STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055799	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Care Center	1090 East Dinuba Avenue Reedley, CA 93654

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Responsible Party (RP-a resident representative who assists with care decisions) was notified of a change in condition for one of four sampled residents (Resident 1) when Resident 1 had bleeding from his mouth on 12/26/25 and the nurse did not notify the RP of the residents change in condition.This failure resulted in Resident 1's rights being violated when his RP was not notified of the resident's change in condition on 12/26/25.During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included muscle wasting (reduction of muscle tissue caused by inactivity or chronic diseases), dementia (progressive state of decline in mental abilities), malignant neoplasm (cancerous tumor) of prostate (gland in the male reproductive system below the bladder), malignant neoplasm of sigmoid colon (final, S-shaped section of the large intestine) and posthemorrhagic anemia (condition that develops when there is rapid, significant blood loss).During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 03 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had a significant cognitive impairment.During a concurrent interview and record review on 4/1/26 at 12:27 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's Change in Condition Evaluation, dated 12/26/25 indicated, . Resident noted with bleeding from the right side of the tongue due to self biting. New orders received to continue monitoring oral cavity bleeding, swelling, pain, or signs of infection and report any changed to MD [medical doctor]. Resident Representative Notification. Responsible party unknown. Date and time of family/resident representative notification. 12/26/25 15:20 [3:20 p.m.]. LVN 2 stated Resident 1's mouth bleeding was a change in condition and the RP should have been notified. LVN 2 stated the note indicated Resident 1's RP was unknown, but the licensed nurse (LN) had documented a date and time of notification. LVN 2 stated Resident 1 may have been notified at the time but had dementia and was unable to make medical decisions for himself, so it was important to also notify his RP. LVN 2 pulled up Resident 1's contact list in the electronic medical record (EMR) and stated Resident 1's RP had been the same throughout his stay. LVN 2 stated the LN would have been able to access the RP's information easily and she was not sure why the LN had documented the RP was unknown.During an interview on 4/1/26 at 1:06 p.m. with the Social Services Director (SSD), the SSD stated Resident 1 had been seeing the facility dentist. The SSD stated Resident 1's RP was involved in his care conferences and should have been notified if there was a change in condition.During an interview on 4/1/26 at 1:46 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1's RP needed to be notified for any change in conditions. The DSD stated if the LN was unable to contact the RP, they needed to document it in the EMR and ask the next shift to follow up. The DSD stated Resident 1's RP contact information was easily available in his EMR. The DSD stated Resident 1's (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding in the mouth was a change in condition and the RP should have been called.During an interview on 4/1/26 at 2:15 p.m. with the Administrator (ADM), the ADM stated RPs should be notified right away when there was a change in condition, if a resident was sent to the hospital or had weight loss.During a review of the facility's policy and procedure (P&P) titled Notification of Changes, dated 9/2/2022, the P&P indicated, . The purpose of this policy is to ensure the facility promptly informs the resident. the resident's representative when there is a change requiring notification. facility must inform the resident, consult with the resident's physician and/or notify the resident's family member. when there is a change requiring such notification. Circumstances requiring notification include. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health. may include. Clinical complications. Residents incapable of making decisions. the representative would make any decisions that have to be made. resident should still be told what is happening to him or her.During a review of the facility's P&P titled Resident Rights, dated 9/22/2022, the P&P indicated, . resident has the right to be informed of, and participate in, his or her treatment. right to be informed, in advance, of changes to the plan of care.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nurses (LN) administered medications in accordance with professional standards of practice for one of four sampled residents (Resident 2), when Resident 2's morning medications were left at the bedside unattended by nursing staff and not administered timely as prescribed by the physician on 4/1/26.This failure resulted in Resident 2 not receiving the medications as prescribed by the physician and placed other residents at risk for ingesting medications not prescribed to them.During a concurrent observation and interview on 4/1/26 at 11:10 a.m. with Resident 2, Resident 2 was lying in bed with his eyes closed, but responded when spoken to. Resident 2's breakfast tray was on his overbed table, next to the tray was a small medicine cup with eight pills in it. There were no licensed nursing staff at bedside, and the medications were left unattended. Resident 2 stated the nurse brought his medication earlier that morning and he told her to leave them and he would take them later, so the nurse had left them at bedside. Resident 2 was unaware of what the medications were prescribed