope of practice and could result in harm to the resident.During an interview on 01/08/2026 at 11:52 AM, MDSC stated a physician's order was needed prior to using a bordered dressing on a resident. MDSC clarified it was important that a physician order was requested prior to using any type of dressing to ensure the correct type of dressing was being used for the correct type of wound, as the physician would know best which type of dressing was appropriate to use on certain type of wound. The MDSC stated if an incorrect dressing was used for a certain type of wound, the wound might worsen and could be a safety risk for the resident.During an interview on 01/09/2026 at 10:31 AM, the Director of Nursing (DON) stated a physician's order was needed prior to using bordered dressing to treat a resident wound. A review of the facility's policy and procedure (P&P) titled Medication Administration-General Guidelines, dated 10/2017, the P&P indicated .medications are administered as prescribed in accordance with good nursing principles and practice. medications are administered in accordance with written orders of the attending physician.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews and record reviews, the facility failed to ensure two out of two sampled residents (Residents 37 and 80's) received care to maintain grooming when fingernails were long with brownish material underneath. This failure could negatively affect the resident's sense of dignity and be an infection control concern. Findings: A review of Resident 37's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 4/2025 with a diagnosis of Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and muscle weakness. A review of Resident 37's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/29/25, section GG Functional Abilities and Goals, indicated Resident 37 needed moderate assistance from staff for personal hygiene tasks. A review of Resident 80's face sheet indicated an admission date in 1/2019 with a diagnosis of Traumatic Brain Injury (TBI, a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). A review of Resident 80's MDS, dated 11/30/25, section GG Functional Abilities and Goals, indicated Resident 80 needed maximum assistance from staff for personal hygiene tasks. During a concurrent observation and interview on 01/06/26 at 12:19 p.m., Resident 80 was noted with long fingernails that had brownish material underneath while he was eating his lunch. Resident 80 stated he had dirt under his fingernails and his fingernails were long because no one will cut them. During an observation on 01/06/2026 at 12:20 p.m., Resident 37 was noted with long fingernails that had brownish material underneath while he was eating his lunch. During an interview on 01/09/2026 at 10:57 a.m., when shown photos of Residents 37 and 80's fingernails, the Director of Staff Development (DSD) verified these residents' fingernails were long and had brownish materials underneath. The DSD stated this was not acceptable since Residents 37 and 80 were dependent on staff to keep their nail short and clean. The DSD stated it was not acceptable to see residents' fingernails long with brownish/blackish materials underneath as it was for their dignity and for infection control concerns. During an interview on 01/09/2026 at 12:05 p.m., the Director of Nursing (DON) stated it was not acceptable for Residents 37 and 80 to have long fingernails with brownish materials underneath. The DON stated the expectation was that resident's fingernails will be kept short and clean. The DON stated he recognized the deficient practice and will strive to be better moving forward. A review of the facility's policy and procedure (P&P) titled Nail Care, undated, the P&P indicated .to provide residents with safe hygienic and thorough nail care assistance .clean nails and under nails .A review of the facility's P&P titled Activities of Daily Living, revised 3/2018, the P&P indicated .residents who were unable to carry out activity of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene.		

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NAME OF PROVIDER OR SUPPLIER North Bay Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Douglas Street Petaluma, CA 94952	
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, interviews, and record review, the facility failed to ensure the bed cane (a type of bed rail that is a bar that attaches to the side of a bed, to help a person get in and out of bed) for one of 24 sampled residents (Resident 8), was in proper use when it was installed without completed assessment of risk of entrapment; Informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was not obtained prior to installation; and It was installed incorrectly. These failures increased the risk of resident injury, including falls or entrapment, which could result in serious harm or death. Findings: A review of Resident 8's admission record indicated she was last admitted to the facility in 8/2018 with the diagnosis of unspecified dementia (a progressive state of decline in mental abilities). A review of Resident 8's physician order, dated 9/21/24, indicated, Bed cane x 1 as an enabler to assist with bed mobility. (non-restraint) 1. A review of Resident 8's bed rail (bars attached to the sides of a bed, serving as safety and mobility aids) evaluations, dated 10/7/24, 4/7/25, 7/8/25, and 10/16/25, indicated entrapment evaluations had not been completed during any of the bed rail evaluations and that a bed cane was in use. During an interview on 1/9/26 at 8:47 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated entrapment assessments were completed by the maintenance department prior to installation of bed canes and bed rails. MDSC also reviewed Resident 8's bed rail evaluations dated 10/7/24, 4/7/25, 7/8/25, and 10/16/25 and confirmed the entrapment evaluations were not completed and should have been. During an interview on 1/9/26 at 10 a.m. with the Director of Nursing (DON), the DON stated the maintenance department kept records of entrapment evaluations completed prior to installation of bed canes and bed rails. A copy of Resident 8's entrapment evaluation completed by the maintenance department was not provided as requested. 2. During an interview on 1/9/26 at 8:47 a.m. with the MDSC, the MDSC stated informed consent should be obtained prior to installation of bed canes and bed rails. MDSC also stated the initial consent for Resident 8's bed cane was not in the electronic health record (EHR). During an interview on 1/9/26 at 10 a.m. with the DON, the DON stated informed consent was obtained prior to the installation of a bed rail due to the risk of entrapment. The DON stated it had not been obtained prior to installation of the bed cane because it was different from a bed rail and there was not risk for entrapment. After viewing a photograph of the bed cane with three, Risk for Entrapment, warnings on it the DON acknowledged. 3. During an observation on 1/7/26 at 10:21 a.m., Resident 8's bed cane was observed to be installed on the left side of the bed, with three clearly visible warning signs for possible entrapment. The bed cane was secured to the bed frame with the safety strap looped over and around the central frame bar repeatedly, creating a bundled wrap at the midpoint of the frame. During an interview on 1/7/26 at 12:46 p.m. with the Maintenance Supervisor (MS), the MS stated he could not provide installation instructions for Resident 8's bed cane. The MS also stated straps which secured the bed cane should go across to the other side of the bed frame. During an interview on 1/7/26 at 2:55 p.m. with the MS, the MS provided an installation video for bed canes which showed safety straps used to secure the bed cane were supposed to go under and across the whole bed frame. During a concurrent observation and interview on 1/7/26 at 3:23 p.m. of Resident 8's bed with the MS, the MS agreed Resident 8's bed cane was not installed properly and stated it needed to be corrected. During an interview on 1/9/26 at 10 a.m. with the DON, the DON stated bed canes were expected to be installed properly, per manufacturer's instructions. The DON viewed the photo of how Resident 8's bed cane was installed and agreed it was not installed properly. During a review of the facility's policy and procedure (P&P) titled, Bed Rails, revised 8/22, the P&P stipulated, For the purpose of this policy bed rails include grab assist bars. The P&P also stipulated, Bed rails are properly installed and used according to the manufacturer's instructions. and The use of bed rails is (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prohibited unless the criteria for use of bed rails have been met including.resident assessment and informed consent.