

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 02/25/2025
NAME OF PROVIDER OR SUPPLIER Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792</p> <p>Based on interview and record review, the facility failed to maintain an effective infection prevention and control program, for a census of approximately 90 residents, when the facility did not report an influenza outbreak to the local public health department (LPHD) for nearly three weeks.</p> <p>This failure had the potential to increase the transmission of influenza among all residents in the facility.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 2/25/25 at 11:05 a.m., with the Infection Preventionist (IP), the facility ' s document titled, Line List Acute Respiratory Illness Outbreak In Long-Term Care Facilities (Including Influenza) (line list, a table that summarizes information about each case of an outbreak), dated 1/29/25, was reviewed. The IP stated the line list indicated, the facility had an influenza outbreak starting on 1/29/25 when two residents tested positive for influenza. The IP stated on 1/31/25 seven more residents tested positive for influenza and, during the outbreak, the facility, the facility had a total of 28 resident and [NAME] staff members who had tested positive for influenza. The IP stated, she hadn ' t notified the LPHD until 2/18/25, she had been away from work for nearly three weekly and the LPHD had not been notified while she was gone. The IP stated the local public health department should have been notified when the first case of influenza had been identified on 1/29/25.</p> <p>During an interview on 2/25/25 at 1:59 p.m., the Director of Nursing (DON) acknowledged she had not notified the LPHD regarding the influenza outbreak, because she thought the Administrator (ADM) was responsible for reporting the outbreak.</p> <p>During an interview on 2/25/25 at 2:10 p.m., the Director of Staff Development (DSD) stated she prepared the line list for the facility ' s influenza outbreak starting on 1/29/25, but had not sent the line list nor reported the outbreak to the LPHD, because she thought it was the responsibility of the ADM.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review, on 2/25/24 at 3:30 p.m., with the ADM, the facility ' s policy and procedure (P&P) titled, Outbreak of Communicable Diseases, dated 9/2022, was reviewed. The ADM confirmed the P&P indicated, .An outbreak of influenza is defined as anything exceeding the endemic rate, or a single case if unusual for the facility . A single case of influenza is reportable to the department of health . The administrator is responsible for: a. communicating data about reportable diseases to the health department .The ADM acknowledged he had not notified the LPHD of the influenza outbreak that started on 1/29/25, because the IP was responsible for reporting to the LPHD. The ADM acknowledged the IP was not working in the facility during the start of the influenza outbreak and the outbreak had not been reported to the LPHD until she returned nearly three weeks later.</p> <p>During an interview on 3/3/25 at 11:03 a.m., the LPHD ' s Infectious Disease Nurse (IDN, a specialized nurse who prevents and controls the spread of infectious diseases) stated during an influenza outbreak, it was important for the facility to notify to the LPHD on the first day of the outbreak, so the LPHD could ensure the facility had regular communications with the LPHD ' s Healthcare-Associated Infections program (HAI, a program that oversees the reporting and response to healthcare associated infections in healthcare facilities). The IDN further explained, HAI would provide education, guidance, and possible onsite support to assist the facility with keeping the spread of the outbreak to a minimum. The IDN further explained, the facility ' s influenza outbreak that started on 1/29/25, was considered a significant or bad outbreak which indicated the facility may have needed education, testing supplies, problem solving support, and close monitoring to protect the facility residents from contracting the illness. The IDN added, but in this case, due to failure to report timely, that did not happen.</p> <p>During a review of document Title 17. California Code of Regulations (CCR), . Reportable Diseases and Conditions, revised 8/2022, indicated, .Reporting to Local Health Authority . The administrator of each health facility .where more than one health care provider may know of a case, a suspected case or an outbreak of a disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the [LPHD] .The document further indicated, .OUTBREAKS of ANY DISEASE . were required to be reported to the LPHD immediately.</p>		