STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineland Post Acute	10830 Oxnard Street North Hollywood, CA 91606

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of five sample residents (Resident 4) was free from significant medication errors by failing to:1. Ensure Resident 4's physician orders were followed. 2. Ensure licensed nurses administered Resident 4's scheduled medications on time. On 1/13/2026, Resident 4's scheduled 9 a.m. medications were administered at 11:33 a.m. (one hour and 33 minutes after the allowable administration time). 3. Ensure Resident 4 received the docusate sodium oral capsule (a medication, taken by mouth, used to soften stool) 250 milligrams (mg - unit of measurement) before the medication was documented as administered in the resident's Medication Administration Record (MAR). These deficient practices had the potential to cause Resident 4's medical condition to worsen. Findings:During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted Resident 1 on 10/23/2024 with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that blocks airflow due to damaged airways and air sacs), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]) with diabetic neuropathy (nerve damage caused by diabetes), and essential hypertension (high blood pressure that was not due to another medical condition).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 10/28/2025, the MDS indicated Resident 4's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact.During a review of Resident 4's Physician Orders, dated 10/24/2024, the Physician Orders indicated following medications:a. Bupropion hydrochloride extended-release oral tablet (a medication, taken by mouth, used to treat major depression [a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in daily activities]) 450 mg once a day for depression.b. Clopidogrel bisulfate oral tablet (a medication, taken by mouth, used to prevent blood clots that cause heart attacks and cerebrovascular accidents [CVA - the loss of blood flow to the brain]) 75 mg once a day for CVA prophylaxis.c. Docusate sodium oral capsule 250 mg once a day for bowel (the long-tube-shaped organ in the abdomen that completes the process of digestion) management.d. Jardiance oral tablet (a medication, taken by mouth, used to lower blood sugar) 25 mg once a day for type 2 diabetes mellitus.e. Losartan oral tablet (a medication, taken by mouth, used to treat high blood pressure) 50 mg once a day for hypertension.During a review of Resident 4's Physician Orders, dated 10/25/2024, the Physician Orders indicated lyrica oral capsule (a medication, taken by mouth, used to treat nerve pain) 150 mg three times a day for polyneuropathy (a condition where multiple peripheral nerves throughout the body were damaged causing weakness, numbness, tingling, and pain).During a concurrent observation and interview on 1/13/2026 at 11:25 a.m., observed Licensed Vocational Nurse (LVN) 1 prepare Resident 4's medications in front of the resident's room. LVN 1 stated Resident 4's medications were bupropion hydrochloride extended-release oral tablet 450 mg, clopidogrel bisulfate oral tablet 75 mg, jardiance oral tablet 25 mg, losartan oral tablet 50 mg, lyrica oral capsule, and docusate sodium oral capsule 250 mg. LVN 1 stated the docusate sodium oral (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555011	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineland Post Acute	10830 Oxnard Street North Hollywood, CA 91606

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	capsule 250 mg was not in the medication cart. During a concurrent observation, interview, and record review on 1/13/2026 at 11:33 a.m., observed LVN 1 gave the prepared medications to Resident 4. LVN 1 observed Resident 4 swallow the medications. LVN 1 stated the medications administered were Resident 4's scheduled 9 a.m. medications. LVN 1 stated Resident 4's systolic blood pressure (SBP - the pressure of blood against the artery wall when the heart finished contracting or pumping out blood) was high at 162. LVN 1 stated Resident 4's lyrica was scheduled three times a day and should be administered at 9 a.m., 1 p.m., and 5 p.m. LVN 1 stated Resident 4's scheduled 9 a.m. medications were administered late and had the potential to cause the resident to experience restlessness, agitation, high blood pressure, and pain. During a review of Resident 4's MAR, dated 1/1/2026 to 1/31/2026, reviewed with LVN 1, the MAR indicated that on 1/13/2026 at 9 a.m., Resident 4 received the docusate sodium oral capsule 250 mg. LVN 1 stated she had not received Resident 4's docusate sodium oral capsule 250 mg and will administer once the medication supply was received. LVN 1 stated Resident 4's docusate sodium oral capsule 250 mg should be documented as given after the medication had been administered to the resident. LVN 1 stated documenting before the medication was administered had the potential to confuse other licensed nurses that the medication had already been administered. During an interview on 1/13/2026 at 3:07 p.m. and a concurrent record review of Resident 4's MAR, dated 1/1/2026 to 1/31/2026, reviewed with the Director of Nursing (DON), the DON stated residents' medications should be administered one hour before up to one hour after the scheduled administration time. The DON stated Resident 4's MAR indicated the medications scheduled time but did not indicate the exact time the medication was administered. The DON stated the facility does not have the capability to generate a report that indicated the actual time the residents' medications were administered. The DON stated Resident 4's medications were administered late. The DON stated Resident 4's physician orders were not followed. The DON stated LVN 1 should not document the medication administration before Resident 4's medication was administered. The DON stated late medication admiration had the potential for the therapeutic purpose of the medication to not be met. The DON stated the facility failed to administer Resident 4's scheduled medications timely, failed to follow Resident 4's physician orders, and failed to follow the facility's policy on medication administration. During a review of the facility's policy and procedure (PnP) titled, Medication Administration, last reviewed on 4/16/2025, the PnP indicated medications are administered by licensed nurses. as ordered by the physician and in accordance with professional standards of practice. The PnP indicated administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. The PnP indicated sign MAR after administered.