

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 09/20/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>46194</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to support a resident's choice to be out of bed by not providing the necessary specialized wheelchair needed for the resident to be out of bed for 1 (Resident #26) of 16 sampled residents.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Rights, with a copyright date of 2024, revealed, 5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has the right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>An Admission Record revealed the facility admitted Resident #26 on 12/05/2023. According to the Admission Record, the resident had a medical history that included diagnoses of abnormalities of gait and mobility, lack of coordination, and weakness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/13/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for chair/bed-to-chair transfers. The MDS indicated the resident had not used a mobility device in the last seven days prior to the ARD.</p> <p>Resident #26's care plan included a focus area, revised 06/13/2024, that indicated the resident had little activity involvement related to physical limitation. Interventions directed staff to assist/escort Resident #26 with activity functions (revised 12/06/2023).</p> <p>A physical therapist's Physical Therapy Treatment Encounter Note, dated 01/05/2024, indicated Resident #26 was able to tolerate sitting in a geri chair (a specialized reclining chair) for approximately 20 minutes during therapy.</p> <p>Resident #26's IDT [Interdisciplinary Team] - Care Conference Summary, dated 09/13/2024, indicated the resident expressed a desire to get up more frequently to participate in activities of interest.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/17/2024 at 1:47 PM, Resident #26's Responsible Party, stated the resident required a special wheelchair with a high back as the resident slumped over when they became too tired. Resident #26's Responsible Party stated the resident did not have a wheelchair, and therefore, could not get out of bed. Resident #26's Responsible Party stated they understood the aides borrowed a wheelchair from another resident for Resident #26 to use. During a concurrent interview, Resident #26 stated if they had a wheelchair, they would get out of bed more. Resident #26 stated they would like to get out of bed more.</p> <p>On 09/19/2024 at 8:23 AM, Certified Nurse Aide (CNA) #2 stated Resident #26 did not have a wheelchair and the staff borrowed one from another resident for Resident #26. CNA #2 stated Resident #26 required a tilting wheelchair, the facility had not provided the resident one, and she was unsure of the reason the resident had not been provided a wheelchair. CNA #2 stated Resident #26 got up about three times weekly, but the resident would not be able to get up if the wheelchair was in use.</p> <p>On 09/19/2024 at 8:57 AM, the Director of Rehabilitation (DOR) stated Resident #26 needed a reclining wheelchair. The DOR stated the chairs were expensive and one had not been ordered for the resident. The DOR stated the facility had a tilt-in-space (a wheelchair designed to allow the entire chair to tilt) wheelchair that was shared between Resident #26 and another resident.</p> <p>On 09/19/2024 at 10:32 AM, Licensed Vocational Nurse (LVN) #3 stated if a resident required a special chair the resident must be measured and given the exact chair needed. LVN #3 stated Resident #26 did not have a wheelchair. LVN #3 stated Resident #26 did get up occasionally, and the resident should have their own wheelchair.</p> <p>On 09/20/2024 at 12:22 PM, the Director of Nursing (DON) stated residents had every right to get out of bed, and they should be gotten up. The DON stated residents should not be required to borrow equipment from other residents. The DON stated the equipment should be ordered, and it only took two or three days to get an order for equipment. The DON stated, if a resident was residing in the facility long-term, the facility should supply the resident with a wheelchair.</p> <p>On 09/20/2024 at 12:40 PM, the Administrator stated staff should work in conjunction with therapy and make him aware of the needed equipment. The Administrator stated he was not aware the need existed, and he was not aware Resident #26 did not have a wheelchair. The Administrator stated, if the chair was needed, he wanted the residents to have what they needed.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46659</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure activities of daily living (ADLs) were provided for 1 (Resident #4) of 16 sampled residents. Specifically, Resident #4's fingernails were not properly trimmed.</p> <p>Findings included:</p> <p>A facility policy titled, Nail Care implemented 10/2022, revealed, 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule.</p> <p>An Admission Record revealed the facility originally admitted Resident #4 on 10/04/2002. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia, contracture of muscle at multiple sites, generalized muscle weakness, pain in an unspecified limb, and wrist drop.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #4 had upper and lower extremity impairments on both sides. The MDS indicated Resident #4 required partial/moderate assistance with personal hygiene.