STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555120	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Post Acute	101 Monroe Street Petaluma, CA 94954

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27532 Based on interview and record review, the facility failed to ensure one (1) or four (4) residents (Resident 2) was treated with respect and dignity and access to care to promote maintenance and enhance his quality of life when Resident 2 was not provided his medication in a timely manner. This failure caused Resident 2 to feel helpless and unimportant. Findings: During an interview on 4/4/24, at 5:55 PM, Resident 2 when asked if he felt safe in the facility, stated: Not entirely safe. When asked when he did not feel safe, Resident 2 stated there was a time he waited for an hour for his pain medication, but because the nurses were doing their shift change, he felt helpless and could do nothing about it. Resident 2 stated he felt it was more important for staff to prepare for their shift or to go home than the patients. During review of medical records, his quarterly minimum data set (MDS - federally mandated clinical assessment of all residents' functional capabilities helping nursing home staff identify health problems) dated 2/7/24 indicated his brief interview for mental status (BIMS - screening tool to identify the cognitive condition of residents.) score was 13, indicating he was cognitively intact. The MDS also indicated he can understand and adequately hear, and easily understood with clear speech. He also received a scheduled pain medication. During an interview on 5/30/24, at 3:06 PM, Licensed Nurse C (LN C) when asked the rights of a resident stated, the five rights of residents when providing medication are: right patient, correct medication, the right time, right dose, and right route. LN C added residents' safety is priority in addition to treat them with respect and dignity, ensure their privacy, and respond to residents' call as soon as possible depending on circumstances. When asked what she would do when a resident calls for assistance during shift change, LN C stated she would inform the other nurse about the call for assistance, check the resident , and if urgent, would provide the care needed. A review of the facility policy titled: Resident rights taken from the 2001 MED-PASS, Inc manual revised 12/2016, indicated, employees shall treat all residents with kindness, respect, and dignity. The rights include amongst other: a dignified existence and be supported by the facility in exercising his or her rights.

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

Printed: 08/28/2024
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Monroe Street Petaluma, CA 94954	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27532 Based on interview and records review, the facility failed to develop a plan of interventions to address the risk of fall for one (1) of four (4) residents (Resident 1) when Resident 1 fell from his wheelchair at the nurses' station. This failure caused Resident 1 a bruise over his right forehead and a trip to the acute hospital for evaluation. Findings: On 3/21/24, the Department received a report of a resident who fell at the facility in the afternoon of 3/20/24, was brought to the acute hospital, brought back to the facility and was again found later that night on the floor by the nursing station wearing only a brief, refusing to be picked up by staff, and combative. During an interview with the Administrator on 4/4/24, at 3:53 PM, he stated he saw the incident happen on 3/20/24. The Administrator stated Resident 1 was in his wheelchair at the nurses' station with a Certified Nursing Attendant (CNA) who was helping him to make a call. The Administrator stated Resident 1 threw himself out of his chair after the CNA fixed his sitting position. When asked to clarify how Resident 1 threw himself out of his wheelchair , the Administrator stated, Resident 1 let himself out of his wheelchair to fall. The Administrator further stated, later that night, Resident 1 crawled out of his room, almost naked. Resident 1 had refused to be changed. The Administrator stated he knew because he and the Director of Nursing (DON) were on the phone being briefed by staff of what was happening. The Administrator stated facility staff were present when Resident 1 was crawling to the nurses' station, but nobody could get him up. Resident 1 refused change and refused help to get up. The Administrator stated he did not recall if Resident 1 was combative. The Administrator stated, facility staff had called 911, and when paramedics came resident cooperated and was sent to the hospital. A review of Resident 1's medical record indicated, his fall risk observation/assessment dated [DATE] scored was 20, meaning he was a fall risk. A review of Resident 1's care plans included plans of intervention for activities, end of life, activities of daily living (ADLs) and mobility decline, impaired vision/eyes, occupational and physical therapy, hemiplegia (refers to complete paralysis) / hemiparesis (refers to partial weakness), alteration of gastro-intestinal status, heart artery disease related to atrial fibrillation (irregular heartbeat that occurs when the electrical signals in the two upper chambers of the heart fire rapidly at the same time causing the heart to beat faster than normal), communication problem (dysarthria - difficulty speaking because the muscles you use for speech are weak) following a stroke, and his post-stroke condition. There was no care plan with interventions to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/24, at 10:35 AM, Licensed Nurse A (LN A) confirmed she did Resident 1's fall risk assessment on Resident 1's admission on 3/18/24. LN A stated after she completed her admission assessment of newly admitted residents, she develops the care plans for skin, ADL, pain, and bowel and bladder (B/B). The care plans may then be updated as needed or during change in conditions (COCs) or other incidents. When told there was no care plan for fall in the care plans reviewed, she wondered why there was no care plan in the resident's medical record and asked herself if she had forgotten doing it. LN A stated if she forgot, the IDT (interdisciplinary team - group of professionals all working together to treat a resident's injury or condition. The team usually is composed of the Administrator, DON, facility physician, activity manager, social services director, and the rehabilitation director.) would have spotted the omission. LN A stated she has 24 hours to finish the care plans before the IDT review. When asked what the interventions for falls were, she stated, when a resident is identified as at risk for falls, she can generate the care plan in point click care (PCC - a computer software used in skilled nursing facility to generate for monitoring patient information and generate customizable reports such as administration record reports, action summary reports, detailed census reports) based on the individual resident characteristics. During an interview with the interim DON on 5/29/24, at 2:15 PM, the DON stated the IDT reviews admissions the next day. The IDT double checks orders, assessments, consents, and care plans among others the day after each residents' admission. If anything is missing, they can delegate the task to any staff to complete. The interim DON could not say why the IDT missed the fall prevention care plan as it is very important for a resident who was identified as a high fall risk. During an interview on 5/29/24, at 3:39 PM, CNA B stated she was not assigned to Resident 1 on the day he fell from his wheelchair, but she was at the nurses' station and dialed the phone for him to call one of his relatives. CNA B stated she was on the other side of the nurses' station dialing the phone and Resident 1 was on the other side near the phone. Resident 1 was in his wheelchair getting a little agitated. After he hung up the phone, he took the wheel brakes off, and turned to move his whole body in the wheelchair, but the wheelchair got stuck on the railing. Resident 1 fell from the wheelchair hitting his shoulder on the floor. During an interview on 6/7/24, at 5:33 PM, CNA C stated he was at Station 2 around 2:30 PM getting ready to go home when Resident 1 fell . CNA C stated he saw the resident on the phone talking to family and had turned his back then all of a sudden the resident was on the floor. CNA C stated the resident was fine the previous day but was agitated the day he fell . When asked how interventions for fall prevention are communicated, CNA C stated nurses give CNAs report on residents like keeping low beds, responding to call as soon as possible, to prevent falls. A review of the facility's policy titled: Managing fall and fall risk, taken from the 2001 MED-Pass, Inc. manual dated 3/2018 indicated, based on evaluation and current data, staff may identify interventions related to the resident's specific risks in the attempt to reduce falls and minimize complications from falling. The policy further indicated, resident-centered fall prevention plans should be reviewed and revised as appropriate.