

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Vineyards at Fowler		STREET ADDRESS, CITY, STATE, ZIP CODE  1306 East Sumner Avenue Fowler, CA 93625	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure residents received adequate supervision to prevent elopement for one of six sampled residents (Resident 1) when Resident 1 left the facility on 2/17/25 without facility staff's knowledge and did not return.</p> <p>This failure resulted for Resident 1 at a higher risk of harm such as dangerous weather exposure, getting hit by a car or being assaulted.</p> <p>Finding:</p> <p>During a review of Resident 1's admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that include . Non displaced intertrochanteric( area between the two trochanters (thigh bone) of the femur) fracture (complete of partial break in a bone) of left femur(bone of the thigh) Alcoholic cirrhosis (a chronic liver disease characterized by the formation of scar tissue) .Bipolar Disease (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) .Pseudocyst (cysts) of pancreas ( a large gland behind the stomach which secretes digestive enzymes) .</p> <p>During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was intact.</p> <p>During an interview on 2/19/25 at 8:45 a.m. with Administrator, (ADM) The ADM stated, the facility could not find Resident 1. The ADM stated, she knew Resident 1 was non-compliant and did not notify staff when leaving the facility. ADM stated, Resident 1did not sign out on the Leave of Absence (LOA) Binder on 2/17/25.</p> <p>During an interview on 2/19/25 at 8:45 a.m. with Social Services Director (SSD), SSD stated, Resident 1 was scheduled to go to a Drug and Alcohol Rehabilitation Facility on 2/18/25 at 8:30 a.m. SSD, stated, Resident 1 left the facility on 2/17/25 and did not return. SSD stated, Resident 1 was noncompliant when leaving the facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/25 at 10:00 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1 liked being outside and would go to the store. LVN 1 stated, he always returned within 1-2 hours. LVN 1 stated she asked to Resident 1 to notify her when leaving the facility and to sign the LOA binder, but Resident 1 did not comply.</p> <p>During an interview on 2/19/25 at 10:15 a.m. with LVN 2, LVN 2 stated, Resident 1 was alert and oriented. LVN 2 stated he asked Resident on several occasions to sign the LOA binder when leaving the facility, but Resident 1 did not comply.</p> <p>During an interview on 2/20/25 at 8:00 a.m., with LVN 1, LVN 1 stated, she worked on 2/17/25 until 7:30 p.m. LVN 1 stated she was not aware Resident 1 was not in the facility when she left. LVN 1 stated Resident 1 did not sign out in the LOA binder on 2/17/25. LVN 1 stated when staff noticed a resident was missing, they were supposed to call the Administrator and authorities. LVN 1 stated when she returned to work on 2/28/25 at 6:22 a.m., LVN 4 told her Resident 1 had not returned. LVN 1 stated staff failed to respond when Resident 1 was missing. LVN 1 stated Resident 1 was missing all night and was at risk of being injured, exposed to the weather, or hit by a car. LVN 1 stated, facility staff were unaware of Resident 1's location and his medical status.</p> <p>During an interview on 2/20/25 at 8:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, she worked the night shift on 2/17/25. CNA 1 stated, when she started her shift on 2/17/25 at 10:30 p.m., she did not see Resident 1. CNA 1 stated, when a resident was missing, staff go outside to look for the resident. CNA 1 stated staff were supposed to call the ADM and the authorities. CNA 1 stated, staff did not know where Resident 1's was. CNA 1 stated the facility staff did not look for Resident 1 and did not notify the ADM and authorities. CNA 1 stated, Resident 1 was at risk of being exposed to cold weather and could have been injured.</p> <p>During a telephone interview on 2/20/25 at 9:15 a.m. with LVN 3, LVN 3 stated, he worked the afternoon shift on 2/17/25. LVN 3 stated, when he arrived for work at 2:30 p.m., he saw Resident 1 in the facility. LVN 3 stated, he saw Resident 1 sitting by the front door in his wheelchair around 6 p.m. LVN 1 stated he did not see Resident 1 leave the facility and Resident 1 did not notify him he was leaving. LVN 3 stated he finished his shift at 10 p.m. and gave a report to the incoming LVN (LVN 4). LVN 3 stated he told LVN 4 Resident 1 had not returned. LVN 3 stated he should have called the ADM, Director of Nursing, and the authorities to report missing resident before leaving on 2/17/25 after his shift ends.