

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  10/25/2024
NAME OF PROVIDER OR SUPPLIER  Vineland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418</b></p> <p>Based on interview and record review, the facility failed to assess residents' ability to self-administer medication for one of four sampled residents (Resident 36) investigated under the accidents care area when Resident 36 was not reassessed for medication self-administration upon re-admission to the facility and quarterly according to Resident 36's care plan.</p> <p>This deficient practice had the potential for medications errors during self-administration of medication for Resident 36.</p> <p>Findings:</p> <p>During a review of Resident 36's Admission Record, the Admission Record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (nerve damage that affects people with diabetes) and encounter for attention to colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body).</p> <p>During a review of Resident 36's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/19/2024, the MDS indicated Resident 36 was able to understand and make decisions, required set-up assistance with eating, supervision or touching assistance with upper body dressing, moderate assistance with oral hygiene, lower body dressing, personal hygiene, rolling left and right, sitting to lying, lying to sitting on the side of the bed, and sit to stand, and needed maximal assistance with toileting hygiene, showering or bathing himself, putting on or taking off footwear, chair or bed-to-chair transfers, and tub or shower transfers.</p> <p>During a review of Resident 36's History and Physical (H&amp;P), dated 9/22/2024, the H&amp;P indicated Resident 36 has the capacity to understand and make decisions.</p> <p>During a review of Resident 36's Self-Administration of Medication, dated 9/7/2023, the Self-Administration of Medication indicated Resident 36 was capable of self-administration of medication.</p> <p>During a review of Resident 36's Care Plan titled, . is able to self administer medication, dated 9/23/2024, the care plan indicated interventions including to assess Resident 36's ability to safely self-administer medications specified on admission, re-admission, quarterly, with change in medication orders and with significant changes in condition.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN), on 10/25/2024, at 1:58 p.m., Resident 36's Medication Self Administration, dated 9/7/2023, was reviewed and indicated Resident 36 was capable of medication self-administration. The MDSN confirmed Resident 36 did not have additional Medication Self- Administration assessments performed after the assessment conducted on 9/7/2023. The MDSN reviewed Resident 36's Care Plan, dated 9/23/2024, and confirmed Resident 36 is able to self-administer medication and has interventions including assessing Resident 36's ability to safely self-administer medications specified on admission, re-admission, quarterly, with changes in medication orders and with significant changes in condition. The MDSN stated based on the interventions in Resident 36's care plan, the resident should have had another assessment performed for medication self-administration. The MDSN stated it is important to perform another assessment because there is a possibility that the resident's status could have changed. The MDSN further stated if the resident assessments are not conducted timely, there is potential for the resident to take extra doses of medications or not taking the medications at the right time.</p> <p>During an interview with the Director of Nursing (DON), on 10/25/2024, at 4:45 p.m., the DON stated residents are reassessed as needed, if there is a medication error, and should be reassessed per the resident's care plan for medication self-administration.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Resident Self-Administration of Medication, last reviewed 4/17/2024, the P&amp;P indicated a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The P&amp;P further indicated a reassessment for safety at a minimum should be considered by the interdisciplinary team for the following:</p> <ul style="list-style-type: none"> <li>a. Significant change in resident's status.</li> <li>b. Medication errors occur.</li> </ul>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>43418</p> <p>Based on observation, interview, and record review, the facility failed to promote the resident rights to examine the results of the state inspection results (a survey to determine compliance with state and federal regulations) of the facility by failing to post survey results in a place that is prominent and accessible (a place where individuals wishing to examine survey results do not have to ask to see them) to residents, family members, and legal representatives of residents.</p> <p>This deficient practice had the potential for residents' and their representatives to not have access to the most recent survey results.</p> <p>Findings:</p> <p>During a general observation conducted between 10/23/2024 to 10/25/2024, around the facility, the results of the state inspection results were not observed in readily accessible areas in the facility.</p> <p>During an observation on 10/25/2024, at 3:20 p.m., a posting on the consumer information board indicated the most recent survey results/licensing visit report supported by the related follow-up plan of correction report are located at the nurse's station and to ask an employee to review them.</p> <p>During a concurrent observation and interview with Registered Nurse (RN) 1, on 10/25/024, at 3:35 p.m., inside the nursing station, RN 1 confirmed the state inspection results were kept in the nursing station inside closed cabinets. RN 1 stated residents and visitors are not allowed inside the nursing station. RN 1 further stated if a resident or a visitor wanted to the state inspection results, they would have to request it from a facility staff member.</p> <p>During an interview with the Director of Nursing (DON), on 10/25/2024, at 4:45 p.m., the DON stated the state inspection results are available at the nursing station. The DON stated residents and visitors are not allowed in the nursing station, but they can request to see the state inspection results at any time. The DON further stated the state inspection results should be readily available for residents and visitors to review so that they have access to seeing how the facility is doing.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Availability of Survey Results, last reviewed 4/17/2024, the P&amp;P indicated the survey binder is located in the main lobby and is available for review by interested persons who wish to review information relative the company's compliance with federal or state rules, regulations, and guidelines governing the company's operation.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>38552</p> <p>Based on observation, interview, and record review, the facility failed to maintain privacy of confidential information for one of one sampled resident (Resident 42) when Licensed Vocational Nurse (LVN 2) left Resident 42's electronic health record (EHR-a digital version of a patient's paper chart) open, unattended, and out of sight of LVN 2.</p> <p>This deficient practice violated Resident 42's right to privacy and confidentiality of their medical records.</p> <p>Findings:</p> <p>During a review of Resident 42's Admission Record (AR), the AR indicated the facility admitted the resident on 8/14/2024 with diagnoses including dementia (a progressive state of decline in mental abilities) and generalized muscle weakness.</p> <p>During a review of Resident 42's History and Physical (H&amp;P), dated 8/15/2024, the HP indicated the resident has fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 42's Minimum Data Set (MDS-a federally required resident assessment tool), dated 10/23/2024, the MDS indicated the resident had severe cognitive impairment.</p> <p>During an observation on 10/23/2024 at 3:13 p.m., outside the nursing station, observed the computer on top of the medication care unattended with Resident 42's electronic chart open.</p> <p>During an interview on 10/23/2024 at 3:14 p.m., with LVN 2, LVN 2 stated he left the computer on top of the medication cart open and unattended when he stepped away from the medication cart to assist a resident's family member. LVN 2 stated he should have clicked the lock icon on the screen before he walked away so the screen would be hidden. LVN 2 stated when he stepped away without locking the electronic chart's screen, unauthorized persons might be able to view the resident's confidential information.