

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/09/2026
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)		
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Dietary Manager was qualified to perform the duties of a dietary supervisor when the facility was unable to provide documentation the Dietary Supervisor (DS) completed a state-approved program in dietetic service supervision. Regulatory requires individuals in this role to meet one of seven recognized qualification pathways. The DS Food Handler Card, high school transcripts, and Regional Occupational Program (ROP-hands on training and career preparation in various fields including culinary arts, health care, automotive and technology) course documentation were insufficient to meet the regulatory requirements under HCS (Health and Safety Code- state laws and regulations governing public health, healthcare facilities, and safety standards, including requirements related to dietary services and staff qualifications)1265.4.This failure had the potential to result in 40 of 41 residents at risk of receiving nutritionally inappropriate meals or inadequate dietary services due to insufficient oversight of food preparation, menu compliance and staff performance.During an interview on 1/6/26 at 12:51p.m. with Kitchen Staff (KS) 1, KS 1 stated she reported to the Dietary Supervisor (DS), who was responsible for training all kitchen staff. KS 1 stated the Registered Dietitian (RD) came onsite to observe the tray line and communicated any identified issues to the DS and not directly to staff. During an interview on 1/7/26 at 10:25 a.m. with the RD, the RD stated his role included assessing residents, attending weight meetings, conducting sanitation audits and ensuring a well-functioning kitchen. The RD stated he was onsite 1-2 days per week due to the small size of the facility, typically rounding on Thursdays and spending the whole day onsite on Fridays. The RD stated he also worked from home and was available to staff for consultation or to come onsite on other days with advanced notice, averaging approximately 12 hours onsite per week. The RD stated he reported to the Administrator (ADM) and if the DS had issues requiring attention, he provided support, but the matters were addressed with the ADM. The RD stated he communicated regularly with the DS and received feedback from her regarding kitchen issues. The RD stated the DS served as the day-to-day manager of the kitchen, was responsible for staff evaluations and performance, managed daily operations and ordering and stated the DS was a Certified Dietary Manager (CDM). During an interview on 1/7/26 at 10:46 a.m. with the DS, the DS stated she began working at the facility in 2015. The DS stated she was not initially hired as the DS; however, shortly after she started, the CDM went out on medical leave. The DS stated she temporarily assumed the role due to her experience with ordering and subsequently continued in the position. During an interview on 1/7/26 at 3:08p.m. with the DS, the DS stated her duties included reviewing temperature logs, attending meetings and completing room rounds with residents. The DS stated she obtained food preferences for new admissions and completed grocery ordering. The DS stated the RD completed resident evaluations, while she entered nutritional data. The DS stated if she had concerns regarding a resident, she addressed them with the RD and stated she and the RD communicated regularly and held weekly meetings. The DS stated kitchen staff reported to her and she was responsible for completing their training, evaluations and performance reviews. The DS stated she was trained in-house by a dietary manager and previously (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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	management and safety from a national certifying body, has an associate's or higher degree in food service management or in hospitality, if the course of study includes food service or restaurant management from an accredited institution of higher learning, has 2 or more years experience in position of director of food and nutrition services in a nursing facility setting and has completed a course of study and management, by no later than 10/1/2023, that includes topics integral to managing dietary operations including but not limited to foodborne illness, sanitation procedures, and food purchasing/receiving.must also meet State requirements for food service managers or dietary managers.During a review of the facilities policy and procedure (P&P) titled, License Verification, dated 2025, the P&P indicated, All personnel that require a license or certification shall be verified through the appropriate issuing agency.the human resources director or designee is responsible for maintaining and ensuring the validity and current status of individual certification/licensure.an individual will not be employed and or/will be terminated from employment if a. the individual has lost licensure/certification for any reason.any licensed/certified employee is responsible for submitting verification of licensure/certification renewal to human resources prior to expiration.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure the food preparation sink was equipped with a required air gap to prevent contamination, when the food preparation sink was observed without an air gap, creating the potential for backflow and contamination of food and food-contact surfaces. This failure had the potential to affect 40 of 41 residents who received meals prepared in the facility. During an observation on 9/30/25 at 8:16a.m. in the kitchen, the one-compartment sink located next to Fridge 2 was observed with beans soaking. During an interview on 1/6/26 at 12:51p.m. with Kitchen Staff (KS) 1, KS 1 stated the small, one-compartment sink was used as the food preparation sink. KS 1 indicated the two-compartment sink was used only as a backup if the dishwasher was not functioning. KS 1 stated she was unsure what an air gap was but stated the piping to the sink had not been altered. During an interview on 1/7/26 at 3:08p.m. with the Dietary Supervisor (DS), the DS stated an air gap was intended to prevent contamination of food if the sink were to overflow. The DS was unsure if an airgap was required and believed the facility may have a waiver. During a concurrent observation and interview on 1/8/26 at 10:25a.m. with the Registered Dietitian (RD) and DS, both confirmed the one-compartment sink in the kitchen was used as the food preparation sink and did not have an air gap. During an interview on 1/9/26 at 9:28a.m. with the Administrator (ADM), the ADM stated an air gap was required, and should have been present. During a review of professional reference titled, FDA Food Code 2022, section 5-402.11 Backflow Prevention, (A) A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (B) Equipment and fixtures used for food preparation or utensil washing must be installed with an air gap or air brake as required to prevent backflow of sewage into the equipment.		