</p> <p>During a telephone interview on 2/20/25 at 9:35 a.m., with LVN 4, LVN 4 stated, LVN 3 informed him Resident 1 had not returned to the facility. LVN 4 stated, he became concerned around 12 a.m. and sent a text message to ADM and DON regarding Resident 1 missing but he did not get a response from them. LVN 4 stated, he should have called the ADM and Authorities at the beginning of my shift at 10:30 p.m. LVN 4 stated he contacted the ADM and DON on 2/18/25. LVN 4 stated, the facility staff did not know where Resident 1 was throughout the night.</p> <p>During an interview on 2/20/25 at 10 a.m. with the DON, the DON stated, Resident 1 left the facility without signing out in the logbook or notifying the staff. The DON stated, she did not see the text message from LVN 4 until the next morning. The DON stated LVN 3 &amp; 4 failed to notify the facility administration and authorities. The DON stated, this put Resident 1 at risk for serious injuries, exposure to cold weather, and being hit by a motor vehicle. The DON stated, we did not follow our Policy and Procedure (P &amp; P) to keep our residents safe.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/25 at 10:15 a.m. with ADM, the ADM stated, when LVN 3 notified LVN 4 Resident 1 had not returned on 2/17/25, LVN 4 should of called us immediately. The ADM stated Resident 1 was non-compliant and did not notify staff before to leaving. The ADM stated, Resident 1 did not sign out on LOA binder. The ADM stated Resident 1 was at risk to exposed to the elements, getting hit by a car, or being assaulted.</p> <p>During a review of the facility's P&amp;P titled Elopements and Wandering Residents dated 2024, the P &amp; P indicated, This facility ensures that residents who exhibit wandering behavior and /or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Elopement occurs when a resident leaves the premises or a safe area without authorization .Procedure for locating Missing Resident . Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol .The designated facility staff will look for the resident .If a resident is not located in the building or on the grounds, Administrator or designee will notify the police department .</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure Licensed Nurses have the competencies necessary to meet the needs and safety of the residents for one of six sampled residents (Resident 1) when Licensed Vocational Nurses (LVN) 3 and LVN 4 failed to notify the facility Administrator (ADM), Director of Nursing (DON) and the authorities when Resident 1 left the facility and did not return.</p> <p>This failure resulted in delayed in emergency response and placed Resident 1 at increased risk for harm such as dangerous weather exposure, getting hit by a car or being assaulted.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that include . Non displaced intertrochanteric( area between the two trochanters (thigh bone) of the femur) ( fracture (complete of partial break in a bone) of left femur(bone of the thigh) Alcoholic cirrhosis (a chronic liver disease characterized by the formation of scar tissue) .Bipolar Disease (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) .Pseudocyst (cysts) of pancreas ( a large gland behind the stomach which secretes digestive enzymes) .</p> <p>During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1's cognition was intact.</p> <p>During an interview on 2/20/25 at 8:00 a.m., with LVN 1, LVN 1 stated, she worked on 2/17/25 until 7:30 p.m. LVN 1 stated she was not aware Resident 1 was not in the facility when she left. LVN 1 stated Resident 1 did not sign out in the LOA binder on 2/17/25. LVN 1 stated when staff noticed a resident was missing, they were supposed to call the Administrator and authorities. LVN 1 stated when she returned to work on 2/28/25 at 6:22 a.m., LVN 4 told her Resident 1 had not returned. LVN 1 stated staff failed to respond when Resident 1 was missing. LVN 1 stated Resident 1 was missing all night and was at risk of being injured, exposed to the weather, or hit by a car. LVN 1 stated, facility staff were unaware of Resident 1's location and his medical status.</p> <p>During an interview on 2/20/25 at 8:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, she worked the night shift on 2/17/25. CNA 1 stated, when she started her shift on 2/17/25 at 10:30 p.m., she did not see Resident 1. CNA 1 stated, when a resident was missing, staff go outside to look for the resident. CNA 1 stated staff were supposed to call the ADM and the authorities. CNA 1 stated, staff did not know where Resident 1's was. CNA 1 stated the facility staff did not look for Resident 1 and did not notify the ADM and authorities. CNA 1 stated, Resident 1 was at risk of being exposed to cold weather and could have been injured.</p> <p>(continued on next page)</p>		

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