

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards to three of three sampled residents (Residents 2, 24, and 4) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq - beneath the skin) insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: 1. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted the resident on 2/24/2025, and readmitted the resident on 9/24/2025, with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar level in the blood), and diabetic chronic kidney disease (diabetes has damaged the kidneys' tiny filters, making them bad at cleaning the blood, so waste builds up, causing swelling, fatigue, and eventually kidney failure if uncontrolled). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severely impaired cognition (a person has significant problems with thinking, learning, memory, and decision-making that are severe enough to interfere with their daily life and require them to depend on others for basic activities like eating and hygiene). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used to lower high blood sugar [glucose] levels in people with diabetes). During a review of Resident 2's Order Summary Report (OSR), dated 9/24/2025, the OSR indicated an order of Humulin R Injection Solution 100 units per milliliter (unit/ml, describes the strength or concentration of the insulin) (Insulin Regular [Human]). Inject as per sliding scale (extra units of insulin to be administered when a person's blood sugar gets high): if 61 - 130 = 0 units notify MD if blood sugar (BS) less than (<) 70 ; 131 - 160 = 2 units; 161 - 200 = 3 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 10 units notify MD, subcutaneously before meals and at bedtime for diabetes mellitus type 2 rotate administration site. Notify MD if BS greater than (>) 400 or BS < 70, and follow hypoglycemia protocol (a simple set of steps to quickly recognize and treat dangerously low blood sugar [glucose] levels). During a review of Resident 2's Location of Administration Report (LOA) of Insulin, for 10/2025 to 12/2025, the LOA indicated insulin was administered on: Humulin R Injection Solution 100 unit/ml 10/19/25 at 9:17 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 10/22/25 at 9:54 p.m. on the Abdomen - LUQ 11/6/25 at 9:33 p.m. on the Abdomen - LUQ 11/11/25 at 10:07 p.m. on the Abdomen - LUQ During a review of Resident 2's Care Plan (CP) Report regarding Resident 2 being at risk for re-hospitalization, age > 65, diabetes, hemodialysis (a treatment to cleanse the wastes and extra fluids artificially through a machine when the kidney(s) have failed) etc., last revised on 9/26/2025, the CP indicated an intervention of medications as ordered and notify MD for signs and symptoms of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555011
		If continuation sheet Page 1 of 48

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adverse (unwanted) side effects. During a concurrent interview and record review on 12/16/2025, at 2:47 p.m., with Registered Nurse (RN) 1, Resident 2's Medical Diagnosis, OSR, LOA, and CP were reviewed. RN 1 stated there was an order for regular insulin with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 10/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo (low) or hyperglycemia on residents. During an interview on 12/17/2025 at 1 p.m. with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the insulin administration sites on Resident 2 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotate the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. During a review of the facility's recent policy and procedure (P&P) titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: 9. Procedure for subcutaneous (SC) injection: b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs), and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. c. For repeated injections, rotate site. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Novolin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1991, the HPI indicated subcutaneous injection subcutaneously 30 minutes before a meal into the abdominal area, buttocks, thigh or the upper arm. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 2. During a review of Resident 24's AR, the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 12/18/2024, with diagnoses including type 2 diabetes mellitus, heart failure (the heart is not pumping blood as well as it should to meet the body's needs, not that it has stopped), and muscle weakness. During a review of Resident 24's H&P, dated 11/17/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 24's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (refers to the ability to think, learn, remember, and make decisions clearly and effectively enough to handle all aspects of daily life independently). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 24's OSR, dated 6/10/2024, the OSR indicated an order of unit/ml (Insulin Aspart). Inject as per sliding scale: unit/ml (Insulin Aspart) Inject as per sliding scale: if 0 - 139 = 0 units notify MD if BS <70; 140 - 199 = 1 unit; 200 - 249 = 3 units; 250 - 299 = 5 units; 300 - 349 = 7 units; 350 - 499 = 9 units notify MD if BS > 400 , subcutaneously two times a day every Mon, Wed, Fri for diabetes type 2 notify MD if BS > 400 or < 70, and follow hypoglycemia protocol. Rotate injection site. During a review of Resident 24's LOA of Insulin, from 9/2024 to 12/2025, the LOA indicated insulin was administered on: Aspart Subcutaneous Solution Cartridge 100 unit/ml 9/1/25 at 4:02 p.m. on the Arm - left 9/5/25 at 4:45 p.m. on the Arm - left 9/8/25 at 4:09 p.m. on the Arm - right 9/15/25 at 4:11 p.m. on the Arm - right 9/22/25 at 4:41 p.m. on the Arm - right 10/13/25 at 4:34 p.m. on the Arm - left 10/17/25 at 6:06 a.m. on the Arm - left 10/20/25 at 5:30 p.m. on the Arm - left 10/24/25 at 4:15 p.m. on the Arm - left During a review of Resident 24's CP Report regarding Resident 24 having diabetes mellitus on insulin, glucagon (control blood sugar levels and keep them within set levels), and Metformin (a common and safe oral medicine used primarily to treat type 2 diabetes), last revised on 8/2/2025, the CP indicated an intervention of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 12/16/2025 at 2:47 p.m. with RN 1, Resident 24's Medical Diagnosis, OSR, LOA, and CP (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were reviewed. RN 1 stated there was an order for aspart insulin with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 9/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo or hyperglycemia on residents. During an interview on 12/17/2025 at 1 p.m. with the DON, the DON stated the licensed staff should have rotated the insulin administration sites on Resident 24 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotated the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. During a review of the facility's recent P&P titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: 9. Procedure for subcutaneous (SC) injection: b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs), and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. c. For repeated injections, rotate site. During a review of the facility-provided HPI on the use of Novolog (insulin aspart) injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 3. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 11/11/2025, with diagnoses including type 2 diabetes mellitus with hyperglycemia, severe sepsis (a life-threatening progression of sepsis, where the body's extreme response to an infection causes damage to its own organs, leading to dysfunction in the heart, brain, kidneys, or lungs, characterized by signs like confusion, difficulty breathing, low urine output, and low blood pressure), and immunodeficiency (a condition where the body's immune system is weakened or does not work properly). During a review of Resident 4's H&P, dated 11/16/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had impaired cognition. During a review of Resident 4's OSR, dated 11/11/2025, the OSR indicated an order of: -(Insulin Glargine) Inject 15 unit subcutaneously at bedtime for diabetes mellitus type 2 [rotate administration site]. Hold if BS < 120. Notify MD if BS > 400 or < 70, and follow hypoglycemia protocol. -Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 70 - 150 = 0 units notify MD if BS < 70 and follow hypoglycemia protocol; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 14 units; 401+ = 16 units notify MD if BS > 400 , subcutaneously before meals and at bedtime for diabetes notify MD if BS > 400 or BS < 70, and follow hypoglycemia protocol. During a review of Resident 4's LOA of insulin for 11/2025 to 12/2025, the LOA indicated insulin was administered on: Insulin Glargine Subcutaneous Solution 100 unit/ml 11/19/25 at 9:50 p.m. on the Abdomen - LUQ 11/20/25 at 9:47 p.m. on the Abdomen - LUQ 11/22/25 at 9:47 p.m. on the Abdomen - LUQ 11/23/25 at 9:57 p.m. on the Abdomen - LUQ 11/24/25 at 9:48 p.m. on the Abdomen - LUQ 11/26/25 at 9:42 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 11/27/25 at 9:51 p.m. on the Abdomen - RLQ Insulin Lispro Injection Solution 100 UNIT/ML 11/12/25 at 6:17 p.m. on the Abdomen - RLQ 11/12/25 at 9:16 p.m. on the Abdomen - RLQ 11/13/25 at 5:55 p.m. on the Abdomen - RLQ 11/13/25 at 9:27 p.m. on the Abdomen - RLQ 11/17/25 at 12:19 p.m. on the Abdomen - RLQ 11/17/25 at 5:28 p.m. on the Abdomen - RLQ 11/17/25 at 9:38 p.m. on the Abdomen - LUQ 11/18/25 at 6:11 a.m. on the Abdomen - LUQ 11/20/25 at 6:05 p.m. on the Abdomen - LUQ 11/20/25 at 9:47 p.m. on the Abdomen - LUQ 11/24/25 at 11:37 a.m. on the Abdomen - LUQ 11/24/25 at 5:24 p.m. on the Abdomen - LUQ 11/24/25 at 9:48 p.m. on the Abdomen - LUQ 11/30/25 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 6:54 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 11/30/25 at 12:29 p.m. on the Abdomen - LLQ 12/1/25 at 4:33 p.m. on the Abdomen- LLQ 12/2/25 at 6:21 a.m. on the Abdomen- LLQ 12/7/25 at 8:59 p.m. on the Abdomen- LLQ 12/8/25 at 6:36 a.m. on the Abdomen- LLQ 12/9/25 at 8:48 p.m. on the Abdomen- LLQ 12/10/25 at 7:26 a.m. on the Abdomen- LLQ During a review of Resident 4's CP Report titled The resident has diabetes mellitus, last revised on 12/10/2025, the CP indicated an order of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 12/16/2025 at 2:47 p.m. with RN 1, Resident 4's Medical Diagnosis, OSR, LOA, and CP were reviewed. RN 1 stated there was an order for insulin glargine and lispro with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 11/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo or hyperglycemia on residents. During an interview on 12/17/2025, at 1 p.m., with the DON, the DON stated the licensed staff should have rotated the insulin administration sites on Resident 4 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotated the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. During a review of the facility's recent P&P titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: 9. Procedure for subcutaneous (SC) injection: b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs), and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. c. For repeated injections, rotate site. During a review of the facility-provided HPI on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 200, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy. During a review of the facility-provided Highlights of Prescribing Information on the use of Humalog (insulin lispro injection, USP [rDNA origin]) for injection, with initial U.S. approval in 1996, the HPI indicated Humalog administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices by failing to administer and document skin care treatments per the physician's orders to the urethral (a hollow tube that lets urine, a waste product, leave the body) orifice penile shaft (the external opening where urine exits the urethra), the bilateral upper arms and legs, and the face on multiple shifts in December 2025 for one of one sampled resident (Resident 25). These deficient practices had the potential to result in the development and / or worsening of skin infections. Findings: During a review of Resident 25's admission Record (AR), the AR indicated the facility admitted the resident on 7/12/2021 and most recently readmitted the resident on 11/18/2025 with diabetes mellitus type two (a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and personal history of other diseases of the male genital organs. During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 7/20/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for moving from sit to stand, bathing, and toileting hygiene. The MDS indicated the resident required the application of ointments / medications and nonsurgical dressing for skin conditions. During a review of Resident 25's History and Physical (H&P), dated 1/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, (Resident 25) had a skin infection secondary to impetiginization (when bacteria infect and worsen an existing skin condition) ., initiated 12/5/2025, the CP indicated an intervention to administer the topical ointment as prescribed. During a review of Resident 25's CP titled, Resident has pink erythematous (redness) scaly plaques (thick patches) to bilateral upper extremities and facial area ., initiated 9/5/2025, the CP indicated to apply topical creams as ordered. During a review of Resident 25's CP titled, (Resident 25) has impaired skin integrity related to urethral orifice penile shaft., initiated 9/27/2025, the CP indicated to provide skin care. During a review of Resident 25's Order Summary Report, the Order Summary Report indicated the following physician's treatment orders: - (Treatment order) Cleanse urethral orifice penile shaft with normal saline (a sterile fluid), pat dry, apply zinc oxide ointment (topical medication used as a skin protectant to treat and prevent minor skin irritations), cover with dry dressing (do not tape) then apply folded abdominal pad (a highly absorbent, thick dressing) to prevent skin to skin contact, one time a day, for 28 days until finished, dated 11/19/2025. - Ammonium lactate external lotion (topical medication to relieve dry, scaly, and itchy skin conditions) 12 percent (%), apply to bilateral arms and legs topically two times a day for atopic dermatitis (a chronic inflammatory skin condition) for 30 days, dated 12/6/2025. - Fluocinonide External Cream (medication to treat skin conditions) 0.05 %, apply to bilateral arms topically two times a day for atopic dermatitis for 30 days. Cleanse open areas to bilateral arms with normal saline, pat dry, apply xeroform dressing (non-adherent medical wound dressing), cover with band aid, dated 11/19/2025. -Fluocinonide External Cream 0.05 %, apply to bilateral legs topically two times a day for atopic dermatitis, for 30 Days, dated 11/19/2025. - Ketoconazole External Cream (a topical antifungal medication) 2 %, apply to face topically, two times a day for seborrheic dermatitis (chronic inflammatory skin condition) for 30 days, avoid eyes and mouth, dated 12/6/2025. - Mupirocin External Ointment 2 % , apply to bilateral arms and Legs topically two times a day for secondary impetiginization, for 30 Days, dated 12/6/2025. During an observation on 12/15/2025 at 9:15 a.m., observed Resident 25 awake and lying in bed. Resident 25 stated the facility staff does not take care of him. During a concurrent interview and record review on 12/16/2025 at 10:42 a.m. with Registered Nurse (RN) 1, Resident 25's physician orders, Treatment Administration Record (TAR - a daily (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation record used by a licensed nurse to document medications and treatments given to a resident), for 12/2025, and Progress Notes, for 12/2025, were reviewed. RN 1 stated for the past two weeks she has been the RN Supervisor and acting as the Treatment Nurse (TN). RN 