</p> <p>During an interview on 10/25/2024 at 4:49 p.m., with the Director of Nursing (DON), the DON stated the importance of safeguarding the medical information of residents is to prevent unauthorized individuals from accessing confidential information and compromising the resident's medical information.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Safeguarding of Resident Identifiable Information, last reviewed 4/17/2024, the P&amp;P indicated the medical records shall not be left in open areas where unauthorized persons could access identifiable resident information.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38552</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 97) was provided a homelike environment by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure the residents' overhead lamp with a pull-on cord had lamp covers on for Residents 42 and 149.</li> <li>2. Maintain two of two shower rooms when shower floors were observed with peeling paint.</li> <li>3. Ensure Resident 33's floor mats were in good condition and did not have a torn segment.</li> </ol> <p>These deficient practices had the potential to violate the resident's right to living in a safe, comfortable, and homelike environment.</p> <p>Findings:</p> <p>1a. During a review of Resident 42's Admission Record (AR), the AR indicated the facility admitted the resident on 8/14/2024 with diagnoses including dementia (a progressive state of decline in mental abilities) and generalized muscle weakness.</p> <p>During a review of Resident 42's History and Physical (H&amp;P), dated 8/15/2024, indicated Resident 42 did have fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 42's Minimum Data Set (MDS-a federally required resident assessment tool), dated 10/23/2024, indicated the resident had severe cognitive impairment.</p> <p>1b. During a review of Resident 149's AR, the AR indicated the facility admitted the resident on 8/14/2024 with diagnoses including metabolic encephalopathy (a disorder that affects brain function due to a chemical imbalance in the blood), dementia, and generalized muscle weakness.</p> <p>During a review of Resident 149's H&amp;P, dated 8/15/2024, indicated the resident did have fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 149's MDS, dated [DATE], indicated Resident 149 had the ability to rarely or never makes self-understood and to understand others. The MDS indicated the resident was dependent on facility staff for activities of daily living including oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/24/2024 at 4:13 p.m., inside Residents 42 and 149's room, with the Maintenance Supervisor (MS), the MS stated both lamp fixtures had a missing lamp cover. The MS stated he does not know if the lamp cover is made of plastic or glass. The MS stated the residents lamp fixture has a pull-on overhead lamp. The MS stated there should be a cover, but he does not know when it was missing. The MS stated this issue has not been brought to his attention. The MS stated he does not know what the potential cause as to why the residents were missing their overhead lamp cover.</p> <p>During an interview on 10/25/2024 at 3:58 p.m., with the Director of Nursing (DON), the DON stated the glass cover for the overhead lamp is used for appropriate lighting in the resident's room. The DON stated if not having the overhead lamp cover would cause it to be too bright then it would not be not homelike setting for the residents. The DON stated there should not be missing parts. The DON stated if the lamp fixture came with a cover, then it should have a cover.</p> <p>2. During an observation on 10/23/2024 at 9:55 a.m., Shower room [ROOM NUMBER]'s floors were observed with peeling paint.</p> <p>During an observation on 10/23/2024 at 11:36 a.m., Shower room [ROOM NUMBER]'s floors were observed with peeling paint.</p> <p>During a record review of the resident shower list of residents who were showered on 10/23/2024, the list indicated a total of seven residents were showered in the shower room.</p> <p>During an observation on 10/24/2024 at 4:05 p.m., with the MS, the MS stated Shower room [ROOM NUMBER] had a topcoat that was peeling off. The MS stated he just noticed it today. The MS stated the topcoat is peeling most likely because the housekeeping uses disinfectant, and it would peel the topcoat. The MS stated when the topcoat is peeling there is a potential for mold growth. The MS stated he would check on the cracks on the tiles but would need a professional to diagnose the extent of the topcoat peeling off.</p> <p>During an interview on 10/25/2024 at 4:14 p.m., the DON stated the residents could be potentially exposed to mold. The DON stated would probably need to re-tile and have a type of coat. The DON stated would need to refer this to maintenance. The DON stated shower rooms should not have peeling paint.</p> <p>3. During a review of Resident 33's AR, the AR indicated the facility admitted the resident on 8/13/2023 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of symptoms), unspecified cataract (a cloudy area in the lens of the eye that can make it difficult to see), and generalized muscle weakness.</p> <p>During a review of Resident 33's H&amp;P, dated 10/1/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 33's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and rarely or never understood others. The MDS indicated the resident normally used a wheelchair and a walker. The MDS indicated the resident required partial to moderate assistance on facility staff for bed mobility, sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 10/25/2024 at 8:46 a.m., while inside Resident 33's room, with the MDS Coordinator (MDSC), the MDSC stated Resident 33's floor mat placed located on the left side of the bed had a tear on the left corner towards the foot of the bed. The MDSC stated they would need to replace this one.</p> <p>During an interview on 10/25/2024 at 4:19 p.m., the DON stated Resident 33's floor mat was replaced right away. The DON stated this was done so no one would trip on the floor mat.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Residents Rights, last reviewed 4/17/2024, the P&amp;P indicated the resident has a right to a safe, clean, comfortable, and homelike environment including receiving treatment and supports for daily living safely.</p> <p>During a review of the facility's P&amp;P titled Safe and Homelike Environment, last reviewed 4/17/2024, the P&amp;P indicated the facility will provide and maintain adequate and comfortable lighting levels in all areas. The P&amp;P indicated housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, comfortable environment. The P&amp;P indicated any unresolved environmental concerns are to be reported to the Administrator.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43418</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for three of four sampled residents (Residents 25, 21, and 33) investigated during review of the physical restraints care area when the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Obtain a physician's order and informed consent (voluntary agreement to accept treatment and/or procedure after receiving education regarding the risks, benefits, and alternatives offered) and perform an entrapment risk assessment for Resident 25's use of bed rails (also known as side rails, adjustable metal or rigid plastic bars that attach to the bed and are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths and may be positioned in various locations on the bed; upper or lower, either or both sides) and placing the bed against the wall.</li> <li>2. Obtain a physician's order and informed consent for placing Residents 21 and 33's bed against the wall.</li> </ol> <p>These deficient practices had the potential to place the residents at risk for entrapment (an event in which a resident is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or hospital bed frame) and to be unaware of the risks and benefits of using bed rails or placing the bed against the wall.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted Resident 25 on 5/31/2024 and readmitted the resident on 4/5/2024 with diagnoses including metabolic encephalopathy (a disorder that affects brain function due to a chemical imbalance in the blood) and generalized muscle weakness.</li> </ol> <p>During a review of Resident 25's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/8/2024, the MDS indicated Resident 25 had difficulty understanding and making decisions and required moderate assistance to maximal assistance with activities of daily living such as eating, hygiene, showering or bathing, dressing, and surface-to-surface transfers.