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 11/23/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on interview and record review, the facility failed to notify the physician when the resident consistently missed scheduled medications when out at dialysis for 1 (Resident #8) of 3 residents reviewed for dialysis. Findings included: On 11/23/2024 at 12:06 PM, the Director of Nursing (DON) stated the facility did not have a specific policy for notification of a change of condition but expected that the physician be notified of any change in status of the resident, and it should be documented. An Admission Record indicated the facility admitted Resident #8 on 10/13/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of end stage renal disease with dependence on renal dialysis. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received dialysis treatments. Resident #8's care plan included a focus area, initiated 11/24/2021, that indicated the resident had an alteration in kidney function due to end stage renal disease evidenced by hemodialysis. Interventions directed staff to administer medications as ordered, collaborating with physician and/or pharmacist for optimal medication dose times. Resident #8's Order Recap Report revealed the following orders: -Clopidogrel (an antiplatelet medication) 75 milligram (mg) give one tablet by mouth one time a day for blood clot prevention. -Incruse Ellipta Inhalation Aerosol Powder one puff inhaled orally one time a day for asthma. -Pregabalin 75mg give one capsule orally in the morning for pain. (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: 555120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/23/2024
NAME OF PROVIDER OR SUPPLIER: Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Monroe Street, Petaluma, CA 94954	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[NAME]-Vite (B-complex with vitamin c and folic acid) give one tablet by mouth in the morning for supplement. -Apixaban 5 mg give one tablet by mouth two times a day for atrial fibrillation (a-fib). -Bumetanide (a diuretic) 2 mg give one tablet by mouth two times a day. -Ferrous Gluconate 324 mg give one tablet by mouth two times a day for supplementation. -Keppra 500 mg give one tablet by mouth two times a day for seizures. -Nystatin External Powder 100,000 units per gram apply to affected areas topically two times a day for fungal rash. -Senna 8.6 mg give one tablet by mouth two times a day for constipation. -Wixela Inhaler Aerosol Powder 500-50 microgram (mcg) one puff inhaled orally two times a day for COPD. -Calcium Acetate 667 mg give two capsules by mouth three times a day for supplement. -Humalog insulin 100 units per milliliter (ml) inject 2 units subcutaneously three times a day before meals, in addition to sliding scale. -Insulin lispro 100 units/ml inject per sliding scale: if blood sugar 0-199 = 0 units; 200-249 = 2 units; 250-299 = 4 units; 300-349 = 6 units; 350-400 = 8 units; 401 and over = 10 units subcutaneously after meals. -Midodrine 10 mg (medication used to treat low blood pressure) give one tablet by mouth three times a day every Tuesday, Thursday, and Saturday with instructions to hold for a systolic blood pressure greater than 130. Resident #8's medication administration record (MAR) for the timeframe 10/01/2024 to 10/31/2024, revealed the resident did not receive their medications that were scheduled between 7:00 AM and 10:00 AM on 10 of 31 days throughout the month. The days the medications were not administered were Tuesdays, Thursdays, and Saturdays, which were days the resident went to dialysis. The documentation indicated the medication was not given because the resident was unavailable or out to dialysis. The medications not administered included clopidogrel, incruse inhaler, pregabalin, apixaban, bumetanide, ferrous gluconate, Keppra, nystatin powder, senna, Wixela inhaler, calcium acetate, Humalog insulin, insulin lispro, and midodrine. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8's MAR for the timeframe 11/01/2024 to 11/30/2024, revealed the resident did not receive their medications that were scheduled between 7:00 AM and 10:00 AM on 3 out of 20 days recorded through the month. The days the medications were not administered were Tuesdays, Thursdays, and Saturdays, which were days the resident went to dialysis. The documentation indicated the medication was not given because the resident was unavailable or out to dialysis. The medications not administered included clopidogrel, incruse inhaler, pregabalin, apixaban, bumetanide, ferrous gluconate, Keppra, nystatin powder, senna, Wixela inhaler, calcium acetate, Humalog insulin, insulin lispro, and midodrine. During an interview on 11/22/2024 at 10:05 AM, Registered Nurse (RN) #15 stated the physician was notified whenever a medication was held unless it was held due to vital signs being out of parameter, and only then if the order specified to notify the physician. During a phone interview on 11/22/2024 at 10:54 AM, the Medical Director, Resident #8's primary care physician, stated if a resident missed a dose of insulin, midodrine or antibiotic, there should be some communication to determine if they should receive it or not. The Medical Director stated he had been notified of an antibiotic being held during the past week but had not been notified of the other times the medications were held for Resident #8. During an interview on 11/22/2024 at 1:28 PM, Licensed Vocational Nurse (LVN) #11 reviewed the October 2024 and November 2024 MARs and confirmed that she coded 14 for Resident #8's morning medications on 10/05/2024, 10/08/2024, 10/26/2024, 10/31/2024, 11/02/2024, and 11/19/2024. She stated 14 meant the resident was out at dialysis and she coded 14 because the resident was not available to give the medication. LVN #11 stated they had asked the physician to clarify the times of the medications on dialysis day but had not gotten a response. She stated she could not remember when it was brought up. She stated the resident had changed physicians frequently and nothing had been done. She stated she had not spoken to the Medical Director about it. During an interview on 11/23/2024 at 8:58 AM, LVN #1 confirmed after reviewing the October 2024 MAR and November 2024 MAR that he coded 14 for the morning medications on 10/03/2024 and 11/16/2024 and confirmed that he did not give the medications once the resident returned. He stated he had not talked to the physician about the medications not being given. During an interview on 11/23/2024 at 9:57 AM, the Director of Nursing (DON) stated the nurse should follow the timing of the medication according to dialysis. She stated they should have an order to hold until after dialysis or change the time of the medication. She stated they should not hold the medication; it should be given after dialysis or whatever the physician said. She stated the physician should be notified anytime a medication was not administered. During an interview on 11/23/2024 at 10:34 AM, the Administrator stated the physician should be notified if a medication was not administered for any reason.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 42192 Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 2 (Resident #7 and Resident #10) of 2 sampled residents reviewed for preadmission screening and resident review (PASARR). Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised 11/2022, indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of the portion of the assessment. 1. An Admission Record indicated the facility admitted Resident #10 on 10/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder and dementia. An admission MDS, with an Assessment Reference Date (ARD) of 10/17/2024, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the resident was not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. Per the MDS, the resident had an active diagnoses to include schizophrenia and non-Alzheimer's dementia. According to the MDS, Resident #10 received an antipsychotic medication during the last seven days of the assessment period. Resident #10's care plan, included a focus area initiated 10/16/2024, that indicated the resident used psychotropic medications related to schizoaffective disorder. Resident #10's Preadmission Screening and Resident Review Level I Screening dated 09/30/2024, revealed the resident was positive for a serious mental illness. 45555 2. An Admission Record indicated the facility admitted Resident #7 on 12/13/2021. According to the Admission Record, the resident had a medical history that included diagnoses of psychosis, major depressive disorder, and anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2023, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. Per the MDS, the resident had an active diagnoses to include anxiety disorder, depression, and psychotic disorder. According to the MDS, Resident #7 received an antipsychotic medication during the last seven days of the assessment period. A letter from the State of California, Department of Health Care Services dated 12/13/2021, revealed Resident #7 was positive for a suspected mental illness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024 at 4:51 PM, the MDS Coordinator stated Resident #8's and Resident #10's positive PASARR was not indicated on their MDS, but it should have. The MDS Coordinator stated she overlooked the residents' PASARR information when the MDSs were completed. During an interview on 11/23/2024 at 8:58 AM, the Administrator stated he expected resident MDS assessments to be accurate. The Administrator stated the MDS for Resident #7 and Resident #10 should have indicated their PASARR status. During an interview on 11/23/2024 at 9:41 AM, the Director of Nursing (DON) stated the MDS assessments should be accurate. The DON stated Resident #7's and Resident #10's PASARR status should have been included in their MDS.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51642 Based on observation, interview, record review, and facility policy review, the facility failed to ensure physician orders were followed for supplemental oxygen flow rates for 1 (Resident #17) of 3 sampled residents reviewed for respiratory care. Findings included: A facility policy titled Oxygen Administration, revised 10/2010, indicated Purpose the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. An Admission Record revealed the facility admitted Resident #17 on 04/24/2023. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had shortness of breath or trouble breathing when lying flat and used oxygen therapy. Resident #17's care plan, included a focus area initiated 05/24/2023, that indicated the resident had emphysema/COPD. Interventions directed staff to give oxygen therapy as ordered by the physician and that Resident #20 was on continuous supplemental oxygen at 2 liters (L) per minute by way of a nasal cannula. Resident #17's Order Summary Report, which contained active orders as of 11/19/2024, revealed an order dated 03/21/2024, for supplemental oxygen at 2L per minute every shift. During a concurrent observation and interview on 11/18/2024 at 10:33 AM, Resident #17's oxygen concentrator was set at 3.5L per minute. Resident #17 stated the oxygen concentrator should be set at 2L. During a concurrent observation and interview on 11/18/2024 at 2:23 PM, Resident #17's oxygen concentrator was set at 3.5L per minute. Resident #17 stated the oxygen concentrator should be set at 2L During a concurrent observation and interview on 11/19/2024 at 1:24 PM, Resident #17's oxygen concentrator was set at 3.5L per minute. Resident #17 stated the oxygen concentrator should be set at 2L Registered Nurse (RN) #8 was interviewed on 11/19/2024 at 1:38 PM. The RN stated Resident #17 was ordered to receive 2L of supplemental oxygen, but confirmed the resident's oxygen concentrator was set at 3.5L and turned the oxygen concentrator back to 2L. RN #8 commented that the resident's oxygen should not be set too high because of the resident's diagnosis of COPD. RN #8 stated the resident's supplemental oxygen could be titrated if Resident #17 was short of breath; however, there was no documentation to support oxygen titration to be set at 3.5L per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 11/19/2024 at 3:07 PM. The DON stated if a resident had an order for 2L of supplemental oxygen, the supplemental oxygen concentrator should not be set at 3.5L. Resident #17's attending physician was interviewed on 11/22/2024 at 9:37 AM. The attending physician stated staff should keep the resident's oxygen at 2L. The attending physician stated the staff were expected the follow the physician orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 45555 Based on interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors for 1 (Resident #8) of 3 residents reviewed for dialysis services. Staff failed to ensure Resident #8 received medications that were used to treat low blood pressure, atrial fibrillation, prevent blood clots, and treat diabetes when the resident was scheduled for dialysis. Further, the facility failed to ensure that the medication to treat low blood pressure was given within the parameters set by the physician for treatment of low blood pressure. Findings included: A facility policy titled, End-Stage Renal Disease, Care of a Resident with, revised 09/2010, indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The policy also indicated, 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. 2. Education and training of staff includes, specifically: f. timing and administration of medications, particularly those before and after dialysis. An Admission Record indicated the facility admitted Resident #8 on 10/13/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of end stage renal disease with dependence on renal dialysis. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received dialysis treatments. Resident #8's care plan included a focus area, initiated 11/24/2021, that indicated the resident had an alteration in kidney function due to end stage renal disease evidenced by hemodialysis. Interventions directed staff to administer medications as ordered, collaborating with physician and/or pharmacist for optimal medication dose times. Resident #8's Order Recap Report revealed the following orders: -Midodrine (medication to treat low blood pressure) 10 milligrams (mg) give one tablet by mouth three times a day every Tuesday, Thursday, and Saturday with instructions to hold for a systolic blood pressure greater than 130, ordered 11/13/2024. Previously the order dated 10/07/2024 indicated to hold the midodrine for a systolic blood pressure greater than 120. -Clopidogrel (an antiplatelet medication) 75 mg give one tablet by mouth one time a day for blood clot prevention, ordered 11/22/2024. -Apixaban 5 mg give one tablet by mouth two times a day for atrial fibrillation (a-fib), ordered 09/27/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Humalog Insulin (medication to treat diabetes) 100 units per milliliter (ml) inject 2 units subcutaneously three times a day before meals, in addition to sliding scale, ordered 11/02/2024. -Insulin Lispro 100 units/ml inject per sliding scale: if blood sugar 0-199 = 0 units; 200-249 = 2 units; 250-299 = 4 units; 300-349 = 6 units; 350-400 = 8 units; 401 and over = 10 units subcutaneously after meals, ordered 08/16/2024. Resident #8's medication administration record for the timeframe 10/01/2024 to 10/31/2024, revealed the following: -clopidogrel 75 mg due at 7:00 AM was coded 14 indicating out to dialysis or 10 indicating resident unavailable for the 7:00 AM dose 10 out of 14 days the resident went to dialysis. -apixaban 5 mg due at 8:00 AM was coded 14 or 10 8 out of 14 days the resident went to dialysis. -Insulin Lispro per sliding scale due at 7:30 AM was coded 14 or 10 13 out of 14 days the resident went to dialysis. -midodrine due at 7:00 AM was coded 14 or 10 for the 7:00 AM dose 11 out of 14 days the resident went to dialysis. Resident #8's MAR for the timeframe 10/01/2024 to 10/31/2024, also revealed that the Midodrine was documented as administered when the systolic blood pressure was greater than 120 on: -10/05/2024 at 5:00 PM when the blood pressure was 157/76. -10/12/2024 at 7:00 AM when the blood pressure was 140/70 and at 5:00 PM when the blood pressure was 140/70. -10/15/2024 at 5:00 PM when the blood pressure was 126/67. -10/17/2024 at 12:00 PM when the blood pressure was 162/92. -10/19/2024 at 5:00 PM when the blood pressure was 126/69. -10/22/2024 at 12:00 PM when the blood pressure was 149/63 and at 5:00 PM when the blood pressure was 124/71. -10/26/2024 at 5:00 PM when the blood pressure was 142/78. -10/29/2024 at 5:00 PM when the blood pressure was 140/74, and -10/31/2024 at 12:00 PM when the blood pressure was 133/75 and at 5:00 PM when the blood pressure was 132/76. Resident #8's MAR for the timeframe 11/01/2024 to 11/19/2024 revealed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-clopidogrel 75 mg due at 7:00 AM was coded 14 three out of four days the resident went to dialysis while at the facility. -apixaban 5 mg due at 8:00 AM was coded 14 three out of four days the resident went to dialysis while at the facility. -Humalog insulin due at 8:00 AM was coded 14 four out of four days the resident went to dialysis while at the facility. -Insulin Lispro per sliding scale due at 7:30 AM was coded 14 four out of four days the resident went to dialysis while at the facility. -midodrine due at 7:00 AM was coded 14 four out of four days the resident went to dialysis while at the facility. Resident #8's MAR for the timeframe 11/01/2024 to 11/19/2024, also revealed the midodrine was documented as being administered when the systolic blood pressure was greater than 120 on 11/14/2024 at 12:00 PM, with a blood pressure of 138/69, and on 11/14/2024 at 5:00 PM with a blood pressure of 121/62. During a telephone interview on 11/21/2024 at 6:30 PM, Licensed Vocational Nurse (LVN) #16 stated she checked the resident's vital signs prior to prepping their medications and held the medication if it was out of parameters. She stated she must have documented in error that she gave Resident #8's midodrine on 10/22/2024. During an interview on 11/22/2024 at 9:32 AM, LVN #2 stated if the resident was not in the building, then they could not give the mediation, but if they returned to the facility and it was still on her shift then she would give it if it was only scheduled once a day. She stated Resident #8 was usually gone by the time she got on shift. She stated the resident did not have orders to hold the medication. LVN #2 confirmed that she documented the resident was out to dialysis on 10/01/2024, 10/19/2024, 10/22/2024, and 10/29/2024, and she did not give any of the medications when the resident returned because it was out of the permitted time frame. LVN #2 stated if a resident had parameters for their medications, she would check the vitals prior to getting the medication ready. She stated if it was out of the parameters, she would hold the medication. She stated if midodrine was given when the blood pressure was high, it could cause the blood pressure to go even higher. LVN #2 confirmed that she signed she gave Resident #8's midodrine on 10/22/2024 at 12:00 PM when the blood pressure was 149/63 but stated it should have been held. During a telephone interview on 11/22/2024 at 10:05 AM, Registered Nurse (RN) #15 stated if a medication had parameters, she would check the vitals of the resident and follow the physician's order. She stated if the medication was held then it would be documented. RN #15 stated midodrine was used for low blood pressures and if given when already high, it could make it go higher. After reviewing the October 2024 MAR with RN #15, she stated the midodrine should have been held on 10/19/2024 at 5:00 PM when the blood pressure was 126/69. RN #15 would not comment about the midodrine being administered on 10/26/2024 at 5:00 PM for a blood pressure of 142/78 or on 10/31/2024 at 5:00 PM for a blood pressure of 132/76. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 11/22/2024 at 10:26 AM, the Medical Director, Resident #11's primary care physician, stated that on the days a resident went to dialysis, their medications should be given regardless, usually after they returned from dialysis. He stated if the medication was scheduled twice a day or three times a day, the timing would depend on the medication and, depending on the medication, it would be okay to miss the dose. He stated medications like midodrine, antibiotics, and insulin required communication with the physician if they should be given or not if they were missed due to dialysis. The Medical Director stated midodrine was given three times a day on dialysis days for low blood pressure because the resident was at a higher risk for low blood pressure due to removing fluid. He stated the midodrine should be scheduled so the nurse checked the blood pressure and gave it as needed. He stated the midodrine should be given according to the parameters. The Medical Director stated clopidogrel was usually given once a day and could be given before or after dialysis and ideally should not be missed more than once or twice a month. He stated the apixaban was usually given twice a day, and the morning dose should be given before dialysis but could be given after dialysis and the second dose given four hours later. He stated the apixaban should not be missed more than two to three times a month. The Medical Director stated insulin should be given regardless of dialysis but also had parameters that should be followed. The Medical Director stated that on days of dialysis if the resident's blood pressure was above the parameters, then the midodrine should be held; otherwise, it should be given prior to dialysis. He said if the blood pressure was already high and the midodrine was given, it could cause the blood pressure to be intermittently elevated and cause it to increase further. He stated that ideally it should not be given if the systolic blood pressure was greater than 120. The Medical Director stated he was contacted the previous day about the scheduling of Resident #8's medications, and the facility should hold the resident's medications prior to dialysis and give after dialysis. He stated he had been notified of the antibiotic not being given once that week but had not been notified of the other times the medications were held or given when it should have been held. During an interview on 11/22/2024 at 1:28 PM, LVN #11 stated if a resident left early for dialysis, the physician should specify whether to hold the resident's medications and what time they should give the medications. She stated if a medication was due when the resident was not at the facility, she would document the resident was not present. She stated there should be an order to hold or give when the resident returned from dialysis. October 2024 and November 2024 MARs were reviewed with LVN #11, and she confirmed that she coded 14 for Resident #8's morning medications on 10/05/2024, 10/08/2024, 10/26/2024, 10/31/2024, 11/02/2024, and 11/19/2024. She stated 14 meant the resident was out at dialysis, and she coded 14 because the resident was not available to give the medication. She stated she did not give the medications when the resident returned. LVN #11 stated she did not give the midodrine on 10/31/2024 at 12:00 PM, even though the MAR indicated she did. She stated it was a technical error because she knew to hold the medication if the blood pressure was above 120. LVN #11 stated they had asked the physician to clarify the times of the medications on dialysis day but had not gotten a response. She stated she could not remember when it was brought up. She stated the resident had changed physicians frequently and nothing had been done. She stated she had not spoken to the Medical Director about it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Vineyard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 Monroe Street Petaluma, CA 94954	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 11/22/2024 at 4:04 PM, Resident #8's Nephrologist stated medications could be held or given prior to dialysis depending on the medication. He stated the midodrine should definitely be given. He stated they had difficulty with Resident #8's blood pressure being low, so the facility should give the midodrine and then the dialysis center could repeat the dose if needed. He stated if midodrine was given when the blood pressure was already high, it would cause the blood pressure to go higher and could potentially cause a stroke or heart attack. He stated the clopidogrel, apixaban, and insulin should be given before dialysis. Even though it could be removed during the dialysis process, it should be given. During a telephone interview on 11/23/2024 at 8:07 AM, LVN #13 stated she was not at the facility when residents went out to dialysis, only when they returned, and she did not give any medications that were missed while the resident was at dialysis. She stated if a resident had a medication with vital sign parameters, she would obtain those before starting to prepare the medications and would hold the medication if it was out of the parameters. She stated that she must have missed the parameters when passing the medications to Resident #8 on 11/14/2024 when the resident's blood pressure was 121/62. She stated she should have checked the order three times and read the whole order. During a phone interview on 11/23/2024 at 8:14 AM, RN #18 stated Resident #8 left for dialysis during her shift. She stated the only medications she gave the resident were the medications that were scheduled on her shift. She stated she did not know if Resident #8's morning medications were held or given after the resident returned. During an interview on 11/23/2024 at 8:26 AM, LVN #3 stated she gave medications according to the MAR and gave them when they were due. She stated the medications should be sent with the resident going to dialysis or given to the resident before they left. LVN #3 confirmed that she documented giving the midodrine to Resident #8 on 10/12/2024 for a blood pressure of 140/70 but stated it should have been held. During an interview on 11/23/2024 at 8:58 AM, LVN #1 stated if a medication was due when the resident was out to dialysis, then they would code that they were out to dialysis. After reviewing the October 2024 MAR and November 2024 MAR, LVN #1 confirmed that he coded 14 for the AM medications on 10/03/2024 and 11/16/2024 and confirmed that he did not give the medications once the resident returned. He stated he had not talked to the physician about the medications not being given. During an interview on 11/23/2024 at 9:57 AM, the Director of Nursing (DON) stated the nurse should follow the timing of the medication according to dialysis. She stated they should have an order to hold until after dialysis or change the time of the medication. She stated they should not hold the medication; it should be given after dialysis or whatever the physician said. She reviewed Resident #8's MARs for October 2024 and November 2024 and confirmed that the nurses were documenting 10 or 14 on dialysis days, indicating that the resident did not receive their medications, and stated they were not given after dialysis. She stated the nurse on the floor and medical records were responsible to review the orders and the MARs to ensure medications were being administered as ordered. During an interview on 11/23/2024 at 10:34 AM, the Administrator stated there should have been some follow-up by the nurses on Resident #8's medication on dialysis days. He stated he would have expected the nurse to contact the physician and get clarification. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/23/2024 at 10:53 AM, the Pharmacist stated a dialysis resident's medications should be given after dialysis. He stated if it was given before, it would be ineffective. He stated if the resident received the medication twice a day, the dose should be given when they returned from dialysis. He stated if midodrine was given when the blood pressure was already high, it could increase the blood pressure higher. During an interview on 11/23/2024 at 11:46 AM, the Medical Records Director stated she checked to ensure there were no problems with new orders and reported any inconsistencies to the DON. She stated she would check to ensure the order was there, and if she saw something unusual, she would report it but stated she would not know if the coding on a medication was correct or not.

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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.

45555

Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately for 1 (Resident #11) of 20 sampled residents.

Findings included:

A facility policy titled, Self-Administration of Medications, revised 02/2021, indicated, Residents have the right to self-administer medication if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy also indicated, 7. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medication of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 8. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

An Admission Record indicated the facility readmitted Resident #11 on 01/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of allergic rhinitis (inflammation of the nose) and chronic pain.

A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/17/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.

Resident #11's care plan, included a focus area revised 10/04/2024, that indicated the resident had a chronic fungal skin rash under bilateral breasts. Interventions directed staff to use high quality moisturizers to rehydrate skin, have the resident avoid scratching and keep hands and body parts from excessive moisture, and monitor skin rashes for increased spread or signs of infection. Resident #11's care plan also included a focus area revised 11/23/2024 that indicated the resident had impaired skin integrity as evidenced by moisture associated skin damage (MASD). Interventions directed staff to administer treatments as ordered, to cleanse with normal saline, pat dry, apply antifungal powder to right breast fold every day and monitor for effectiveness; keep skin clean and dry to the extent possible; and monitor skin deterioration and notify the physician of worsening condition or any changes. Resident #11's care plan included a focus area, revised 06/10/2022, that indicated the resident had Chronic Obstructive Pulmonary Disease (COPD). Interventions directed staff to give aerosol or bronchodilators as ordered, monitor, and document side effects and effectiveness.

Resident #11's Nursing-Self-Administration of Medication Observation dated 11/23/2022, indicated the resident wanted to self-administer their muscle rub cream, which was over the counter (OTC). The evaluation indicated the resident was able to administer cream to bilateral knees and the medication would be stored in the resident's room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/18/2024 at 11:33 AM, revealed Resident #11 was sitting in their wheelchair by the bed. There was a medication cup of what the resident stated was cough medication on the over-the-bed (OTB) table, with a tube of diclofenac gel (topical medication used for arthritis and joint pain) and a tube of hydrophilic wound gel (a wound gel that creates a moist environment on the wound surface to aid in healing). Observation on 11/20/2024 at 12:10 PM, revealed a wicker basket on the bed, with a bottle of antifungal powder, two tubes of hydrophilic wound gel, a tube of muscle cream and an Ipratropium Bromide inhaler (medication used to treat lung disease) in the basket. Another basket on the shelf contained a bottle of Tylenol. Observation on 11/21/2024 at 10:19 AM, revealed Resident #11 was sitting in their wheelchair. The basket of creams was no longer visible, but the bottle of Tylenol in the basket on the shelves behind the resident was still there. Resident #11 stated they were putting everything away in the drawer and had not gotten to the Tylenol yet. Resident #11 stated a staff member just came in the room and told them that they could not have the medications out. The resident stated they did their own nasal spray, and the nurses put on the creams, but they kept them in their room. Resident #11 stated they did not take the Tylenol very often and did not tell the staff when they did, and then the resident stated maybe they should. During an interview on 11/23/2024 at 8:26 AM, Licensed Vocational Nurse (LVN) #3 stated a resident that wanted to self-administer their own medications would need to have an order to keep the medications at the bedside. She stated the medications should be kept in the bedside drawer. During an interview on 11/23/2024 at 8:58 AM, LVN #1 stated residents were able to self-administer their medication if they were assessed and had an order. He stated Resident #11 stored their medications in their drawer. During an interview on 11/23/2024 at 9:57 AM, the Director of Nursing (DON) stated a resident would be able to self-administer their own medications if they were capable and had been assessed. She stated the medication would be stored in the medication cart and provided when the resident requested. She stated if the resident wanted to keep the medication at the bedside, they would need to be assessed, it would need to be care planned, and they would need an order to keep the medication at the bedside. The DON stated the nurse and the certified nursing assistant (CNA) should be checking when they were in the room and if they saw a medication, it should be removed. If the resident insisted on keeping the medication, then they should be assessed, educated, and an order received.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51642 Based on interview, record review, and facility policy review, the facility failed to provide occupational therapy as ordered by the physician for 1 (Resident #20) of 2 sampled residents reviewed for rehabilitation and restorative services. Findings included: A facility policy titled, Scheduling Therapy Services, revised 07/2013, indicated, Therapy services shall be scheduled in accordance with the resident's treatment plan. An Admission Record indicated the facility readmitted Resident #20 on 10/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of congestive heart failure (CHF), generalized muscle weakness, and a need for assistance with personal care. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident started occupational therapy on 10/21/2024. Resident #20's Order Summary Report, which contained active orders as of 11/23/2024, revealed an order dated 10/18/2024, for occupational therapy evaluation and treatment as indicated. Resident #20's Occupational Therapy Medicare OT Evaluation & Plan of Treatment,: with a start of care date of 10/21/2024, indicated the resident was to receive occupational therapy two times a week for four weeks. Resident #20's physician order dated 10/21/2024, indicated an occupational therapy clarification order that specified the resident was ordered occupational therapy three times a week for four weeks. Resident #20's care plan, included a focus area initiated 10/21/2024, that indicated the resident was referred to skilled occupational therapy secondary to recent hospitalization for CHF. Per the care plan, the resident presented with decreased safety and independence with activities of daily living (ADL) and transfers. Interventions directed staff to provide occupational therapy three times weekly for four weeks. The Service Log Matrix for the timeframe 10/01/2024 to10/31/2024, indicated Resident #20 received occupational therapy on 10/21/2024. The Service Log Matrix for the timeframe 11/01/2024 to11/30/2024, indicated Resident #20 received occupational therapy on 11/10/2024 and 11/20/2024. Resident #20 was interviewed on 11/18/2024 at 11:35 AM. The resident stated they should be receiving three days of therapy, but they had only received one day of therapy since readmitted on [DATE]. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Occupational Therapist (OT) was interviewed on 11/21/2024 at 3:14 PM. The OT stated she was the only OT in the facility at the present time and Resident #20 was not seen at the levels needed because of staffing. According to the OT, Resident #20 should be seen for occupational therapy three times a week, but confirmed the resident had only been seen on 10/21/2024, 11/10/2024, and 11/20/2024. The OT stated the expectation was that therapy be provided as ordered. The Director of Rehabilitation (DOR) was interviewed on 11/21/2024 at 3:33 PM. The DOR stated staffing was a challenge and the expectation was that therapy be provided as ordered by the physician. Physician #7 was interviewed on 11/22/2024 at 9:44 AM. Physician #7 stated it was hard to state whether the resident declined due to not receiving occupational therapy because the resident was mostly bed bound; however, the expectation for the facility would be to follow all physician orders, to include orders for occupational therapy. The Director of Nursing (DON) was interviewed on 11/23/2024 at 9:23 AM. The DON stated the expectation was that therapy orders be followed. The Administrator was interviewed on 11/23/2024 at 9:42 AM. The Administrator stated the expectation was that residents received therapy as ordered by the physician.