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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 stored and disposed of in a manner that prevented unsanitary conditions when 3 of 3 outdoor dumpsters were observed with lids open and one dumpster was overflowing. This failure had the potential to attract pests, create offensive odors and negatively impact food safety and the overall sanitary environment of the facility. During an observation on 1/6/26 at 12:44 p.m. the facility's dumpsters located behind the building were observed with all three lids in the open position. One dumpster contained overflowing boxes, which prevented the lid from closing securely. During an interview on 1/6/26 at 12:51 p.m. with Kitchen Staff (KS) 1, KS1 stated the lids of the dumpsters were required to remain closed at all times to prevent pests. During an interview on 1/7/26 at 3:08p.m. with the Dietary Supervisor (DS), the DS stated the dumpsters were required to remain closed at all times and the surrounding area should be kept clear to prevent unwanted pests. The DS stated the facility's location next to agricultural orchards placed the facility at increased risk for pests. During an interview on 1/9/26 at 9:28a.m. with the Administrator (ADM), the ADM stated her expectation was for the dumpster lids to remain closed at all times for infection control purposes and the dumpsters should not be overflowing. During a review of the facility's policy and procedure (PNP), titled, Disposal of Garbage and Refuse dated 12/18/2025, the PNP indicated, .dumpsters shall be kept covered when not being loaded. surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 1Based on observation, interview and record review, the facility failed to ensure professional standards of practice and the facility's policies and procedures were followed for one of four sampled residents (Resident 46) when Resident 46's psychotropic medication (psychoactive drugs that alter brain chemistry to treat mental illness) brexpiprazole (used to treat Alzheimer's disease- disease characterized by a progressive decline in mental abilities) ordered on 12/7/25, was not available for administration and was documented in the Electronic Medication Administration Record (EMAR- a digital system that replaces paper charts to streamline and secure the process of giving medications to patients) as administered on 12/10/25, 12/18/25, 12/19/25, 1/5/26 and 1/6/26. The EMAR for the medication was documented as refused on 12/8/25, 12/12/25 and 12/13/25 when the medication was not available for administration on those datesThis failure resulted in Resident 46 not receiving the physician ordered medication and not achieving the intended therapeutic outcome. During a review of Resident 46's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated resident 46 was admitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest, and changes in sleep, appetite, and energy that interfere with daily life), Alzheimer's Disease and dementia (a progressive state of decline in mental abilities). During a review of Resident 46's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 11/15/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 4 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 46 had severe cognitive impairment. During a medication observation on 1/7/26 at 8:17 a.m. with Licensed Vocational Nurse (LVN) 1 outside of Resident 46's room, LVN 1 prepared Resident 46 medications. LVN 1 stated Resident 46's psychotropic medication was not available and was still waiting for pharmacy to deliver the medication. LVN 1 stated she would contact pharmacy to follow up on the medication. Resident 46 was observed sitting up in her wheelchair inside her room next to her bed. Resident 46 was alert, verbally responsive, and appropriately dressed. During a concurrent interview and record review on 1/7/26 at 2:55 p.m. with LVN 1, Resident 46's EMAR dated 1/2026 was reviewed. LVN 1 stated the checkmark in the EMAR indicated the medication was administered and nine (9) indicated Other/See Nurse Notes. LVN 1 stated she did not know why there was a checkmark documented on 1/5/26 and 1/6/26 in the EMAR, LVN 1 stated medication was not available because the pharmacy had not delivered the medication. LVN 1 stated, the medication was still being processed and the pharmacy was waiting for Resident 46's insurance approval LVN 1 stated she did not notify Resident 46's physician the medication was unavailable. LVN 1 statedI notified the Director of Nursing (DON) and the Administrator today. LVN 1 stated she was not sure if the DON contacted the physician. During an interview on 1/8/26 at 9:25 a.m. with the Director of Nursing (DON), the DON stated Resident 46's brexpiprazole medication was ordered by the Psychiatric-Mental Health Nurse Practitioner (PMHNP). The DON stated she discussed the cost of medication with the PMHNP because Resident 46's insurance did not cover the cost. The DON stated the PMHNP did not want to change the medication and rewrote the order stating Resident 46's insurance should approve it. However, the insurance did not approve the medication. The DON stated the PMHNP instructed nursing staff to place the medication on-hold until insurance approval was obtained. The DON stated she did not recall discussing the medication with the primary physician for recommendation and did not contact the pharmacist for an alternative equivalent medication. The DON reviewed Resident 46's EMAR for December 2025 and January 2026. The DON stated licensed nurses documented the medication was administered on 12/10/25, 12/18/25, 12/19/25, 1/5/26 and 1/6/26. DON stated the medication was documented as refused on 12/8/25, 12/12/25 and 12/13/25. The DON stated the documentation of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	both administered and refused was inaccurate because the medication was not available. The DON stated her expectation was to verify medications availability before documenting administration or refusal. During a concurrent interview and record review on 1/8/26 at 10:05 a.m. with LVN 2, LVN 2 reviewed Resident 46's EMAR dated 12/1/25 through 12/31/25 and 1/1/2026 through 1/31/26. LVN 2 stated she signed the December EMAR indicating she administered the medication on 12/18/25 and signed the January 2026 EMAR indicating she administered the medication on 1/6/26. LVN 2 stated she was not aware of the documentation error and stated, I was just told today. LVN 2 stated she did not recall contacting the physician regarding the medication not available and did not contact the pharmacy to follow up on the medication. LVN 2 stated, I should have been more attentive to what I was doing. LVN 2 stated it was an error to document the medication was administered when it was not. During a concurrent interview and record review on 1/8/26 at 10:48 a.m. with LVN 3, Resident 46 EMAR was reviewed, LVN 3 stated she documented she administered Resident 46's brexpiprazole on 1/6/26. LVN 3 stated she documented the medication as administered and did not realize the medication was not available. LVN 3 stated she was notified by the DON today that she documented the medication incorrectly in the EMAR. LVN 3 stated the brexpiprazole medication was ordered by the PMHNP LVN 3 stated she notified the PMHNP and the medication order was rewritten and faxed to the pharmacy, but Resident 46's insurance did not approve the medication. LVN 3 stated she did not recall notifying the primary physician to let him know the medication was not covered by Resident 46's insurance. During a review of facility's document titled, Charge Nurse Job Description, dated 2023, the Job Description indicated, .Ensures that policies and procedures are complied with by nursing personnel assigned . Prepares and administers medications as per physicians' orders and observed for adverse effects . Ensures that there is adequate stock of medications, supplies, equipment and notifies appropriate personnel of needs . During a review of facility's policy and procedure (P&P) titled, Medication Administration, General Guideline, dated 9/18, The P&P indicated, . Medications are administered in accordance with written orders of the prescriber . Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart. b. When dose is prepared. c. Before dose is administered . Documentation: 1. The individual who administers the medication dose, records the administration on the residents EMAR immediately following the medication being given . 2. If a dose of a regularly scheduled medication is withheld, refused, or given at other than the scheduled time . an explanatory note is entered . During a review of facility's policy and procedure (P&P) titled, Medication Orders Non-Controlled Medication Orders, dated 12/12, the P&P indicated, .The prescriber should be contacted by nursing when delivery of a medication will be delayed or the medication is not available . Non-emergency medication orders; The first dose of medication is scheduled to be given after the next regularly scheduled pharmacy delivery to the nursing care center . During a review of facility's policy and procedure (P&P) titled, Documentation of Medication Administration, dated 2001, the P&P indicated, .A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR) . Documentation of medication administration includes, as a minimum: .reason(s) why a medication was withheld, not administered, or refused . During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, .Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 6Number of residents cited: 2Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was 9.68 percent. There were 31 opportunities for errors and three medication errors occurred for three of six sampled residents (Resident 5 and Resident 46) when:1.Licensed Vocational Nurse (LVN)1 did not follow Resident 46's physician's order of multivitamins when she administered multivitamin with minerals to Resident 46 on 1/7/26. This failure had the potential for Resident 46 to develop adverse reaction to medication that was not prescribed to her which could result in serious health condition.2.LVN 1 did not follow Resident 5's physician's order of senna-docusate (used to prevent/treat constipation) when she administered senna and a routine inhaler (a small handheld medical device that delivers medicine as a mist or spray directly to the lungs for treating respiratory conditions like asthma) medication Advair HFA (used for the treatment of breathing problems in patients with asthma) was not available to administer to Resident 5 on 1/7/26.These failures resulted in the potential for Resident 5 to experience shortness of breath and constipation which could lead to more serious health condition. 1. During an observation on 1/7/26 at 8:17 a.m. with LVN 1, outside of Resident 46's room, LVN 1 prepared Resident 46's medications including multivitamin with minerals. LVN 1 crushed the medications and added apple sauce in the medication cup and administered to Resident 46. During a review of Resident 46's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated resident 46 was admitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest, and changes in sleep, appetite, and energy that interfere with daily life), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 46's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 11/15/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 4 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 46 had severe cognitive impairment. During a concurrent interview and record review on 1/7/26 at 2:55 p.m. with LVN 1, Resident 46 Electronic Medication Administration Record (EMAR-an electronic daily documentation record used by licensed nurse to document medications and treatments given to a resident), dated 1/2026 was reviewed. The EMAR indicated, .Multivitamin Oral Tablet (Multiple Vitamin) Give 1 (one) tablet by mouth one time a day for Supplement. Start Date 10/14/23. LVN 1 stated she signed Resident 46's EMAR on 1/7/26 indicating she administered multivitamin to Resident 46. LVN 1 stated, I administered multivitamin with minerals because it is the only over the counter medication available for us to administer, it is the same medication. LVN 1 refused to answer possible side effects to Resident 46 when administered with the wrong medication. During a concurrent interview and record review on 1/8/26 at 10:10 a.m. with LVN 2, Resident 46 medication physician's orders was reviewed. LVN 2 stated Resident 46's order was multivitamin and not multiple vitamin with minerals. LVN 2 stated, Medications are over the counter but are not the same. LVN 2 stated Resident 46 could develop allergic reactions to the medication. LVN 2 stated the physician order has to be followed. During an interview on 1/8/26 at 10:50 a.m. with LVN 3, LVN 3 stated Resident 46's medication physician's order should be followed as ordered LVN 3 stated Resident 46 may develop allergic reaction to a medication administered not ordered by her physician. 2. During an observation and interview on 1/7/26 at 8:21 a.m. with LVN 1, outside of resident 5's room. LVN 1 prepared Resident 5's 8 a.m. medications including senna (stool softener). LVN 1 stated Resident 5's routine [brand name] inhaler was not available to administer. LVN 1 crushed Resident 5's medications and added apple sauce in the medication cup. LVN 1 stated Resident 5 was hard of hearing and had to write on a white board to (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communicate with Resident 5. During a review of Resident 5's admission Record, dated 1/8/26, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included asthma (narrowing of the small airways in the lungs making it hard to breath), shortness of breath and constipation (infrequent bowel movements and stools are hard, dry, lumpy, and difficult or painful to pass).During a review of Resident 5's MDS dated [DATE], the MDS indicated a BIMS of 13 which indicated Resident 5 had no cognitive impairment.During concurrent interview and record review on 1/7/26 at 3:05 p.m. with LVN 1, Resident 5's EMAR dated 1/2026 was reviewed. The EMAR indicated, .(brand name) inhalation Aerosol 115-21 MCG/ACT [micrograms per actuation] 1 puff inhale orally one time a day . Start date 8/8/25 .Senna-Docusate Sodium Oral Tablet . Give two [2] tablet by mouth every morning and at bedtime for constipation. Start Date 4/4/25 . LVN 1 stated she administered senna to Resident 5 because it was the only over the counter medication available. LVN 1 refused to answer whether both medications are the same. LVN 1 refused to answer possible consequences of Resident 5 not receiving the right medication. LVN 1 stated Resident 5's [brand name] inhaler was a routine medication and should have been available to administer. LVN 1 stated Resident 5 could develop respiratory problem because of the medication not available and not administered as ordered by the physician. LVN 1 stated licensed nurses are responsible in making sure all routine medications are available to administer to residents and to follow up with the pharmacy.During an interview on 1/8/25 at 10:05 a.m. with LVN 2, LVN stated Resident 5's medication order should be followed as ordered by her physician. LVN 2 stated Resident 45 may not be getting the result needed if not administered the right medication. LVN 2 stated routine medications should be available to residents because they need the medication. LVN 2 stated Resident 5 needed her inhaler to prevent her from having respiratory problems. LVN 2 stated Resident 5 has asthma and she needed her inhaler to prevent