</p> <p>Resident #4's care plan included a focus area, initiated 12/01/2022, that indicated the resident had an ADL self-care performance deficit related to quadriplegia. Interventions directed staff to assist Resident #4 with personal hygiene as the resident was totally dependent on staff for physical assistance (initiated 12/01/2022).</p> <p>Resident #4's Personal Hygiene task record, for the timeframe from 08/22/2024 through 09/20/2024, did not indicate any refusals for personal hygiene care.</p> <p>During a concurrent observation and interview on 09/17/2024 at 10:40 AM, Resident #4 was observed with long fingernails on both hands. Resident #4 stated that sometimes staff would offer to trim their fingernails, but the resident would ask the staff to come back later, and they did not come back.</p> <p>During an interview on 09/19/2024 at 1:39 PM, Resident #4 stated it had been a while since staff had offered to trim their fingernails.</p> <p>During an interview on 09/19/2024 at 1:42 PM, Certified Nurse Aide (CNA) #8, stated part of giving a resident a bath or shower included trimming the resident's fingernails, unless the resident was diabetic. CNA #8 stated she had never offered to trim Resident #4's fingernails.</p> <p>During an interview on 09/19/2024 at 1:50 PM, CNA #9 stated part of giving a resident a shower/bath included trimming their nails. CNA #9 stated he had never given Resident #4 a bed bath or trimmed their fingernails, but the resident had never refused any type of care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/19/2024 at 2:05 PM, Licensed Vocational Nurse (LVN) #3 stated CNAs were supposed to trim the residents' fingernails during shower/baths or when needed. LVN #3 stated Resident #4 did not refuse care. LVN #3 stated Resident #4 was not diabetic, and the CNAs should be trimming Resident #4's fingernails.</p> <p>During a concurrent observation and interview on 09/19/2024 at 2:09 PM, CNA #8 confirmed that Resident #4's fingernails were long and needed to be trimmed. CNA #8 stated she would trim Resident #4's nails right away.</p> <p>During a concurrent observation and interview on 09/19/2024 at 2:10 PM, LVN #3 revealed that she would let the staff know that Resident #4 needed their nails trimmed.</p> <p>During a concurrent observation and interview on 09/19/2024 at 2:15 PM, the Director of Nursing (DON) stated Resident #4 needed to have their fingernails trimmed. The DON stated she expected the staff to offer to trim the fingernails of the residents on their shower days and as needed. The DON stated she would get someone to trim Resident #4's fingernails as soon as possible.</p> <p>An observation on 09/20/2024 at 10:42 AM revealed Resident #4's fingernails had not been trimmed at that time.</p> <p>During an interview on 09/20/2024 at 2:21 PM, the Administrator stated he expected the staff to trim the residents' fingernails to promote good hygiene.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>28196</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to have a physician's order for the use of supplemental oxygen for 1 (Resident #98) of 1 sampled resident reviewed for respiratory care.</p> <p>Findings included:</p> <p>A facility policy titled, Oxygen Administration, implemented 10/2022, revealed, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The policy further indicated, Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency.</p> <p>An Admission Record revealed the facility originally admitted Resident #98 on 04/14/2023 and readmitted the resident on 09/16/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia, acute pulmonary edema, and chronic obstructive pulmonary disease (COPD).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/26/2024, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received oxygen therapy during the assessment period.</p> <p>Resident #98's care plan, included a focus area revised 04/01/2024, that indicated the resident had altered respiratory status and difficulty breathing related to anxiety, (COPD, and acute and chronic respiratory failure with hypoxia. Interventions directed staff to administer supplemental oxygen as ordered (initiated 01/19/2024).</p> <p>Resident #98's care plan, included a focus area revised 04/01/2024, that indicated the resident had oxygen therapy related to the diagnosis of COPD. Interventions included supplemental oxygen settings at 2-4 liters by nasal canula (revised 04/19/2024).</p> <p>Resident #98's Order Summary Report, dated 09/18/2024, with active orders, revealed it did not include an order for supplemental oxygen.</p> <p>During an observation on 09/17/2024 at 10:24 AM, Resident #98 was observed receiving supplemental oxygen at 2 1/2 liters per minute (lpm) by nasal cannula. During a concurrent interview Resident #98 stated they were readmitted the previous evening (09/16/2024) and were receiving oxygen because of their COPD. Resident #98 stated when they were in the hospital, they received oxygen at 4 lpm but were supposed to be on 3 lpm now.</p> <p>An observation on 09/20/2024 at 9:00 AM revealed Resident #98 was receiving supplemental oxygen at 3 lpm.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 09/20/2024 at 9:05 AM, Licensed Vocational Nurse (LVN) #3 observed Resident #98's supplemental oxygen and stated it was set at 3 lpm.