STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056259	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northvine Postacute Care	446 Arrowood Dr Santa Rosa, CA 95407

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** 39792 Based on interviews and record reviews, the facility failed to protect one resident (Resident 1) out of five sampled residents from a staff member (Licensed Staff A) verbally abusing Resident 1. This failure had the effect of causing emotional distress as evidence by Resident 1 crying. Findings: During an interview on 9/25/24 at 2:52 pm. Administrator stated, Licensed Staff B presented him with a recording, dated 6/23/24, of Licensed Staff A and Resident 1 which Resident 1 ' s family member had sent to the facility. Administrator stated the audio recording consisted of Licensed Staff A, berating, cursing and demeaning Resident 1. Administrator stated Licensed Staff A was put on immediate suspension and then subsequently employment was terminated by the facility. Administrator stated Resident 1 was no longer residing at the facility and had been discharged on [DATE]. During an interview on 10/2/24 at 11:10 am with Licensed Staff B, Licensed Staff B stated the tone from Licensed Staff A was badgering and there were many [derogatory comments] throughout the conversation. Licensed Staff B stated it was shocking to hear those words [derogatory comments] coming from Licensed Staff A. (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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(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	During an interview on 10/9/24 at 10:47 a.m., with the Administrator, the Administrator played the audio recording which was sent to the facility. Licensed Staff A was heard saying to Resident 1, I want you to stop this (stern voice), I, why are you crying now, what is the [derogatory comment] problem with your bipolar (disorder is a mental illness that causes extreme shifts in mood, energy and activity levels) [derogatory comment]. What is wrong now? You need to (unintelligible comment from Licensed Staff A), (unable to understand Resident 1 ' s response was garbled) .Licensed Staff A continued .You are not going anywhere . (unable to hear Resident 1 ' s response) .License Staff A continues . I don ' t care, you need to stop this . (Resident 1 ' s response is unintelligible) License Staff A continues .Who is going to pick you up, that is the police? That is the only way you leaving out of here. Who? .(Resident 1 responds but is unintelligible). Licensed Staff A continues .Tell them to take you far away, we have had enough of your [derogatory comment], Licensed Staff A was yelling at Resident 1, Why did you do that a long time ago, Why are waiting, DO IT! (Resident 1 was responding but unintelligible and muffled crying was heard) Licensed Staff A continued, It ' s [derogatory comment] every three months you pop off, go back where? (Unable to hear Resident 1 ' s response), License Staff A continued, It ' s the same everywhere (unable to hear Resident 1 ' s response), it ' s too much, YOU ARE AN EMOTIONAL ROLLER COASTER, stop this crying, I will get the [derogatory comment] when you stop crying. (Unable to hear Resident 1 ' s response, it was garbled but there were attempts to respond) License Staff A continued, Stop [derogatory comment] crying, shut up. The audio concluded. Administrator stated it was not easy to listen to (audio recording). Review of Resident 1 ' s, Admission Record, dated 3/25/21, indicated Resident 1 had been admitted to the facility originally on 3/25/21 and most recently on 6/5/23. Resident 1 had a history of quadriplegia (a form of paralysis that affects al four limbs, plus the torso), bipolar disorder, dysphagia (a condition that makes it difficult to understand and produce language) and blindness due to the absence of eyes. Review of Resident 1 ' s, Care Plan dated, 4/8/21, indicated Resident 1 was in a motor vehicle accident that results in loss of eyes, impaired mobility, and subsequent pain. A review of the facility ' s policy and procedure titled, Abuse Prevention Program, dated 1/18, our residents have the right to be free from abuse .This includes but is not limited to freedom from .verbal .3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our residents .5. Implement measures to address factors that may lead to abusive situations, for example: a. provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation: b. instruct staff regarding appropriate ways to address interpersonal conflicts: and c. help staff understand how cultural, religious, and ethnic differences can lead to misunderstanding and conflicts. 6. Identify and assess all possible incidents of abuse. 9. Establish and implement a QAPI (Quality Assurance Performance Improvement) review and analysis of abuse incidents; and implement changes to prevent future occurrences of abuse.