respiratory complications.During a concurrent interview and record review on 1/8/26 at 10:55 a.m. with LVN 3, Resident 5's EMAR was reviewed. LVN 3 stated she worked on 1/6/26 and she administered Resident 5's inhaler. LVN 3 stated she signed the EMAR on 1/6/26 because she administered the inhaler medication to Resident 5. LVN 3 stated Resident 5's inhaler was routine and should be available to administer as ordered by the physician to prevent Resident 5 from getting respiratory complications. LVN 3 stated Resident 5 should have been administered the Senna-docusate as ordered by the physician. LVN 3 stated Senna and Senna -docusate are not the same medications. LVN 3 stated Resident 5 could develop constipation because she was not given the medication ordered by her physician. During an interview on 6/9/26 at 12:42 p.m. with the Director of Nursing (DON), the DON stated her expectation was for routine medications to be readily available to administer to residents. The DON stated licensed nurses should have called pharmacy when a routine medication was not available. The DON stated licensed nurses during medication administration should be following the medication physician's order and administering the correct medication. The DON stated her expectation was for licensed nurses to compare medication order and the medication at hand making sure medications are the same to prevent medication error. The DON stated medication errors are harmful to residents which could potentially be debilitating to residents and may end up in the acute hospital. During a review of facility's policy and procedure (P&P) titled, Medication Administration, General Guideline, dated 2007, the P&P indicated, . Prior to administration, review and confirm medication order for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label . Medications are administered in accordance with written orders of the prescriber .Verify medication is correct three (3) times before administering the medication .During a review of facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy Provider, Ordering and Receiving non-Controlled Medications, dated 1/20, the P&P indicated, .All medications should be reordered in advanced by writing medication names and prescription number . and faxing or otherwise transmitting the order to the pharmacy . Timely delivery of new medications is required so that medication is not delayed . During a review of the professional (continued on next page)		

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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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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, .Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review, the facility failed to ensure proper storage and disposal of medications and biologicals in accordance with facility policy and procedures when:1.Two expired medications were found in one of one medication rooms. This failure had the potential for residents to receive medication that no longer had the desired efficacy with the potential to slow healing, and or relieve pain and discomfort.2. Station 1's medication cart, contained Resident 21's lactulose (used to treat constipation) medication with label different from the medication's physician order in the Electronic Medication Administration Order (Electronic Medication Administration Record (EMAR- an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/2026.This failure placed Resident 21 at risk of not receiving the physician's prescribed dose which could lead to serious health condition. 1.During a concurrent observation and record review on 1/8/26 at 11:10 a.m. with Director of Nurses (DON), in the Medication Storage Room, a bottle of Simethicone (a medication to ease gas symptoms) 80 milligrams (MG &ndash; unit of measurement), with an expiration date of 12/2024 and an injectable vial of Dulaglutide (a medication to treat high blood sugar) 1.5 MG with an expiration date of 10/15/25. The DON stated that expired medications are to be destroyed following the policy on destruction of medications. Expired medications may not have the same strength and not benefit the resident. During an interview on 1/9/26 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all expired meds should be removed from the medication carts and medication so as not to give them to the residents. Expired meds could have unwanted side effects and may no longer have the same efficacy resulting in the resident not receiving the full effect of the medication. During a review of the facility's policy and procedure titled, Destruction of Unused Drugs, dated 12/18/25, indicated, .All unused, or expired drugs shall be disposed of in accordance with state laws and regulations . 2.During a review of Resident 21's admission Record [AR- a document containing resident profile information], dated 1/8/26, the AR indicated Resident 21 was readmitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest, and changes in sleep, appetite, and energy), anxiety (persistent, excessive, and uncontrolled worry or fear about everyday situations) and heart failure. During a review of Resident 21's Order Summary Report[OSR], dated 1/9/26, The OSR indicated, .Lactulose Oral Solution 10 GM[gram-unit of measurement]/15ML [milliliter-unit of measurement] Give 45 ml by mouth three times a day for Constipation related to QUADRIPLÉGIA [paralysis from the neck down, including legs, and arms, usually due to a spinal injury] . During an observation on 1/7/26 at 8:51 a.m. with Licensed Vocational Nurse (LVN) 1 outside of Resident 21's room. LVN 1 observed preparing Resident 21's prescribed medication including lactulose. LVN 1 poured 45 ml of lactulose in a medicine cup and administered to Resident 21. Resident 21's lactulose medication bottle with direction to administer 30ml. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/7/26 at 2:55 p.m. with LVN 1, LVN 1 reviewed Resident 21's medication orders and stated Resident 21's lactulose order was 45 ml three times a day. LVN 1 stated she followed Resident 21's physician order in the EMAR. LVN 1 stated she looked at the lactulose medication bottle prior to preparing medication and did not realize the medication direction was different from the medication direction in the EMAR. LVN 1 refused to answer what she could have done when a medication bottle direction was different from the medication direction in the EMAR. During an interview on 1/8/26 at 10:17 a.m. with LVN 2, LVN 2 stated it was the responsibility of the licensed nurse receiving a medication order to notify pharmacy of new orders. LVN 2 stated for medication direction changes in dose and frequency, put a change of direction sticker on the bottle of medication or the bubble pack (blister pack) until pharmacy send us medication with the new label. LVN 2 stated not placing a change of direction sticker was a potential for medication error, not following the physician order and resident not achieving the intended therapeutic outcome. During an interview on 1/8/26 at 11:20 a.m. with LVN 3, LVN 3 stated it was the responsibility of the licensed nurse administering medications to contact physician when a prescribed medication direction label was different from the medication direction in the EMAR to prevent medication error. LVN 3 stated the nurse receiving the medication order was responsible in contacting the pharmacy to let them know of the new order. LVN 3 stated to place a change of direction sticker on the medication bottle or medication blister pack while waiting for the new medication with the correct label and to avoid medication error. During an interview on 1/9/26 at 12:53 p.m. with the Director of Nursing (DON), the DON stated, I expect licensed nurses to notify pharmacy of new prescribed medication dose and frequency and put a sticker on medication bottles and blister pack. The DON stated licensed nurses should be comparing prescribed medication orders in the EMAR and the medication bottle or blister pack available to avoid medication error. The DON stated, Medication error could result in harm to residents, and we do not want that to happen. During a review of facility's policy and procedure (P&P) titled, Medications and Medication Labels, dated 5/16, the P&P indicated, .a. If the prescriber's directions for use change of the label is inaccurate, the nurse may place a direction change, change of order-check chart or similar label on the container indicating there is a change in directions for use, taking care not to cover important label information. b. When such a direction change label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the prescriber's order for current information. 