</p> <p>After reviewing Resident #98's orders in the electronic health record, LVN #3 stated there was no order for the supplemental oxygen. LVN #3 stated she would let the doctor know so they could get an order.</p> <p>On 09/20/2024 at 9:07 AM, the Director of Nursing (DON) stated she expected residents receiving supplemental oxygen to have a physician's order for it. The DON reviewed Resident #98's orders in the electronic health record and confirmed the resident did not have an order for supplemental oxygen.</p> <p>On 09/20/2024 at 12:19 PM, the Administrator stated that anyone receiving supplemental oxygen should have a physician's order for it.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46659</p> <p>Based on interview, facility document review, and facility policy review, the facility failed to ensure a registered nurse (RN) was on duty daily for eight consecutive hours. This deficient practice had the potential to affect all residents who resided in the facility.</p> <p>Findings included:</p> <p>A facility policy titled, Nursing Services-Registered Nurse (RN), implemented 10/2022, revealed, 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.</p> <p>A facility nursing schedule for September 2024, indicated there were no RNs scheduled to work on 09/05/2024. However, RN #5's Employee Time Cards, dated 09/05/2024, revealed she worked 1.40 hours that day.</p> <p>A facility nursing schedule for September 2024, indicated there were no RNs scheduled to work on 09/08/2024. However, a Nursing Staffing Assignment and Sign-in Sheet, dated 09/08/20024, revealed RN #7 worked nonconsecutively for 7 hours that day.</p> <p>During an interview on 09/20/2024 at 1:07 PM, the Director of Nursing (DON) stated she was out sick from 09/01/2024 through 09/05/2024, but she thought she had scheduled adequate RN coverage during that time. The DON stated she was aware that the RN on 09/05/2024 was only able to work a few hours, but she did not have any other options.</p> <p>During an interview on 09/20/2024 at 1:10 PM, RN #7 stated she did not know she had to work eight hours in a row to meet the regulation.</p> <p>During a follow-up interview on 09/20/2024 at 1:41 PM, the DON stated that she was not aware that the RNs had to work eight hours consecutively, but after reviewing the regulation she would in-service the RNs on the importance of meeting the requirement.</p> <p>During an interview on 09/20/2024 at 2:21 PM, the Administrator stated he expected the facility to have a RN on duty at least 8 hours consecutively, daily.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a PRN (pro re nata, as-needed) psychotropic medication had a 14-day stop date for 1 (Resident #12) of 5 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Use of Psychotropic Medication, implemented 10/2022, indicated, 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. [id est, that is] 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>An Admission Record revealed the facility initially admitted Resident #12 on 07/06/2023 and readmitted the resident on 08/08/2024. According to the Admission Record, the resident had a medical history that included a diagnoses of schizoaffective disorder.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had a diagnosis of schizophrenia.</p> <p>Resident #12's care plan, included a focus area revised 05/25/2024, that indicated the resident took aripiprazole (an atypical antipsychotic injection used for the treatment of agitation) related to schizoaffective disorder with agitation. Interventions directed staff to administer psychotropic medications as ordered by the physician (initiated 07/09/2023).</p> <p>Resident #12's Order Summary Report, with active orders as of 09/17/2024, included an order dated 08/08/2024, for aripiprazole oral tablet 2 mg with instructions to give one tablet by mouth every 24 hours nightly as needed for agitation. Further review revealed there was no end date for the order.</p> <p>On 09/19/2024 at 11:43 AM, the Director of Nursing (DON) stated PRN psychotropic medications should have a 14-day end date.</p> <p>On 09/20/2024 at 12:36 PM, the Administrator stated the order should have a stop date of 14 days. The Administrator stated PRN orders must be updated and reviewed every 14 days and evaluated for routine use based on the resident's needs.</p> <p>On 09/20/2024 at 8:08 AM, the Pharmacist stated PRN psychotropic medications should have a 14 day stop date unless addressed by the physician and the medication ordered for more than 14 days.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>46659</p> <p>Based on interview, facility document review, and facility policy review, the facility failed to ensure the facility-wide assessment was updated and reviewed annually. This deficient practice had the potential to affect all residents who resided in the facility.</p> <p>Findings included:</p> <p>A facility policy titled, Facility Assessment, implemented 06/2024, revealed, 10. The facility assessment will be reviewed and updated as necessary and at least annually.</p> <p>A Facility Assessment Tool, revealed the sections for Date(s) of assessment or update and Date(s) assessment reviewed with QAA [Quality Assurance Assessment]/QAPI [Quality Assurance and Performance Improvement] committee, were dated 08/31/2023.