

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 03/30/2026
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interviews and record reviews, the Licensed Nurses (LN) failed to notify the Responsible Party (RP, a person designated to makes healthcare and/or financial decisions for a person who is no longer able) for one resident (Resident 1) of three sampled residents, when:LN 1 (Licensed Nurse 1) did not notify Resident 1's RP that Resident 1 had eloped (when a resident leaves the facility unattended, without permission, or without staff awareness) on 2/28/26;and,LN 2 did not notify Resident 1's RP on 3/1/26 that Resident 1 had a fever of 100.4 degrees Fahrenheit (F, a unit measurement of temperature).These failures decreased the facility's potential to ensure Resident 1's RP was well informed regarding Resident 1's health status and plan of care.Findings:A review of Resident 1's admission record indicated medical diagnosis of Dementia (a progressive state of decline in mental abilities), Bipolar Disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), Cognitive Communication Deficit (an communication impairment due to poor memory or attention) and Repeated Falls. The admission record also indicated Resident 1's emergency contact number one and RP was his daughter.A review of Resident 1's Brief Interview on Mental Status (BIMS) conducted on 12/11/25, indicated a score of 6, which meant Resident 1 had a severe cognitive impairment (when you have problems remembering things, concentrating, making decisions and solving problems).A review of Resident 1's Order Summary Report, indicated Resident 1 had the following active orders:- Resident [1] is not capable of making his own health decisions [dated 10/24/24].- Wanderguard(R) to alert [Resident 1's exit-seeking behavior [dated 9/13/25].A review of Resident 1's change of condition note dated 2/28/26 at 7:25 a.m., indicated, episode [sic] of elopement early this morning, last time we check [sic] resident is [sic] at around 0400 [4 a.m.] and resident is still in his bed, [sic] resident went out of the building and went as far as the baseball field across the facility according to the police who found him [sic] brought him back here at around 0500 [5 a.m.] Wanderguard(R) is in place but it did not alarmed [sic] when resident went out of the facility. There was no documented evidence that the LN notified Resident 1's RP of his elopement.A review of Resident 1's progress note dated 3/1/26 at 10:29 p.m., documented by LN 2 indicated, .COC [Change of Condition] D1 [Day 1] for fever. Resident noted sneezing. At [5:54 p.m.] T [temperature]100.4 [F] forehead (non-contact), Acetaminophen administered, at [6:20 p.m.] fever 101.1 [F] noted.Resident [1] was congested so MD [physician] was notified for congestion medicine. There was no documented evidence that the LN notified Resident 1's RP of his fever.During an interview with Resident 1's RP on 3/30/26 at 11:55 a.m., , the RP stated she had not been informed by the facility that Resident 1 had an eloped. The RP stated she learned about his elopement from a friend who recognized her father's name during a dispatch call related to the incident. The RP also stated she visited Resident 1 on 3/2/26 after the elopement incident and noticed he was coughing which was new.During a concurrent record review and interview with the DON (Director of Nursing) on 3/30/26 at 3:45 p.m., the DON reviewed Resident 1's progress notes dated 2/28/26. The DON stated she expected licensed nurses to complete a change of condition report for an elopement and fever and notify the resident's RP.During an interview with LN 2 on 4/1/26 at 1:37 p.m., LN 2 stated she remembered Resident 1 had a fever on 3/1/26 and (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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>acknowledged she had not reported this to Resident 1's RP because she did not know she had to report it. During an interview with the DON on 4/1/26 at 2:42 p.m., the DON stated she checked Resident 1's progress notes and acknowledged she did not see any documented evidence that indicated Resident 1's changes of condition on 2/28/26 and 3/1/26 were reported to his RP. A review of the facility's policy and procedure (P&P) titled Wandering and Elopements dated March 2019 indicated, When the resident returns to the facility, the director of nursing services or charge nurse shall notify the resident's legal representative (sponsor). document relevant information in the resident's medical record. A review of the facility's P&P titled, Change in Resident's Condition or Status, dated February 2021 indicated, Our facility promptly notifies the resident and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his medical care or nursing treatments.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision to one resident (Resident 1) of three sampled residents, when Resident 1 eloped (when a resident leaves a facility unattended, without permission, or without staff awareness) from the facility on [DATE]. This failure decreased the facility's potential to prevent injury illness to Resident 1. Findings: A review of Resident 1's Elopement and Wandering Risk Observation/assessment dated [DATE], indicated a score of 12. According to this assessment, a score of 10 or greater would be considered at risk for wandering or elopement. A review of Resident 1's admission record indicated he was admitted to the facility in [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Bipolar Disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), Cognitive Communication Deficit (a communication impairment as a result of issues with memory and thinking processes), Atrial Flutter (a heart rhythm disorder that results in the upper chambers of the heart beat too fast [around 300 beats per minute; normal is 60-100 beats per minute]) Repeated Falls. The admission record indicated Resident 1's emergency contact number one and Responsible Party (a person designated to make decisions about healthcare and finances when a person is no longer able to do so for themselves) was his daughter. A review of Resident 1's Brief Interview on Mental Status (BIMS) conducted on [DATE], indicated a score of 6, which meant Resident 1 had a severe cognitive impairment (when you have problems remembering things, concentrating, making decisions and solving problems). A review of Resident 1's Order Summary Report, indicated Resident 1 had the following active orders:- Resident [1] is not capable of making his own health decisions [dated [DATE]].