1 stated she works every Monday to Friday day shift (7 a.m. to 3 p.m.) and administers all the resident treatments for that shift. RN 1 stated the assigned Licensed Nurses (LN) perform resident treatments on the weekends and for the evening (3 p.m. to 11 p.m.) and night shift (11 p.m. to 7 a.m.). RN 1 stated Resident 25 has upper and lower extremity dermatitis that Resident 25 scratches. RN 1 stated she provides skin care to Resident 25s extremities, face, and urethral penile shaft. RN 1 stated she documents in the TAR after providing treatments. RN 1 stated it is important to provide the skin care to Resident 25 to resolve dermatitis and prevent the worsening and spread of skin infections. RN 1 stated Resident 25 never refuses treatments. RN 1 reviewed Resident 25's TAR for 12/2025 and Progress Notes for 12/2025 and noted there was no documented evidence that the resident received treatment per physician's orders on the following dates: -On 12/4/2025 for the day shift (7 a.m. to 3 p.m.) there was no documented evidence that treatment orders were completed for the urethral orifice penile shaft, fluocinonide cream treatment to the bilateral arms and legs, or Ketoconazole cream to the face. RN 1 stated RN 1 worked on 12/4/2025, but RN 1 could not remember if she provided treatments to Resident 25. RN 1 stated if it was not documented then it was not done. - On 12/6/2025 for the day shift, there was no documented evidence that treatment orders were completed for the ammonium lactate lotion or mupirocin cream to the bilateral arms and legs, or ketoconazole cream ointment to the face. RN 1 stated RN 1 did not work on 12/6/2025. RN 1 stated if it was not documented then it was not done. - On 12/7/2025 for the day shift, there was no documented evidence that any treatment orders were completed for the urethral orifice penile shaft, the bilateral arms and legs, or the face. - On 12/7/2025 for the evening shift, there was no documented evidence that any treatment orders were completed for the urethral orifice penile shaft, the bilateral arms and legs, or the face. -On 12/8/2025 for the day shift, there was no documented evidence that any treatment orders were completed for the urethral orifice penile shaft, the bilateral arms and legs, or the face. RN 1 stated RN 1 worked on 12/8/2025, but RN 1 could not remember if she provided treatments to Resident 25. - On 12/13/2025 for the day shift, there was no documented evidence that treatment orders were completed for the urethral orifice penile shaft, the bilateral arms and legs, or the face. RN 1 further stated the importance of providing wound care treatment is to ensure the residents skin conditions do not spread or get worse. RN 1 stated when wound care is not provided there is the potential that Resident 25 would have a risk of complications like worsening of infection on the skin. During a concurrent interview and record review on 12/17/2025 at 9:36 a.m. with the Director of Nursing (DON), Resident 25's TAR, physician's order, and the facility P&P regarding dressing changes, medication administration, and documentation were reviewed. The DON stated skin care treatments are provided per physician's orders and documented in the TAR to verify that the treatment was completed. The DON stated that even if a resident refuses treatment, the LN will document the refusal in the TAR because it is the standard of practice in nursing to document care provided. The DON stated if the LN does not document care, then the care was not provided. The DON stated the P&P was not followed when there was no documented evidence that skin care treatments were provided to Resident 25 potentially resulting in worsening of skin infections leading to sepsis (a life-threatening blood infection). During a review of the facility P&P titled, Clean Dressing Change, last reviewed 4/16/2025, the P&P indicated, Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection Physician's orders will specify type of dressing and frequency of changes. During a review of the facility P&P titled, Medication Administration, last reviewed 4/16/2025, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent . infection. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 17. Sign MAR after (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered. During a review of the facility P&P titled, Documentation in Medical Record, last reviewed 4/16/2025, the P&P indicated, Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. 1.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation can be completed at the time of service, but no later than the shift in which the . care service occurred. 3. Principles of documentation include but are not limited to: . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.		

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent complications in the feet from medical conditions for one sampled resident (Resident 25) by failing to provide and document treatments per the treatment orders to the right foot- second toe diabetic ulcer (an open sore or wound on the foot of a person with diabetes [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing]) and the left heel diabetic ulcer on multiple shifts in December 2025. These deficient practices had the potential to result in worsening of diabetic foot ulcers and infection. Findings: During a review of Resident 25's admission Record (AR), the AR indicated the facility admitted the resident on 7/12/2021, and most recently readmitted the resident on 11/18/2025, with diabetes mellitus type two with diabetic polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and left and right foot drop (a medical condition where the front part of the foot cannot be lifted). During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 7/20/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for moving from sit to stand, bathing, and toileting hygiene. The MDS indicated the resident required the application of medications for skin conditions. During a review of Resident 25's History and Physical (H&P), dated 1/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, The resident has a diabetic ulcer of the right foot second toe., initiated 9/30/2025, the CP indicated a goal that the resident's ulcer would improve by 3/27/2026. During a review of Resident 25's CP titled, The resident has a diabetic ulcer of the left heel ., initiated 9/5/2025, the CP indicated a goal that the resident would have no complications related to the ulcer through the review date of 3/27/2025. During a review of Resident 25's Order Summary Report, the Order Summary Report indicated the following physician's treatment orders: - (Treatment order) Right foot second toe: Cleanse with normal saline (a sterile fluid), pat dry, paint with betadine (topical antiseptic medication to prevent infection), leave open to air, every day shift for diabetic ulcer, dated 11/19/2025. - (Treatment Order) Cleanse left heel diabetic wound with normal saline, pat dry, paint with povidone iodine solution (topical antiseptic medication to prevent infection), leave open to dry, one time a day, dated 11/18/2025. During an observation on 12/15/2025 at 9:15 a.m., observed Resident 25 awake and lying in bed. Resident 25 stated the facility staff does not take care of him. During a concurrent interview and record review on 12/16/2025 at 10:42 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 25's physician orders, Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2025, and Progress Notes for 12/2025. RN 1 stated for the past two weeks she has been the RN Supervisor and acting as the Treatment Nurse (TN). RN 1 stated she works every Monday to Friday day shift (7 a.m. to 3 p.m.) and administers all the resident treatments for that shift. RN 1 stated the assigned Licensed Nurses (LN) perform resident treatments on the weekends and for the evening (3 p.m. to 11 p.m.) and night shift (11 p.m. to 7 a.m.). RN 1 stated Resident 25 has diabetic ulcer foot care that she provides daily and documents in the TAR after providing treatments. RN 1 stated the importance of providing diabetic ulcer care treatment is to ensure the residents ulcers heal and do not get worse. RN 1 stated Resident 25 never refuses treatments. RN 1 reviewed Resident 25's TAR for 12/2025 and Progress Notes for 12/2025 and noted there was no documented evidence that the resident received diabetic foot ulcer treatment per physician's orders on the following dates: -On 12/4/2025 for the day shift (7 a.m. to 3 p.m.) there was no documented evidence that treatment orders were completed for the right foot second toe diabetic ulcer or the left heel diabetic wound. RN 1 stated RN 1 worked on 12/4/2025, but RN 1 could not remember if she provided treatments to Resident 25. RN 1 stated if it was not (continued on next page)		