</p> <p>During a review of Resident 25's History and Physical (H&amp;P), dated 4/5/2024, the H&amp;P indicated Resident 25 has the capacity to understand and make decisions.</p> <p>During an observation on 10/23/2024, at 9:51 a.m., inside Resident 25's room, Resident 25 was sleeping in bed. Resident 25's bed was placed against the wall, with the left side of the bed touching the wall. Resident 25's bed had quarter rails at both sides of the head of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/25/2024, at 8:24 a.m., inside Resident 25's room, Resident 25 was sleeping in bed with her bed against the wall, with the left side of the bed touching the wall. Resident 25's bed had quarter rails at both sides of the head of the bed.</p> <p>During a concurrent observation and interview with the Infection Preventionist (IP), on 10/25/2024, at 8:59 a. m., the IP confirmed Resident 25 had quarter rails on both sides of the head of the bed and Resident 25's bed was placed against the wall, with the left side of the bed touching the wall. The IP stated there should be an informed consent for the use of bed rails and she was unsure if there should be an informed consent for placing Resident 25's bed against the wall.</p> <p>During a concurrent interview and record review with the IP, on 10/25/2024, at 9:21 a.m., Resident 25's Order Summary Report was reviewed, and the IP confirmed Resident 25 did not have a physician's order for the use of bed rails or placing the resident's bed against the wall and stated Resident 25 should have an order for bed rails for the safety of the resident and because bed rails can be considered a form of restraint. The IP reviewed Resident 25's medical record, current as of 10/25/2024, and confirmed Resident 25 did not have a consent for the use of bed rails and stated Resident 25 should have a consent for the use of bed rails because the consent would provide education to the resident for treatment options and if not provided with an informed consent, it would go against the resident's rights and the resident would not be aware of what they are being treated with. The IP further reviewed Resident 25's medical record and confirmed Resident 25 did not have an entrapment risk assessment and stated the bed rail assessment is used to check for entrapment for use of the bed rail but does not address the risk of entrapment from placing the bed against the wall. The IP stated placing the bed against the wall can be considered a restraint because it limits the resident's mobility to exit out of the bed. The IP further stated residents should be provided an informed consent for placing the bed against the wall so that there is proof that the resident was informed of the risks and benefits of placing the bed against the wall.</p> <p>During an interview with the Director of Nursing (DON), on 10/25/2024 at 4:45 p.m., the DON stated an informed consent discussing the risks and benefits and a physician's order for use of bed rails and placing the bed against the wall should be obtained. The DON further stated when the bed rails are in place and the bed is placed against the wall, residents have the potential for entrapment due to the gap created by the bed rails.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Restraint Free Environment, last reviewed 4/17/2024, the P&amp;P indicated each resident shall attain and maintain his or her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant use of restraints. The P&amp;P indicated physical restraints may include using bed rails to keep the residents from voluntarily getting out of bed and placing a bed close enough to a wall that the resident is prevented from voluntarily getting out of bed. The P&amp;P further indicated a resident or resident representative may request the use of a physical restraint; however, the facility is responsible for evaluating the appropriateness of the request and the facility shall explain to the resident and or representative the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use.</p> <p>During a review of the facility's P&amp;P titled, Proper Use of Bed Rails, last reviewed 4/17/2024, the P&amp;P indicated informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Informed Consent, last reviewed 4/17/2024, the P&amp;P indicated when situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, application of a physical restraint.</p> <p>2a. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia and fluctuations (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), fracture (broken bone) of the lower end of the right femur (thighbone), and generalized muscle weakness.</p> <p>During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 has difficulty understanding and making decisions, required moderate or was completely dependent on facility staff for activities of daily living including eating, hygiene, showering or bathing themselves, dressing, and surface-to-surface transfers.</p> <p>During a review of Resident 21's H&amp;P, dated 10/4/2024, the H&amp;P indicated Resident 21 had fluctuating capacity to understand and make decisions.</p> <p>During an observation on 10/23/2024, at 9:41 a.m., inside Resident 21's room, Resident 21 was sleeping in the bed placed in the upper left most corner of the room from the doorway, with the left side of the bed placed against the wall and two quarter bedrails at both sides of the head of the bed.</p> <p>During a concurrent observation and interview with the IP on 10/25/2024, at 9:05 a.m., inside Resident 21's room, the IP confirmed and stated Resident 21 was sleeping in a bed placed in the upper left most corner of the room from the doorway, with the left side of the bed against the wall, and two quarter bed rails on both sides of the head of the bed.</p> <p>During a concurrent interview and record review with the IP on 10/25/2024, at 9:38 a.m., Resident 21's Order Summary Report was reviewed, and the IP confirmed Resident 21 did not have a physician's order for placing the bed against the wall and stated the resident should have a physician's order to place the bed against the wall. The IP reviewed Resident 21's medical record, current as of 10/25/2024, and confirmed Resident 21 did not have an informed consent for placing the resident's bed against the wall. The IP stated placing the bed against the wall can be considered a restraint because it limits the resident's mobility to exit from the bed. The IP stated residents should be informed of the risks and benefits of placing the bed against the wall and an informed consent would provide documentation that the risks and benefits were discussed with the resident. The IP further stated there is a potential risk for entrapment when placing a resident's bed against the wall.</p> <p>During an interview with the DON, on 10/25/2024, at 4:45 p.m., the DON stated a consent informing the resident of the risks and benefits of placing the bed against the wall should be discussed and obtained from the resident. The DON stated for residents who are not cognitively intact, a physician's order should be obtained for placing the bed against the wall. The DON further stated when the bed rails are in place and the bed is placed against the wall, residents have the potential for entrapment due to the gap created by the bed rails.</p> <p>(continued on next page)</p>		

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  10/25/2024