- Apixaban oral tablet 5 mg [milligrams, a unit of measure] Give 1 tablet by mouth two times a day for atrial flutter [dated [DATE]].- Anticoagulant medication (apixaban)- Monitor for [signs and symptoms of bleeding because it is a common side effect] every shift [dated [DATE]].- Attention Nurses: Wanderguard(R) is expiring on [DATE]. Please make sure to notify Activity Director for replacement. every shift [sic]. [dated [DATE]].- Wanderguard(R) to alert [Resident 1's exit-seeking behavior [dated [DATE]].- Wanderguard(R) function checked by maintenance staff [dated [DATE]].- Check Wanderguard(R) for placement. Location left ankle every shift [dated [DATE]]. A review of all Resident 1's care plans indicated:-On [DATE], a care plan was initiated for Resident 1's risk of falls related to his history of repeated falls. Resident 1's goal was to minimize his risk of falls. Staff were expected to keep Resident 1 within supervised view as much as possible in order to help him meet his goal.-On [DATE], a care plan was initiated for Resident 1's risk of elopement and wandering related to his impaired safety awareness. Resident 1's goal was for his safety to be maintained. Staff were expected to implement the following interventions to help Resident 1 meet his goal: Identify a pattern of wandering and intervene as appropriate and place a Wanderguard(R) on his right wrist.-On [DATE], a care plan was initiated for Resident 1's risk of bleeding associated with his use of anticoagulants. Resident 1's goal was to minimize side effects of the medication. Staff were expected to provide Resident 1 with safety measures to avoid injury to help him meet his goal.-On [DATE], a care plan was initiated because Resident 1 had an unwitnessed fall. Resident 1's goal was to minimize his risk for additional falls. Staff were expected to implement the following interventions to help Resident 1 meet his goal: anticipate and meet his needs and provide verbal reminders to ask for assistance as needed. A review of Resident 1's change of condition note dated [DATE] at 7:25 a.m., indicated, episode [sic] of elopement early this morning, last time we check [sic] resident is [sic] at around 0400 [4 a.m.] and resident is still in his bed, [sic] resident went out of the building and went as far as the baseball field across the facility according to the police who found him [sic] brought him back here at around 0500 [5 a.m.] (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Wanderguard(R) is in place but it did not alarmed [sic] when resident went out of the facility. During a concurrent observation and interview with Resident 1 on [DATE] at 2:40 p.m., Resident 1 was observed sitting on his bed. Resident 1 stated he remembered going out of the building late at night to see his friend who was a policeman and lived one-and-a-half houses away from the facility. Resident 1 stated he did not remember if he had his wander alarm on or if the door alarm sounded. Resident 1 stated he did not hurt himself /while he was out. While this surveyor and Resident 1 stood in the front lobby, Resident 1 pointed toward the closest baseball field from the facility to indicate where he had gone when he left the facility at night. In order to get to the baseball field, Resident 1 would have had to cross a neighborhood intersection with a three-way stop sign to get to the nearest baseball field. During a concurrent record review and interview with the DON (Director of Nursing) on [DATE] at 3:45 p.m., the DON stated nobody noticed that Resident 1 had left the facility. The DON also stated she was not sure if Resident 1's care plan was updated after the elopement incident on [DATE]. The DON reviewed Resident 1's care plan regarding his risk of wandering and elopement dated initiated on [DATE] and acknowledged it had not been updated to indicate Resident 1's elopement incident on [DATE]. During an interview with the Activity Director (AD) on [DATE] at 10:29 a.m., the AD stated she was on leave from work which started on [DATE] and the Human Resources Director (HRD) helped with the activity department. The AD stated she and anyone who was designated to carry out her duties while she was out on leave was responsible for keeping track of the expiration date of the Wanderguard(R). During an interview with the HRD on [DATE] at 10:50 a.m., the HRD stated she did not recall anyone informing her that Resident 1's Wanderguard(R) had expired. During an interview with the DON on [DATE] at 2:42 p.m., the DON stated there was a potential for Resident 1 to have fallen and sustained injuries when he eloped. During an interview with the Maintenance Director on [DATE] at 4:31 p.m., he stated he checked the door alarm system to ensure it was functioning properly every Friday and that he kept a log of the weekly checks. He stated when the door alarm was activated, the alarm would be loud enough for staff to hear and respond to. The Maintenance Director further stated there were monitors at Nurse Station 1 and Nurse Station 2 that would notify the nurses which door was alarming. The Maintenance Director stated he was unable to determine how Resident 1 was able to leave the building through the front door without sounding the alarm. A review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, dated [DATE], indicated, The facility will identify residents who are at risk of unsafe wandering. If identified as at risk for wandering, elopement. the resident's care plan will include strategies and interventions to maintain the resident's safety.</p>		