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	04/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38335 Based on interviews and record reviews, the facility failed to ensure professional standards of practice were conducted for one resident (Resident 1) of four sampled residents when Resident 1 did not have: A sliding scale (a method used to manage blood sugar levels in people with diabetes, where insulin doses are adjusted based on current blood sugar readings) for use of insulin (a hormone produced by the pancreas that helps regulate blood sugar levels) and Blood sugar parameters (levels that indicate when blood sugar is considered too high or too low) ordered for insulin administration. These failures placed Resident 1 at risk for ineffective monitoring of insulin usage and worsening of Resident 1 ' s condition. Findings: Resident 1 was a [AGE] year-old male admitted to the facility on [DATE], with a medical diagnosis that included: Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and dysphagia (difficulty swallowing). A review of Resident 1 ' s physician order summary report dated 2/21/25, indicated the following: -Insulin glargine (a long-acting, manmade version insulin used to manage blood sugar levels in people with diabetes) solution 100 Unit/milliliters (ml, a unit of measure) Inject 16 unit subcutaneously (a layer of fatty tissue just below the skin) at bedtime for diabetes mellitus. -Insulin lispro (a short-acting, manmade version of insulin) Injection Solution 100 Unit/ml Inject 5 unit subcutaneously in the morning for diabetes mellitus. -Insulin lispro Injection Solution 100 Unit/ml Inject 8 unit subcutaneously in the afternoon for diabetes mellitus. There was no documented evidence that indicated Resident 1 had an order for a sliding scale for the administration of insulin lispro and parameters which indicated when a nurse was supposed to hold (not administer) the insulin. (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
	555120	A. Building B. Wing	04/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Medication Administration Record (MAR) dated March 2025, indicated no documented evidence blood sugar levels had been obtained prior to the administration of insulin lispro 8 units subcutaneously every day at 5 p.m. between 3/1/25 and 3/26/25. A review of Resident 1 ' s nursing note dated 3/25/25 at 1:56 p.m., indicated vital signs (measurements that indicate a person's basic biological functions and overall health status) for Resident 1 at the time of the episode were: blood pressure 99/58 (less than 120/80 is considered a normal value) millimeters of mercury (mmHg, a measurement of pressure), heart rate was 56 beats per minute (bpm, a normal resting heart rate is considered to be between 60 and 100 bpm) and oxygen saturation (the percentage of red blood cells carrying oxygen) on room air was 93% (a healthy oxygen saturation is between 95% and 100%). The paramedics arrived and checked Resident 1 ' s blood sugar level which was 69 milligrams per deciliter (mg/dl, a unit of measure). Resident 1 was sent to the hospital. A review of Resident 1 ' s Emergency Department discharge summary report dated 3/25/25, indicated [Resident 1 ' s] blood work is at baseline [a level considered normal for the person, it is used as a reference point to compare] his blood sugar did drop, he was fed and given D50 [a solution of sugar water used to increased blood sugar levels] and instructed to cut his insulin doses in half. I favor that the patient likely had a hypoglycemic [blow blood sugar level] mildly hypotensive [low blood pressure] episode. During an interview on 4/10/25 at 1:30 p.m., Licensed Staff A (LS A) stated she had not thought of checking Resident 1 ' s blood sugar level when he was showing distress on 3/25/25. LS A stated blood sugar parameters were usually ordered for residents who received insulin and would be found in the residents ' MAR. LS A stated nurses were supposed to always check blood sugar levels before giving a resident insulin. On 4/10/25 at approximately 4 p.m. a review of Resident 1 ' s MAR dated March 2025 was conducted. The review indicated Resident 1 received an order for a sliding scale for his insulin lispro on 3/26/25 at 6 p.m. and an order for hypoglycemia protocol for conscious and unconscious (in the state of not being awake and not aware of things around you) resident on 3/27/25 at 10:26 a.m. and 10:24 a.m. respectively. During an interview and concurrent record review on 4/22/25 at 11:38 a.m., LS B stated she had been assigned to Resident 1 on 3/25/25. LS B stated residents with standing orders for insulin should always have their blood sugar levels checked prior to insulin being given. LS B stated these levels would be documented in the residents ' MAR. LS B reviewed Resident 1 ' s MAR and acknowledged it did not indicate Resident 1 ' s blood sugar levels were obtained prior to the administration of insulin lispro but it should. LS B also acknowledged Resident 1 ' s food intake fluctuated based on how he was feeling, and Resident 1 had had a rough night and was unable to complete his physical therapy session on 3/25/25. LS B also stated parameters would sometimes be ordered, but regardless of the order, insulin cannot be given unless we check the blood sugar level. LS B stated she would call the physician to notify him if a resident ' s blood sugar level was below 100 mg/dl. (continued on next page)

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	04/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/23/25 at 12:55 p.m., Consultant Pharmacist C (CP C) stated parameters should always be ordered because blood sugar levels can suddenly drop. The parameters are used to monitor the effect of the combination of insulin usage on the resident. CP C stated she usually recommends the physician to order parameters for blood sugar monitoring and a hypo/hyperglycemic protocol (orders a set of orders to manage both low and high blood sugar levels for diabetic residents). CP C stated she had not reviewed Resident 1 ' s medication orders because Resident 1 had been discharged to the hospital before she conducted her review at the facility in March. During a telephone interview on 4/25/25 at 2:55 p.m., Physician D stated his standard of practice when writing insulin orders for residents included ordering: a sliding scale for residents who had orders for long-acting insulin, hypoglycemic protocol, and parameters to notify the physician if a resident ' s blood sugar level was too high (greater than 300 mg/dl) or too low (less than 100 mg/dl). Physician D also stated he expected blood sugar levels to be checked before each meal and an hour after each meal to check the effectiveness of the insulin. Physician D stated staff usually notified him when a resident did not have parameters ordered. During a telephone interview on 5/2/25 at 2:45 p.m., the Director of Nursing (DON) stated sliding scale orders and blood sugar parameter orders usually came with a resident who was admitted from a hospital. The DON stated she expected licensed nurses to call the physician to ask for sliding scale, parameter orders, and blood sugar checks if the resident did not have them. The DON further stated the Physicians were at the facility most of the time and were very accessible. During a telephone interview on 5/7/25 at 3:30 p.m., the DON verified there was no sliding scale or blood sugar parameters listed on Resident 1's MAR prior to 3/26/25. A review of the facility ' s policy and procedure (P&P) titled Administering Medications dated revised April 2019, indicated, If .a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administrating the medication will contact the prescriber, the resident ' s attending physician or the facility ' s medical director to discuss the concerns .Each nurses ' station has a current Physician ' s Desk Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for .(Pharmacy Services) available. A review of the facility ' s policy and procedure titled, Insulin Administration, revised March 2025 indicated, Purpose to provide guidelines for the safe administration of insulin .The nurse will notify the provider or any discrepancies prior to administering insulin .Steps in the Procedure .Check blood glucose per physician order or facility protocol .Documentation .The resident ' s blood glucose result, as ordered .