NAME OF PROVIDER OR SUPPLIER  Vineland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Restraint Free Environment, last reviewed 4/17/2024, the P&amp;P indicated each resident shall attain and maintain his or her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant use of restraints. The P&amp;P indicated physical restraints may include placing a bed close enough to a wall that the resident is prevented from voluntarily getting out of bed. The P&amp;P further indicated a resident or resident representative may request the use of a physical restraint, however the facility is responsible for evaluating the appropriateness of the request and the facility shall explain to the resident and or representative the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use.</p> <p>During a review of the facility's P&amp;P titled, Informed Consent, last reviewed 4/17/2024, the P&amp;P indicated when situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, application of a physical restraint.</p> <p>38552</p> <p>2b. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 8/13/2023 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of symptoms), unspecified cataract (a cloudy area in the lens of the eye that can make it difficult to see), and generalized muscle weakness.</p> <p>During a review of Resident 33's H&amp;P dated 10/1/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 33's MDS dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and rarely to never understood others. The MDS indicated the resident normally used a wheelchair and a walker. The MDS indicated the resident required partial/moderate assistance on facility staff for bed mobility, sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers.</p> <p>During an observation on 10/23/2024 at 10:13 a.m., inside Resident 33's room, observed Resident 33 asleep in bed with right side of bed up against the wall, head of bed facing towards the restroom and left side of bed facing the entry door to the room. Observed Resident 33's bed with bilateral (both) side rails up.</p> <p>During a concurrent observation and interview on 10/25/2024 at 8:46 a.m., inside Resident 33's room with the MDS Nurse (MDSN), the MDSN stated Resident 33's right side of the bed was up against the wall with bilateral side rails up. The MDSN stated Resident 33 is unable to put the side rails down because the resident requires assistance from staff and has cognitive impairment.</p> <p>During an interview on 10/25/2024 at 9:21 a.m., with the DON, the DON stated the use of the side rail and the bed up against the wall is a potential for entrapment because Resident 33 is not able to move the side rails down and requires assistance with mobility.</p> <p>(continued on next page)</p>		

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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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/25/2024 at 9:35 a.m., with the MDSN, the MDSN stated there is no informed consent done of bed up against the wall for Resident 33. The MDSN stated she does not know if the resident would need to have an informed consent for bed against the wall. The MDSN stated they do not have a form specifically about the bed against the wall. The MDSN stated she would need to ask the Director of Nursing (DON).</p> <p>During an interview on 10/25/2024 at 4:20 p.m., with the Director of Nursing (DON) stated DON stated they should have an informed consents informing the residents and their family of the risks and benefits of having the bed against the wall. The DON stated for not cognitively intact residents a physician order would need to be obtained. The DON stated Resident 33 does not have the capacity and family representative makes the decision for him.</p> <p>During a review of the facility's P&amp;P titled, Restraint Free Environment, last reviewed 4/17/2024, the P&amp;P indicated each resident shall attain and maintain his or her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant use of restraints. The P&amp;P indicated physical restraints may include using bed rails to keep the residents from voluntarily getting out of bed and placing a bed close enough to a wall that the resident is prevented from voluntarily getting out of bed. The P&amp;P further indicated a resident or resident representative may request the use of a physical restraint; however the facility is responsible for evaluating the appropriateness of the request and the facility shall explain to the resident and or representative the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use.</p> <p>During a review of the facility's P&amp;P titled, Informed Consent, last reviewed 4/17/2024, the P&amp;P indicated when situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, application of a physical restraint.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43418</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of five sampled residents (Residents 21 and 33) investigated during review of the physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) care area when Residents 21 and 33 did not have a care plan for placing the bed against the wall.</p> <p>This deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay in care or lack of delivery of care and services for the residents.</p> <p>Findings:</p> <p>During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia and fluctuations (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), fracture (broken bone) of the lower end of the right femur (thighbone), and generalized muscle weakness.</p> <p>During a review of Resident 21's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/6/2024, the MDS indicated Resident 21 has difficulty understanding and making decisions, required moderate or was completely dependent on facility staff for activities of daily living including eating, hygiene, showering or bathing themselves, dressing, and surface-to-surface transfers.</p> <p>During a review of Resident 21's History and Physical (H&amp;P), dated 10/4/2024, the H&amp;P indicated Resident 21 had fluctuating capacity to understand and make decisions.</p> <p>During an observation on 10/23/2024, at 9:41 a.m., inside Resident 21's room, Resident 21 was sleeping in the bed placed in the upper left most corner of the room from the doorway, with the left side of the bed placed against the wall and two quarter bedrails (also known as side rails, adjustable metal or rigid plastic bars that attach to the bed and are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths and may be positioned in various locations on the bed; upper or lower, either or both sides) at both sides of the head of the bed.</p> <p>During a concurrent observation and interview with the Infection Preventionist (IP) on 10/25/2024, at 9:05 a. m., inside Resident 21's room, the IP stated Resident 21 was sleeping in a bed placed in the upper left most corner of the room from the doorway, with the left side of the bed against the wall, and two quarter bed rails on both sides of the head of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with the IP on 10/25/2024, at 9:38 a.m., Resident 21's care plans, current as of 10/25/2024, were reviewed and the IP confirmed Resident 21 did not have a care plan addressing Resident 21's bed placement against the wall. The IP stated Resident 21 should have a care plan for having his bed placed against the wall so that the facility staff know what interventions are in place for the resident. The IP further stated without the care plans, Resident 21 would be at risk for injury.</p> <p>During an interview with the Director of Nursing on 10/25/2024, at 4:45 p.m., the DON stated care plans should be developed so that facility staff can follow the plan of care for the resident. The DON stated care plan interventions include checking for risks and potential safety hazards. The DON further stated placing a bed against the wall with a bed rail places residents at risk for entrapment (an event in which a resident is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or hospital bed frame).</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Care Plans, last reviewed 4/17/2024, the P&amp;P indicated the facility develops and implements 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.</p> <p>38552</p> <p>b. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 8/13/2023 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of symptoms), unspecified cataract (a cloudy area in the lens of the eye that can make it difficult to see), and generalized muscle weakness.</p> <p>During a review of Resident 33's H&amp;P dated 10/1/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 33's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and rarely to never understood others. The MDS indicated the resident normally used a wheelchair and a walker. The MDS indicated the resident required partial/moderate assistance on facility staff for bed mobility, sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers.</p> <p>During an observation on 10/23/2024 at 10:13 a.m., inside Resident 33's room, observed Resident 33 asleep in bed with right side of bed up against the wall, head of bed facing towards the restroom and left side of bed facing the entry door to the room. Observed Resident 33's bed with bilateral side rails up.</p> <p>During a concurrent observation and interview on 10/25/2024 at 8:46 a.m., inside Resident 33's room with the MDS Nurse (MDSN), the MDSN stated Resident 33's right side of the bed was up against the wall with bilateral side rails up. The MDSN stated Resident 33 is unable to put the side rails down.