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	09/16/2025

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. (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received care within professional standards of practice when licensed nursing staff failed to administer physician ordered pain medications to treat her moderate to severe pain, which led to ceaseless pain that worsened in numerical order and severity. This failure resulted in Resident 1 experiencing severe pain and had the potential to result in suffering and feelings of abandonment.A review of Resident 1's admission record indicated she was admitted to the facility in August, 2025 with medical diagnoses which included surgical aftercare of the digestive system (postoperative care after a procedure of the digestive system, which includes monitoring for complications, managing pain and medications, and regular follow-ups with a doctor). A review of Resident 1's clinical record included the following documents:A Nursing Care Plan initiated on 8/18/25, indicated Resident 1 had Pain, with the stated goal, Pain will be relieved to a tolerable level as indicated by resident, using verbal or non-verbal communication to the extent possible, with nursing care interventions which included, Administer treatment as ordered. Assess for pain every shift, and as indicated. Notify physician if resident experiences unmanageable or intolerable pain.A review of Resident 1's medication administration record (MAR - a daily documentation record where licensed nursing staff document medications and treatments administered to a resident) dated 8/18/25 at 12:26 p.m., indicated Medical Doctor 1 (MD1) ordered the following medication for mild pain: Acetaminophen (A medication, also called Tylenol used to treat pain) Tablet 325 MG (milligram).Give two tablet by mouth every 4 hours as needed for Mild Pain. and contained documented administrations of Acetaminophen with correlating pain scale entries of five (5) (Numeric pain scale where 0 indicates no pain, and 10 is the worst pain experienced during a person's lifetime) at 6:30 a.m., six (6) at 3:04 p.m., and six (6) at 7:25 p.m. on 8/19/25, as well as seven (7) at 10:50 a.m., on 8/20/25.A review of Resident 1's MAR dated 8/19/25 at 5:15 p.m., indicated MD 1 ordered the following medication for moderate to severe pain: Morphine Sulfate (A controlled substance to treat moderate to severe pain) Oral Solution 20 MG/ML (Milliliter = ML).Give 0.5 ml by mouth every 6 hours as needed for moderate to severe pain (5-10), and indicated Resident 1 did not receive any administrations of Morphine Sulfate for pain relief on 8/19/25, 8/20/25 or 8/21/25.A review of a progress note dated 8/19/25 at 10:44 p.m. entered by Licensed Nurse 2 (LN 2), indicated, Complaint of pain to surgical site, medicated with Tylenol with minimal effect. A review of a progress note dated 8/21/25 at 4:47 a.m., entered by Licensed Nurse 3 (LN 3), indicated, Resident complains of generalized pain, but resident's PRN (As needed) morphine has not been delivered yet . Resident reports Acetaminophen causes nausea.A review of a facility document titled, Change of Condition, dated 8/21/25 at 9:22 p.m., entered by Licensed Nurse 1 (LN 1) indicated Resident 1 was sent to a general acute care hospital (GACH) around 9:14 p.m. on 8/21/25 due to persistent nausea and vomiting with high blood pressure and tachycardia (heart rate above 100 beats per minute). During an interview with MD 1 on 9/16/25 at 5:00 p.m., he stated he saw and assessed Resident 1 at the facility on the afternoon of 8/19/25 and ordered the PRN Morphine Sulfate to treat Resident 1's moderate to severe pain due to her recent digestive system surgery and her current medical diagnoses. MD 1 added that Medical Doctor 2 (MD 2), who was familiar with Resident 1 then took over the care of Resident 1 on the evening of 8/19/25 and was Resident 1's attending physician for the remainder of her stay in the facility. During an interview with Resident 1 on 9/16/25 at 5:08 p.m., she stated she asked the facility nurse repeatedly for pain medication when she began experiencing pain after being admitted to the facility on [DATE], and over the next several days (from 8/18/25 through 8/21/25) she experienced severe pain that was not controlled despite her using her call light to request more pain medications multiple times, which left her feeling, scared, terrified and alone. She added that one nurse (referring to LN 1), would either not answer the call light, turn the call light off, or just come in her room and stare at her like he didn't believe me.During a concurrent interview and record review with the Director of Nursing (DON) on 9/16/25 at 11:30 a.m., Resident 1's August 2025 MAR was reviewed. The DON stated nursing staff who had cared for Resident 1 from 8/19/25 through 8/21/25 were not working during the Surveyor's visit, so they were not able to be interviewed, and she didn't know why Resident 1 was not administered the ordered Morphine Sulfate to treat her documented high pain levels and instead had only been administered Acetaminophen ordered for the treatment of mild pain. The DON stated her expectation was that nursing staff administered the pain medication that correlated with the resident's pain level, adding that if the physician order was unclear