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	03/10/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure only authorized personnel had access to one out of four medication carts when Medication cart #2 was unlocked when it was unattended.This failure could result in unauthorized access to medications and unintentional ingestion which could lead to overdoses, drug interactions, or severe adverse effects.During a concurrent observation and interview on 3/10/26 at 12:25 p.m., while walking in the hallway with the Nursing Supervisor (NS), medication cart #2 that was parked outside of room [ROOM NUMBER], was unlocked and unattended. The NS walked over medication cart # 2 and locked the cart. The NS stated medication carts should always be locked when left unattended. NS stated medication carts needed to be locked as unauthorized people, including residents, might access the medications in the medication cart which could jeopardize their safety. Licensed Nurse (LN) A was then seen coming out of room [ROOM NUMBER], LN A stated she oversaw cart # 2 and had left it unlocked and unattended. LN A stated the facility policy was to ensure medication carts were locked when unattended, for resident safety, so confused residents could not access the medications inside the medication cart.During an interview on 3/10/26 at 2:27 p.m., the Director of Nursing (DON) stated medication cart must always be locked when unattended because only nurses were authorized to access the medications. The DON stated leaving the medication cart unlocked while unattended was a safety issue and made it possible for unauthorized people to access the medications in the cart.A review of the facility's policy and procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated, .the cart must be visible to the personnel administering medications and all outward sides must be inaccessible to residents or others passing by.

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