</p> <p>During a concurrent interview and record review on 10/25/2024 at 9:08 a.m., with MDSN, the MDSN stated there was no care plan developed addressing Resident 33's bed up against the wall.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/25/2024 at 9:21 a.m., with the DON, the DON stated the use of the side rail and the bed up against the wall is a potential for entrapment (an event in which a resident is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or hospital bed frame) because Resident 33 is not able to move the side rails down and requires assistance with mobility. The DON stated there should have been a care plan developed addressing the bed against the wall.</p> <p>During an interview on 10/25/2024 at 4:20 p.m., with the DON, the DON stated care plans should be developed so that facility staff can follow the plan of care for the resident. The DON stated care plan interventions include checking for risks and potential safety hazards.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Care Plans, last reviewed 4/17/2024, the P&amp;P indicated the facility develops and implements 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.</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>38552</p> <p>Based on interview and record review, the facility failed to address the resident's needs for a home health agency referral prior to discharge for one of one sampled resident (Resident 48) reviewed under discharge care area.</p> <p>This deficient practice placed the resident at risk for not receiving the necessary care and services related to the resident's discharge goals and needs.</p> <p>Findings:</p> <p>During a review of Resident 48's Admission Record (AR), the AR indicated the facility admitted the resident on 8/5/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by progressive decline in mental abilities, type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and repeated falls.</p> <p>During a review of Resident 48's Clinical Admission, dated 8/5/2024, the clinical admission indicated the resident had chronic confusion, orientation to person only, and had moderate cognitive impairment (memory loss).</p> <p>During a review of Resident 48's Cognitive Assessment and Care Plan Service, dated 8/7/2024, the cognitive assessment and care plan service indicated the resident had cognitive impairment and functional limitation (restrictions that prevent one from fully performing activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person and performs daily to care for themselves).</p> <p>During a review of Resident 48's Progress Notes titled GG Data Collection Tool (section required in the completion of the Minimum Data Set [MDS-a federally required assessment tool]), dated 8/7/2024, indicated the resident required assistance from facility staff on ADLs including oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and with personal hygiene.</p> <p>During a concurrent interview and record review of Resident 48's Post Discharge (PD) Plan of Care and Summary, dated 8/7/2024, on 10/25/2024, at 3:10 p.m., with the Social Services Director (SSD), the SSD stated he carried out the home health orders and will be referred by the board and care. The SSD stated this referral is for the board and care to follow through. The SSD stated the discharge order indicated home health services including nursing and home health aide, physical therapy, and occupational therapy services and did not indicate the name of the agency because the board and care will be the one to refer the resident to the home health agency (HHA-an agency (clinical care services provided to residents at their home for an illness or injury).</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of the facility's policy and procedure titled, Discharge Planning, last reviewed 4/17/2024, with the SSD, the P&amp;P indicated the facility will assist residents and their resident representatives in choosing an appropriate post-acute care provider including HHA that will meet the resident's needs, goals, and preferences. The P&amp;P indicated the SSD, or designee, shall compile available data on other post-acute care options to present to the resident including data on providers within the resident's desired geographic area, where available. When the SSD was asked if these lines in the policy was done for Resident 48, the SSD failed to answer the question.</p> <p>During a follow-up interview on 10/25/2024 at 3:41 p.m., the SSD stated he did not document his conversation with the family member about the home health referral. The SSD stated he should have documented so he can assure that the resident will be followed up by a home health agency and prevent rehospitalization .</p> <p>During an interview on 10/25/2024 at 4:02 p.m., the Director of Nursing (DON) stated the purpose of documentation is to prove that staff made the referral.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Documentation in Medical Record, last reviewed 4/17/2024, the P&amp;P indicated licensed and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the state law and facility policy.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>38552</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for one of two sampled residents (Resident 41) being investigated under urinary catheters (a hollow tube inserted into the bladder to drain or collect urine) by failing to ensure the resident's urinary drainage bag was not lying flat on the floor.</p> <p>This deficient practice had the potential to result in Resident 41 to develop a catheter associated urinary tract infection (CAUTI, an infection of the urinary tract caused by a tube [urinary catheter] that has been placed to drain urine from the bladder [an organ inside the body that stores urine until it can be excreted]).</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record (AR), the AR indicated the facility originally admitted the resident on 3/1/2024 and readmitted the resident on 8/9/2024 with di indwelling urethral catheter, UTI, and sepsis (a life-threatening blood infection).</p> <p>During a review of Resident 41's History and Physical (H&amp;P), dated 8/9/2024, the H&amp;P indicated Resident 41 had cognitive (mental action or process of acquiring knowledge and understanding) impairment.</p> <p>During a review of Resident 41's Minimum Data Set (MDS-a federally required assessment tool), dated 8/16/2024, the MDS indicated the resident had the ability to make self-understand and to understand others. The MDS indicated the resident required assistance from facility staff for personal hygiene. The MDS indicated the resident had an indwelling catheter appliance.</p> <p>During a review of Resident 41's Care Plan (CP) addressing the resident's indwelling urinary catheter, dated 8/27/2024, the CP included interventions for positioning of the urinary drainage catheter bag and tubing below the level of the bladder and away from the entrance room door.</p> <p>During an observation and interview on 10/24/2024 at 9:34 a.m., inside Resident 41's room, Resident 41 stated he does not know why he has a urinary catheter. Observed Resident 41's indwelling urinary catheter drainage bag laying flat on the floor placed at the resident's left side of the bed.</p> <p>During an observation on 10/24/2024 at 9:37 a.m., inside Resident 41's room, Certified Nursing Assistant 1 (CNA 1) stated Resident 41's urinary drainage bag is inside a privacy bag which is lying flat on the floor. CNA 1 stated it should not be placed on the floor, as it may come into contact with floor contaminants such as dirt and bacteria, particularly if the floor has not been cleaned.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/24/2024 at 4:29 p.m., with the Director of Nursing (DON), the DON stated the urinary indwelling catheter drainage bag should not be lying flat on the floor. The DON stated it should be hanging and inside a privacy bag. The DON stated there is a potential for infection control and should not be exposed on the floor.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Indwelling Cather Use and Removal, last reviewed 4/17/2024, the P&amp;P indicated care practices include securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38552</p> <p>Based on interview and record review, the facility failed to ensure a resident who received hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) was assessed after dialysis treatment and to document the assessment for one of one sampled resident (Resident 18) investigated during a review of dialysis care area.</p> <p>This deficient practice had the potential for unidentified complications such as swelling, pain, bleeding, and bruising and had the potential to result in lack of provision of necessary treatment and services after dialysis treatment.