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

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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 12/17/2025
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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented then it was not done. - On 12/7/2025 for the day shift, there was no documented evidence that treatment orders were completed for the right foot second toe diabetic ulcer or the left heel diabetic wound. RN 1 stated RN 1 did not work on 12/7/2025 day shift, but if it was not documented then it was not done. - On 12/8/2025 for the day shift, there was no documented evidence that treatment orders were completed for the right foot second toe diabetic ulcer or the left heel diabetic wound. RN 1 stated RN 1 worked on 12/8/2025, but RN 1 could not remember if she provided treatments to Resident 25. - On 12/13/2025 for the day shift, there was no documented evidence that treatment orders were completed for the right foot second toe diabetic ulcer or the left heel diabetic wound. RN 1 stated when diabetic foot ulcer care is not provided there is the potential that Resident 25's ulcers would get worse. During a concurrent interview and record review on 12/17/2025 at 9:36 a.m. with the Director of Nursing (DON), the DON reviewed Resident 25's TAR, physician's order, and the facility P&P regarding dressing changes, medication administration, and documentation. The DON stated diabetic ulcer foot care is provided per physician's orders and documented in the TAR to verify that the treatment was completed. The DON stated that even if a resident refuses treatment, the LN will document the refusal in the TAR because it is the standard of practice in nursing to document care provided. The DON stated if the LN does not document care, then the care was not provided. The DON stated the P&P was not followed when there was no documented evidence that diabetic foot care was provided to Resident 25 potentially resulting in the worsening of the diabetic foot ulcers. During a review of the facility P&P titled, Clean Dressing Change, last reviewed 4/16/2025, the P&P indicated, Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection Physician's orders will specify type of dressing and frequency of changes. During a review of the facility P&P titled, Medication Administration, last reviewed 4/16/2025, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent . infection. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 17. Sign MAR after administered. During a review of the facility P&P titled, Documentation in Medical Record, last reviewed 4/16/2025, the P&P indicated, Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation can be completed at the time of service, but no later than the shift in which the . care service occurred. 3. Principles of documentation include but are not limited to: . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for three of four sampled residents (Resident 31, 5, and 22) reviewed for accidents by failing to ensure: 1. Resident 31 did not use her personal heating blanket (a blanket with thin, insulated electric wires or heating elements built into the fabric) in the facility without staff supervision. 2. Resident 5's floor mat (its main purpose is to soften the impact if the resident falls out of bed, which helps prevent serious injuries like fractures) did not have any equipment or furniture on top of them. 3. Resident 22 did not self-administer medications left unattended on her overbed table without a physician's order. These deficient practices increase the risk of accidents such skin burns and falls with injuries on the residents and had the potential to result in ongoing unauthorized medication administration, duplication or substitution of ordered eye drop treatment and lack of physician oversight for medication the resident was using without a physician's order. Findings: 1. During a review of Resident 31's admission Record (AR), the AR indicated the facility admitted the resident on 11/6/2025, with diagnoses including hypothyroidism (the thyroid gland is not making enough hormones, causing the body's functions to slow down, leading to fatigue, weight gain, feeling cold, dry skin, constipation, and brain fog), polyneuropathy (the damage or disease of many peripheral nerves throughout the body), and localized edema (swelling caused by fluid buildup in a specific part of the body). During a review of Resident 31's History and Physical (H&P), dated 11/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 31's Minimum Data Set (MDS, a resident assessment tool), dated 11/9/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (noticeable problems with thinking, memory, or judgment that are more significant than normal aging, but the person can still live independently). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated that the resident was at risk for developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 31's Order Summary Report (OSR), dated 12/17/2025, the OSR did not indicate an order of may use personal heating blanket. During a review of Resident 31's Care Plan (CP) Report titled The resident has depression, last revised on 11/19/2025, the CP indicated an intervention to monitor/document/report if needed (prn) risk for harm to self: suicidal plan, past attempt at suicide, risky actions etc. During a concurrent observation and interview on 12/15/2025 at 9:14 a.m., with Registered Nurse (RN) 1, inside Resident 31's room, Resident 31 was observed using her own heating blanket. RN 1 confirmed the heating blanket was brought from home by the resident. During a concurrent interview and record review on 12/16/2025 with RN 1, reviewed with RN 1 Resident 31's Medical Diagnosis, OSR, and CP. RN 1 stated there was no order from the physician for the resident to use own heating blanket in the facility and there was no care plan on the heating blanket use. RN 1 stated she does not believe that the heating blanket needs a physician's order, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	however it should have a care plan to ensure its safe use. RN 1 stated the resident had a diagnosis of hypothyroidism which can affect the resident's reception to heat that can possibly cause burn to the resident. During an interview on 12/17/2025 at 1 p.m., with the Director of Nursing (DON), the DON stated the staff should have obtained an order from the physician to use Resident 31's heating blanket in the facility and monitored for its use. The DON stated the maintenance department should have also checked the electrical heating blanket for its safe use. The DON stated the failure of the staff to get a physician's order, assess for its use, and develop and implemented a care plan on the use of heating blanket had the potential to overheat the body and possible burns to Resident 31. The DON also stated that the presence of hypothyroidism predisposes the resident to accidents such as skin burns due to the effect of hypothyroidism on the resident's body temperature regulation. During a review of the facility's recent policy and procedure (P&P) titled Safe and Homelike Environment, last reviewed on 4/16/2025, the P&P indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. 2. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 8/18/2025, and readmitted the resident on 9/27/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (condition that causes weakness on one side of your body) following cerebral infarction (a brain cell death [tissue death] from a blocked artery in the brain, which cuts off oxygen and nutrients). During a review of Resident 5's H&P, dated 8/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment (a significant decline in thinking, memory, judgment, and other mental skills, making it hard to perform daily activities like eating, dressing, or managing finances, often leading to a loss of independence, with conditions like dementia being a common manifestation of this severity). The MDS indicated the resident was totally dependent on mobility and ADLs. During a review of Resident 5's OSR, dated 12/17/2025, the OSR did not indicate an order for floor mat. During a review of Resident 5's Fall Risk Assessment (FRA), dated 8/18/2025, the FRA indicated the resident was at risk for falls. During a review of Resident 5's CP Report regarding the resident being at risk for falls related to gait (the way someone walks or moves on foot)/balance problems, last revised on 8/24/2025, the CP indicated an intervention to review information on past falls and attempt to determine the cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT, is a group of various healthcare professionals who work together to create, implement, and review a personalized care plan for each resident, focusing on their overall physical, mental, and social well-being) as to causes. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/16/2025 at 8:30 a.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 5's room, observed a floor mat at the right side of Resident 5's bed with oxygen concentrator (a medical machine that takes ordinary air from the room, removes the nitrogen, and provides a continuous supply of highly concentrated [90-95% pure] oxygen for people who struggle to get enough oxygen from normal breathing) and trash can on top of the floor mat. LVN 2 stated there should be no oxygen concentrator and trash can on top of the fall mat as it defeats the purpose of placing a fall mat at the right side of the bed to have a soft-landing surface for the resident when they roll down. LVN 2 stated the resident will land on the objects on top of the floor mat and can possibly cause injury to them such as bumps, bruises and potential fracture (break in bone). During an interview on 12/17/2025 at 1 p.m., with the DON, the DON stated the staff should have kept the floor mat free of any objects or furniture on top of it to prevent injuries to Resident 5. The DON stated the purpose of the floor mat is to provide a soft landing-surface to the resident when they fall but if we place hard objects or furniture on top of them it defeats its purpose as the resident will land on the hard objects that is on top of the floor mat increasing the risk of injuries to the residents such as bruising, laceration or even fractures. During a review of the facility's recent policy and procedure (P&P) titled Accidents and Supervision, last reviewed on 4/16/2025, the P&P indicated the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents: This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s) 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. During a review of the facility's recent P&P titled Fall Prevention Program, last reviewed on 4/16/2025, the P&P indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 4. Fall interventions include but not limited to: a. Implement a universal environment intervention that decrease the risk of resident falling, including, but not limited to: i. A clear pathway to the bathroom and bedroom doors. iii. Call light and frequently used items are within reach. During a review of the facility-provided Fall Mat (FM) 1 User Instruction, undated, the UI indicated when used as a component of a comprehensive fall prevention program, the FM 1 reduces the impact of fall from bed to help minimize injury. In addition to Low height beds that have been found to help reduce the incidence of falls; impact reduction fall mats placed alongside the bed have become a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cost-effective means to help reduce the incidence of patient trauma and severity of injury by providing a cushioned, slide resistant surface. 3. During a review of Resident 22's AR, the AR indicated the facility originally admitted Resident 22 on 8/18/2021, and readmitted the resident on 8/1/2021, with diagnoses including mild-protein calorie malnutrition (a condition where a person is not consistently eating enough protein and calories [energy] to meet their body's needs). During a review of Resident 22's H&P dated 8/12/2025 the H&P indicated Resident 22 had fluctuating capacity to understand and make decisions. During a review of Resident 22's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a person's thinking, memory, or judgment issues are noticeable to others and cause some trouble). The MDS indicated Resident 22 was dependent with activities of daily living (ADLs- activities such as bathing, dressing, and toileting). During a concurrent interview and observation on 12/15/2025 at 8:25 a.m., inside Resident 22's room, Resident 22 stated that she (Resident 22) keeps her eye drops on her table and uses them as much as possible for her dry eyes. A bottle of GeriCare Artificial Tears (eyedrop to moisten dry eyes) without a lid was observed on Resident 22's overbed table. During a review of Resident 22's physician orders for 12/2025, there was no order for administration of artificial tears. During an interview on 12/16/2025 at 2:00 p.m. with Resident 22, Resident 22 stated that she (Resident 22) had the eyedrop for several weeks given to her by a special nurse. During an interview on 12/16/2025 at 2:00 p.m. with Registered Nurse (RN) 1, RN1 stated Resident 22 had no physician order for artificial tears at the bedside for self-administration. RN1 stated medications at the resident's bedside without an order is against facility policy. RN 1 stated having the eye drops at the bedside puts the resident at risk for medication error and possible infection. During an interview on 12/17/2025 at 10:45 a.m. with the DON, the DON stated medications kept at the bedside without a physician's order poses a risk for infection, medication errors, and adverse reactions. The DON stated that without an order, medication could be inappropriately duplicated with other prescribed medication or administered at an incorrect dose. During a review of the facility's P&P titled Resident Self-Administration of Medication dated 12/19/2022, the P&P indicated, A resident may only self-administer medications after the facility interdisciplinary team has determined which medication may be self-administered safely. A resident's preference to self-administer medications will be documented on the appropriate form and placed in the medical record.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for four sampled residents (Residents 19, 2, 24, and 4) by failing to: 1. Administer clonidine (medication to treat high blood pressure [BP]) as needed (PRN) for a systolic blood pressure (SBP - the first / top number in the BP measurement) greater than (>) 160 millimeters of mercury (mm Hg - measurement of pressure) when on 12/16/2025 at 8:56 a.m. Resident 19's BP measured 171/63 mm Hg. This deficient practice had the potential to result in adverse effect (unwanted, unintended result) from high BP resulting in an increased risk for myocardial infarction (MI - heart attack), stroke (loss of blood flow to a part of the brain), kidney disease, and vision problems. 2. Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites for Residents 2, 24, and 4. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F658. Findings: a. During a review of Resident 19's admission Record (AR), the AR indicated the facility originally admitted the resident on 7/13/2022, and most recently admitted the resident on 10/30/2025, with diagnoses that included adult failure to thrive (a state of overall physical and mental decline), anemia, osteoporosis (weak and brittle bones), and essential (primary) hypertension (HTN - high blood pressure [BP] with an unknown cause). During a review of Resident 19's Minimum Data Set (MDS &ndash; resident assessment tool) dated 10/31/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for toileting, bathing, lower body dressing, and mobility. During a review of Resident 19's Physician Order Summary, the Physician Order Summary indicated an order for clonidine HCL Oral Tablet 0.1 milligram (mg &ndash; a unit of measurement) give one (1) tablet by mouth every six (6) hours PRN for hypertension (SBP > 160 or DBP [the second / bottom number in the BP measurement] > 100), dated 11/1/2025. During a review of Resident 19's Care Plan titled, (Resident 19) has HTN .clonidine HCL oral tablet 0.1 mg, give one tablet by mouth every six hours as needed for SBP > 160. initiated 9/11/2025, the CP indicated interventions to observe BP parameters and to give hypertensive medications as ordered. During a Medication Administration Observation on 12/16/2025 at 8:34 a.m., with LVN 1 at Medication Cart 1, LVN 1 measured Resident 19's BP resulting in a BP reading of 171/63 mm Hg. Observed LVN 1 prepared and administered Resident 19's routine medications. The surveyor observed LVN 1 did not prepare or administer PRN clonidine. During a concurrent interview and record review on 12/16/2025 at 11:45 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 19's physician orders and MAR for 12/2025. RN 1 stated the facility process for the administration of PRN medication for high BP is the licensed nurse should make note when the BP is high and administer PRN medication per the order parameters. RN 1 stated Resident (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19's SBP was considered high on 12/16/2025 during the routine 9 a.m. medication pass when the resident's BP measured 171/63 mm Hg. RN 1 stated Resident 19 had an order to treat high BP with PRN clonidine in addition to the routine medications. RN 1 stated LVN 1 should have noted Resident 19's high SBP and administered PRN clonidine. RN 1 stated there was no documentation indicating LVN 1 administered PRN clonidine or took any actions to address Resident 19's high BP of 171/63 mm Hg. During a follow-up interview and record review on 12/16/2025 at 12:15 p.m. with LVN 1, LVN 1 stated he did not administer any PRN medication for Resident 19's BP during or after the 9 a.m. medication pass on 12/16/2025 because LVN 1 was not aware that Resident 19 had any PRN orders for high BP and it didn't cross his mind to check. LVN 1 then reviewed Resident 19's physician orders and stated Resident 19 had an order for PRN clonidine for a SBP >160. LVN 1 stated he should have checked for a PRN medication and administered the PRN clonidine when Resident 19 had a BP of 171/63 mm Hg during the 9 a.m. medication pass, but he did not. LVN 1 stated when LVN 1 did not administer PRN clonidine to Resident 19 there was the potential that the resident could have a stroke or other complications of high BP. During a follow-up interview on 12/16/2025 at 12:27 a.m. with RN 1, RN 1 stated LVN 1 should have rechecked Resident 19's BP and administered PRN clonidine immediately when Resident 19 had a BP of 171/63 mm Hg, but LVN 1 did not. RN 1 stated it was important to administer the medication right away to make sure the BP did not continue to elevate potentially leading to an aneurism (swelling in a blood vessel in the brain that can burst and can cause bleeding) when the blood vessels expanded. During an interview on 12/17/2025 at 10:11 a.m. with the Director of Nursing (DON), the DON stated PRN clonidine is a medication to lower blood pressure. The DON stated when Resident 19's SBP was elevated on 8/16/2025, the LVN 1 should have immediately rechecked the BP to verify the resident BP met the parameters for PRN clonidine and then administered the medication. During a follow up interview and record review on 12/17/2025 at 1:20 p.m. with the DON, the DON reviewed Resident 19's MAR and policy and procedures (P&P) regarding medication administration and medication errors. The DON stated on 12/16/2025 at 12:44 p.m., LVN 1 rechecked Resident 19's BP, the BP was still high at 147/108 mm Hg, and LVN 1 administered PRN clonidine to the resident. The DON stated it was considered a significant medication error when LVN 1 did not immediately verify Resident 19's high BP and administer PRN clonidine on 12/16/2025 at 8:56 a.m. The DON stated the error was considered significant because it jeopardized Resident 19's health and safety when the resident's BP remained high and untreated potentially resulting in a stroke. The DON stated the facility P&P was not followed. During a review of the facility P&P titled, Medication Administration, last reviewed 4/16/2025, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: . 8. Obtain and record vital signs, when applicable or per physician orders. 10. Review MAR to identify medication to be administered. 14. Administer medication as ordered . During a review of the facility P&P titled, Medication Errors, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors.Definitions: 'Medication error' means the observed or identified (continued on next page)		

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 12/17/2025
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; . or accepted professional standards and principles which apply to professionals providing services. 'Significant medication error' means one which causes the resident discomfort or jeopardizes his/her health and safety . The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include but not limited to: . ii. Medication omission. b. During a review of Resident 2's AR, the AR indicated the facility admitted the resident on 2/24/2025, and readmitted the resident on 9/24/2025, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar level in the blood), and diabetic chronic kidney disease (diabetes has damaged the kidneys' tiny filters, making them bad at cleaning the blood, so waste builds up, causing swelling, fatigue, and eventually kidney failure if uncontrolled). During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had severe impaired cognition (a person has significant problems with thinking, learning, memory, and decision-making that are severe enough to interfere with their daily life and require them to depend on others for basic activities like eating and hygiene). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used to lower high blood sugar [glucose] levels in people with diabetes). During a review of Resident 2's Order Summary Report (OSR), dated 9/24/2025, the OSR indicated an order of Humulin R Injection Solution 100 units per milliliter (unit/ml, describes the strength or concentration of the insulin) (Insulin Regular [Human]) Inject as per sliding scale (extra units of insulin to be administered when a person's blood sugar gets high): if 61 - 130 = 0 units notify MD if blood sugar (BS) less than (<) 70 ; 131 - 160 = 2 units; 161 - 200 = 3 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 &ndash; 400 = 10 units; 401+ = 10 units notify MD, subcutaneously before meals and at bedtime for diabetes mellitus type 2 rotate administration site. Notify MD if BS greater than (>) 400 or BS <70 and follow hypoglycemia protocol (a simple set of steps to quickly recognize and treat dangerously low blood sugar [glucose] levels). During a review of Resident 2's Location of Administration Report (LOA) of Insulin, for 10/2025 to 12/2025, the LOA indicated insulin was administered on: Humulin R Injection Solution 100 unit/ml 10/19/25 at 9:17 p.m. on the Abdomen &ndash; Left Upper Quadrant (LUQ) 10/22/25 at 9:54 p.m. on the Abdomen - LUQ 11/6/25 at 9:33 p.m. on the Abdomen &ndash; LUQ 11/11/25 at 10:07 p.m. on the Abdomen &ndash; LUQ During a review of Resident 2's CP Report regarding Resident 2 being at risk for re-hospitalization, age > 65, diabetes, hemodialysis (a treatment to cleanse the wastes and extra fluids artificially through a machine when the kidney(s) have failed) etc., last revised on 9/26/2025, the CP indicated an intervention of medications as ordered and notify MD for signs and symptoms of adverse (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(unwanted) side effects. During a concurrent interview and record review on 12/16/2025 at 2:47 p.m., with RN 1, reviewed with RN 1 Resident 2's Medical Diagnosis, OSR, LOA, and CP. RN 1 stated there was an order for regular insulin with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 10/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo (low) or hyperglycemia on residents. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 12/17/2025 at 1 p.m., with the DON, the DON stated the licensed staff should have rotated the insulin administration sites on Resident 2 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotate the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. The DON stated the failure of the licensed staff to rotated insulin administration site constitutes a medication error. During a review of the facility's recent P&P titled Medication Errors, last reviewed on 4/16/2025, the P&P indicated it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error mean the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's orders; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing the services. During a review of the facility's recent P&P titled Physician Services last reviewed on 4/16/2025, the P&P indicated the medical care of each resident is under the supervision of a licensed physician. Policy Interpretation and Implementation: 2. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting routine visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc., to ensure that the resident receives quality care and medical treatments. During a review of the facility's recent P&P titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: 9. Procedure for subcutaneous (SC) injection: b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs) and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. For repeated injections, rotate site. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Novolin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1991, the HPI indicated subcutaneous injection subcutaneously 30 minutes before a meal into the abdominal area, buttocks, thigh or the upper arm. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. c. During a review of Resident 24's AR, the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 12/18/2024, with diagnoses including type two diabetes mellitus, heart failure (the heart is not pumping blood as well as it should to meet the body's needs, not that it has stopped), and muscle weakness. During a review of Resident 24's H&P, dated 11/17/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 24's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (refers to the ability to think, learn, remember, and make decisions clearly and effectively enough to handle all aspects of daily life independently). The MDS indicated the resident was on a high-risk drug class hypoglycemic. During a review of Resident 24's OSR, dated 6/10/2024, the OSR indicated an order of unit/ml (Insulin Aspart) Inject as per sliding scale: unit/ml (Insulin Aspart) Inject as per sliding scale: if 0 - 139 = 0 units notify MD if BS < 70; 140 &ndash; 199 = 1 unit; 200 - 249 = 3 units; 250 - 299 = 5 units; 300 - 349 = 7 units; 350 - 499 = 9 units notify MD if BS > 400 , subcutaneously two times a day every Mon, Wed, Fri for diabetes type 2 notify MD if BS > 400 or < 70, and follow hypoglycemia protocol. Rotate injection site. During a review of Resident 24's LOA of Insulin, from 9/2024 to 12/2025, the LOA indicated insulin was administered on: Aspart Subcutaneous Solution Cartridge 100 unit/ml 9/1/25 at 4:02 p.m. on the Arm - left 9/5/25 at 4:45 p.m. on the Arm - left 9/8/25 at 4:09 p.m. on the Arm - right 9/15/25 at 4:11 p.m. on the Arm - right 9/22/25 at 4:41 p.m. on the Arm - right 10/13/25 at 4:34 p.m. on the Arm - left 10/17/25 at 6:06 a.m. on the Arm &ndash; left 10/20/25 at 5:30 p.m. on the Arm - left (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/24/25 at 4:15 p.m. on the Arm &dash; left During a review of Resident 24's CP Report regarding Resident 24 having diabetes mellitus on insulin, glucagon (control blood sugar levels and keep them within set levels), and Metformin (a common and safe oral medicine used primarily to treat type 2 diabetes), last revised on 8/2/2025, the CP indicated an intervention of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 12/16/2025, at 2:47 p.m., with RN 1, reviewed with RN 1 Resident 24's Medical Diagnosis, OSR, LOA, and CP. RN 1 stated there was an order for aspart insulin with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 9/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo or hyperglycemia on residents. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 12/17/2025, at 1 p.m., with the DON, the DON stated the licensed staff should have rotated the insulin administration sites on Resident 24 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotate the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. The DON stated the failure of the licensed staff to rotated insulin administration site constitutes a medication error. During a review of the facility's recent P&P titled Medication Errors, last reviewed on 4/16/2025, the P&P indicated it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error mean the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's orders; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing the services. During a review of the facility's recent P&P titled Physician Services last reviewed on 4/16/2025, the P&P indicated the medical care of each resident is under the supervision of a licensed physician. Policy Interpretation and Implementation: 2. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting routine visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc., to ensure that the resident receives quality care and medical treatments. During a review of the facility's recent P&P titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Procedure for subcutaneous (SC) injection: b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs) and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. c. For repeated injections, rotate site. During a review of the facility-provided HPI on the use of Novolog (insulin aspart) injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. d. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 11/11/2025, with diagnoses including type two diabetes mellitus with hyperglycemia, severe sepsis (a life-threatening progression of sepsis, where the body's extreme response to an infection causes damage to its own organs, leading to dysfunction in the heart, brain, kidneys, or lungs, characterized by signs like confusion, difficulty breathing, low urine output, and low blood pressure), and immunodeficiency (a condition where the body's immune system is weakened or does not work properly). During a review of Resident 4's H&P, dated 11/16/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had impaired cognition. During a review of Resident 4's OSR, dated 11/11/2025, the OSR indicated an order of: -(Insulin Glargine) Inject 15 unit subcutaneously at bedtime for diabetes mellitus type 2 [rotate administration site]. Hold if BS < 120. Notify MD if BS > 400 or < 70 and follow hypoglycemia protocol. -Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 70 - 150 = 0 units notify MD if BS < 70 and follow hypoglycemia protocol; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 14 units; 401+ = 16 units notify MD if BS > 400, subcutaneously before meals and at bedtime for diabetes notify MD if BS > 400 or BS < 70, and follow hypoglycemia protocol. During a review of Resident 4's LOA of insulin for 11/2025 to 12/2025, the LOA indicated insulin was administered on: Insulin Glargine Subcutaneous Solution 100 unit/ml 11/19/25 at 9:50 p.m. on the Abdomen - LUQ 11/20/25 at 9:47 p.m. on the Abdomen &ndash; LUQ 11/22/25 at 9:47 p.m. on the Abdomen - LUQ (continued on next page)		

