STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055212	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Vineyards Healthcare Center	76 Fenton Street Livermore, CA 94550

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide care for Resident 1 that met professional standards of practice when:1. Resident's NPO status before PEG placement procedure was not verified with the physician (NPO is a medical abbreviation for the Latin phrase nil per os, which means nothing by mouth. It is a strict instruction from a doctor to not consume any food, liquids, or sometimes oral medications for a specific period, usually before surgery, PEG stands for Percutaneous Endoscopic Gastronomy. This is commonly referred to as a feeding tube that is placed directly into the stomach through the skin of the abdomen). 2. The resident's follow-up blood pressure (BP) readings were not obtained following administration of PRN blood pressure medication for seven occasions, and the physician was not notified of the interventions (PRN is a medical abbreviation for the Latin phrase pro re nata, meaning as needed).This failure resulted in Resident 1 in being transferred to the hospital and increased the resident's risk of developing health complications. Review of Resident 1's Situation, Background, Assessment, and Recommendation notes (SBAR, is a structured communication framework that can help teams share information about the condition of a resident) dated 7/2/25, indicated Resident 1 was for NPO in preparation for PEG placement. The SBAR indicated that the resident was not given his BP medications because he was on NPO. The SBAR indicated that when the resident's BP was checked at 1:00 p.m., the BP reading was 207/97 mmHg (A critical blood pressure reading defined as a systolic pressure (top number) of 180 mmHg or higher, mmHg is a form of measurement). Resident 1 was sent to the hospital on 7/2/26 at 3:00 p.m. for the critical high blood pressure. A review of Resident 1's admission Record (AR), dated 1/28/26, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (memory loss and impaired decision-making capacity) and hypertensive heart disease (a group of heart problems that happen because the heart has been forced to work too hard for too long due to high blood pressure). Review of Admission-Minimum Data Set (MDS), Resident Assessment and care guide tool, dated 6/20/25, indicated Resident 1's Basic Interview of Mental Status (BIMS) score was 00 (meaning poor cognition). During an interview on 2/5/26 at 2:00 p.m., with the Director of Nursing (DON), the DON stated the expectation from the charge nurses was to verify with the physician if the BP medications were to be given when the resident was to be on NPO due to an impending procedure or surgery. Stated Resident' 1s critical blood pressure placed the resident at risk to have a stroke (a medical emergency that happens when blood flow to the brain is suddenly cut off). Review of the facility's policy titled Surgery-Related (Pre- and Postoperative) Management - Clinical Protocol, Revised October 2010, indicated, Assessment and Recognition: 1. As needed, the physician will evaluate a resident who is scheduled to undergo surgery. a. The assessment will focus on pertinent items including a recent medical history, level of cognition and function, controlling active medical co-morbidities (such as congestive heart failure and hypertension). Treatment/Management: 1. As much as possible, the physician will address modifiable risk factors and potentially (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
	055212	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Vineyards Healthcare Center	76 Fenton Street Livermore, CA 94550

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatable active medical conditions prior to the individual's transfer for surgery; for example, stabilize blood sugar and blood pressure. Monitoring. 2. The staff and physician will review the continuing relevance of the preoperative medications and treatments, along with those added postoperatively, and adjust them accordingly. 2. A review of Resident 1's physician's order dated 1/28/26 with a start date of 2/6/.25, indicated an order of hydralazine HCl Oral Tablet 25 MG (Hydralazine HCl) Give 1 tablet by mouth every 6 hours as needed for HTN SBP >160, (hydralazine is a medication for high blood pressure. MG or milligrams is a form of measurement. HTN is hypertension or high blood pressure and SBP means systolic blood pressure, systolic is the top part of the blood pressure reading). During a concurrent interview and record review on 1/28/26 at 2:00 p.m., with the DON, Resident 1's clinical records for the months of May 2025 through August 2025 were reviewed. The DON confirmed that Resident 1 was given PRN hydralazine for BP of more than systolic of 180 and BP were not rechecked after giving the medication during the following dates: 1. For the month of May: on 5/9/25 at 3:53 p.m., BP was 195/85 mmHg. 2. For the month of July: On 7/16/25 at 8:32 a.m., BP was 198/86 mmHg; on 7/23/25 at 8:00 a.m., BP was 195/89 mmHg; on 7/20/25 at 9:50 a.m., BP was 183/75 mmHg; on 7/26/25 at 8:26 a.m., BP was 189/88 mmHg and on 7/29/25 at 8:49 a.m., BP was 190/81 mmHg. 3. For the month of August: on 8/1/25 at 8:00 a.m., BP was 197/87 mmHg. During an interview on 2/5/26 at 3:30 p.m., with the Director of Staff Development (DSD), the DSD stated that licensed nurses must recheck blood pressure 30 minutes after administering the PRN hydralazine to monitor its effectiveness, document the results, and notify the physician if the pressure remains elevated. Failure to monitor and follow up on high blood pressure readings can result in adverse outcomes, including stroke or unnecessary hospitalization. During another interview on 2/5/26 at 4:15 p.m., with the DON, the DON stated licensed nurses must recheck blood pressure after administering PRN blood pressure medications to assess effectiveness. The goal is to monitor for efficacy, as failure of PRN hydralazine to lower blood pressure puts the resident at risk for a stroke. Review of the facility's policy titled Acute Condition Changes - Clinical Protocol, Revised March 2018, indicated, . Assessment and Recognition.the nurse shall assess and document/report the following baseline information: a. Vital signs;. g. Onset, duration, severity;. 7. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician, for example, the history of present illness and previous and recent test results for comparison. a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. 8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less) .