</p> <p>Findings:</p> <p>During a review of Resident 18's Admission Record (AR), the AR indicated the facility originally admitted the resident on 12/13/2023 and readmitted on [DATE] with diagnoses including dependence on renal dialysis and end-stage renal disease (ESRD- irreversible kidney failure).</p> <p>During a review of Resident 18's History and Physical, dated 7/15/2024, indicated the resident did have the capacity to understand and make decisions.</p> <p>During a review of Resident 18's Minimum Data Set (MDS-a federally required assessment tool), dated 7/26/2024, indicated the resident had the ability to make self-understood and understood others. The MDS indicated Resident 63 received dialysis on admission and while a resident. The MDS indicated the resident received hemodialysis while a resident in the facility.</p> <p>During a review of Resident 18's telephone/verbal order signature details indicated the following orders:</p> <p>- Hemodialysis access site monitoring type: arterio-venous (AV-connection of blood vessels) fistula (dialysis access point) left forearm every shift for bruit (a whooshing sound heard near the fistula) and thrill (vibration felt through the dialysis access site), P=present, A=absent. Notify physician if absent, dated 7/19/2024.</p> <p>During a concurrent interview and record review of Resident 18's Treatment Administration Record for the month of 10/2024, on 10/25/2024, at 4:05 p.m., with the Director of Nursing (DON), the DON stated the licensed nurse did not document on 10/18/2024 and 10/21/2024 during the 11 p.m. to 7 a.m. shift. The DON stated the dialysis access site monitoring should be documented every shift as ordered. The DON stated when the licensed nurses assessed the site, they then document to show that it was done. The DON stated when the licensed nurses do not document they can potentially miss a problem with the resident's dialysis access site.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Hemodialysis, last reviewed on 4/17/2024, the P&amp;P indicated the nurse will monitor and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications.</p> <p>(continued on next page)</p>		

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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 0698  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of the facility's P&P titled, Documentation in Medical Record, last reviewed 4/17/2024, the P&P indicated licensed and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the state law and facility policy.		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43497</p> <p>Based on interview and record review, the facility failed to provide in-services regarding the use of physical restraints.</p> <p>This deficient practice placed the residents are risk for the inappropriate use of physical restraints.</p> <p>Cross reference F604</p> <p>Findings:</p> <p>a. During a review of Resident 33's Admission Record (AR), the AR indicated the facility admitted the resident on 8/13/2023 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of symptoms), unspecified cataract (a cloudy area in the lens of the eye that can make it difficult to see), and generalized muscle weakness.</p> <p>During a review of Resident 33's History and Physical Examination (H&amp;P), dated 10/1/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 33's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/16/2024, the MDS indicated the resident sometimes had the ability to make self-understood and rarely to never understood others. The MDS indicated the resident normally used a wheelchair and a walker. The MDS indicated the resident required partial/moderate assistance on facility staff for bed mobility, sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers.</p> <p>During an observation on 10/23/2024 at 10:13 a.m., inside Resident 33's room, observed Resident 33 asleep in bed with right side of bed up against, head of bed facing towards the restroom and left side of bed facing the entry door to the room. Observed Resident 33's bed with bilateral side rails up.</p> <p>During a concurrent observation and interview on 10/25/2024 at 8:46 a.m., inside Resident 33's room with the MDS Nurse (MDSN), the MDSN stated Resident 33's right side of the bed was up against the wall with bilateral side rails up. The MDSN stated Resident 33 is unable to put the side rails down.</p> <p>b. During a review of Resident 14's Admission Record (AR), the AR indicated the facility originally admitted the resident on 5/16/2021 and readmitted on [DATE] with diagnoses including COPD, spinal stenosis (when the space in the backbone is too small which can cause pain), bilateral (both) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knees, pain in right shoulder, chronic pain syndrome, and abnormalities of gait and mobility.</p> <p>During a review of Resident 14's History and Physical Examination (H&amp;P), dated 8/1/2024, the H&amp;P indicated the resident have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 14's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understood others. The MDS indicated the resident required supervision from facility on activities of daily living including oral hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a concurrent observation and interview on 10/25/2025 at 8:25 a.m., inside Resident 14's room, observed Resident 14 sitting up in bed with left side of bed against the wall and right side of bed facing towards the entry door to the room. Resident 14 stated his bed was against the wall. Resident 14 stated he needed the space in his room to maneuver his wheelchair to get around. Resident 14 stated he does not remember how long his bed had been against the wall, but his had it like this for a while.</p> <p>During a concurrent observation and interview on 10/25/2024 at 8:31 a.m., inside Resident 14's room, with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 14's bed was up against the wall.</p> <p>During an interview with the Director of Staff Development (DSD) on 10/24/2024 at 3:00 p.m., DSD stated, a bed against the wall in considered a form of restraint. DSD stated, she could not locate and competencies or in services regarding the use of physical restraints in the facility. The DSD stated, it is the responsibility of the facility to provide education regarding the use of physical restraints to prevent inappropriate use and for the safety of the residents.</p> <p>During an interview with the Director of Nurses (DON) on 10/25/2024 at 3:30 p.m., the DON stated they will provide in services to the staff regarding the use of physical restraints. The DON stated, it is important for the nurses to conduct the appropriate assessments, obtain and evaluate the form of physical restraints.</p> <p>During a review of the facility's policy titled, Competency Evaluation dated 12/9/2023, it indicated, it is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job. Competency is measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual need to perform work roles or occupational functions successfully.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Restraint Free Environment, last reviewed 4/17/2024, the P&amp;P indicated each resident shall attain and maintain his or her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant use of restraints. The P&amp;P indicated physical restraints may include using bed rails to keep the residents from voluntarily getting out of bed and placing a bed close enough to a wall that the resident is prevented from voluntarily getting out of bed. The P&amp;P further indicated a resident or resident representative may request the use of a physical restraint; however, the facility is responsible for evaluating the appropriateness of the request and the facility shall explain to the resident and or representative the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>43497</p> <p>Based on observation, interview and record review, the facility failed to post in a visible and prominent place daily the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift.</p> <p>This deficient practice resulted in the actual staffing information not being readily accessible and available to residents and visitors. The deficient practice had the potential to cause inadequate staffing.</p> <p>Findings:</p> <p>During a tour of the facility on 10/25/2024 at 10:00 a.m., did not observe staff posting in a visible and prominent place of the facility.