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	05/01/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39621 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) with metastatic breast cancer (The most advanced stage of breast cancer, which occurs when breast cancer cells spread from the breast to other organs) in moderate to severe pain, was discharged from the facility with her physician prescribed controlled opioid medications (Highly addictive non-synthetic medications whose use and distribution are tightly controlled by the government because of their abuse potential or risk) to manage her pain. Resident 1 was discharged without her controlled pain medications, and as a result, experienced severe pain, nausea, and vomiting, at the facility where she was discharged , prompting her to call emergency services to be taken to a General Acute Care Hospital (GACH), one day after being discharged from nursing facility. The GACH where she was transferred to, indicated Resident 1 had experienced opiate withdrawal, related to not taking her opiate medications for more than 24 hours. Findings: Record review indicated Resident 1 was admitted to the facility on [DATE] with medical diagnoses including Malignant Neoplasm of Left Female Breast (Cancer to the left breast), and Secondary Malignant Neoplasm of Bone (Cancer that had spread to the bone), according to the facility Face Sheet (Facility demographic). Record review of an e-mail sent by the Administrator to the Surveyor on 5/03/24 at 4:43 p.m., indicated Resident 1's undated BIMS (Brief Interview of Mental Status-A cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 15, which indicated her cognition was intact (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). Record review of physician discharge orders for Resident 1 dated 3/27/24 indicated, Discharge with remaining medication supply except narcotics (Controlled medications containing opioid derivatives). Discharge with 7 days narcotics only. This form was signed by the facility physician on 3/27/24, and included the following medications, oxyCODONE/acetaminophen (A combination of Oxycodone (A narcotic opioid medication to treat severe pain) and Acetaminophen (Analgesic for mild to moderate pain) for pain control 5mg (Milligrams)/325mg Tab . Take one Tab by mouth every 4 hours as needed .morphine 12Hr-CR (12 hour-controlled release) 15mg Tab (Morphine is a controlled narcotic opioid medication to treat moderate to severe pain) .Take one Tab by mouth twice daily Morning and Night. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 1's Medication Administration Record for April 2024, indicated Resident 1 received 10 mg of Oxycodone for a pain level of 6 (Pain scale where 0 stands for no pain, and 10 is the worst pain experienced during a person's lifetime. A pain level of 0-3 signifies mild pain, 4-6 is moderate pain, and 7-10 is severe pain) on 4/01/24 (Day of discharge) at 8:58 a.m. Record review of a nursing note documented by Licensed Staff A on 4/01/24 at 1:42 p.m., indicated, @1235PM (At 12:35 p.m.) [Resident 1] discharge home today. Picked up by a taxi. Record review of a facility document titled, POST-DISCHARGE PLAN OF CARE 3.1, dated 4/01/24, had a section to document the medications Resident 1 was discharged with. This section inquired for each medication's purpose and special instructions, and amount sent with the resident. The section on medications was left blank, and instead, a handwritten note signed by Licensed Staff A on 4/01/24, appeared on this document indicating, PLS. (Please) SEE ATTACHED MEDICATION LIST. MEDICATION INSTRUCTIONS GIVEN & VERBALIZES UNDERSTANDING. Record review of a GACH emergency department note dated 4/02/24 at 3:57 p.m., indicated, [Resident 1] is a [AGE] year old female with metastatic breast cancer who presents from a new long-term care facility with 1 day of nausea, vomiting and diarrhea. Of note, patient was out of subacute rehabilitation center and was recently transitioned to a different long-term care facility, patient states that her opiate prescription did not follow her and she has not had any of her opiate pain medicine for her metastatic cancer for over 24 hours. Patient concerned that her symptoms may be related to her opiate withdrawal. Also with generalized nonfocal (Not specific to a certain area) abdominal pain in setting of vomiting and diarrhea .patient's symptoms improved with IV (IV-Intravenous-administered though the veins) fluids, IV antiemetics (Medications for nausea) as well as home opiate doses. Case management help set up home nursing care, patient's opiate sent to 2 different pharmacies, spoke with patient at length to ensure that the opiates can get picked up to prevent reoccurrence of opiate withdrawal. During a phone interview with Witness XX on 4/22/24 at 11:43 a.m., she stated Resident 1's discharge from the facility on 4/01/24 was, Terribly irresponsible. Witness XX stated the discharging nurse was not prepared and not aware of Resident 1's scheduled discharge, therefore she just gave Resident 1 whatever medications she could find in the medication cart, missing Resident 1's pain medications in the process. Witness XX stated Resident 1 was not discharged from the facility with her pain medication, which she needed for her hip and back pain caused by Resident 1's cancer metastasis. Witness XX stated that after 12 hours of not taking any pain medications, Resident 1 started having withdrawal symptoms such as vomiting, which triggered her to call an ambulance to be taken to a GACH. Witness XX stated staff from the GACH where Resident 1 was transferred to, as well as herself, called the nursing facility multiple times to find out what medication she was taking, but received no response. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	During an interview with Licensed Staff A on 5/01/24 at 10:38 a.m., with the Director of Staff Development (DSD) present, Licensed Staff A stated she was not the assigned nurse for Resident 1 on 4/01/24, on the day of the discharge, and was notified by a Social Services staff member that Resident 1 was being discharged (on 4/01/24) when the nurse assigned to Resident 1 was taking her lunch break. Licensed Staff A stated she assisted with the discharge when the taxi was already waiting for Resident 1. Licensed Staff A stated she did not believe she had provided Resident 1 with Morphine upon discharge from the facility, but she believed she had given her the Oxycodone. Licensed Staff A and the DSD were asked to provide the controlled medication reconciliation forms (A reconciliation form is a document used in nursing homes to record the amount of drugs that are received, used, and discarded. It is intended to reconcile the controlled medication use to prevent abuse or theft of controlled substances) for Resident 1's Morphine and Oxycodone, and any other evidence, to determine if Resident 1 had been discharged with these medications from the facility. Neither of the two staff members returned to speak to the Surveyor or provided the controlled reconciliation sheets or any other evidence indicating Resident 1 was discharged with her Morphine and Oxycodone from the facility. During a concurrent interview and record review with the Medical Records Director (MRD) on 5/01/24 at 1:12 p.m., with the Administrator present, the MRD was shown the handwritten note by Licensed Staff A indicating, PLS. (Please) SEE ATTACHED MEDICATION LIST. MEDICATION INSTRUCTIONS GIVEN & VERBALIZES UNDERSTANDING. The MRD was asked to provide the medication list this handwritten note referenced. The MRD was also asked to provide the last training on the discharge process or discharge planning that had been provided to Licensed Staff A at the facility. The MRD and Administrator were given until Friday 5/03/24 at the end of the day to provide these documents by e-mail. These documents requested were not provided, and instead, the Administrator sent an e-mail to the Surveyor on 5/03/24 at 4:43 p.m., indicating this requested medication list was not being provided because it had been sent to the Surveyor previously, which was not the case. The Administrator had provided the discharge signed order from the facility physician (dated 3/27/24, above) which indicated what medications Resident 1 was to be discharged with (Which included the Morphine and Oxycodone) but this document did not indicate the actual medications sent with Resident 1, and amount of each medication. During an interview with the Director of Nursing (DON) on 5/01/24 1:45 p.m., he was asked about the documentation requirements for medications provided to a resident upon discharge from the facility. The DON stated discharging staff should document what medications the resident was discharged with, and the number of pills provided of each medication. During a phone interview with Resident 1 on 5/02/24 at 1:08 p.m., she corroborated Witness XX story, and stated she was discharged from the facility without her Morphine or Oxycodone. Resident 1 stated the nurse on duty the day of discharge was not aware she was leaving, so she appeared to be in a rush gathering the medications for her when the taxi was already waiting outside. Resident 1 stated she attempted to call the facility multiple times after the discharge to let them know she had been discharged without her Oxycodone and Morphine but was unable to communicate with anybody. Resident 1 stated a few hours after her discharge from the facility she started experiencing vomiting, diarrhea, and pain of 8 of 10 (Severe pain). Resident 1 stated she called emergency services to be taken to a GACH (Refer to GACH emergency department note dated 4/02/24 at 3:57 p.m. above). Record review of the facility policy titled, Transfer or Discharge, last revised in August of 2018, indicated, Transfers or discharges may be necessary to protect the health and/or well-being of the resident(s). This policy did not indicate the process for discharging a resident non-emergently to another facility, nor did it mention medications to be provided to the resident upon discharge.