</p> <p>During an interview on 09/17/2024, the Administrator stated the facility assessment had not been reviewed prior to 08/31/2023. The Administrator stated they planned to review the facility assessment the last week of 09/2024.</p> <p>During an interview on 09/20/2024 at 2:21 PM, the Administrator stated the facility assessment was done on 09/10/2024, but it had not been reviewed or revised. The Administrator stated the assessment was his responsibility.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to accurately transcribe hospital discharge medication orders for 1 (Resident #12) of 5 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>A facility policy titled, Transcribing Physician Orders and Consulting Physician/Practitioner Orders, implemented 10/2022, revealed, 2. For consulting physician/practitioner orders received in writing or via fax [facsimile], the nurse in a timely manner will: c. Follow facility procedures for verbal or telephone orders including: noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.</p> <p>An Admission Record revealed the facility initially admitted Resident #12 on 07/06/2023 and readmitted the resident on 08/08/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of schizoaffective disorder.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had a diagnosis of schizophrenia.</p> <p>Resident #12's care plan, included a focus area revised 05/25/2024, that indicated the resident took aripiprazole (an atypical antipsychotic injection used for the treatment of agitation) related to schizoaffective disorder with agitation. Interventions directed staff to administer psychotropic medications as ordered by the physician (initiated 07/09/2023).</p> <p>A hospital record titled, Case Management Discharge Summary/Orders Report, dated 08/08/2024, indicated Resident #12's discharge medications included aripiprazole (Abilify) with instructions to take one tablet 2 milligrams (mg) total by mouth daily.</p> <p>Resident #12's Order Summary Report, with active orders as of 09/17/2024, included an order dated 08/08/2024, for aripiprazole oral tablet 2 mg with instructions to give one tablet by mouth every 24 hours nightly as needed for agitation.</p> <p>On 09/19/2024 at 1:15 PM, Licensed Vocational Nurse (LVN) #1 stated the order was transcribed incorrectly, and it should not have been entered as an as-needed order.</p> <p>On 09/19/2024 at 11:43 AM, the Director of Nursing (DON) stated the aripiprazole should not have been an as-needed order. The DON stated the aripiprazole should not have been given as a PRN (pro re nata, as-needed) order unless it had been prescribed like that from the hospital. The DON stated it looked like Resident #12 went out of the facility, and, when the resident returned, the order was not transcribed correctly.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/20/2024 at 12:36 PM, the Administrator stated the order would be reviewed and the transcription would reflect the orders from the physician at the hospital. The Administrator stated the errors would be revised based on the order and sent to the physician for approval.</p> <p>On 09/20/2024 at 8:08 AM, the Pharmacist stated the admission nurse should check the orders and make sure they were accurate. The Pharmacist stated the order was transcribed incorrectly, and it would be written up as a medication error.</p>

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 09/20/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28196</p> <p>Based on interview and facility policy review, the facility failed to maintain an effective infection control program. Specifically, the facility failed to establish and implement a surveillance plan to identify, track, and monitor infections. This had the potential to affect all residents who resided in the facility.</p> <p>Findings included:</p> <p>A facility policy titled, Infection Prevention and Control Program, implemented 10/2022, revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The section titled Policy Explanation and Compliance Guidelines, included, 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.</p> <p>On 09/18/2024 at 11:17 AM, the Infection Preventionist (IP) was unable to provide evidence of tracking and trending each month of all infections. The IP stated she had been in the position for two months and no one had shown her how or what to do with the infection information. The IP stated she was waiting for guidance from the corporate infection control consultant. The IP stated she had access to the previous IP, who still worked at the facility, but the previous IP had not shown her how to track, monitor, or trend infections for surveillance purposes.</p> <p>During an interview on 09/19/2024 at 11:27 AM, the Director of Nursing (DON) stated the IP should keep up with all infections for every resident at least monthly. The DON stated the IP should also look for infection trends such as clusters of urinary tract infections (UTIs). The DON stated the IP was relatively new to their position but had other staff members that were coaching her and had a consultant the IP called for guidance. The DON stated she was unaware the IP had not been tracking infections daily or looking for monthly trends and possible resolutions to prevent the spread of infections. The DON stated she expected the IP to track all infections daily and to identify, track, and trend infections and clusters of infections monthly.