</p> <p>During an interview with the Staff Developer (DSD) on 10/25/2024 at 10:30 a.m., DSD stated the posting is located inside the nursing station. The DSD stated, she was not aware that it needs to be posted in a visible area of the facility. The DSD stated, she will make sure to post the actual hours worked by the staff in a visible area.</p> <p>During an interview with the DON on 10/24/2024 at 3:00 p.m., the DON stated, the staffing information was not posted in a visible area, however it is now updated and placed next to where the staff clock in. The DON stated, the staffing information should be visible to residents and visitors for the facility staffing information.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Nursing Department-Staffing, Scheduling and Postings dated 9/16/24, the P&amp;P indicated the facility will post the following information on a daily basis: Facility name, the current date. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurse, Licensed Practical Nurses, Certified Nurse Aids, and resident census.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43418</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of residents for one of five sampled residents (Resident 21) reviewed under the unnecessary medications care area and one of four sampled residents (Resident 15) reviewed under medication administration facility task by:</p> <p>1. Failing to monitor side effects related to the use of psychotropic medications (a broad class of drugs that affect the mind, emotions, and behaviors) and for signs of bleeding were not conducted on 10/18/2024 for Resident 21.</p> <p>These deficient practices had the potential for side effects to be missed and cause a delay in care for Resident 21.</p> <p>2. Failing to indicate the aspirin (used as a pain reliever or blood thinner) dosage for Resident 15.</p> <p>This deficient practice had the potential to result in effective treatment in treating the resident's condition.</p> <p>Findings:</p> <p>1. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia and fluctuations (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), fracture (broken bone) of the lower end of the right femur (thighbone), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness.</p> <p>During a review of Resident 21's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/6/2024, the MDS indicated Resident 21 has difficulty understanding and making decisions, required moderate assistance or was completely dependent on facility staff for activities of daily living including eating, hygiene, showering or bathing themselves, dressing, and surface-to-surface transfers.</p> <p>During a review of Resident 21's History and Physical (H&amp;P), dated 10/4/2024, the H&amp;P indicated Resident 21 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 21's Order Summary Report, the Order Summary Report indicated Resident 21 was ordered the following:</p> <p>- On 10/3/2024, quetiapine fumarate (antipsychotic medication [used to manage abnormal condition of the mind described as involving a loss of contact with reality]) 100 milligrams (mg, a unit of measure for mass) oral tablet, give one tablet by mouth at bedtime for dementia manifested by yelling at staff for no apparent reason, informed consent obtained by physician from responsible person.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 10/3/2024, memantine hydrochloride (a type of medication used to treat dementia) 10 mg give one tablet by mouth one time a day for dementia.</li> <li>- On 10/3/2024, Aspirin (a medication used to reduce pain, fever, inflammation, and blood clotting) 81 mg oral tablet, give one tablet by mouth twice a day for cerebrovascular accident (CVA, also known as stroke, loss of blood flow to a part of the brain) prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease).</li> <li>- On 10/3/2024, monitor for side effects related to use of psychotropic medications every shift.</li> <li>- On 10/3/2024, monitor behavior manifested by yelling at staff for no apparent reason and record the number of times the behaviors has manifested every shift.</li> <li>- On 10/3/2024, monitor for blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic (escape of blood from a ruptured blood vessel) area, and petechiae (small red or purple spots caused by bleeding into the skin).</li> </ul> <p>During a review of Resident 21's Care Plan titled, . uses psychotropic medications related to Behavior Management, dated 10/3/2024, the care plan indicated Resident 21 uses quetiapine fumarate with interventions including to monitor and record occurrences for target behavior symptoms and document per facility protocol.</p> <p>During a review of Resident 21's Care Plan titled, . has impaired cognitive function/dementia or impaired thought process related to Dementia, dated 10/3/2024, the care plan indicated Resident 21 takes memantine hydrochloride with interventions including to administer medications as ordered and to monitor and document for side effects and effectiveness.</p> <p>During a review of Resident 21's Care Plan titled, . has an alteration in hematological (related to blood) status related to Anticoagulant side effects, dated 10/3/2024, the care plan indicated Resident 21 uses aspirin with interventions including to give medications as ordered and monitor for side effects and effectiveness.</p> <p>During a concurrent interview and record review with Registered Nurse 2 (RN 2), on 10/24/2024, at 4:32 p.m. , Resident 21's Monitor Record, dated 10/18/2024, was reviewed and RN 2 stated the following were not documented:</p> <ul style="list-style-type: none"> <li>- Monitor behavior manifested by agitation and irritability with difficulty to redirect.</li> <li>- Monitor behavior manifested by yelling at staff for no apparent reason.</li> <li>- Monitor for any signs of blood in the urine, blood in the stool, unusual bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic wounds, and petechiae.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN 2 stated the monitoring should have been documented because if it was not documented, the facility would not know if the monitoring was performed or not and there could be a potential for a missed behavior. RN 2 stated it is important to monitor the residents because if monitoring is missed, it possible a behavior or adverse effect might be missed, and the facility staff would not know to notify the physician for possible changes in orders.</p> <p>During an interview with the Director of Nursing (DON), on 10/25/2024, at 4:45 p.m., the DON stated it is important for the facility to monitor for signs of bleeding and to monitor changes in the resident's condition. The DON further stated if the resident is not monitored, the potential changes could be missed and the facility staff would not be able to notify the physician, responsible person, or update the plan of care, which would cause a potential delay in care.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Documentation in Medical Record, last reviewed 4/17/2024, the P&amp;P indicated licensed and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the State law and facility policy.</p> <p>During a review of the facility's P&amp;P titled, Use of Psychotropic Medication, last reviewed 4/17/2024, the P&amp;P indicated the effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as but not limited to in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and resident's comprehensive plan of care.</p> <p>38552</p> <p>2. During a review of Resident 15's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/11/2024 and readmitted the resident on 7/15/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following other cerebrovascular disease (a group of conditions that affect the blood vessels and blood supply to the brain) affecting the right dominant side and acute (sudden) myocardial infarction (MI-heart attack).</p> <p>During a review of Resident 15's H&amp;P, dated 7/17/2024, the H&amp;P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident had the ability to sometimes make self-understand and understand others. The MDS indicated the resident was dependent on facility staff on activities of daily living including oral hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 15's Order Review History Report (ORHR), the ORHR indicated a physician's order aspirin oral (by mouth) tablet chewable, give one tablet via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GT) one time a day for cerebrovascular accident (CVA-stroke) prophylaxis (prevention), dated 9/9/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/24/2024 at 8:16 a.m., Licensed Vocational Nurse 1 (LVN 1) prepared Resident 15's morning medication including aspirin 81 mg chewable, one tablet, expiration date 9/2025. Observed LVN 1 crushed the aspirin tablet and placed in a medicine cup.