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	07/28/2025

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of nursing care when one resident (Resident 1) of three sampled residents did not have documented weekly skin assessments in their medical chart and wound care treatments were not implemented to Resident 1's right great toe.This failure resulted in the development of infection and maggots in Resident 1's right great toe, which required hospitalization and subsequent amputation to his right great toe. Cross reference F925.A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (a condition characterized by paralysis of one side of the body), and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of a Nursing admission Assessment, dated [DATE], indicated Resident 1's skin assessment was documented as Right Toe-Bruising. A review of Resident 1's Right Great Toe Ulcer Care Plan, dated [DATE], indicated Resident 1 had developed an ulcer (an open wound that fails to heal properly) with redness and swelling to his right great toe. Interventions included: monitor and document wound; to monitor, document and report any signs of infection; weekly documentation of wound which will include measurement of skin breakdown's width, length, depth, type of tissue and exudate (fluid seeping from wound). A review of Resident 1's Order Summary Report dated [DATE] indicated the following orders were written by Medical Doctor 1 (MD 1):[DATE]: Cleanse right great toe with normal saline (a solution of salt and water used in medicine to clean wounds), pat dry, apply small amount of triple antibiotic cream (a topical medication used to prevent infections in minor cuts) and cover with dry dressing. Every day shift for wound to right great toe. Start [DATE].[DATE]: Cleanse right great toe with normal saline, pat dry, apply small amount of betadine [antiseptic used to treat skin infections] and leave open to air every day shift for wound to right great toe. Start [DATE]. A review of a Treatment Administration Record (TAR) dated [DATE] indicated Resident 1 did not receive treatment for his right great toe as ordered on [DATE] and [DATE] for a total of 2 missed treatments. A review of Resident 1's Progress Notes dated [DATE] at 10:52 p.m., indicated, CNA [Certified Nursing Assistant] noticed [Resident 1's] right toe tip bleeding.minimal blood.small drainage . A review of Resident 1's Order Summary Report, dated [DATE], indicated a wound care order written by MD 1 for Resident 1's right great toe expired on [DATE]. There was no documented evidence that new orders were obtained after the expiration date. Due to this Resident 1 did not receive wound care treatment from [DATE] to [DATE] for a total of six missed treatments. A review of Resident 1's Order Summary Report dated [DATE], indicated a wound care order written by MD 1 for Resident 1's right great toe expired on [DATE]. There was no documented evidence that new orders were obtained after the expiration date. Due to this Resident 1 did not receive wound care treatment from [DATE] to [DATE] for a total of three missed treatments. A review of a document titled Skin Weekly Assessment dated [DATE], indicated a skin and wound assessment was performed on Resident 1. There was no further documented evidence of weekly skin assessments prior to or after [DATE] for a total of eight missed weekly skin assessments. A review of Resident 1's Progress Notes dated [DATE] at 1:49 p.m., indicated, While in the process of cleaning [Resident 1's] wound to better view base and surrounding area.observed.lifting of the skin. Upon further assessment.there was movement at the lifted spot. When.[Licensed Nurse 1 (LN 1)] wiped the area.saw a small white larvae [sic] looking bug coming up from the tip of the wound.Repetitive motion of cleaning the wound with warm water caused several more small ones to appear. A review of Resident 1's Progress Notes, dated [DATE], at 3:51 p.m., indicated Resident 1 was transferred to the hospital for evaluation of right great toe wound. A review of the hospital document titled Emergency Department [ED] Provider Note dated [DATE], indicated Resident 1 was evaluated and admitted to the hospital for Maggots on right first toe, open chronic wound and necrosis [dead or dying tissue]. A review of Resident 1's hospital document titled Computed Tomography [CT scan-medical imaging procedure using Xray and computers to obtain detailed cross-sectional images of the body] Foot Right with contrast [a substance used to make images clearer and more detailed] dated [DATE] indicated, Findings are concerning for septic arthritis [serious joint infection caused by bacteria] and gangrenous osteomyelitis [tissue death from a severe infection of the bone]. Soft tissue swelling of the great toe. A review of a hospital document titled Surgery Information dated [DATE] at 1:25 p.m., indicated Resident 1 had surgery for Partial First Ray Resection Right Foot [a surgical procedure when part of the first metatarsal [a group of five long bones in the midfoot] and the big toe are removed due

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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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. (continued on next page)

