| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555011 | A. Building<br>B. Wing | 03/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vineland Post Acute | 10830 Oxnard Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall for one of three sampled residents (Resident 1) by failing to create a care plan for the use of a tab alarm (a safety monitoring device connected to the resident's clothes and onto a bed or chair/wheelchair that alarms to notify caregivers once contact is separated). This deficient practice denied Resident 1 an outlined, personalized set of interventions for staff to implement for the specific use of the tab alarm, resulting in Resident 1 encountering a fall and requiring hospitalization for further evaluation. Cross reference F689 Findings:During a review of Resident 1's undated admission record, the admission record indicated the facility originally admitted Resident 1 on 4/10/2024 with diagnoses of metabolic encephalopathy (a brain dysfunction caused by underlying systemic illnesses causing chemical imbalances that affect the brain), Parkinsons disease (an incurable movement disorder affecting coordination and motor function), difficulty in walking, dementia (a decline in memory, language, thinking that severely interferes with daily life), and Alzheimer's disease (a progressive brain disorder affecting memory, thinking, and behavior). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 had severe impairment in cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) and was fully dependent on staff (helper does) all the effort) for toileting needs, upper & lower body dressing, and personal hygiene needs. During a review of Resident 1's Physician's order report, the order report indicated on 2/18/2026, at an undocumented time, the physician ordered to use a tab alarm for Resident 1.During a review of Resident 1's Fall Risk assessment dated [DATE] at 8:15 p.m., Resident 1 was assessed and identified to be at risk for falls. During a review of Resident 1's Physician's Orders dated 2/26/2026 at 9:22 a.m., the order indicated to transfer Resident 1 to a higher level of care for further evaluation at the General Acute Care Hospital 1 (GACH 1).During an interview with Certified Nurse Assistant 1 (CNA 1) on 3/18/2026 at 2:57 p.m., CNA 1 stated Resident 1 was not alert, and was fully dependent on staff and required two people to assist with transfers from the bed to the wheelchair and from the wheelchair back to bed. CNA 1 stated Resident 1 has an alarm to alert the staff. Whenever Resident 1 moves the alarm makes a beeping alarm sound. CNA 1 indicated the tab alarm also has a magnet. If the magnet moves, the tab alarm would also make noise. CNA 1 indicated the same tab alarm is used for Resident 1 while in the bed or while in the wheelchair. CNA 1 stated Resident 1 had a fall on 2/25/2026 at approximately 5:45 p.m. to 6 p.m. CNA 1 stated when Resident 1's family member asked about providing personal hygiene care for Resident 1, CNA1 didn't have the hamper, or towels and wipes. CNA 1 stated, The alarm was on the bed, but it was not connected to the resident. CNA 1 stated Resident 1 was in the wheelchair when CNA 1 left to get the supplies, and the tab alarm was on the bed. CNA 1 indicated the tab alarm's magnet was still connected to the alarm. CNA 1 stated, That is why it didn't sound. I remember the alarm was on her (Resident 1) before 5 p.m., or 4:30 p.m. The staff are responsible for the safety of the residents. If I heard the alarm, I would run to see the resident. It could have prevented the fall. That is why we have to go soon to see once the alarm goes off. At that time, there was no alarm and no one heard the (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: 555011 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/18/2026 |
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| NAME OF PROVIDER OR SUPPLIER Vineland Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 10830 Oxnard Street North Hollywood, CA 91606 | |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | alarm.During a concurrent interview and record review of Resident 1's Interdisciplinary Care Conference (IDT- a collaborative gathering of healthcare professionals such as doctors, nurses, and social workers) notes with Licensed Vocational Nurse 1 (LVN 1) on 3/18/2026 at 3:15 p.m., LVN 1 stated, Resident 1's IDT, dated 3/2/2026 at 12:40 p.m., indicated on 2/25/2026, Resident 1 slid off the wheelchair onto the floor. (CNA 1) stepped out of the room to gather supplies for resident (Resident 1) and left the resident with a family member. The IDT indicated Resident 1's family member walked out of the room with the tab alarm off. Once CNA 1 returned to the room, Resident 1 was lying on the floor. Resident 1 was assessed and reported left elbow pain. LVN 1 stated, We cannot definitively identify who removed the alarm. The failure in the system was not educating staff on the use of the tab alarm, lack of knowledge on the family's part, and not implementing the use of the alarm correctly.During a record review on 3/18/2026 at 3:28 p.m., Resident 1's comprehensive care plan records were reviewed. There was no specific care plan for the use of a tab alarm identified. During an interview with LVN 1 on 3/18/2026 at 4:03 p.m., LVN 1 stated that care plans are important, because it provides instructions for individualized, resident focused care. LVN 1 stated, for Resident 1, there was no care plan for the use of the tab alarm. The tab alarm was ordered on 2/18/2026. LVN 1 stated, the failure was that there was no care plan created for use of the tab alarm and there were no interventions in place for the nurses to follow. LVN 1 stated, ultimately, the tab alarm was off, and the resident (Resident 1) was found on the floor.During a review of the facility's policy and procedure titled Resident Alarms last revised on 12/19/2022, the policy stated, It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, psychosocial well-being. The P & P also indicated for (6) Monitoring and modification: a. Supervision shall be provided to the residents in accordance with the residents' plan of care. b. When alarms are utilized, additional monitoring shall be provided, including but not limited to: i. Verifying alarms are used in accordance with the resident's care plan. ii. Verifying alarms are working properly. iii. Monitoring adverse consequences associated with the use of alarms, including psychosocial concerns. During a review of the facility provided policy and procedure titled Comprehensive Care Plans last revised on 12/19/2022, the policy stated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. |