</p> <p>During an observation on 10/24/2024 at 8:52 a.m., LVN 1 administered the resident's medications via GT including aspirin.</p> <p>During a concurrent interview and record review of Resident 15's ORHR, on 10/25/2024, at 4:03 p.m., the DON stated the aspirin dose was not indicated. The DON stated it should be indicated because it is part of the medication rights. The DON stated the medication rights include the right medication, route, dose, patient, and time. The DON stated the purpose of the medication rights is to ensure administration of the correct dose. The DON stated when the dose is missing the licensed nurse could potentially give the wrong medication dose.</p> <p>During a review of the facility's P&amp;P titled, Medication Administration, last reviewed 4/17/2024, the P&amp;P indicated the licensed nurse will compare medication source with the medication administration record to verify resident name, medication name, form, dose, route, and time.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43418</p> <p>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of four sampled residents (Resident 19) observed during medication administration facility task by failing to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted isolation gown and glove use during high contact resident care activities) when:</p> <ol style="list-style-type: none"> <li>Licensed Vocational Nurse (LVN) 2 did not don (put on) an isolation gown while administering medications through a gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, common for people with swallowing problems) to Resident 19.</li> <li>LVN 2 and Certified Nursing Assistant (CNA) 1 did not don an isolation gown while repositioning Resident 19 in bed.</li> </ol> <p>These deficient practices had the potential to spread infections and illnesses among residents and staff.</p> <p>Findings:</p> <p>During a review of Resident 19's Admission Record, the Admission Record indicated the facility originally admitted Resident 19 on 9/23/2024 and readmitted the resident on 10/9/2024 with diagnoses including encounter for gastrostomy, dysphagia (difficulty swallowing), and generalized weakness.</p> <p>During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/30/2024, the MDS indicated Resident 19 was rarely or never understood, was dependent on facility staff for activities of daily living such as eating, toileting, hygiene, dressing, and surface-to-surface transfers, and receives nutrition by a feeding tube.</p> <p>During a review of Resident 19's History and Physical (H&amp;P), dated 9/25/2024, the H&amp;P indicated Resident 19 does not have the capacity to understand and make decisions and has a GT.</p> <p>During a review of Resident 19's Order Summary Report, dated 9/25/2024, the Order Summary Report indicated an order for enhanced barrier precautions related to indwelling device and to apply enhanced barrier to prevent the spread of infections for specific care activities such as morning and evening care, toileting and changing incontinence briefs, care for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room and cleaning and disinfecting environment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 19's Care Plan titled, Resident on Enhanced Barrier Precaution Gastrostomy Tube use, dated 9/25/2024, the care plan indicated interventions to apply EBP to prevent the spread of infections for specific care activities such as morning and evening care, toileting and changing incontinence briefs, care for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room and cleaning and disinfecting environment.</p> <p>During an observation on 10/24/2024, at 8:11 a.m., outside of Resident 19's room, above the room number placard, an EBP signage indicated providers and staff must also wear gloves and a gown for transferring and device care or use of feeding tubes.</p> <p>During a concurrent observation and interview with LVN 2, on 10/24/2024, at 8:22 a.m., inside Resident 19's room, LVN 2 administered medications to Resident 19 through the GT wearing gloves. LVN 2 did not wear an isolation gown while administering medications to Resident 19. At 8:41 a.m., LVN 2 and CNA 1 entered Resident 19's room, wearing gloves and no isolation gown, and repositioned Resident 19 higher up in bed. LVN 2 stated he was not wearing a gown while administering medication through Resident 19's GT and stated he should have worn a gown while administering medications to prevent infections from occurring.</p> <p>During an interview with CNA 1 on 10/24/2024, at 9:18 a.m., CNA 1 stated he was not wearing an isolation gown while repositioning Resident 19 with LVN 2. CNA 1 further stated he should have worn an isolation gown because Resident 19 has a GT and there is a potential for cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and the potential for the resident to get an infection.</p> <p>During an interview with the Director of Nursing (DON) on 10/25/2024, at 4:45 p.m., the DON stated staff should wear an isolation gown when administering medications through a GT and when repositioning a resident with a GT because resident with GT are more vulnerable. The DON further stated when an isolation gown is not worn while providing care to residents with a GT, there is a potential exposure to microorganisms and lack of infection control.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Enhanced Barrier Precautions, last reviewed 4/17/2024, the P&amp;P indicated EBP is indicated for residents with indwelling medical devices such as feeding tubes. The P&amp;P indicated personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) is only necessary when performing high-contact care activities. The P&amp;P indicated high-contact resident care activities include transferring and device care or use. The P&amp;P further indicated it may be acceptable to use gloves alone for passing medications through a GT and is only appropriate if the activity is not bundled together with other high-contact care activities and there is no evidence of ongoing transmission in the facility.</p>		

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  10/25/2024
NAME OF PROVIDER OR SUPPLIER  Vineland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>43418</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' bedrooms meet the requirement of 80 square feet (a unit of measure for length) per resident in multiple resident bedrooms for 18 of 20 rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 16, 17, 18, 19, and 20).</p> <p>This deficient practice had the potential to result in inadequate space to provide safe nursing care, privacy for the residents, and limit the residents' ability to maneuver personal care devices.</p> <p>Findings:</p> <p>During a general observation of the facility, between 10/23/2024 to 10/25/2024, observed residents in multiple resident bedrooms. The residents had adequate space to move about freely inside the rooms and nursing staff had enough space to safely provide care to these residents, with space for the beds, side tables, dressers, and resident care equipment.</p> <p>During a group interview with residents, on 10/23/2024, at 10:31 a.m., during Resident Council meeting, Residents 44, 10, 35, 46, and 24 stated they did not have any issues with lack of space in their rooms and the facility staff are able to provide care for the residents safely.</p> <p>During a review of the facility's Client Accommodations Analysis, dated 10/23/2024, the Client Accommodations Analysis indicated the following:</p> <table border="1"> <thead> <tr> <th>Room Number</th> <th>Number of Beds</th> <th>Total Square Feet</th> </tr> </thead> <tbody> <tr><td>1</td><td>2</td><td>148.5</td></tr> <tr><td>2</td><td>2</td><td>148.5</td></tr> <tr><td>3</td><td>2</td><td>148.5</td></tr> <tr><td>4</td><td>2</td><td>148.5</td></tr> <tr><td>5</td><td>2</td><td>148.5</td></tr> <tr><td>6</td><td>2</td><td>148.5</td></tr> <tr><td>7</td><td>2</td><td>148.5</td></tr> <tr><td>8</td><td>2</td><td>148.5</td></tr> <tr><td>9</td><td>2</td><td>148.5</td></tr> <tr><td>10</td><td>1</td><td>148.5</td></tr> </tbody> </table> <p>(continued on next page)</p>	Room Number	Number of Beds	Total Square Feet	1	2	148.5	2	2	148.5	3	2	148.5	4	2	148.5	5	2	148.5	6	2	148.5	7	2	148.5	8	2	148.5	9	2	148.5	10	1	148.5
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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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