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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 0687 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of hemiplegia (a condition characterized by paralysis of one side of the body), expressive language disorder (a communication disorder impacting a person's ability to communicate their thoughts), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 1's History and Physical, dated 11/1/24, indicated Medical Doctor 1 (MD 1) planned for a wound care consult, currently foam dressing to right dorsal [top of foot] foot ulcer every Monday, Wednesday, Friday. MD 1 noted the wound measurement taken on 10/4/24 was, 1 centimeter [cm-a unit of measure] x 1cm x 0.2cm. A review of the Physician's Progress Notes dated 5/16/25, indicated Resident 1 had an infection in his right great toe and was ordered antibiotics, warm compresses as needed and to cleanse the area with normal saline (a solution of salt and water used in medicine to clean wounds), apply betadine (antiseptic used to treat skin infections) and leave wound open to air. A review of a wound consultant document titled Preliminary Wound Report, dated 6/2/25 indicated Resident 1 had, necrotic [tissue that is dead or dying] right great toe with intact black eschar [a thick crust like area of dead tissue that forms on the skin].peripheral pulses [the beats of the heart felt in the extremities when touched] non-palpable [pulse cannot be felt]. Extremities cold to touch. Great toe nail [sic] is almost detaching. Referral to podiatrist [a doctor specializing in treatment of the foot]. A review of Resident 1's Order Summary Report, dated 6/6/25, indicated a podiatry consult was ordered. A review of a wound consultant document titled Preliminary Wound Report, dated 6/9/25 indicated, Black eschar stable and dry. Paint wound with betadine and leave open to air. Follow up with Podiatrist.to [discharge from services] today. A review of Resident 1's Progress Notes dated 6/13/25 at 11:09 p.m., indicated Resident 1's right great toenail came off. A review of Resident 1's Progress Notes dated 6/14/25 at 10:05 p.m., indicated, Wound to [Resident 1's] right great toe is worsening. Will notify [Wound Consultant ((WC) a healthcare professional who specializes in the assessment, treatment, and management of acute and chronic wounds)] with further information. A review of Resident 1's Progress Notes, dated 7/21/25, at 1:49 p.m., indicated, While in the process of cleaning [Resident 1's] wound to better view base and surrounding area.observed.lifting of the skin. Upon further assessment.there was movement at the lifted spot. When.[Licensed Nurse 1-LN 1] wiped the area.saw a small white larvae [sic] looking bug coming up from the tip of the wound.Repetitive motion of cleaning the wound with warm water caused several more small ones to appear. A review of Resident 1's Progress Notes, dated 7/21/25 at 3:51 p.m., indicated Resident 1 was transferred to the hospital for evaluation of right great toe wound. A review of the hospital document titled Emergency Department (ED) Provider Note dated 7/21/25, indicated Resident 1 was evaluated and admitted to the hospital for, Maggots on right first toe, open chronic wound and necrosis [death of cells and living tissue]. A review of hospital document titled Computed Tomography [CT scan-medical imaging procedure using Xray and computers to obtain detailed cross-sectional images of the body] Foot Right with contrast [a substance used to make images clearer and more detailed], dated 7/21/25, indicated, Findings are concerning for septic arthritis [serious joint infection caused by bacteria] and gangrenous osteomyelitis [tissue death from a severe infection of the bone]. Soft tissue swelling of the great toe. A review of a hospital picture of Resident 1's right great toe wound, taken on 7/22/25, at 9:43 a.m., depicted Resident 1's right great toe with approximately 3.5 cm of black eschar. A small amount of light-yellow discharge was seen oozing from the center of the wound. Resident 1's toenails to healthy digits were yellowed, stained and long. A review of a hospital document titled Surgery Information, dated 7/25/25 at 1:25 p.m., indicated Resident 1 had surgery for, Partial First Ray Resection Right Foot [a surgical procedure when part of the first metatarsal (a group of five long bones in the midfoot)] and the big toe are removed due to infection or gangrene [dead tissue]. During an interview on 7/28/25 at 10:15 a.m., the Wound Nurse (WN) remembered the last orders placed for Resident 1's wound care was to, wash with soap and water then leave open to air. During an interview on 7/28/25 at 10:44 a.m., LN 2 stated she remembered Resident 1 had initially received wound care with betadine, then it was changed to soap and water. LN 2 stated, For some reason, Resident 1 was removed from [WC's] service, but I don't know why. [Resident 1's] wound was still bad. During an interview on 7/28/25 at 2:11 p.m., the Director of Nursing (DON) stated the WN should complete the weekly skin assessments for any residents with skin issues or wounds. The DON stated if assessments were completed weekly, the deterioration of the wound might have been caught and

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain an effective pest control program when flies were observed in common hallways and three resident rooms and four resident rooms had torn window screens. This failure decreased the facility's potential to prevent vector (an insect or rodent that transmits bacteria and viruses) borne illnesses for a census of 54 residents.During a concurrent observation and interview on 7/28/25 at 10:30 a.m., Resident 3 was lying in bed. Upon observation a half full and open urinal and partially eaten personal food items had been placed on Resident 3's bedside table. In addition, a strip of fly paper with 3 dead flies attached and a live fly was seen on Resident 3's curtain Resident 3 stated he had seen flies in his room, all the time. Upon inspection, Resident 3's window screen was torn.During a concurrent observation and interview on 7/28/25 at 10:51 a.m., Resident 4 was sitting on the edge of his bed. Resident 4 stated flies had randomly been entering his room throughout the day and made him annoyed. Resident 4 stated, They land on your head and buzz around. A dead fly was observed on his windowsill.During an observation on 7/28/25 at 10:55 a.m., a torn window screen was found in resident room [ROOM NUMBER]. During an observation on 7/28/25, at 10:56 a.m., a fly was seen flying around in resident room [ROOM NUMBER].During a concurrent observation and interview on 7/28/25 at 10:58 a.m., in Resident 5's room, holes were observed in the window screen. Resident 5 stated, Flies come in here all the time. I told them about this.During an observation on 7/28/25 at 11:02 a.m., a torn window screen was found in resident room [ROOM NUMBER].During an interview on 7/28/25 at 1:30 p.m., the Maintenance Worker (MW) reviewed the maintenance binder and could not locate a work order to repair any window screens. The MW confirmed he did not proactively work on pest prevention.During an observation on 7/28/25 at 1:40 p.m., at the nurse's station, a fly was persistently buzzing around this surveyor.During an interview on 7/28/25 at 2:51 p.m., the Administrator (ADM) stated he was not aware of a fly problem in the facility. The ADM stated flies in the facility, pose a significant problem.A review of the facility's policy titled Pest Control, dated 1/18, indicated, This facility maintains an on-going pest control program to ensure that the building is kept free of insects.