7. If directions for use change, the provider pharmacy is informed prior to next refill of the prescription so the new container will show an accurate label .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 1Based on interview and record review, the facility failed to ensure Minimum Data Set Assessment (MDS-assessment of physical and psychological function needs) accurately reflected resident's health and function for one of four sampled residents (Resident 21) when Resident 21's use of lorazepam (medication uses for anxiety) was inaccurately coded in the MDS assessment dated [DATE].This failure had the potential to result in Resident 21's care needs not being met and the potential risk for adverse medication reactions not be monitored. During a review of Resident 21's admission Record [AR- a document with personal identification and medical information], dated 1/8/26, the AR indicated Resident 21 was re-admitted to the facility on [DATE] with diagnoses which included anxiety (feeling of worry, fear or unease, often triggered by stress, that helps cope with challenges by creating focus and energy), depression (persistent sadness, loss of interest, and changes in sleep, appetite and energy) and mood disorder (persistent emotional state, causing extreme sadness or highs often with swings between them, significantly disrupting daily life, functioning, and relationship). During a review of Resident 21's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/15/25, the MDS indicated a Brief Interview for Mental Status (BIMS- an assessment of cognitive function) score of 14 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 21 had no cognitive impairment. During a concurrent interview and record review on 1/9/26 at 8:38 a.m. with Minimum Data Set Nurse (MDSN), the MDSN reviewed Resident 21's MDS assessment dated [DATE] Section N (Medications). The MDSN stated Resident 21 was taking medications for anxiety but Section N was not marked. The MDSN stated she did not code Resident 21 was taking medication for anxiety and she should have marked Section N. The MDSN stated it was her responsibility to ensure MDS assessment was accurate. The MDSN stated, I have to make sure I captured the right data because we utilize the data for payments and has to be done the right way. During an interview on1/9/26 at 1:25 p.m. with the Director of Nursing (DON), the DON stated her expectation regarding MDS assessment was To ensure assessments are accurate to ensure the right care was provided to residents to move on to the next level. The DON stated each staff member completing an MDS assessments are responsible for ensuring accuracy of their own assessments. During an interview on 1/9/26 at 1:55 p.m. with the Administrator (ADM), the ADM stated her expectation was for MDS assessment to be accurate and data to be transmitted to Centers for Medicare and Medicaid Services (CMS-federal agency that runs Medicare, Medicaid, and the Children's Health Insurance Program) on time. The ADM stated each staff member completing the MDS assessment are responsible for ensuring the accuracy of their own assessments. During a review of facility's policy and procedure (P&P) titled Resident Assessment-RAI dated 2025, the P&P indicated, The facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences .The assessment will include at least the following: .Disease diagnosis and health conditions . Medications . During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 10/24, indicated, .Identify Diagnoses: The disease conditions in this section require a physician-documented diagnosis . in the last 60 days . Check the following information sources in the medical record for the last 7 [seven] days to identify active diagnoses: transfer documents, physician progress notes, recent history . medication sheets, doctor's orders .		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 2Based on interview and record review, the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASARR-a federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not appropriately placed in a nursing home) were completed and the state mental health authority or stated intellectual disability authority was notified promptly after a significant change of condition for two of four sampled residents (Resident 21 and Resident 46).This failure had a potential risk for Resident 21 and Resident 46 not to have received the appropriate services related to their mental health needs. During a review of Resident 21's admission Record [AR- a document containing resident profile information], dated 1/8/26, the AR indicated Resident 21 was readmitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest, and changes in sleep, appetite, and energy), anxiety (persistent, excessive, and uncontrolled worry or fear about everyday situations) and heart failure. During a review of Resident 21's Order Summary Report[OSR], dated 1/9/26, The OSR indicated, .Duloxetine HCl [hydrochloride] [used to treat depression] Oral Capsule Delayed Release Sprinkle 30 MG[milligram-unit of measurement] . Order Date: 12/06/25, Start Date: 12/06/25 . Lorazepam [used to treat anxiety] Oral Tablet 0.5 MG . Start Date: 12/13/25, Start Date 12/14/25 . Mirtazapine [used to treat depression] Oral tablet 15 MG . Start Date: 1/9/26, Start Date: 1/9/26 . During a review of Resident 21's PASARR Level I screening Report, dated 9/12/23, the PASARR level I indicated, .Negative Level I Screening Indicates a Level II Mental Health Evaluation is Not Required . During a review of Resident 46's AR dated 1/8/26, the AR indicated Resident 46 was admitted to the facility with diagnoses which included depression, Alzheimer's disease (disease characterized by a progressive decline in mental abilities) and dementia (progressive decline in mental abilities). During a review of Resident 46's OSR, dated 1/9/26, the OSR indicated , .Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 1 [one] tablet by mouth in the evening . Start Date: 1/12/25, Start Date: 1/12/25 . During a concurrent interview and record review on 1/9/26 at 8:50 a.m. with Minimum Data Set Nurse (MDSN), the MDSN stated she started working at the facility in 10/2025 and she was responsible in reviewing PASARR screening for residents. The MDSN stated PASARR screening are completed for new admission, readmission, and when there was a change in condition, including the initiation of psychotropic medication. The MDSN reviewed Resident 21's PASARR level I dated 9/12/23 and stated, at the time of admission, Resident 21 did not have diagnosis of mental disorder, such as depression, and was not prescribed any psychotropic medication. Resident 21 was re-admitted to the facility on [DATE] and was prescribed lorazepam on 12/13/25, mirtazapine 1/9/26 and duloxetine 12/06/25. The MDSN stated a new PASARR level I screening should have been completed following Resident 21's readmission and initiation pf psychotropic medications, but the record revealed no evidence a PASSAR Level I screening was completed. During a concurrent interview and record review on 1/9/26 at 9:05 a.m. with MDSN, the MDSN reviewed Resident 46's PASARR level 1 dated 9/29/23. The MDSN stated Resident 46 was diagnosed with major depression on 12/5/23. The MDSN stated a new PASARR level I screening should have been completed following this diagnosis but there was no evidence in the record that a PASARR level I screening was completed. The MDSN stated Resident 46 started on mirtazapine on 1/12/25 and a new PASARR level I screening should have been completed but there was none. The MDSN stated she did not remember completing any PASARR level I screening since she started working in the facility. During an interview on 1/9/26 at 1:20 p.m. with the Director of Nursing (DON), the DON stated PASARR Level I screening are completed at the acute hospital and sent to the facility as part of resident's record. The DON stated her expectation was to make sure all residents who require a PASARR Level I screening have an updated assessment completed. The DON stated she will be working with the MDSN and other licensed nurses to ensure PASARR level 1 screening are (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed when a change in a resident's condition occurred. During an interview on 1/9/26 at 2:10 p.m. with the Administrator (ADM), the ADM stated PASARR Level I are completed in the acute hospital and are sent to the facility upon resident's admission. The ADM stated the admission coordinator made sure a PASARR Level I screening was completed prior to resident admission to the facility. During a review of facility's policy and procedure (P&P) titled, Resident Assessment-Coordination with PASARR Program, revised dated 12/16/25, the P&P indicated, .All applicants to this facility will be screened for serious mental disorder s or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . Any residents who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Example include: a. A resident who exhibit s behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR .		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure a nurse staffing data was posted in a visible location for residents, families, and visitors. This failure did not allow the residents and their families to access important information about the facility staffing levels, which could affect their ability to make informed decisions about safety and quality of care provided. During a concurrent observation and record review on 1-8-26 at 12:30 p.m., with the facility's administrator (ADM), outside of the business office, the nurse staffing data was not displayed. The ADM stated that the nurse staffing data belongs in the empty clear folder that is taped to the outside of the window. The business office is to place the nurse staffing data for the day inside the clear plastic folder so that it is visible for residents and visitors to see as they first enter the facility. The ADM stated there was no reason for the nurse staffing not to be posted. During a review of the facility's policy and procedure titled, Nurse Staffing Posting Information, dated 12/18/25, indicated, . nurse staffing readily available in a readable format to residents, staff and visitors at any given time. the nurse staffing sheet will be posted on a daily basis . at the beginning of each shift .		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Number of residents sampled: 6Number of residents cited: 2 Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured appropriate administration of medications to meet residents needs for two of six sampled residents (Resident 46 and Resident 5) when Resident 46's psychotropic (medications that alter brain chemistry to affect mood, thoughts, and behavior) medication brexpiprazole (used to treat Alzheimer's Disease-a disease characterized by a progressive decline in mental abilities) and Resident 5's inhaler (a small, handheld medical device that delivers medicine as a mist or spray directly to the lungs for treating respiratory conditions like asthma) medication fluticasone propionate/salmeterol (used for treatment of breathing problems in patients with asthma) were not available to administer on 1/7/25. These failures resulted in Resident 46 and Resident 5 not receiving their routine medications, which could have led to serious health conditions. During a concurrent observation and interview on 1/7/26 at 8:17 a.m. with Licensed Vocational Nurse (LLVN)1 outside Resident 46's room, LVN 1 prepared Resident 46's medications. LVN 1 stated Resident 46's brexpiprazole medication was not available for administration. Resident 46 was observed sitting in her wheelchair inside her room next to her bed. Resident 46 was alert, verbally responsive, and appropriately dressed. During a review of Resident 46's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated Resident 46 was admitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest, and changes in sleep, appetite, and energy that interfere with daily life), Alzheimer's Disease and dementia (a progressive state of decline in mental abilities). During a review of Resident 46's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 11/15/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 4 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 46 had severe cognitive impairment. During a review of Resident 46's Electronic Medication Administration Record (EMAR-an electronic daily documentation record used by licensed nurse to document medications and treatments given to a resident), dated 12/2025. The EMAR indicated, . Brexpiprazole Oral tablet 0.5 MG [milligram-unit of measurement] (Brexipiprazole) Give one (1) tablet by mouth in the morning . Start Date 12/07/25 . During a concurrent observation and interview on 1/7/26 at 8:21 a.m. with LVN 1, outside of Resident 5's room. LVN 1 prepared Resident 5's medication. LVN 1 stated Resident 5's routine inhaler was not available for administration. Resident 5 was observed lying in bed with the head of the bed elevated and working on her crosswords puzzles. Resident 5 looked up when LVN 1 touched her shoulder. LVN 1 stated Resident 5 was hard of hearing and communication required writing on a white board. During a review of Resident 5's admission Record, dated 1/8/26, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included asthma (narrowing of the small airways in the lungs making it hard to breath), shortness of breath and constipation (infrequent bowel movements and stools are hard, dry, lumpy, and difficult or painful to pass). During a review of Resident 5's EMAR dated 1/2026, the EMAR indicated, . [brand name] HFA [hydrofluoroalkane-non-ozone-depleting chemicals used as propellants in aerosol inhalant] 115-21 MCG/ACT [micrograms/actuation] (Fluticasone-Salmeterol) one (1) puff orally one time a day related to COUGH VARIANT ASTHMA . rinse mouth with water and spit back into cup after use Start Date 08/08/2025 . During an interview on 1/7/26 at 2:38 p.m. with LVN 1, LVN 1 stated it was the responsibility of all nurses to ensure routine medications were available for administration to residents. LVN 1 stated she checked the medication room and the medication cart for Resident 5's inhaler, but it was not available, so she faxed pharmacy to send the medication. LVN 1 stated Resident 46's medication was not available to administer because, according to the pharmacy, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was still being processed. LVN 1 stated she did not remember notifying the physician Resident 46's prescribed medication was unavailable since it was ordered. LVN 1 stated she was not sure when the psychotropic medication had been ordered. During an interview on 1/8/26 at 10:08 a.m. with