STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately (but not later than 2 hours if serious bodily injury is involved, or within 24 hours if no serious bodily injury) to the local ombudsman (neutral, independent public official or office tasked with defending the public's interests and investigating complaints), state survey agency (SA- a state-level government department that inspects health care facilities) and local law enforcement for one of four sampled residents (Resident 1) when Resident 1 reported to Licensed Vocational Nurse (LVN) and Infection Preventionist (IP- professionals who make sure healthcare workers and patients are doing all the things they should to prevent infections) that Certified Nurse Assistant (CNA) 1 showed her a nude video of CNA 2, and the facility did not report the allegation to the required government agencies. This failure had the potential risk for delayed protective interventions and external investigation, allowing ongoing inappropriate conduct and placed Resident 1 at risk for further abuse. During a phone interview on 3/3/26 at 9:46 am with the Ombudsman (OMB), the OMD stated he was not aware of Resident 1's abuse allegation and did not have an SOC 341(a form used by mandated reporter to document and report suspected abuse or neglect of an elder) on file. During a review of Resident 1's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/5/26, the AR indicated Resident 1 admitted to the facility on [DATE] with diagnoses: Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), Type 2 Diabetes Mellitus (DM2- a condition where your body does not use a hormone that helps move sugar from your blood into your cells for energy properly) with Diabetic Neuropathy (a type of nerve damage that can happen with diabetes), asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways making it hard to breathe), Epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), Bipolar Disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or manic episodes) to lows (depression or depressive episode), Major Depressive Disorder (persistent feeling of sadness and loss of interest), Post-Traumatic Stress Disorder (extreme fear during or after witnessing or experiencing potentially traumatic events, such as war, accidents, natural disasters or sexual violence), and Age-Related Cognitive Decline. During a review of Resident 1's Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 12/18/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment. During an interview on 3/4/26 at 9:41 am with Resident 1 in the resident's room, Resident 1 stated CNA 1 showed her a nude video of CNA 2 posing naked in the bathroom with a small towel over his privates. Resident 1 stated she told one person and the Administrator (ADM) called her to her office. Resident 1 stated the ADM interviewed her and she identified CNA 1 showed her the nude video of CNA 2. Resident 1 stated she was shocked that an employee would show her a nude video of CNA 2. During an interview on 3/4/26 at 11:23 am with (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Vocational Nurse (LVN) in the ADM office, the LVN stated LVNs ensure resident safety and residents are treated with dignity and respect. The LVN stated staff should protect residents from abuse and should report abuse allegations right away. The LVN stated staff showing residents a video of a naked person was not acceptable because residents could take offense and could be considered a form of abuse and could be degrading for the residents to see and affect their dignity. The LVN stated more than a month ago around 6:30 am Resident 1 alleged CNA 1 showed her a naked video of CNA 2. The LVN stated the Infection Preventionist (IP) was notified and they interviewed Resident 1. The LVN stated she reported the alleged incident to the ADM between 8:00am-8:30am. The LVN stated she did not complete the SOC 341. The LVN stated she would report the allegation to the ADM who was the Abuse Coordinator and the ADM would advise whether SOC 341 would need to be completed. The LVN stated the alleged sexual incident should have been reported to the required government agencies. During a concurrent interview and record review on 3/4/26 at 11:43 am with the IP, the facility's policy and procedure titles, Abuse, Neglect and Exploitation, dated 12/16/25 was reviewed. The P&P indicated, VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administer, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes; a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. The IP stated Resident 1 informed her she saw a naked video of CNA 2. The IP stated staff showing a video of a naked person to a resident would be considered a potential abuse situation. The IP stated all facility staff are mandated reporters and must report if they witness or suspect abuse. The IP stated the SOC 341 should have been completed and the allegation of abuse reported within two hours. During an interview on 3/4/26 at 12:10 pm with the Director of Staff Development (DSD), the DSD stated it was not appropriate for staff to show a video of a naked person to residents, and could be considered as abuse. The DSD stated all facility staff were mandated reporters which meant if there was suspected abuse, they must report to the abuse coordinator. The DSD stated the abuse coordinator would complete the SOC 341 and report to the local law enforcement and the ombudsman. The DSD stated the SOC 341 should have been completed. During a phone interview conducted on 3/4/26 at 1:09 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated it was not appropriate for staff to show a resident a naked video as it could be considered abuse. CNA 1 stated she did not show Resident 1 a video of CNA 2 naked. CNA 1 stated she was taken off the schedule 2/5/26-2/13/26 by the ADM until the allegation was investigated. CNA 1 returned to work 2/14/26. CNA 1 stated if was aware of an abuse allegation, she would complete the SOC 341 form and notify the ombudsman. She explained that SOC 341 should be filled out and submitted immediately to ensure the facility was informed and could address the issue promptly. CNA 1 stated delayed reporting of alleged abuse could result in continued occurrences. During a concurrent interview and record review on 3/4/26 at 2:42 pm with the DON, the facility's P&P titled, Abuse, Neglect and Exploitation was reviewed. The P&P indicated, .VI. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. The DON stated the facility should report allegations of abuse immediately, no later than 2 hours after the allegation of abuse was made. The DON stated Resident 1's informed her CNA 1 showed her a naked video of CNA 2. The DON stated Resident 1 described the video as CNA 2 was getting out or going into the shower and you could see his nude behind. The DON stated the facility did not report the allegation because Resident 1 did not report distress after seeing the video. The DON stated it was inappropriate for staff to show residents a nude video. The DON stated all facility staff were mandated reporters, meaning if you witnessed or were aware of any form of abuse, they were obliged to report. The DON stated it was important to report abuse allegations to ensure the incident does not recur. The DON stated the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility would be at risk of jeopardizing their license if they did not report allegations of abuse. The DON stated the facility did not maintain mandated reporting for Resident 1's incident because they did not report the allegation. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, not dated, the P&P indicated, Purpose-to ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification,, investigation, and reporting of abuse, neglect, mistreatment.and crime in accordance with federal and state requirements.Procedure I. The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility, including A. The Director of Nursing Services, B. The Director of Social Services, C. The Director of Staff Development.III. Training A. All employees.will be trained.on the following topics: i. Who is a covered individual responsible for reporting? .iii. Identification and recognition of signs and symptoms of abuse.vi. Reporting and documentation of abuse.x. Penalties associated with failure to report.IX. Reporting/Response A. Facility Staff are Mandated Reporters i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults. ii. The Facility will not impede or inhibit a Facility's Staff member's reporting duty, nor will Facility Staff reprimanded or disciplined for reporting abuse.iv. Failure to report suspected or known abuse may result in legal action against the individual(s) withholding such information.C. Reporting Requirements i. The Facility will report known or suspected instances of .sexual abuse.to the proper authorities by telephone or through a confidential internet reporting tool as required by state and federal regulations.iii. If the reportable event relates to an incident.including emotional or psychological abuse.that occurred at the Facility, a telephone report and a written report will be made to the local Ombudsman or to the local law enforcement agency within 24 hours.vi. Failure to file a report within the required tie frames may be result in disciplinary action, up to and including termination.E. Submission of Report i. If multiple staff members become aware of the same incident, Facility Staff may choose to submit individual reports or submit a joint report containing each staff member's name and information about the suspected abuse from each staff person.XI. Penalties Associated with Failure to Report A. Anyone who fails to report within mandated timeframes will be subject to a civil money penalty of not more than $200,00 and the covered individual who failed to report may be excluded from participation in any Federal health care program.XXVI. Sexual abuse means non-consensual contact of any type, including but not limited to.forced observation of .pornography. During a review of Administrator Job Description (JD) dated 2023, the JD indicated Major Duties and Responsibilities plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations.Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse.mistreatment.are reported to the correct entity within the stated regulatory requirement.Additional Tasks.Reports noncompliance with policies and procedures, regulations.to appropriate personnel.Reports any allegations of abuse.or mistreatment of residents to appropriate regulatory entities. Protects residents from abuse and cooperates with all investigations. Compliance as a Condition of Employment and Performance Appraisal Agreement to abide by all standards, policies, and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment. Compliance will be a factor in evaluating job performance. Violations, including failure to report violations, will result in disciplinary action, up to and including termination . During a review of Certified Nursing Assistant JD, dated 2023, the JD indicated the Position Purpose-provides certified nursing assistant services to assigned residents in accordance with care plans, facility policies and procedures and at the direction of supervisor(s).Additional Assigned Tasks Treats all residents with dignity and respect. Promotes and protects all residents' rights. Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	business conduct, and state/federal regulations and guidelines. Reports noncompliance with policies and procedures, regulations.to appropriate personnel.Protects residents from abuse. Compliance as a Condition of Employment and Performance Appraisal Agreement to abide by all standards, policies and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment.Violations, including failure to report violations, will result in disciplinary action, up t and including termination. During a review of Charge Nurse JD, dated 2023, the JD indicated the Position Purpose-Provides direct nursing care to the residents and supervises the day-to-day nursing activities performed by the certified nursing assistants in accordance with current federal, state, and local regulations and guidelines and established facility policies and procedures.Major Duties and Responsibilities.Ensures that policies and procedures are complied with by nursing personnel assigned.Additional Tasks.Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines.Reports noncompliance with policies, procedures, regulations.to appropriate personnel . Reports any allegations of abuse.mistreatment of residents to supervisor and/or administrator. Protects residents from abuse. Compliance as a Condition of Employment and Performance Appraisal Agreement to abide by all standards, policies and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment.Violations, including failure to report violations, will result in disciplinary action, up t and including termination. During a review of Director of Nursing JD, dated 2023, the JD indicated Position Purpose-Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents.Major Duties and Responsibilities.Interprets and communicates policies and procedures to nursing staff, and monitors staff practices and implementation.Oversees resident incidents and concerns daily to identify any unusual occurrences and reports them promptly to the Administrator and/or state agency for appropriate action.Additional Tasks.Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines.Reports noncompliance with policies, procedures, regulations.to appropriate personnel .Reports any allegations of abuse.mistreatment of residents to supervisor and/or administrator. Protects residents from abuse. Compliance as a Condition of Employment and Performance Appraisal Agreement to abide by all standards, policies and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment.Violations, including failure to report violations, will result in disciplinary action, up t and including termination. During a review of Infection Preventionist JD, dated 2023, the JD indicated Additional Assigned Tasks. Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines.Reports noncompliance with policies, procedures, regulations.to appropriate personnel .Reports any allegations of abuse.mistreatment of residents to supervisor and/or administrator. Protects residents from abuse. Compliance as a Condition of Employment and Performance Appraisal Agreement to abide by all standards, policies and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment.Violations, including failure to report violations, will result in disciplinary action, up t and including termination.