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| | 555011 | A. Building<br>B. Wing | 03/18/2026 |

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| Vineland Post Acute | 10830 Oxnard Street<br>North Hollywood, CA 91606 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall for one of three sampled residents (Resident 1) by failing to: 1). Develop a care plan for the use of a tab alarm (a safety monitoring device connected to the resident's clothes and onto a bed or chair/wheelchair that alarms to notify caregivers once contact is separated). 2). Implement the use of a tab alarm correctly as ordered. These deficient practices resulted in Resident 1 encountering a fall and sustaining an acute fracture which required hospitalization for further evaluation. Cross reference F656Findings:During a review of Resident 1's undated admission record, the admission record indicated the facility originally admitted Resident 1 on 4/10/2024 with diagnoses of metabolic encephalopathy (a brain dysfunction caused by underlying systemic illnesses causing chemical imbalances that affect the brain), Parkinsons disease (an incurable movement disorder affecting coordination and motor function), difficulty in walking, dementia (a decline in memory, language, thinking that severely interferes with daily life), and Alzheimer's disease (a progressive brain disorder affecting memory, thinking, and behavior). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1 had severe impairment in cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) and was fully dependent on staff (helper does) all the effort) for toileting needs, upper & lower body dressing, and personal hygiene needs. During a review of Resident 1's Physician's order report, the order report indicated on 2/18/2026, at an undocumented time, the physician ordered to use a tab alarm for Resident 1.During a review of Resident 1's Fall Risk assessment dated [DATE] at 8:15 p.m., Resident 1 was assessed and identified to be at risk for falls. During a review of Resident 1's Physician's Orders dated 2/26/2026 at 9:22 a.m., the order indicated to transfer Resident 1 to a higher level of care for further evaluation at the General Acute Care Hospital 1 (GACH 1).During an interview with Certified Nurse Assistant 1 (CNA 1) on 3/18/2026 at 2:57 p.m., CNA 1 stated Resident 1 was not alert, and was fully dependent on staff and required two people to assist with transfers from the bed to the wheelchair and from the wheelchair back to bed. CNA 1 stated Resident 1 has an alarm to alert the staff. Whenever Resident 1 moves the alarm makes a beeping alarm sound. CNA 1 indicated the tab alarm also has a magnet. If the magnet moves, the tab alarm would also make noise. CNA 1 indicated the same tab alarm is used for Resident 1 while in the bed or while in the wheelchair. CNA 1 stated Resident 1 had a fall on 2/25/2026 at approximately 5:45 p.m. to 6 p.m. CNA 1 stated when Resident 1's family member asked about providing personal hygiene care for Resident 1, CNA1 didn't have the hamper, or towels and wipes. CNA 1 stated, The alarm was on the bed, but it was not connected to the resident. CNA 1 stated Resident 1 was in the wheelchair when CNA 1 left to get the supplies, and the tab alarm was on the bed. CNA 1 indicated the tab alarm's magnet was still connected to the alarm. CNA 1 stated, That is why it didn't sound. I remember the alarm was on her (Resident 1) before 5 p.m., or 4:30 p.m. The staff are responsible for the safety of the residents. If I heard the alarm, I would run to see the resident. It could have prevented the fall. That is why we have to go soon to see once the alarm goes off. At that time, there was no alarm and no one heard the alarm.During a concurrent interview and record review of Resident 1's Interdisciplinary Care Conference (IDT- a collaborative gathering of healthcare professionals such as doctors, nurses, and social workers) notes with Licensed Vocational Nurse 1 (LVN 1) on 3/18/2026 at 3:15 p.m., LVN 1 stated, Resident 1's IDT, dated 3/2/2026 at 12:40 p.m., indicated on 2/25/2026, Resident 1 slid off the wheelchair onto the floor. (CNA 1) stepped out of the room to gather supplies for resident (Resident 1) and left the resident with a family member. The IDT indicated Resident 1's family member walked out of the room with the tab alarm off. Once CNA 1 returned to the room, Resident 1 was lying on the floor. Resident 1 was assessed and reported left elbow pain. LVN 1 stated, We cannot definitively identify who removed the alarm. The failure in the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | system was not educating staff on the use of the tab alarm, lack of knowledge on the family's part, and not implementing the use of the alarm correctly.During a record review on 3/18/2026 at 3:28 p.m., Resident 1's comprehensive care plan records were reviewed. There was no specific care plan for the use of a tab alarm identified. During an interview with LVN 1 on 3/18/2026 at 4:03 p.m., LVN 1 stated that care plans are important, because it provides instructions for individualized, resident focused care. LVN 1 stated, for Resident 1, there was no care plan for the use of the tab alarm. The tab alarm was ordered on 2/18/2026. LVN 1 stated, the failure was that there was no care plan created for use of the tab alarm and there were no interventions in place for the nurses to follow. LVN 1 stated, ultimately, the tab alarm was off, and the resident (Resident 1) was found on the floor.During a review of the facility's policy and procedure titled Resident Alarms last revised on 12/19/2022, the policy stated, It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, psychosocial well-being. The P & P also indicated for (6) Monitoring and modification: a. Supervision shall be provided to the residents in accordance with the residents' plan of care. b. When alarms are utilized, additional monitoring shall be provided, including but not limited to: i. Verifying alarms are used in accordance with the resident's care plan. ii. Verifying alarms are working properly. iii. Monitoring adverse consequences associated with the use of alarms, including psychosocial concerns. During a review of the facility provided policy and procedure titled Comprehensive Care Plans last revised on 12/19/2022, the policy stated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. |