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	12/05/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure an abuse allegation was reported to the appropriate agencies within 2 hours after an allegation was made for one out of two sampled residents (Resident 1). This failure could put the resident's safety at risk and potentially hinder the ability to properly investigate and protect the resident due to a lack of time to intervene effectively. Findings: A review of Resident 1's face sheet (demographics) indicated he was admitted to the facility on [DATE] with a diagnoses of Muscle Weakness and Anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Resident 1's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 10/7/24 indicated Resident 1 had intact cognition (memory). Resident 1's MDS also indicated he was dependent on staff with his care except for eating and oral hygiene on which needed substantial assistance from staff. A review of the facility initial report dated 11/14/24 indicated this verbal abuse allegation occurred on 11/12/24. A review of Resident 1's Progress note dated 11/12/24 at 8:00 p.m. indicated Resident 1's brother-in-law approached Licensed Staff D to complain about Unlicensed Staff B working with Resident 1 of using vulgar words. During an interview on 12/4/24 at 11:15 a.m., Unlicensed Staff A stated, using vulgar words on residents or telling resident to f--- off or f--- you was a verbal abuse and should have been reported right away. Unlicensed Staff A stated all abuse allegations had to be reported within 2 hours after learning about the allegation. Unlicensed Staff A stated not reporting abuse allegations timely could put the resident's safety at risk. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 11:32 a.m., Licensed Nurse (LN) B stated using vulgar or swear words or telling a resident to f--- off or f---you were considered a verbal abuse and should be reported to the Ombudsman (assist in the resolution of problems and advocate for the rights of residents of long-term care facilities), the state and local police department (PD) within 2 hours after an allegation was made. LN B stated not reporting abuse allegation within 2 hours put residents' safety at risk. LN B stated not reporting an abuse allegation timely could also result to resident feeling nobody believed their complaint and could be distrustful to staff. LN B stated reporting the abuse allegation timely within 2 hours not only protect the resident involved but the rest of the facility's residents as well. During a concurrent interview and abuse policy and procedure record review on 12/4/24 at 12:15 p.m., the Administrator (ADM) stated when this allegation was reported to the nurse on 11/12/24, this allegation should have been reported to the state, ombudsman, and local PD within 2 hours. The ADM verified the facility did not report the abuse allegation to the state, local PD and the Ombudsman within 2 hours of Resident 1 making the allegation. The ADM stated not reporting abuse allegations within 2 hours after an abuse allegation was made, would be a possible safety risk for the residents. During a concurrent interview and abuse policy and procedure record review on 12/4/24 at 12:45 p.m., the Director of Nursing (DON) verified the facility's policy on abuse was not followed when the abuse allegation was not reported to the state, ombudsman and the local PD within 2 hours after an abuse allegation was made. The DON stated not reporting abuse allegation timely within 2 hours after an allegation was made would likely put the resident's safety at risk. A review of the facility's policy and procedure (P&P) titled Abuse Investigation and Reporting , updated 2/2024, the P&P indicated, .an alleged violations of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property will be reported to the proper agencies as guided per regulations

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40214 Based on interview and record review, the facility failed to protect the resident when a staff member (Unlicensed Staff C) was allowed to continue working on her shift while the investigation for the abuse allegation was in progress. This failure reduced the facility ' s potential to protect Resident 1 from further abuse while the alleged abuse investigation was in progress. Findings: A review of Resident 1 ' s face sheet (demographics) indicated he was admitted to the facility on [DATE] with a diagnoses of Muscle Weakness and Anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Resident 1 ' s Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 10/7/24 indicated Resident 1 had intact cognition (memory). Resident 1 ' s MDS also indicated he was dependent on staff with his care except for eating and oral hygiene on which needed substantial assistance from staff. A review of the facility initial report dated 11/14/24 indicated this verbal abuse allegation occurred on 11/12/24. A review of Progress note dated 11/12/24 at 8:00 p.m. indicated the alleged staff (Unlicensed Staff C) working with Resident 1 during the incident was not suspended immediately after an abuse allegation was made against her and was only reassigned to another room. During a concurrent interview and abuse policy and procedure record review on 12/4/24 at 12:15 p.m., the Administrator (ADM) verified the facility did not suspend Unlicensed Staff C immediately after Resident 1 accused her of verbal abuse per facility policy. The ADM stated not putting the alleged staff on suspension immediately after an abuse allegation was made against her might taint the investigation and could influence staff or residents judgement so there could be a risk of not getting an impartial investigation. During a concurrent interview and abuse policy and procedure record review on 12/4/24 at 12:45 p.m., the Director of Nursing (DON) verified the alleged staff (Unlicensed Staff C) was not immediately suspended after Resident 1 made the abuse allegation against her per facility policy. The DON stated not suspending Unlicensed Staff C immediately after an abuse allegation was made against her could put residents safety at risk and could compromise the investigation. A review of the facility ' s policy and procedure (P&P) titled Abuse Investigation and Reporting, updated 2/2024, the P&P indicated, .the administrator will suspend immediately any employee who has been accused of resident abuse pending outcome of the investigation .