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	02/13/2025

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 0678

Level of Harm - Actual harm

Residents Affected - Few

Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41175

Based on interview and record review, the facility staff failed to recognize a cardiorespiratory arrest (a life-threatening medical emergency that occurs when the heart and lungs stop functioning properly) for one of three sampled residents (Resident 1), which resulted in a delay in performing CPR (or cardiopulmonary resuscitation, a procedure to keep the blood pumping when the heart stops or when it beats too ineffectively to circulate blood to the brain and other vital organs) on Resident 1 who was a full-code (a medical directive indicating that a patient wishes to receive all possible life-saving measures in the event of a medical emergency) after he was found unresponsive. This failure led to Resident 1 ' s death.

Findings:

During an interview on [DATE] at 9 a.m., Complainant 5 stated he arrived at the facility on [DATE] approximately five to seven minutes after receiving a call about an unresponsive patient who was having difficulty breathing. Complainant 5 stated he found Resident 1 on a non-rebreather mask (a mask that delivers high concentrations of oxygen), but was apneic (not breathing spontaneously), unresponsive and diaphoretic (covered with sweat), and pulseless. Complainant 5 stated he immediately started chest compressions on Resident 1. Complainant 5 stated he continued to perform CPR on Resident 1 until his time of death, about ,d+[DATE] minutes later. Complainant 5 stated there was an AED (automated external defibrillator, or a portable medical device that can analyze the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart re-establish an effective rhythm) at Resident 1 ' s bedside, but the machine was not on nor were the pads applied on Resident 1 ' s chest. Complainant 5 stated he was later told by the staff that Resident 1 had been unresponsive and had oxygen saturation levels (a measure of how much oxygen is in your blood) in the 60 ' s or 70 ' s approximately 40 minutes before his arrival (the normal range for oxygen saturation is typically between 95% and 100%).

A review of Resident 1 ' s Face Sheet indicated he was admitted to the facility with diagnoses including acute and chronic respiratory failure (a condition where the body is not getting enough oxygen due to a failure of the lungs to properly exchange gases, which can occur suddenly or over time).

(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: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Post Acute	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 0678 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Progress Notes, dated [DATE], indicated, . At around 1650 (4:50 p.m.) respiratory nurse was doing her rounds and noticed this resident was not wearing his NC (nasal cannula [a device with two prongs that deliver oxygen directly into the nostrils]). The nurse put resident back on his O2 (oxygen) via NC, states when she was with the pt (patient) he woke up but didn ' t say anything. At around 1655 (4:55 p.m.) this writer went to give resident his evening medications. Resident was asleep and unable to wake up. This LN (Licensed Nurse) did a sternum rub (to determine if a person is conscious and responsive) and resident would wake up and fall straight back to sleep. This LN then took resident V/S (vital signs) again . BP (blood pressure) ,d+[DATE], 97.5 F, 22 RPM (respirations per minute), 75 SPO2 (oxygen saturation), BG (blood glucose [blood sugar level]) 156 on 2L (2 liters of oxygen) via NC. Immediately this LN called the respiratory nurse, put his bed into high fowlers [positioned with the head elevated between ,d+[DATE] degrees], increase his 02 (oxygen) to 4L, and gave this resident his nebulizer tx [a treatment involving a device that delivers medications directly into the lungs], Resident's 02 was not increasing so this writer called 911. Respiratory nurse and Nurse Supervisor 2 was with the resident monitoring (sic). Upon completion of nebulizer tx resident's 02 was unchanged. The respiratory nurse then put a nonrebreather mask on resident and increased the 02 to 15L. Resident's 02 then went up to 97%. At around 1730 (5:30 p.m.) at the same (sic) this resident stopped breathing, and the paramedics arrived on scene. CPR was initiated by paramedics . 30 minutes of CPR was conducted. Time of death was called at 1753 (5:53 p.m.) . During an interview on [DATE] at 1:31 p.m., Licensed Staff A stated she was called into Resident 1 ' s room because of his oxygen level was low. Licensed Staff A was unable to recall the time nor how low the oxygen level was. Licensed Staff A stated she replaced Resident 1 ' s nasal cannula to a non-rebreather mask. Licensed Staff A stated Resident 1 was diaphoretic and would briefly open his eyes as she performed sternal rubs. Licensed Staff A stated she told Licensed Staff C to call 911, as she and another staff stayed at Resident 1 ' s bedside. Licensed Staff A stated she continued to monitor Resident 1 ' s breathing and performing sternal rubs. Licensed Staff A stated Resident 1 stopped breathing very suddenly, and as she was about to get the crash cart from outside the room, she almost ran straight into the paramedics. Licensed Staff A stated she never had a chance to start CPR. During an interview on [DATE] 1:40 p.m., Licensed Staff B stated she recalled Resident 1 ' s death and added she was in the room very briefly. Licensed Staff B stated Resident 1 was nonresponsive to sternal rubs. Licensed Staff B demonstrated gasping motions when asked to describe how Resident 1 ' s breathing was. Licensed Staff B stated she was checking Resident 1 ' s carotid pulse (the rhythmic pulse of the carotid arteries located on either side of the neck) while she was at the bedside, and stated Resident 1 never lost a pulse. Licensed Staff B stated there was an AED at the bedside, but it was not used. Licensed Staff B stated she had never used an AED outside of training. Licensed Staff B stated AED pads were placed on patients when CPR was started, and the AED was used when a patient became pulseless. (continued on next page)