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and record review, the facility failed to maintain accurate records of controlled medications (medications that the use and possession of are controlled by the federal government) for one out of 92 residents of the facility (Resident 24), when a dose of Resident 24's Oxycodone Hydrochloride (Oxycodone, a controlled medication that treats pain) was not documented as administered in the Medication Administration Record (MAR a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). This failure had the potential for a medication error to occur, which could cause Resident 24 to experience increased sedation (increased sleepiness), respiratory depression (condition where breathing becomes dangerously slow and shallow) and/or hospitalization. Findings: A review of Resident 24's Order Summary Report, an order dated 11/7/25, indicated Oxycodone 5 milligrams (mg, a unit of measure) to be given one tablet by mouth every six hours as needed (PRN) for severe pain (pain level 7-10 on a number pain scale [A number pain scale, usually a 0 to 10 scale, helps people rate their pain intensity, with 0 meaning no pain and 10 representing the worst pain imaginable]). During a concurrent interview and record review on 1/6/26 at 4 p.m. with Licensed Nurse 1 (LN 1), Resident 24's document titled, Antibiotic or Controlled Drug Record, dated 12/19/25 at 9:30 p.m., indicated Resident 24's Oxycodone 5 mg was signed out by a nurse but Resident 24's MAR, dated 12/19/25, revealed the nurse did not document Oxycodone 5 mg was administered to Resident 24 at 9:30 p.m. LN 1 verified Resident 24's Oxycodone 5 mg was signed out in his narcotic log (another term used for the Antibiotic or Controlled Drug Record) by a nurse, but not inputted into Resident 24's MAR to show the nurse had administered the Oxycodone. During an interview on 1/6/26 at 4:26 p.m., LN 1 stated that she was expected to document the administration of controlled medication in the resident's MAR, including the date and time it was given, after administering the medication. During an interview on 1/6/26 at 4:50 p.m., the Director of Nursing (DON) stated a narcotic (controlled medications used to treat pain) given to a resident should be documented in the resident's narcotic log to show the narcotic count was accurate as well as the resident's MAR to indicate the controlled medication was administered to the resident. The DON stated if the narcotic logged out was not documented in the resident's MAR, there could be a potential issue with narcotic diversion (when a medication is taken for use by someone other than whom it is ordered for). The DON stated the resident's physician would review the resident's MAR to see if the resident was still needing the narcotic, so accurate documentation was essential. A review of the facility policy/procedure titled, Medication Administration-General Guidelines, dated 10/2017, indicated: . C. Documentation: 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. 4) The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided on MAR. 5) When PRN medications are administered, the following documentation is provided: a. Date and time of administration, medication, dose.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident for dental services (Resident 6) received timely and appropriate dental evaluation and treatment, when the resident had broken teeth, and a history of uncompleted dental referrals with no follow-up or treatment plan. This failure resulted in Resident 6 not being able to eat effectively, placing the resident at risk for decreased nutritional intake and potential further decline. Findings: A review of Resident 6's admission record indicated she was admitted in 5/2021 with the diagnosis of dementia (a progressive state of decline in mental abilities). A review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/26/25, indicated she had no memory impairment. A review of Resident 6's progress notes, dated 12/8/25 to 12/9/25, indicated Resident 6 was being monitored for unplanned weight loss. A review of Resident 6's weights summary, dated 8/4/25, indicated Resident 6's weight was 109 lbs. (pounds, an unit of measurement) and on 12/8/25 Resident 6's weight was 101 lbs., a loss of 8 lbs. in 4 months. A review of Resident 6's physicians' orders, dated 12/5/25, indicated an order for Health shakes to be given 3 times a day and for staff to monitor percentage meal consumed. During an interview on 1/8/26 at 10:30 a.m. with Resident 6, Resident 6 stated she had mouth pain and the discomfort affected her ability to eat. Resident 6 expressed that she did not like her mechanical soft diet (foods that are easy to chew by being pureed, mashed, or chopped to change the food's texture) and wanted food with more normal texture. Resident 6 stated her mouth pain was 5 of 10 on a number pain scale (A number pain scale, usually a 0 to 10 scale, helps people rate their pain intensity, with 0 meaning no pain and 10 representing the worst pain imaginable). During a concurrent observation and interview on 1/8/26 at 10:45 a.m. with Resident 6 and the SSD, Resident 6 again reported mouth pain and pointed to her right lower jaw. Observation revealed the resident had only five remaining teeth in the front lower jaw. During an interview on 1/8/26 at 10:47 a.m. with the SSD, the SSD acknowledged the resident needed to see a dentist. The SSD stated that if the resident received dental treatment, Resident 6 would likely enjoy eating more, potentially gain weight, and have more energy. During a concurrent interview and record review on 1/8/26 at 9:20 a.m. with the SSD, the SSD confirmed she had reviewed resident 6's dental notes and acknowledged the documentation was not informative regarding any plan for improving oral health. The SSD confirmed that although a referral to a local dentist was made on 2/13/25, there was no documentation an appointment had been made. During a concurrent interview and record review on 1/9/26 at 12:30 p.m. with the Director of Nursing (DON), the DON stated he expected residents to receive timely follow-up for outside services. After reviewing Resident 6's dental notes, the DON confirmed there had not been timely follow-up and that treatment appointments had not been made as he would expect. During a review of the facility's policy titled, Dental Services Policy, implemented 2/2025, the policy indicated Social Services would assist residents in making dental appointments.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observations, interview, and record review the facility failed to properly maintain the residents' food refrigerator for a census of 92 when a food item was not properly labeled and another food item was past the expiration date. These failures had the potential to result in residents consuming spoiled or contaminated food, increasing the risk of foodborne illness and adverse health outcomes. Findings: During an observation on 1/7/26 at 1:06 p.m., the resident refrigerator contained an open pack of string cheese with five pieces remaining, labeled with the resident's room and bed number, and, Date in 9/30/25. The five pieces of string cheese were marked with an expiration date of 12/26/25. The freezer unit of the resident refrigerator also contained one quart of cookie butter ice cream only labeled with, Date in 11/25. During an interview on 1/9/26 at 10:30 a.m. with the Director of Nursing (DON), the DON stated he expected items placed in the resident refrigerator were labeled properly with dates and who the items belonged to, otherwise resident food could be shared with another resident if not properly labeled. The DON also stated he would expect foods to be removed when they are expired. During a review of the facility's policy and procedure (P&P) titled, Food Brought by Family/Visitors, revised 3/22, the P&P stipulated, items left for the resident to consume later will be labeled and stored in a distinguishable manner and the nursing staff will discard foods on or before the use by date.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observations, interviews and record reviews, the facility failed to ensure smoking safety was practiced for one out of four sampled residents who smoke when: 1. a smoking evaluation was not completed upon Resident 72's admission, 2. quarterly smoking assessments were not completed for Resident 72, and 3. Resident 72 kept a pack of cigarettes at his bedside. These failures increased safety risks for Resident 72 and other residents who could have gained access to Resident 72's cigarettes. Findings: A review of Resident 72's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated an admission date in 9/2024 with a diagnosis of Schizophrenia (a mental illness that is characterized by disturbances in thought) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that could interfere with daily activities). A review of Resident 72's care plan (a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) titled [Resident 72] is a smoker, dated 2/14/25, indicated the resident smoking supplies are stored at activity department. A review of Resident 72's Smoking-Safety Screen assessment, dated 1/6/25, indicated safety, the facility was to store Resident 72's lighter and cigarettes. During an observation on 01/07/2026 at 10:13 a.m., in Resident 72's room, Resident 72 had a pack of cigarettes tucked underneath the right side of his bed. During a concurrent observation and interview on 01/07/2026 at 10:20 a.m., the Director of Staff Development (DSD) verified Resident 72 had a pack of cigarettes tucked underneath the right side of his bed. The DSD stated Resident 72 was not supposed to keep cigarettes in their room for safety purposes. During a concurrent interview and record review on 01/07/2026 at 10:27 a.m. with the Director of Nursing (DON), Resident 72's care plan (CP, a detailed, written document that outlines a resident's individual needs, goals, and how their care will be managed) titled Resident 72 .is a smoker was reviewed with. The DON verified Resident 72 was not supposed to keep cigarettes in his room and verified Resident 72's care plan indicated the activity department would keep his cigarettes. During a concurrent interview and record review on 01/07/2026 at 11:18 a.m. with the Minimum Data Set coordinator (MDSC), Resident 72's care plan titled Resident 72 .is a smoker, dated 2/14/25, and Resident 72's Smoking-Safety Screen assessment, dated 1/6/25, was reviewed. The MDSC verified that the Smoking-Safety Screen assessment should have been completed upon Resident 72's admission, however, Resident 72's Smoking-Safety Screen assessment was not completed until 1/6/25 and no other smoking assessments were completed after that one. The MDSC stated that at a minimum, there should be a quarterly smoking assessment to determine if there were changes so the facility could adjust Resident 72's care plan accordingly. The MDSC verified Resident 72's cigarettes should have been kept by the activity department as the care plan indicated. The MDSC stated it was not safe for residents to keep cigarettes in their room as the facility has confused residents who could get a hold of the cigarettes, ingesting them, and cause poisoning and endangering their safety. A review of the facility's policy and procedure (P&P) titled Smoking Policy-Residents, undated, indicated .the resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. a residents ability to smoke safely will be evaluated quarterly. residents without any independent smoking privileges may not have or keep any smoking articles including cigarettes except when they are under direct supervision.		