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	09/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41206 Based on interview and record review, the facility failed to prevent abuse for one resident (Resident 3) of four sampled residents when Resident 4 threw water on Resident 3. This failure resulted in Resident 3 feeling unsafe at the facility. Findings: A review of an admission record indicated Resident 4 was admitted to the facility in 2023 with diagnoses which included neurocognitive disorder with Lewy Bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). A Minimum Data Set (MDS, an assessment tool) dated 9/3/24 indicated Resident 4 scored a 15 on a Brief Interview for Mental Status (BIMS, a questionaire used to determine if a person's cognition (the process of thinking) is intact. A score of 15 suggests intact cognition). A review of an admission record indicated Resident 3 was admitted to the facility in 2024 with diagnoses which included anoxic brain damage (brain injury caused by a complete lack of oxygen to the brain), abnormalities of gait and mobility, and unspecified mood disorder (a disturbance of mood which significantly impacts a person's life and wellbeing). A review of Resident 3's social history assessment dated [DATE] indicated, Cognitive Pattern .Score .15 . [Resident 3 is] Cognitively Intact. A review of Resident 3's document titled SBAR [Situation, Background, Assessment, and Recommendation, a communication framework used to share information about the condition of a resident] Summary for Providers dated 9/15/24 at 5:30 p.m. indicated, During Med [medication] passing the writer notice [sic] [Resident 3's] gown wet but almost drying, the writer asked what happen [sic] and why it was wet since [Resident 3] is total dependent [and] has no capacity to hold a cup. [Resident 3] stated 'One Res. in a W/C [wheelchair] came inside the room and pour out water on me a [NAME] guy.' (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's social service note dated 9/16/24 at 7:49 p.m. indicated, Spoke with [Resident 4] regarding altercation with neighbor across the hall. [Resident 4] went to room and poured water on [Resident 3's] lap .I asked [Resident 4] why he did that and he said 'when we are in war we use guns and back here we use ice water.' [Resident 4] has [diagnosis] of PTSD [Post Traumatic Stress Disorder, a mental and behavioral disorder that develops from experiencing a traumatic event] and was triggered by the continuous screaming of [Resident 3] across the hall. Reminded this resident to not throw water on residents or harm other residents that it makes someone also feel not safe . In an interview on 9/23/24 at 11:07 a.m., Resident 4 stated he liked his stay at the facility except for Resident 3 who lived across the hallway who screamed throughout the day. Resident 4 stated Resident 3 screamed so loudly he could still hear her scream even when he had his headphones on. Resident 4 stated he notified staff Resident 3's screaming bothered him but was told they could not tell him why she screamed. Resident 4 stated his hands have started to shake because he has had difficulty sleeping at night due to her screaming. Resident 4 stated one day he went to Resident 3's room and threw water on her because she kept screaming. Resident 4 confirmed he did it not long ago and was told not to do it again. In an interview on 9/23/24 at 11:24 a.m., Resident 3 stated a man wheeled himself into her room, approached her bed, and threw water on her while she was in bed then left the room. Resident 3 stated she did not feel safe in the facility because Resident 4 could come back and throw hot boiling water on her if he wanted. In an interiew on 9/25/24 at 7:03 p.m., Licensed Nurse 3 (LN 3) confirmed upon observation on 9/15/24 Resident 3's gown, pillows, and stuffed animal were damp to touch. The LN 3 stated the situation was curious because Resident 3 was on a fluid restriction and was unable to hold a cup so it did not make sense for the gown, pillows, and stuffed animal to be wet. The LN 3 stated Resident 3 reported a male in a wheelchair threw water at her and then left the room between lunch and the time LN 3 entered her room. A review of the facility's policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation Program dated Arpil 2021 indicated, Residents have the right to be free from abuse .This includes but is not limited to .verbal, mental .or physical abuse .The resident abuse .prevention program consists of a facility-wide commitment and resource allocation to support the following objectives .Protect residents from abuse by anyone including .other residents .Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems .