

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 12/18/2025
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)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage was properly contained when an outside garbage dumpster was overfilled, which prevented the lid from closing, and resulted in the food debris and trash surrounding the area and garbage can lids in the kitchen were not closed and the exterior surfaces were smeared with food debris. These failures decreased the facility's potential to prevent an infestation of insects and other pests, prevent offensive odors and contribute to cross-contamination from unsanitary environmental conditions. Findings: During a concurrent observation and interview in the garbage disposal area of the facility with the Dietary Manager (DM) on 12/15/25 at 8:50 a.m., several large garbage dumpsters were observed. The dumpster nearest to the facility's back door was full of garbage bags, and the lids on each side of the bin were unable to close. The ground surrounding the garbage disposal area was wet and littered with small bits of food debris and trash. The DM could not say exactly when the trash was scheduled for pickup or explain why the other garbage bins had not been utilized when the one closes to the door was so full. During a concurrent observation and interview in the garbage disposal area of the facility with the Maintenance Director (MTD) on 12/15/25 at 9:19 a.m., the MTD stated the facility staff should not be overfilling any of the garbage dumpsters so that the lids cannot close tightly. During a concurrent observation and interview in the kitchen with the DM on 12/16/25 at 9:15 a.m., a grey trash bin located in the food preparation area was stuck open, with food debris wiped along the top edges. In addition, a black trash bin in the kitchen was not completely closed, with the contents of the bin seen to be almost spilling out. The DM stated these bins should be cleaned so the lids could close tightly. The DM also stated new lids would be ordered to replace the inoperable ones. During an interview on 12/17/25 at 3:23 p.m., the MTD stated it was important for all garbage to be contained in bins with tightly covered lids so as not to attract rodents and other pests, and so the areas do not stink. A review of the facility's Policy and Procedure (P & P) titled, Sanitation, dated November 2022 indicated, All kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). A review of the Food and Drug Administration (FDA) Food Code 2022, Section 5-501.110 Storage Refuse, Recyclables, and Returnable, dated January 2023 indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to properly dispose of and monitor destruction of an assortment of medications when: The collection receptacle had multiple fully intact medications of different forms which were retrievable by staff; and, 24 medication disposition sheets, representing 172 prescriptions, were not signed or witnessed by licensed staff. This failure decreased the facility's potential to prevent drug diversion (illegally taking prescription drugs for unauthorized use, like self-medication, selling, or addiction) and theft of resident medications. Findings: During a concurrent observation, interview, and record review in the Station 2 medication room with Licensed Nurse B (LN B) on 12/17/25 at 9:10 a.m., the medication destruction bin was noted to contain multiple undestroyed medications. These included fully retrievable intact medications in different forms such as powder, capsules, tablets, inhalers and injector pens (a handheld device used to inject medication into the fatty tissue just under the skin). There was no liquid or undesirable product to destroy the medication was noted in the bin. LN B stated the proper way to dispose of medications was to open all containers and packages, pour medication into the disposable container, then add the liquid deactivator to the bin covering the medication. Upon observation, a stack of disposition sheets was found in a pile next to the Medication Disposition Sheet binder. The stack of sheets contained 24 incomplete medication disposition sheets which were not witnessed by a licensed staff member. LN B stated when a non-controlled medication was discontinued, the tag which contained the resident name, medication, dose and prescription number should be removed from the medication container and placed on the medication disposition sheet. The licensed staff should then place the quantity of medication that was disposed of. The licensed staff completing the form must sign at the bottom where indicated, along with the signature of another licensed staff as a witness. LN B stated the completion of the medication disposition sheet signified the medications were placed in the bin, destroyed and rendered unretrievable. During an interview on 12/17/25 at 10:34 a.m., the Director of Nursing (DON) stated to destroy medications nurses were expected to remove all medication from their containers and place them in the collection receptacle. Nurses would then add the liquid medication destroyer to the medication to dissolve the pills, which would make them non-retrievable. The DON confirmed the collection receptacle in Medication room [ROOM NUMBER] was unacceptable and was not an appropriate practice. The DON further confirmed the medication disposition sheets needed to be completely filled out and signed by two licensed nurses to confirm the medication was destroyed to deter drug diversion. A review of the facility's policy titled Discarding and Destroying Medications, revised June 2025 indicated, Medications are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals. The medication disposition record contains, as a minimum, the following information: resident's name, name and strength of the medication, prescription number, name of dispensing pharmacy, date medication destroyed, quantity destroyed, method of destruction, reason for destruction, signature of witness(s).		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to ensure its medication rate was below five percent when four errors were observed during 28 medication passes, resulting in a 14.29% error rate. This failure decreased the facility's potential to ensure medication was administered as ordered by the physician and decreased the expected efficacy of the medication. (Cross-reference F760 & F761) Findings: During a medication pass observation on 12/17/25 at 9:46 a.m., Licensed Nurse A (LN A) administered the following medications to Resident 20: Empagliflozin (medication used to manage blood sugar levels) 10 milligrams (mg-a unit of measure) by mouth. Apixaban (medication used to prevent and treat blood clots) 5 mg by mouth. Metoprolol Tartrate (medication used to treat various heart and blood vessel conditions) 25 mg by mouth. A record review of Resident 20's Medication Administration Record (MAR) dated 12/1/25 through 12/31/25 indicated empagliflozin was scheduled to be given daily at 8 a.m. and apixaban and metoprolol tartrate were scheduled to be given twice daily at 8 a.m. and 8 p.m. During a medication pass observation on 12/17/25, at 11:20 a.m., LN B was preparing to administer six units of lispro insulin (a rapid acting medication which manages blood sugar levels via an injection into the fatty tissue just under the skin) for Resident 4. LN B prepared an expired vial of insulin dated 12/8/25, stated the expiration date on this bottle is 12/8 and withdrew six units of insulin. LN B recapped the insulin syringe, grabbed an alcohol wipe to prep Resident 4's skin, locked the medication cart and turned toward Resident 4's room. Before reaching Resident 4's threshold, LN B was asked to recite the date. LN B correctly identified date. LN B was then asked to recite the expiration date written on the insulin bottle again. LN B reiterated 12/8. Oh, I can't use this. LN B stated she was unsure why she did not catch this error when preparing the insulin syringe. During an interview in the facility conference room on 12/17/25, at 2:47 a.m., the Director of Nursing (DON) stated medication administration was considered on time as long as it was within a one-hour time frame before or after the scheduled time. She further stated a late medication administration can cause reduced efficacy for the resident recipient. The DON stated expired medications should not be given for the same reason. Furthermore, the DON stated expired insulin products had the potential for preservative breakdown resulting in possible bacterial growth. A review of the facility's policy titled Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label is checked prior to administering. The individual administering the medication checks to verify the right time.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure two residents out of 10 sampled residents were free from significant medication errors when: Resident 20 received a dose of Metoprolol Tartrate (medication used to treat heart and blood vessel conditions by slowing heart rate and lowering blood pressure) 45 minutes late; and, Resident 4 would have received a dose of expired lispro insulin (a rapid acting medication which manages blood sugar levels via an injection into the fatty tissue just under the skin) if not asked by the surveyor to recite the expiration date a third time prior to entering the resident room. These failures decreased the facility's ability to maintain medication safety and placed the residents at risk for harm. (Cross-reference F759 & F761) Findings: A review of Resident 20's admission record indicated she was admitted to the facility on [DATE] with diagnoses of Hypertension (persistent high blood pressure), Artherosclerotic Heart Disease (condition where the blood vessels supplying blood to the heart muscle become hardened and narrow due to buildup of fat, cholesterol, calcium and other substances) and Atrial Fibrillation (a heart rhythm characterized by a rapid heart rate and chaotic electrical signals in the upper chamber of the heart causing quivers instead of full contractions). A review of Resident 4's admission record indicated he was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus (a chronic condition where the body does not produce enough insulin or becomes resistant to its effect which, if left untreated, could lead to multiple organ failure). During a medication pass observation on 12/17/25 at 9:46 a.m., Licensed Nurse A (LN A) was observed administering metoprolol tartrate 25 milligrams (mg-a unit of measure) by mouth to Resident 20. A record review of Resident 20's Medication Administration Record (MAR) dated 12/1/25 through 12/31/25, indicated metoprolol tartrate was scheduled to be given twice daily at 8 a.m. and 8 p.m. to treat and prevent hypertension. A record review of Resident 4's Medication Administration Record (MAR) indicated Resident 4 had a blood sugar level of 282 on 12/17/25 at approximately 11 a.m. Based on Resident 4's sliding scale (a prescribed variable dose based on a person's current blood sugar level) order, Resident 4 was to receive six units of lispro insulin via subcutaneous injection (delivered via injection into the fatty tissue just below the skin) before meals. During a medication pass observation on 12/17/25 at 11:20 a.m., LN B was preparing to administer six units of insulin for Resident 4. LN B prepared an expired vial of insulin dated 12/8/25 by wiping the top of the vial with an alcohol pad, stated the expiration date on this bottle is 12/8 and withdrew six units of insulin. LN B recapped the insulin syringe, grabbed an alcohol pad to prep Resident 4's skin, locked the medication cart and turned toward Resident 4's room. Just before reaching Resident 4's threshold, LN B was asked to recite the date. LN B correctly identified date. LN B was then asked to recite the expiration date written on the insulin vial again. LN B reiterated 12/8. Oh! I can't use this. LN B stated she was unsure why she did not catch this error when preparing the insulin syringe. During an interview in the facility conference room on 12/17/25 at 2:47 a.m., the Director of Nursing (DON) stated medication administration was considered on time as long as it was within a one-hour time frame before or after the scheduled time. She further stated a late medication administration can cause reduced efficacy for the resident recipient. The DON stated expired medications should not be given for the same reason. Furthermore, the DON stated expired insulin products had the potential for preservative breakdown resulting in possible bacterial growth. A review of the facility's policy titled Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label is checked prior to administering. the individual administering the medication checks to verify. the right time.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to ensure expired insulin (a hormone medication used to control blood sugar levels) vials were removed from the facility's medication carts when inspection of two medication carts revealed one expired vial of insulin in each location. This failure decreased the facility's opportunity to maintain resident safety and placed these residents at risk for harm. (Cross-reference F759 & F760) Findings: During a concurrent observation and interview on 12/17/25 at 10:05 a.m., an open vial of insulin glargine (a long-acting insulin used to maintain steady blood sugar levels via an injection into the fatty tissue just under the skin) was found during inspection of Medication Cart 1. The box containing the insulin glargine was marked as Open 11/17/25; DC [discontinue] 12/15/25. Licensed Nurse A (LN A) stated, This insulin has expired, it should be thrown out. During a concurrent observation and interview on 12/17/25 at 10:23 a.m., an open vial of insulin lispro (a rapid acting medication which manages blood sugar levels via an injection into the fatty tissue just under the skin) was found during inspection of Medication Cart 3. The box containing the insulin lispro was marked as 11/8/25 opened: DC 12/8/25. LN B stated the expiration date on this vial was incorrect and further stated, Insulin expires 28 days after opening, the date on this insulin should be 12/6/25. During an interview on 12/17/25 at 10:34 a.m., the Director of Nursing (DON) stated all expired medications should be removed from the medication carts by the licensed nursing staff and properly disposed of. She stated expired medications can have a reduced or increased intended efficacy and further stated expired insulin products had the potential for preservative breakdown resulting in possible bacterial growth. A review of the facility's policy titled Medication Labeling and Storage, revised February 2023, indicated, Multi-dose vials that have been opened or accessed are dated and discarded within 28 days.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when:1. The following were observed in the facility kitchen: kitchen floors were dirty and littered with food debris and trash; the ceiling vent cover located directly over the clean and ready-to-use dish storage area was covered with reddish-black and blackish-brown dirt and dust; the wall behind the hand-washing sink was cracked and uneven, with heavy orange and black colored residue in the crevices; one plastic green cutting boards were excessively scratched with deep gashes; and, the stove top/burners had extensive caked-on food and rust-colored residue;2. The temperature log for a resident snack refrigerator indicated out-of-range temperatures recorded on multiple days;3. Fresh ready-to-eat oranges stored in the walk-in refrigerator had skins that were discolored and broken open; and,4. Individual hand-sanitizing wipe packets were stored directly beside ingestible resident food items.These failures decreased the facility's potential to prevent food-borne illnesses or poisoning in a highly susceptible population who received food from the kitchen and/or snack refrigerators.Findings:1. During an initial tour of the kitchen on 12/15/25 at 8:50 a.m. a concurrent observation and interview with the Dietary Manager (DM) was conducted. Upon entrance, the floor in front of the stove/oven and food preparation area was littered with debris and covered with a dull blackish/grey residue. The DM stated that the floor was cleaned daily but acknowledged that it looked dirty because it was right after the daily morning meal service. During a concurrent observation and interview with the DM on 12/15/25 at 8:55 a.m. in the kitchen, a square ceiling vent cover had reddish-black and blackish-brown material on it and small pieces of this debris, was over the clean dish storage area. In addition, there was a large crack in the ceiling adjacent to the vent. The DM stated the vent cover needed to be replaced as dirt/debris could fall onto clean cups, plates and other dishes and be served to residents during meal service. During a concurrent observation and interview in the kitchen with the DM on 12/16/25 at 9:15 a.m., the wall area behind the hand-washing sink was observed to be cracked and uneven, with a heavy orange and black colored residue in multiple crevices around the back of the sink. The DM agreed it did not look clean. During a concurrent observation and interview in the kitchen food preparation area with the DM on 12/16/25 at 9:20 a.m., the cutting boards were examined. One large green cutting board was heavily scratched with the green coating completely gone and had several deep gashes in the plastic. The DM stated cutting boards were generally replaced every month, and this one had reached its life expectancy and needed to be replaced immediately.During a concurrent observation and interview in the kitchen with Maintenance Director (MTD) and DM on 12/17/25 at 3:23 p.m., the stovetop/burner/oven was inspected. The stovetop area was heavily covered in caked/burnt-on food droppings and had a general rusty appearance. The DM stated the stove/oven was cleaned daily; however, the stovetop was noted to be in the same condition as was seen the day prior. The DM agreed that uncleaned food on surfaces could become moldy and cross-contaminate food served to residents. The MTD stated he removed the vent cover above the clean-dish storage area and acknowledged it was indeed very rusty and dirty and had created a contamination hazard to the ready-for-use dishes below. The MTD stated it has since been replaced.During an interview on 12/18/29 at 1:07 p.m. with the Registered Dietitian (RD), the RD stated cutting boards with deep scratches posed a hazard to residents because pieces of the plastic cutting board material could become mixed with food as it's cut/sliced and be ingested by residents in their meals. Additionally, the RD stated food could become embedded in the deep crevices and remain on the board after washing, causing food-borne illness due to cross-contamination.During a review of the facility's Policy & Procedure (P & P) titled, Sanitation, dated November 2022, indicated, All kitchens, kitchen areas and dining areas are kept clean, free from garbage and protected from rodents and insects.All utensils, counters, shelves and equipment are (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.2. During a concurrent observation and interview on 12/17/25 at 9:38 a.m., Certified Nursing Assistant E (CNA E) stated residents were allowed to have outside food brought in for them, and that resident foods were kept in a refrigerator in the nursing station. This refrigerator was inspected, and the December temperature log was reviewed. The log showed notable temperatures as follows:12/5/25= 43 degrees12/7/25= 44 degrees12/9/25= 42 degrees12/11/25= 42 degrees12/13/25= 45 degrees12/16/25= 45 degreesDuring an interview on 12/18/25 at 10:15 a.m. with Licensed Nurse D (LN D), LN D stated residents are allowed to have food brought in and kept in snack refrigerators. LN D stated nursing staff was responsible for maintaining the refrigerator but stated she did not know the acceptable temperature ranges for safe food refrigeration.During an interview on 12/18/25 at 10:30 a.m. with Licensed Nurse E (LN E), LN E stated she believed night-shift nurses were responsible for checking the refrigerator temperatures and stated she did not know acceptable temperature ranges for safe food refrigeration, but she thought this information was listed on the temperature log sheet itself.A review of a blank copy of the facility's Refrigerator Temperature Log, not dated, indicated, Temperature Ranges: Refrigerator 35 - 45 [degrees] F [Fahrenheit] .A review of the facility's P & P titled Food Receiving and Storage, dated November 2022, indicated, Food and Snacks Kept on Nursing Units-All food items are to be kept at or below 41 degrees Fahrenheit are placed in the refrigerator located at the nurses' station and labeled with a 'use by' date.A review of the Food and Drug Administration (FDA) Food Code 2022, Chapter 3, section 501.17, indicated commercially processed food prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days.3. During a concurrent observation and interview in the facility's walk-in refrigerator with the DM on 12/16/25 at 9:15 a.m., a carton of tangerines was observed. Several of the fruit had skins with green-colored spots, and some were yellow all over. One of the fruits had a break in the skin with hard black matter coming through the skin. The DM stated some of the fruits inside this carton should not be served to residents.During an interview on 12/19/25 at 1:08 p.m., the RD stated that spoiled or damaged fruit should be removed from the refrigerator because the food stored there is considered ready for resident use and might make it on to a resident's food tray for consumption.A review of the facility's P&P titled Food Receiving and Storage dated November 2022 indicated, Refrigerated foods are.monitored so they are used by their ?use-by' date, frozen, or discarded.4. During a concurrent observation and interview on 12/15/25 at 9a.m. with the DM, the dry food storage area was toured. A shelf with self-serve food packets of jelly, peanut butter, and other condiments was inspected, and boxes of hand-sanitizer wipes were stored among these edible items. The DM stated the boxes of hand-sanitizer should be moved to the Janitor's closet, instead of stored with food items. During an interview on 12/19/25 at 1:10 p.m., the RD stated hand-sanitizing wipes should not be stored with food in dry storage, since the individual packets might become mixed with condiment packets and other small, packaged food items. The RD agreed residents with cognitive decline may confuse the small packages and ingest something inedible and harmful.A review of the facility's P & P titled Food Receiving and Storage, dated November 2022 indicated, Pesticides and other toxic substances and drugs will not be stored in the kitchen area or in storerooms for food or food preparation equipment or utensils. Soaps, detergents cleaning compounds or similar substances will be stored in separate storage areas from food storage and labeled clearly.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure bathroom call lights (a system to notify nursing staff for help) were accessible when two pull strings to trigger the call light system were too short for residents to reach and four pull strings were missing in six sampled bathrooms. This failure decreased the facility's potential to respond to residents' calls for assistance and increased the risk for falls. During an observation on 12/15/25 at 9:13 a.m. in room [ROOM NUMBER] and subsequently in Rooms 21, 24, 25, and 26, the bathroom call light systems had no call light string. During an observation on 12/15/25 at 9:27 a.m. in room [ROOM NUMBER] the bathroom call light system had a short pull string measuring approximately 10 in. (inches- a unit of measure). During an observation and concurrent interview on 12/16/25 at 12:10 p.m. with Certified Nurse Assistant C (CNA C), in room [ROOM NUMBER], the bathroom call light system had a broken call light string. The call light string was approximately 2 in. in length. CNA C verified the call light string was broken. CNA C stated, Residents can not pull that [the string], they [the residents] need more string. CNA C stated the importance of the call light string was so residents can call for help while unattended in the bathroom. CNA C stated the Maintenance Department should be aware that they needed to be repaired. During a concurrent review of the maintenance binder (a communication binder between staff and the maintenance department where repairs are reported), CNA C confirmed the broken call light string had not been reported. CNA C further stated, If it was [reported], it hasn't been fixed. CNA C verified the bathroom was shared between resident rooms [ROOM NUMBERS]. During an observation and concurrent interview on 12/16/25 at 12:25 p.m. with CNA D, in room [ROOM NUMBER], the bathroom call light system had no call light string. CNA D stated there should be a string on the call light. CNA D further stated, If the residents cannot reach the button or it's too hard to push [the call light button], it should have a string. CNA D confirmed the bathroom call light system with no string should have been reported to maintenance for repair. CNA D stated, The string is very important. During an interview on 12/17/25 at 2:55 p.m. with the Maintenance Director (MTD), he confirmed maintenance staff was responsible for replacing bathroom call light strings. The MTD stated the pull strings were needed so residents can call for help when using the bathroom. The MTD stated the replacement bathroom call light strings were approximately 16 in. long. The MTD further stated residents could not reach a 16 in. string if they [the residents] were on the floor and not near the toilet. The MTD confirmed CNAs should report broken, missing, or items that require replacement in the maintenance binder. The MTD stated he had not noted entry into the maintenance binder regarding missing or broken bathroom call light strings. A review of the facility's policy and procedure (P&P) titled, Resident Safety, dated 2001, indicated, Resident safety to prevent accidents are facility wide priorities. Employees demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the state mental health authority after one resident (Resident 70) of six sampled residents experienced a decline in mental illness. This failure decreased the facility's potential to ensure Resident 70 received appropriate required mental health services and treatment. Findings: A review of Resident 70's admission Record indicated Resident 70 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities)), major depressive disorder (a mood disorder that causes persistent sadness and loss of interest in activities), psychosis (a state where a person loses touch with reality, characterized by symptoms like hallucinations (seeing/hearing things not there)) and delusions (strong false beliefs leading to disorganized thoughts and speech), and anxiety. A review of Resident 70's Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 11/3/25, indicated moderate cognitive impairment, a need for assistance with self-care activities, and a need for staff assistance or was totally dependent on staff for transfers. During a review of the state mental health authority's correspondence to the facility regarding Resident 70's Preadmission Screening Resident Review (PASRR- a required form to help ensure that individuals with mental disorders or intellectual disabilities are not inappropriately placed in nursing homes for long term care) dated 11/5/25, indicated, After reviewing the Positive Level I Screening and speaking with [Facility] staff, a Level II Mental Health Evaluation was not scheduled for the following reason. The individual has no serious mental illness (SMI). No functional limitations in the past 6 months. To reopen, the facility must resubmit a new Level I Screening. SNFs [Skilled Nursing Facilities] must submit another screening as a Resident Review (RR). During an interview on 12/17/25 at 10:20 a.m. with the MDS Coordinator (MDSC), the MDSC stated the admissions department and the IDT (Interdisciplinary Team, a group of healthcare professionals working together for holistic patient care) were responsible for ensuring PASRR Level I screenings were completed correctly and PASSR Level II's were completed when necessary. During a review of Resident 70's physician's note, dated 12/15/25 at 12 a.m., indicated, .11/26/25. staff has been noting that patient has been refusing most of meal. 12/9/25. sertraline [medication used to treat depression] increased to 75 mg [milligrams, a unit of measurement]. [daughter] agreeable with dose increase. because [Resident 70] seems more withdrawn than usual. discussed that med doses can be changed to best support him. 11/12/25. [physician discussed with] daughter. that [Resident 70] reports feeling depressed. 11/18/25. [Resident 70] feels his depression is ?situational' and feels ok today. 11/24/25] 11 [pound] weight loss in 6 days, consider secondary to depression. 11/25/25]. [Resident 70's] unwillingness to take medications, clenching of jaw [sic, supposed to be jaw], grinding teeth, worsening of mask facies [sic] and tics [sudden involuntary movements or sounds caused by a nervous system condition]. overall symptoms are concerning for extrapyramidal [sic, supposed to be extrapyramidal (involuntary movement disorders or uncontrolled muscle contractions caused by certain antipsychotic medications) symptoms. 12/8/25] discussed with staff and nursing team, [Resident 70] continues to have decreased appetite unwilling to take medication and clenching of jaw. [Resident 70's] noncompliance with [oral intake] more likely behavioral. A review of Resident 70's behavior note dated 12/9/25 at 1:58 p.m. indicated, . [Resident 70] needs encouragement to complete [Activities of Daily Living, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves]. [Resident 70] has [history] of episodes of FTT [Failure to Thrive, a general decline in physical and cognitive function]. During a concurrent interview and record review with the MDSC on 12/18/25 at 12:35 p.m., Resident 70's Order Summary Report, dated 12/18/25 was reviewed. The MDSC agreed Resident 70 was on multiple medications for mental illness, manifested by behaviors that interfered with activities (continued on next page)		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of daily living, necessitating a recent new medication for anxiety started on 12/17/25. The MDSC stated she was aware the PASRR process was to ensure residents were placed in an appropriate type of facility, and residents received necessary services from the state mental health authority The MDSC further stated the IDT team would restart the PASRR screening process for Resident 70.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 72) of 27 sampled residents obtained informed consent (a voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of bedrails when Resident 72's responsible party (RP- a person who makes health care decisions on behalf of the resident when the resident does not have the mental capacity to do so) did not give informed consent for the use of side/bed rails. This deficient practice decreased the facility's potential to decrease Resident 72's risk for falls, serious injury, and entrapment (when a person becomes trapped in the bed rail gaps, often resulting in serious injury or death). Findings: A review of Resident 72's admission record indicated she was admitted to the facility in May 2017 with medical diagnosis which included senile degeneration of the brain (dementia- a progressive state of decline in mental abilities) and delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking). Resident 72's admission record also indicated her son was her RP. A review of Resident 72's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/19/25, indicated her Brief Interview of Mental Status (BIMS- a cognition (the processes of thinking and reasoning) assessment) score was one, which indicated she had severe cognitive impairment (a score of 1-7 indicates cognition is severely impaired). A review of Resident 72's active order summary report indicated the following order was placed on 10/20/25, May have bilateral [both sides] 1/4 side rails placed on the middle of bed as enabler for bed mobility and positioning. A review of Resident 72's care plans was last conducted on 10/15/25 and indicated report indicated a focus on Resident 72's use of 1/4 side rails. This care plan listed the following interventions licensed nursing staff was supposed to implement Follow facility fall protocol. Recommend bilateral side rails up when in bed for safety during care provision . Discuss risks and benefits and obtain consent. A review of Resident 72's facility document titled Bed Rail and Entrapment Risk Observation/Assessment dated 5/21/25, 6/12/25, and 7/23/25 indicated bed rails were currently in use. These documents also indicated, I (Resident or Resident Representative) have been informed of the risks and benefits related to the use of side/bed rails, including the risks associated with entrapment. Yes [was check marked]. I am providing my Informed Consent signature for the use of side/bed rails and understand the risks and benefits. Yes [was check marked]. Print Name (Resident/Resident Representative). documented typed text as self . Signature and Date [were left blank]. Print Name (Staff obtaining signatures). During an observation on 12/17/25 at 10:28 a.m., Resident 72 was lying in bed with 1/4 side rails installed on both sides of her bed. During an interview on 12/17/25 at 10:40 a.m., Licensed Nurse B (LN B) stated she believed an informed consent should be obtained for the use of bed rails. LN B further stated she was not aware of the facility's policies and procedures (P&P) related to the use of bed rails. During an interview on 12/17/25 at 10:45 a.m., LN C stated she was unsure of the facility's P&P related to the use of bed rails or where to obtain the policies. During an interview on 12/17/25 at 4:18 p.m., the Director of Staff Development (DSD), stated she was unsure if an informed consent was required for the use of 1/4 side rails. The DSD further stated she believed it was the responsibility of nursing staff to obtain the consent for the use of bed rails. The DSD stated if the resident had an RP, she expected the RP to sign the informed consent for the use of bed rails. The DSD stated, The risk [of bed rail use] is entrapment and injury to the resident. During an interview and concurrent record review on 12/18/25 at 2:25 p.m. the Director of Nursing (DON) reviewed Resident 72's bed rail and entrapment risk assessment dated [DATE] and confirmed the typed text name of the person signing the consent was Resident 72. The DON confirmed a wet signature on the document; however, she could not confirm who's signature it (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was. The DON stated the typed text name of the person who gave the consent should be the name of the person who signed the consent. The DON verified it was not appropriate for Resident 72 to sign her own consent. Subsequently, the DON reviewed Resident 72's bed rail and entrapment risk assessments dated 5/21/25, 6/12/25, and 7/23/25. The DON stated the informed consents were not completed. The DON confirmed the documents were not signed by Resident 72's RP. The DON stated, It can be dangerous if the resident doesn't understand why they [the bed rails] are used. The DON discussed the use of bed rails increased the resident's risk of skin issues, falls, and entrapment, especially if the resident was confused. A review of the facility's P&P titled, Bed Safety and Bed Rails, dated 2001, indicated, The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including informed consent. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.		

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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** Based on interview and record review, the facility failed to provide specialized rehabilitative services in accordance with the physician's orders for one resident (Resident 6) of four sampled residents when Resident 6 received physical therapy (PT) three times out of 12 scheduled sessions between 11/27/25 and 12/17/25 and received occupational therapy (OT) once out of three expected sessions between 11/27/25 and 12/3/25. This failure resulted in Resident 6 feeling frustrated and increased the risk of his physical deconditioning. Findings: During a review of Resident 6's Face Sheet (a summary of the resident's information), Resident 6 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- a chronic lung condition caused by damage to the lungs and results in limited airflow into and out of the lungs), generalized muscle weakness, and depression (a serious mood condition causing persistent sadness and loss of interest, affecting thoughts, feelings, and daily life). A review of Resident 6's Order Summary Report indicated an order for PT Evaluation and Treatment as indicated, dated 11/12/25. Resident 6's report further indicated the following active orders: PT re-Clarification: Please continue skilled PT 5x/wk [five times a week] for 4wks [four weeks] . OT re-Clarification: Please continue skilled OT 3x/wk [three times a week] for 4wks . During a concurrent observation and interview on 12/15/25 at 9:37 a.m., Resident 6 was lying in bed as he stated being very upset about therapy. Resident 6 stated therapy schedules varied each week. Resident 6 stated he would be notified of afternoon sessions, which would later be cancelled, or he would be told there was not enough time. Resident 6 stated it was disrespectful to be told one thing then see another one done. A review of Resident 6's care plan with a focus area for ADL (Activities of Daily Living/Mobility), initiated on 11/12/25, indicated Resident 6 had an actual/at risk for ADL/mobility decline and required assistance related to behavioral symptoms, recent hospitalization and weakness. Interventions and tasks directed staff to provide occupational and physical therapy referrals and treatments as indicated. During a concurrent interview and record review on 12/17/25 at 9:44 a.m. with the Director of Rehab (DOR), Resident 6's Projections (a combined schedule of PT and OT), dated 11/13/25 to 12/17/25, was reviewed. The DOR confirmed Resident 6 had orders for PT five times a week, and OT three times a week. The Projections indicated during the three-week period of 11/27/25-12/17/25, Resident 6 had 12 PT sessions scheduled. The Projections further indicated 0/40 on nine dates: 11/18/25, 11/19/25, 11/21/25, 11/24/25, 12/9/25, 12/11/25, 12/12/25, 12/15/25, and 12/16/25. The DOR stated 0/40 meant therapy was scheduled but not provided. Further review of the Projections indicated Resident 6 was scheduled for and received OT only once, on 12/3/25, during the seven-day period of 11/27/25 to 12/3/25. When queried why the number of therapies scheduled per week did not consistently match the orders, the DOR did not respond. The DOR stated Resident 6 had several days of missed therapy. During an interview on 12/17/25 at 12:55 p.m., the Director of Nursing (DON) stated therapy was needed for residents to get better and stronger, which were the goals for discharge. The DON stated it was her expectation for therapy orders to be followed as ordered. During an interview on 12/17/25 at 2:26 p.m., the Administrator stated therapy orders follow the same policy as medications and treatments and should be given as ordered.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was clean and in a usable state for one resident (Resident 42) out of 27 sampled residents when the oxygen concentrator in Resident 42's room had visible dust and debris in the vents and needed a filter change. This failure decreased the facility's potential to prevent bacteria and debris from directly entering Resident 42's lungs, placing her at risk for infection. Findings: A review of Resident 42's face sheet indicated admission to the facility on [DATE] with diagnoses of pneumonitis (a condition in which the delicate tissue and tiny air sacs in the lungs become swollen and intensely irritated) and Acute Respiratory Failure with Hypoxia (a serious condition in which the respiratory system fails to provide enough oxygen to the blood to support vital organ function). A review of Resident 42's physician orders, dated 12/5/25, indicated, Oxygen 2 L [liters, a unit of measure] via nasal cannula [a flexible device used to deliver oxygen through the nose] continuous per concentrator/tank. A review of Resident 42's Care Plan indicated the following goals and interventions: A care plan dated 12/4/25 indicated Resident 42 required the use of oxygen related to her acute respiratory failure. Resident 42's goal was to be compliant with oxygen therapy and to maintain unlabored breathing and a patent airway. To reach this goal, staff were expected to change humidification and oxygen tubing, monitor for signs of hypoxia (the body's tissues do not receive enough oxygen to function properly) and to observe oxygen precautions. A care plan dated 12/9/25 indicated Resident 42 had an altered respiratory status/difficulty breathing related to pneumonitis due to inhalation of food and vomit. Resident 42's goal was to be free of complications from her shortness of breath and to exhibit no signs of poor oxygen absorption. To meet this goal, staff were expected to provide oxygen as ordered and to encourage sustained deep breaths. A review of the facility's Deep Cleaning Checklist dated 12/11/25, indicated Resident 42's room was deep cleaned. The checklist housekeeping staff followed did not include wiping down or cleaning visible dust on the outside filters of Resident 42's oxygen concentrators. During an observation in Resident 42's room on 12/15/25 at 10:25 a.m., an oxygen concentrator (a medical device that pulls air from the surrounding environment, filters out impurities and delivers medical-grade oxygen to residents with a respiratory condition) was located near Resident 42's bed. The oxygen concentrator was noted to have no preventative maintenance sticker on the machine. The outside filters on both sides of the concentrator had visible clumps of lint and dust. During a phone interview on 12/16/25 at 10:22 a.m., Resident 42's family member stated Resident 42 had previously been diagnosed with Respiratory Syncytial Virus (RSV-a common respiratory virus which could lead to serious lung infections, especially in older adults) and was hospitalized. The family member stated Resident 42 had required the use of oxygen ever since. During an interview on 12/17/25 at 8:27 a.m., the Administrator stated the oxygen concentrators belonged to the facility. He further stated the maintenance department was responsible for preventative maintenance and proper functioning of the oxygen concentrators. During an interview on 12/17/25 at 2:55 p.m., the Maintenance Director (MTD) stated the oxygen concentrators were checked daily by housekeeping staff during their rounds and would remove any visible dirt on the oxygen concentrators, including washing the outside filters to remove dust and debris. The MTD stated all oxygen concentrators were rented locally through a vendor. He stated the vendor made monthly visits to the facility and was responsible for all filter changes, troubleshooting of equipment malfunction and preventative maintenance. The MTD further stated the facility kept two or three extra concentrators on hand, in the event one was urgently needed. The MTD could not find a preventative maintenance sticker on the oxygen concentrator in Resident 42's room and provided contact information for the vendor. He declined to open the internal filter flap, as he was sure the oxygen concentrator was a rented piece of equipment. The MTD acknowledged the outside filters of the oxygen concentrator needed cleaning. A review of an email exchange with the area manager of the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's local oxygen vendor on 12/17/25 at 7:32 p.m., indicated, I verified that is not our concentrator and has no history in our inventory system. During a concurrent observation and interview on 12/18/25 at 8:36 a.m., the MTD was informed the oxygen concentrator in Resident 42's room was not owned by the vendor per the vendor area manager. The MTD agreed to open the internal filter flap which was stuck shut and required the use of the MTD's pocketknife to be opened. The internal compartment and filter were dirty and had visible dust and debris throughout. The MTD acknowledged the machine needed to be cleaned, including a filter change. During an interview on 12/18/5 at 8:47 a.m., the Administrator stated the facility maintenance staff was responsible for maintaining cleanliness and functionality of the respiratory equipment. During an interview on 12/18/25 at 11 a.m., the Infection Preventionist (IP) stated a dirty filter in an oxygen concentrator would not properly filter the air coming through it. In turn, this could allow micro-organisms to contaminate the air the resident breathed in through the nasal cannula. A review of Job Description: Maintenance Director, dated February 2024, indicated an essential duty was to make periodic rounds to check equipment and to assure that necessary equipment is working properly. A review of the facility's policy titled Maintenance Service, dated December 2009, indicated, The maintenance director is responsible for maintenance service to assure that equipment are maintained in a safe and operable manner.		