</p> <p>During an interview on 09/20/2024 at 1:38 PM, the Administrator stated he expected the IP to implement a system of surveillance for the purposes of preventing and controlling infections for all residents. The Administrator stated he expected the system of surveillance to include the identification of all infections by room and unit and the reporting and investigation of infections. The Administrator stated, at the end of each month, he expected the IP to map out the infections on the facility map, so, at a glance, the different infections could be seen by resident name and location. The Administrator stated the surveillance information was needed to provide in-services such as proper hand hygiene, perineal care, or other interventions to decrease the spread of infection.</p>		

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NAME OF PROVIDER OR SUPPLIER Vineyards at Fowler		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 East Sumner Avenue Fowler, CA 93625	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46194</p> <p>Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure 2 (room [ROOM NUMBER] and room [ROOM NUMBER]) of 16 residents' rooms accommodated no more than four residents per room.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Rooms, implemented 10/2022, revealed, Resident bedrooms will not accommodate more than four residents.</p> <p>A Client Accommodations Analysis, dated 09/19/2024, revealed that room [ROOM NUMBER] had a floor area of 963.9 square (sq) feet (ft) with an approved capacity of eight residents. Further review revealed room [ROOM NUMBER] had a floor area of 733.22 sq ft with an approved capacity of eight resident.</p> <p>An observation on 09/20/2024 at 10:21 AM, revealed there were seven residents residing in room [ROOM NUMBER]. The observation revealed the room size was comfortable, with bedside tables and adequate closet space. The observation revealed there were no concerns with square footage per resident.</p> <p>An observation on 09/20/2024 at 10:23 AM, revealed there were eight residents residing in room [ROOM NUMBER]. The observation revealed the room size was comfortable, with bedside tables and adequate closet space. The observation revealed there were no concerns with square footage per resident.</p> <p>On 09/20/2024 at 12:47 PM, the Administrator stated a maximum of four residents should resident in a room. The Administrator stated the facility had two rooms that had eight beds.</p>		

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NAME OF PROVIDER OR SUPPLIER Vineyards at Fowler		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 East Sumner Avenue Fowler, CA 93625	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46659</p> <p>Based on observation, interview, facility document review, and facility policy review, the facility failed to provide the required 80 square (sq) feet (ft) of living space per resident in 6 (Rooms 1, 6, 8, 10, 11, and 16) of 16 multiple occupancy resident rooms. This failure had the potential for residents to not have reasonable accommodations for privacy or adequate space for care to be rendered.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Rooms, implemented 10/2022, revealed, 2. Resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms.</p> <p>A Client Accommodation Analysis, dated 09/19/2024, revealed the following living space per resident:</p> <ul style="list-style-type: none"> - In room [ROOM NUMBER], there was 72.5 sq ft for each resident. - In room [ROOM NUMBER], there was 77.4 sq ft for each resident. - In room [ROOM NUMBER], there was 78.9 sq ft for each resident. - In room [ROOM NUMBER], there was 73.1 sq ft for each resident. - In room [ROOM NUMBER], there was 73.1 sq ft for each resident. - In room [ROOM NUMBER], there was 64.9 sq ft for each resident. <p>On 09/20/2024 at 10:30 AM, during a concurrent observation and interview, the Department Head of Maintenance (DHM) measured Rooms 1, 6, 8, 10, 11, and 16. The DHM stated Rooms 1, 6, 8, 10, 11, and 16 did not meet the requirement of 80 sq ft per resident. The observation revealed residents had privacy, closet and storage space for their belongings, and bedside tables for personal items. The observation revealed resident bathrooms were unobstructed. The observation revealed there was sufficient room for staff to provide care, and residents did not voice any concerns about the space.</p> <p>During an interview on 09/20/2024 at 12:30 PM, the Director of Nursing (DON) stated each resident must have 80 sq ft per resident.</p> <p>During an interview on 09/20/2024 at 12:47 PM, the Administrator stated each resident was supposed to have 80 sq ft per resident.</p> <p>During a follow-up interview on 09/20/2024 at 1:41 PM, the DON stated she was aware of the issue with the rooms' square footage per resident, and they had requested a waiver for those rooms.</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/20/2024 at 2:21 PM, the Administrator stated he was aware they would be cited for the rooms' square footage per resident, and he had submitted a waiver request.</p>