for.During a review of Resident 2's admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included muscle wasting (reduction of muscle tissue caused by inactivity or chronic diseases), muscle weakness, abnormalities of gait (manner of walking) and mobility (ability to move around independently), recurrent pneumonia (infection that inflames the air sacs in one or both lungs making it difficult to breathe) and human immunodeficiency virus (HIV-a virus that attacks the body's immune system making it harder to fight infections) disease.During a review of Residents 2's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 10 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 had moderate cognitive impairment.During a concurrent observation and interview on 4/1/26 at 11:15 a.m. with the Director of Staff Development (DSD), at Resident 2's bedside, a medicine cup was observed on the overbed table. The DSD picked up the medicine cup and inside the cup there were eight pills: two large white tablets, one smaller white tablet, one small yellow tablet, one pinkish round tablet, one yellow capsule, one dark tablet and one reddish-orange tablet. The DSD stated medication should never be left unattended at bedside because the nurse needed to ensure the resident took the medications as prescribed and to prevent other residents from taking medication not prescribed to them. The DSD stated if the resident declined to take medication at the time the nurse administered them, the nurse should take the medications with them and not leave it in the resident's room.During a concurrent interview and record review on 4/1/26 at 11:18 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she had left Resident 2's morning medications with him at bedside. Resident 2's MAR dated 4/2026 was reviewed, the MAR indicated, . Ascorbic Acid Tablet [vitamin C-nutrition supplement] . 1 tablet by mouth one time a day. 0800 [8:00 a.m.] . ferrous sulfate [iron supplement] . 1 tablet by mouth one time a day. 0800. folic acid [vitamin supplement] . 1 tablet by mouth one time a day . 0800. Multiple vitamin [supplement] . 1 tablet by mouth one time a day. 0800 . sulfamethoxazole-trimethoprim [an antibiotic used to treat bacterial infections including pneumocystis pneumonia] . 1 tablet by mouth one time a day for PCP [pneumocystis pneumonia (rare, serious lung infection caused by a fungus most commonly in people with a weakened immune system)] prophylaxis [treatment to prevent disease] . 0800. Vitamin A [supplement] . 1 capsule by mouth one time a day. 0800 . vitamin B-12 [supplement]. 1 tablet by mouth one time a day. 0800. Zinc Oral Capsule [supplement] . 1 capsule by mouth one time a day. 0800. LVN 1 stated she had prepared Resident 2's 8:00 a.m. medications and left the medications on the resident's overbed table at approximately 9:00 a.m. because the resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told her he would take them later. LVN 1 stated she should have followed up later to make sure Resident 2 had taken his medication. LVN 1 stated Resident 2 was on an antibiotic for PCP prophylaxis, and it was important for him to take the medication timely to prevent infection. LVN 1 stated medications should never be left unattended at the bedside because the nurse would not know if the resident had taken the medication, if they were thrown away or if another resident had taken the medication in error. LVN 1 stated she should not have left Resident 2's medication at bedside. During an interview on 4/1/26 at 1:41 p.m. with the Nurse Consultant (NC), the NC stated medications should not be left unattended at bedside. The NC stated the resident may not take the prescribed medication or a confused resident could have taken the medication. The NC stated it was important for Resident 2 to take his antibiotic on time to decrease risk of infection.During an interview on 4/1/26 at 2:15 p.m. with the Administrator (ADM), the ADM stated medication was not supposed to be left at bedside. The ADM stated it was important for the nurse to watch the resident take the medication, otherwise the nurse would not know if the resident took his prescribed medication, or if another resident had taken it. The ADM stated medications left unattended at bedside placed confused residents at risk of taking medication not prescribed to them.During a professional reference review titled Medications, Unnecessary Drugs and Chemical Restraints, dated 6/24/2025, retrieved from https://canhr.org/nursing-home-care-standards/ the reference indicated, . Mediations Errors. Medications shall be administered as prescribed. A medication error is an instance when the facility's preparation or administration of a medication is not in accordance with . accepted professional standards and principles. It is illegal to give a medication to someone other than the resident for whom it was prescribed.During a review of the facility's Job Description. Licensed Vocational Nurse (LVN), dated 8/2025, the job description indicated, . LVN is also responsible for the delivery of medications to residents in accordance with physician's orders. Will be in compliance with federal and state laws and regulations.During a review of a professional reference titled The California Code of Regulations. S 72313. Nursing Service--Administration of Medications and Treatments, dated 3/27/2026, the reference indicated, . All medications and treatments shall be administered only by licensed medical or licensed nursing personnel. Medications shall be administered as soon as possible, but no more than two hours after doses are prepared. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. No medication shall be used for any patient other than the patient for whom it was prescribed.