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	04/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49091 Based on interview and record review, the facility failed to initiate and implement resident-centered nursing care plans for one of three sampled residents, when: 1. A nursing care plan was not initiated when Resident 1 developed a urinary tract infection (UTI- when bacteria enter the urinary tract, which includes the kidneys, bladder, and urethra. Most UTIs are caused by bacteria from the bowel); and, 2. Nursing care plan interventions were not implemented when Resident 1 experienced constipation for three days These failures had the potential to worsen or delay improvement of Resident 1's medical conditions. Findings: A review of Resident 1's Admission Record, printed 4/10/25, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis (hemiplegia is a severe condition involving paralysis on one side of the body, while hemiparesis is a milder form of weakness on one side) of the right dominant side, vascular dementia (a type of dementia caused by impaired blood flow to the brain, leading to damage and eventual loss of brain cells), anxiety, and muscle weakness. A review of Resident 1's Minimum Data Set (MDS - a standardized, comprehensive assessment tool used in long-term care facilities to evaluate residents' health status and functional capabilities), dated 1/14/25, indicated Resident 1 had a BIMS (Brief Interview for Mental Status-a standardized cognitive assessment used in nursing homes and other long-term care facilities to quickly screen for cognitive impairment, particularly dementia) of four (4), indicating severe cognitive deficit. 1. A record review of Resident 1's Progress Notes, dated 4/2/25 at 15:01 p.m., indicated Resident 1 left the facility with her sister. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's Progress Notes, dated 4/2/25 at 20:12 p.m., indicated Resident 1's sister called the facility to tell them Resident 1 was at Santa [NAME] Memorial Hospital due to stomach pain. A record review of Resident 1's Providence After Visit Summary, dated 4/2/25, indicated Resident 1 received blood and urine testing, and a computed tomography scan (CT scan - a medical imaging technique that uses X-rays to create detailed cross-sectional images of the body) of the abdomen. Resident 1 was diagnosed with an acute (a condition or illness that has a sudden onset and relatively short duration) UTI with abdominal pain and was treated with intravenous (existing or taking place within, or administered into, a vein or veins) fluids, pain medications and an antibiotic (medications that specifically target and eliminate bacteria causing infections in humans and animals) injection. Resident 1 was then discharged back to the facility via ambulance at 12:45 a.m. on 4/3/25. A review of Resident 1's Order Summary Report, dated 4/10/25, indicated Resident 1 was prescribed the following: Cefpodoxime Proxetil (used to treat bacterial infections in many different parts of the body) Oral Tablet 200 mg (milligram-a unit of measure), give 1 tablet by mouth two times a day for UTI for 10 days. Order date 4/3/25, end date 4/13/25. During a concurrent interview and record review with the Director of Nursing (DON) on 4/10/25 at 2:51 p.m., the DON acknowledged nursing staff did not initiate a nursing care plan for Resident 1's UTI or for antibiotic treatment. The DON stated this slipped by because the condition was found by an outside hospital, and Resident 1 arrived back at the facility late at night. The DON also stated a UTI care plan was important because it directed nursing staff in appropriate interventions. During an interview on 4/10/25 at 3:35 p.m. with Licensed Vocation Nurse 1 (LVN 1), LVN 1 stated Resident 1 was still on antibiotic treatment for UTI and was doing well. LVN 1 acknowledged there was no nursing care plan for Resident 1's UTI, and this was not facility policy. LVN 1 stated many nursing interventions, such as increased water intake and observing for signs of systemic (affecting the entire body) infection, were typical interventions in a UTI care plan, and nursing staff should have notified the DON that the care plan was missing. During a review of facility policy and procedure (P & P) titled, Urinary Tract Infections/Bacteriuria-Clinical Protocol, dated 1/2018, it indicated, empirical treatment should be based on documented description of an individual's symptoms and on consideration of relevant test results, co-existing conditions, and pertinent risk factors, and, .nursing staff will review the status of individuals who are being treated and adjust treatment accordingly. During a review of facility P & P titled, Care Plans - Comprehensive Person Centered, dated 1/2018, it indicated, the nurse and/or the interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition . 2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/10/25 at 3:15 p.m. with the DON, Resident 1's Progress Notes, dated 1/15/25, and the Medication Administration Report (MAR- keeps track of every dose that the individual takes or misses for whatever reason) for January 2025, were reviewed. The DON agreed Resident 1 did not have a bowel movement (BM) for three days on 1/15/25, but no bowel care medications were administered. The DON stated facility bowel protocol was to implement specific interventions if a resident did not have a BM in three days. During a record review of Resident 1's Care Plan Report, printed 4/10/25, it indicated interventions for constipation instructed, administer Dulcolax (rectally inserted medicine used to relieve constipation), Fleet's enema (liquid is inserted into the rectum and colon through the anus), and MOM (Milk of Magnesia-Magnesium hydroxide, used to orally treat occasional constipation in children and adults on a short-term basis) as ordered .Follow facility bowel protocol for bowel management. During a record review of Resident 1's Order Details, dated 7/10/24, it indicated the following, Milk of Magnesia (MOM) Suspension 1200 mg/ml (milliliter-a unit of measure) by mouth; give 30 ml by mouth as needed for bowel care management/bowel care; give 30 ml PO (by mouth) if no bowel movement in 3 days in the evening, and Dulcolax Suppository 10 mg rectally; insert 1 suppository rectally as needed for bowel care management/bowel care; give 1 suppository if no (sic) MOM is ineffective on NOC (night) shift. During an interview on 4/10/25 at 3:35 p.m. with LVN 1, LVN 1 stated bowel care, including suppository administration, was done and documented by Licensed Nursing staff, not Certified Nursing Assistants (CNAs), and bowel care intervention is triggered in the electronic medical record (EHR) if a resident has not had a BM in three days. During an interview on 4/10/25 at 3:15 p.m. with the DON, the DON stated she did not know if Resident 1 failed to receive bowel care management per the nursing care plan on 1/15/25, or if the nurse just failed to document it. A record review of facility P & P titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, dated 1/2018, indicated, treatment/management: the physician will identify and order cause-specific and symptomatic interventions; for example institute a regimen to prevent constipation.