LVN 2, LVN 2 stated all licensed nurses are responsible for ordering medication refills. LVN 2 stated medication refills are faxed to pharmacy when medication supplies is less than a week and staff follow up with the pharmacy as needed. LVN 2 stated all routine medications should be available for administration to residents to ensure no doses are missed, which could result in residents becoming seriously ill. During an interview on 1/8/26 at 10:15 a.m. with LVN 3, LVN 3 stated Nurses are responsible for ensuring routine medications are available to administer to residents. LVN 3 stated medications are ordered from pharmacy when supplies are running low to prevent residents from missing doses. LVN 3 stated residents needs their medications, and if not administered, it could affect their health making residents sicker. During an interview on 1/9/26 at 1:05 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the licensed nurses to ensure routine medications are available to administer to residents. The DON stated licensed nurses should call pharmacy for new medications and to ensure all medications are available. The DON stated missed doses could negatively affect a residents health, and depending on the medications, it could result in diminished breathing, uncontrolled pain, or worsening of mental health conditions . During a review of facility's document titled, Charge Nurse Job Description, dated 2023, the Job Description indicated, .Ensures that policies and procedures are complied with by nursing personnel assigned . Prepares and administers medications as per physicians' orders and observed for adverse effects . Ensures that there is adequate stock of medications, supplies, equipment and notifies appropriate personnel of needs . During a review of facility's policy and procedure (P&P) titled, Medication Orders Non-Controlled Medication Orders, dated 12/12, the P&P indicated, .The prescriber should be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available . Non-emergency medication orders: The first dose of medication is scheduled to be given after the next regularly scheduled pharmacy delivery to the nursing care center . During a review of facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy Provider Ordering and Receiving Non-Controlled Medications, dated 1/20, the P&P indicated, . all medications shall be reordered in advance by writing in the medication name and prescription number or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. All medication order, changes or discontinuation must be communicated to the pharmacy, timely . Timely delivery of new orders is required so that medication order is not delayed . A medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, discontinuation, etc, of new medications .		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 1Based on observation, interview, and record review, the facility failed to ensure food preferences were accommodated for one of four sampled residents (Resident 16) when Resident 16's standing physician order for strawberry shake was not served to Resident 16 during lunch on 9/30/25. This failure had the potential risk to result in Resident 16 not meeting nutritional needs, which could lead to unplanned weight loss. During a concurrent interview and record review on 9/30/25 at 12:20 p.m. in the dining room, Resident 16 was sitting in her wheelchair with her lunch tray positioned in front of her. Resident 16's lunch tray did not include a strawberry health shake. Certified Nursing Assistant (CNA) 1, was observed seated next to Resident 16 and assisting with lunch. CNA 1 stated Resident 16 needed assistance with meals to ensure adequate intake and prevent weight loss. CNA 1 reviewed Resident 16's meal ticket and stated, There should be a milk shake with her meal tray. CNA 1 stated she was not sure why Resident 16 had an order for milk shake. CNA 1 stated, Health shakes are ordered for residents experiencing weight loss. CNA 1 stated Resident 16 could experience further weight loss when the ordered health shake was not given as ordered by the physician. During a review of Resident 16's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (complete paralysis) and hemiparesis (weakness or partial paralysis) and muscle weakness. During a review of Resident 14's meal ticket, dated 9/30/25, the meal ticket indicated, .Diet Order: National Dysphagia 2 (Mechanical Soft), Regular, -Fluids-Regular (Thin) Liquids . Standing Orders: >four [4] ounces [oz- unit of measurement] carton Ready Care Strawberry Shake . During an interview on 1/8/26 at 1:43 p.m. with CNA 2, CNA 2 stated during mealtimes in the dining room, certified nursing assistants ensure residents' hands are cleaned and residents" are ready for lunch. CNA 2 stated fluids, including water and juices, are provided to residents. CNA 2 stated once the meal cart was brought in the dining room, licensed nurses checked the meal trays, and CNAs then deliver the food tray to residents. CNA 2 stated, We are supposed to compare the food with the meal ticket to ensure the food matches the meal ticket order. CNA 2 stated nutritional supplements, such as health shakes, are ordered for residents with poor appetite and experiencing weight loss. CNA 2 stated, We have to make sure residents received the health shake as ordered to prevent weight loss. During an interview on 1/8/26 at 1:10 p.m. with the Dietary Supervisor (DS), the DS stated she has worked at the facility as the DS for four years. The DS stated she maintains a list of residents with orders for milk shake. The DS stated milk shakes are labeled with resident names. The DS stated, We placed all the health shakes in a tray and pushed in the dining room before meals, The DS stated CNAs are responsible for ensuring residents' received their milkshakes The DS stated health shakes are ordered for residents experiencing weight loss and to support wound healing. The DS stated residents with milk shake orders could experience weight loss and delayed wound healing if the milkshakes are not provided to residents as ordered. During an interview on 1/9/26 at 1:14 p.m. with the Director of Nursing (DON), the DON stated, I expect residents with orders for health shakes be served as ordered. The DON stated health shakes have extra nutrients and are ordered for residents experiencing weight loss. The DON stated residents may experience weight loss if they do not serve health shakes as ordered. The DON stated, We want to prevent any further weight loss for all residents. The DON stated nursing staff should ensure to check and compare the meal trays and the meal ticket when serving residents and communicating with the dietary staff any missing items in the meal tray.During a review of facility's document titled, Certified Nursing Assistant Job Description, dated 2023, the Job Description indicated, .Coordinates dining room services at assigned meal times, including se-up and clean-up, meal tray delivery, feeding assistance, and documentation of meal intake. Delivers (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutritional supplements to residents at assigned times and provides assistance as necessary to ensure intake . During review of facility's policy and procedure (P&P) titled, Resident Food Preferences, revised 7/17, the P&P indicated, .The dietician and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations . The dietitian will discuss with the resident or representative the rationale of any prescribed diet .The food service department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks .		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 2Based on observation, interview, and record review, the facility failed to ensure adaptive equipment was provided for two of four sampled residents (Resident 14 and Resident 16) when:1.During a meal observation in the dining room on 9/30/25, Rehabilitative Nursing Assistant (RNA) used plastic straws instead of spoon for Resident 14's liquids.This failure had the potential for Resident 14 to aspirate while drinking fluids.2.Resident 16 was not provided sippy cup on her meal tray during lunch on 9/30/25. This failure had the potential to limit Resident 16's ability to drink independently and safely. 1.During a concurrent observation and interview on 9/30/25 at 12:12 p.m. in the dining room, Resident 14 was observed seated in a geriatric chair (large, padded, reclining room with wheels, designed for individuals with limited mobility, offering comfort and support for relaxing, dining or medical procedures) assisted by RNA with his meals. Resident 14's drinks of water and juice was thickened, and plastic straws was placed in each drink. Resident 14's meal ticket indicated, Liquids by spoon no straws. RNA stated it was her first time to assisting Resident 14 and she did not know not to use a straw for Resident 14's drinks. RNA stated she should have read Resident 14's meal ticket and followed the instruction not to use a straw. RNA stated Resident 14 could aspirate from using a strawReview of Resident 14's meal ticket indicated, Notes: 1:1 Feeder Liquids by spoon no straws.Review of Resident 14's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated, Resident 14 was admitted to the facility on [DATE] with diagnoses which included dehydration (body uses or loses more fluids than it takes in), dementia (a progressive state of decline in mental abilities) and adult failure to thrive (gradual and unexplained decline in older adult's physical and mental health marked by symptoms like poor appetite and weight loss).During an interview on 1/9/26 at 1:20 p.m. with Dietary Supervisor (DS), the DS stated use of straws was not recommended for residents who are at high risk of aspiration. The DS stated residents who are ordered to not use straws are unable to safely suck fluids through them. The DS stated, Using a straw could cause residents to aspirate. 2.During a concurrent observation and interview on 9/30/25 at 12:20 in the dining room, Resident 16 was observed sitting in a wheelchair assisted by Certified Nursing Assistant (CNA) 1 with her meals. Resident 16's drinks were in a regular cups without handles. CNA 1 stated, I thought she only used sippy cup when in bed. CNA 1 reviewed Resident 16's meal ticket and stated the order should have been followed and placed all of Resident's 16's fluids in a sippy cup. CNA 1 stated not providing Resident 16 with a sippy cup for her drinks could affect her ability to drink independently and safely. Review of Resident 16's meal ticket indicated, Adap [Adaptive] Equip [Equipment]: Sippy Cup During a review of Resident 16's admission Record [AR-a document containing resident profile information], dated 1/8/26, the AR indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (complete paralysis) and hemiparesis (weakness or partial paralysis) and muscle weakness. During an interview on 1/8/26 at 1:15 p.m. with DS, The DS stated dietary staff placed all the sippy cups in the dining room prior to each meals. The DS stated the CNAs in the dining room are responsible in ensuring residents with orders for sippy are provided with a sippy cup. The DS stated sippy cups are ordered for residents because they are easier to hold and allow residents to drink independently. The DS stated they have enough sippy cups for residents who needed them. During an interview on 1/8/26 1:55 p.m. with CNA 2, CNA 2 stated she helps in the dining room to ensure residents are ready for their meals and provide assistance to residents during meals. CNA 2 stated sippy cups are provided to residents with orders to use them with their drinks. CNA 2 stated sippy cups makes it easier for residents to hold and drink independently. CNA 2 stated regular cups do not have handles and residents could spill their drinks on themselves and not drink at all. CNA 2 stated meal trays do not include straws, the staff assisting (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents picked up the straws if needed. CNA 2 stated staff must read the meal ticket and follow the orders. CNA 2 stated using a straw on resident when the meal ticket indicated not to use a straw could result in resident choking and aspirating fluid. During an interview on 1/9/26 at 1:35 p.m, with the Director of Nursing (DON), the DON stated, Depending on the reason for the order, it can be detrimental to the resident. The DON stated sippy cups are important because it help residents hold the cup with better control and prevent from drinking too fast or too much, which could lead to aspiration. The DON stated her expectation was for nursing staff to ensure they are checking meal trays and comparing meal tickets. The DON stated nursing staff are expected to ensure any adaptive equipment ordered for residents are provided and to follow meal ticket directions. During a review of facility's policy and procedure (P&P) titled, Adaptive Feeding Equipment, dated 12/18/25, the P&P indicated, Residents requiring assistance in feeding are potential candidates for a restorative dining program pr adaptive utensil use, as determined by the occupational therapist . The resident may, depending on the rehabilitative potential . train in the use of adaptive feeding equipment . The dietary department should be notified of residents needing adaptive feeding equipment . Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization .		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview during the survey period from 9/30/25 through 1/9/26, the facility failed to ensure each bedroom accommodated no more than four residents (rooms [ROOM NUMBERS]). This failure had the potential to adversely affect care provided to residents in room [ROOM NUMBER] and 14. During an observation on 9/30/25 through 1/9/26, in room [ROOM NUMBER] and 14, the two resident bedrooms had more than four residents. Each room met the required needs of the residents, as well as the square footage. Closet and storage space were adequate. Bedside stands were available. There were sufficient room for nursing care to be provided to the residents. Wheelchair and toilet facilities were accessible. The health and safety of residents would not be adversely affected by the continuance of this waiver. Room Number Number of Beds Square footage 4 8 735.19 14 8 732.52 Recommend waiver continue in effect.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review during the survey period of 9/30/25 to 1/9/2026, the facility failed to provide the minimum of at least 80 square feet per resident in multiple rooms (Rooms 1, 6, 8, 10, 11 and 16). This failure had the potential for residents not to have reasonable accommodations for privacy or adequate space for care to be rendered. During a concurrent observation and interview on 1/9/25, at 12:47 P.m., with the Maintenance Supervisor (MS), an environmental tour was conducted. The MS measured six rooms and stated the rooms did not meet the minimum square footage of 80 square feet per resident. These rooms were as follows: Room Number: Square Feet: Number of Residents room [ROOM NUMBER] 145.96 2 bedroom [ROOM NUMBER] 312.0 4 bedroom [ROOM NUMBER] 159.17 2 bedroom [ROOM NUMBER] 147.17 2 bedroom [ROOM NUMBER] 147.25 2 bedroom [ROOM NUMBER] 300.9 4 beds During the observations made on 9/30/25 to 1/9/26, the residents had reasonable amount of privacy. Closets and storage space were adequate, bedside stands were available. There was sufficient room for nursing to provide care and for residents to ambulate. Toilet facilities and wheelchairs were accessible. The waiver will not adversely affect the health and safety of residents. Recommend waiver continue in effect.		