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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 0678 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:58 p.m., Licensed Staff C stated she was about to give Resident 1 his medications the evening of [DATE] when he would not wake up. Licensed Staff C stated Resident 1 would briefly open his eyes as she did sternal rubs but would fall back to sleep after. Licensed Staff C stated Resident 1 ' s vital signs (temperature, blood pressure, heart rate and respiratory rate) were normal except for his low oxygen saturation. Licensed Staff C stated she started the nebulizer treatment and called for Licensed Staff A for further assistance. Licensed Staff C stated after a few minutes of the nebulizer treatment, she called 911. Licensed Staff C stated she brought the AED to Resident 1 ' s room per 911 ' s instructions. Licensed Staff C stated the AED was for Licensed Staff A and B to use, as they were at Resident 1 ' s bedside. Licensed Staff C stated CPR was not started on Resident 1 as he never lost pulse, nor had his breathing stopped. During an interview on [DATE] at 3:10 p.m., the Director of Nursing (DON) stated CPR was performed when someone was unresponsive, not breathing or has lost their pulse. The DON stated she expected staff to follow the paramedics ' instructions during emergency situations. A review of a national standard by the American Heart Association titled, Cardiac Arrest, dated 2025, indicated, Cardiac arrest can strike without warning . The signs are: Sudden loss of responsiveness - The person doesn ' t respond, even if you tap them hard on the shoulders or ask loudly if they're OK. The person doesn ' t move, speak, blink or otherwise react. No normal breathing - The person isn ' t breathing or is only gasping for air . If you think the person may be suffering cardiac arrest and you're a trained lay rescuer: Ensure scene safety. Check for response. Shout for help. Tell someone nearby to call 911 or your emergency response number. Ask that person or another bystander to bring you an AED, if there ' s one on hand. Tell them to hurry - time is critical. If you ' re alone with an adult who has signs of cardiac arrest, call 911 and get an AED (if one is available). Check for no breathing or only gasping. If the person isn ' t breathing or is only gasping, begin CPR with compressions. Administer high-quality CPR. Push down at least two inches in the center of the chest at a rate of 100 to 120 pushes a minute. Allow the chest to come back up to its normal position after each push. Use an AED. As soon as it arrives, turn it on and follow the prompts. Continue CPR. Administer it until the person starts to breathe or move, or until someone with more advanced training, such as an EMS team member, takes over . A review of the document titled, CPR Facts and Statistics by The American Red Cross Training Services, published [DATE], indicated, Out-of-Hospital Cardiac Arrest Facts: Survival chances decrease by 10% for every minute that immediate CPR and use of an AED is delayed. Immediate CPR can triple the chance of survival . Based on interview and record review, the facility staff failed to recognize a cardiorespiratory arrest (a life-threatening medical emergency that occurs when the heart and lungs stop functioning properly) for one of three sampled residents (Resident 1), which resulted in a delay in performing CPR (or cardiopulmonary resuscitation, a procedure to keep the blood pumping when the heart stops or when it beats too ineffectively to circulate blood to the brain and other vital organs) on Resident 1 who was a full-code (a medical directive indicating that a patient wishes to receive all possible life-saving measures in the event of a medical emergency) after he was found unresponsive. This failure led to Resident 1's death. Findings: (continued on next page)

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