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/23/25 at 9:57 p.m. on the Abdomen - LUQ 11/24/25 at 9:48 p.m. on the Abdomen - LUQ 11/26/25 at 9:42 p.m. on the Abdomen – Right Lower Quadrant (RLQ) 11/27/25 at 9:51 p.m. on the Abdomen – RLQ Insulin Lispro Injection Solution 100 UNIT/ML 11/12/25 at 6:17 p.m. on the Abdomen - RLQ 11/12/25 at 9:16 p.m. on the Abdomen – RLQ 11/13/25 at 5:55 p.m. on the Abdomen – RLQ 11/13/25 at 9:27 p.m. on the Abdomen – RLQ 11/17/25 at 12:19 p.m. on the Abdomen - RLQ 11/17/25 at 5:28 p.m. on the Abdomen - RLQ 11/17/25 at 9:38 p.m. on the Abdomen - LUQ 11/18/25 at 6:11 a.m. on the Abdomen – LUQ 11/20/25 at 6:05 p.m. on the Abdomen - LUQ 11/20/25 at 9:47 p.m. on the Abdomen – LUQ 11/24/25 at 11:37 a.m. on the Abdomen - LUQ 11/24/25 at 5:24 p.m. on the Abdomen - LUQ 11/24/25 at 9:48 p.m. on the Abdomen – LUQ 11/30/25 at 6:54 a.m. on the Abdomen – Left Lower Quadrant (LLQ) 11/30/25 at 12:29 p.m. on the Abdomen – LLQ 12/1/25 at 4:33 p.m. on the Abdomen- LLQ 12/2/25 at 6:21 a.m. on the Abdomen- LLQ 12/7/25 at 8:59 p.m. on the Abdomen- LLQ 12/8/25 at 6:36 a.m. on the Abdomen- LLQ 12/9/25 at 8:48 p.m. on the Abdomen- LLQ (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/10/25 at 7:26 a.m. on the Abdomen- LLQ During a review of Resident 4's CP Report titled The resident has diabetes mellitus, last revised on 12/10/2025, the CP indicated an order of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 12/16/2025, at 2:47 p.m., with RN 1, reviewed with RN 1 Resident 4's Medical Diagnosis, OSR, LOA, and CP. RN 1 stated there was an order for insulin glargine and lispro with sliding scale and to rotate insulin administration sites. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration site from 11/2025 to 12/2025. RN 1 stated the licensed staff should have rotated insulin administration sites to prevent lipodystrophy on residents. RN 1 stated injecting insulin on lipodystrophy sites can affect the medication absorption causing hypo or hyperglycemia on residents. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 12/17/2025, at 1 p.m., with the DON, the DON stated the licensed staff should have rotated the insulin administration sites on Resident 4 to prevent lipodystrophy to residents. The DON stated there are ways to check on where the last insulin administration site was given on their electronic healthcare record and there was no excuse for the staff not to rotate the administration site. The DON stated that administering insulin on sites of lipodystrophy affects the absorption of the medication and will not be effective in controlling the blood sugar of the residents. The DON stated the failure of the licensed staff to rotated insulin administration site constitutes a medication error. During a review of the facility's recent P&P titled Medication Errors, last reviewed on 4/16/2025, the P&P indicated it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error mean the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's orders; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing the services. During a review of the facility's recent P&P titled Physician Services last reviewed on 4/16/2025, the P&P indicated the medical care of each resident is under the supervision of a licensed physician. Policy Interpretation and Implementation: 2. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting routine visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc., to ensure that the resident receives quality care and medical treatments. During a review of the facility's recent P&P titled Administration of Injections, last reviewed on 4/16/2025, the P&P indicated injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: 9. Procedure for subcutaneous (SC) injection: (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs) and clean the injection site with an alcohol pad. Avoid injection site that is inflamed, edematous, or with breaks in skin integrity. c. For repeated injections, rotate site. During a review of the facility-provided HPI on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 200, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy. During a review of the facility-provided Highlights of Prescribing Information on the use of Humalog (insulin lispro injection, USP [rdNA origin]) for injection, with initial U.S. approval in 1996, the HPI indicated Humalog administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure resident's medical records were updated to show documented evidence that advanced directives (a legal document indicating resident preference on end-of-life treatment decisions) were discussed with one of thirteen (13) sampled residents (Resident 26) reviewed for advance directive by failing to ensure Resident Representative was provided with advance directive formulation information. These deficient practices violated the resident's rights and/or representative's right to be fully informed of the option to formulate their advanced directives. Findings: During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2025, and readmitted the resident on 11/5/2025, with diagnoses including adult failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments), atherosclerotic heart disease of native coronary artery (the buildup of fats, cholesterol and other substances in and on the artery walls), and dementia (a progressive state of decline in mental abilities). During a review of Resident 26's History and Physical (H&P), dated 11/7/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderately impaired cognition (a person's thinking, memory, and problem-solving skills are noticeably worse than normal for their age). The MDS indicated the resident and significant other participated in the assessment and goal planning of the resident's care. During a review of Resident 26's Baseline Care Plan and Summary (BCPS), dated 11/5/2025, the BCPS indicated the resident had a representative. The BCPS did not indicate if an advanced healthcare directive formulation information was provided to the resident representative. During a review of Resident 26's Advanced Healthcare Directive (AHCD) Acknowledgement Form, dated 4/11/2025, the AHCD Acknowledgement Form indicated the Resident Representative was contacted via phone if Resident 26 had an advance directive. The AHCD Acknowledgement Form indicated the resident did not have an advance directive. The AHCD Acknowledgement Form did not indicate if the Resident Representative was provided an advance directive formulation information. During a concurrent interview and record review on 12/15/2025 at 11 a.m. with Registered Nurse (RN) 1, Resident 26's BCPS and AHCD were reviewed. RN 1 stated the AHCD was incomplete as it does not indicate whether an advance directive formulation information was provided to the Resident Representative and the BCPS did not indicate whether and advance directive formulation information was provided to the Resident Representative. RN 1 stated the AHCD should have indicated that the information was provided to the Resident Representative to honor their right to formulation of advanced healthcare directive. During a concurrent interview and record review on 12/15/2025 at 3:07 p.m. with the Director of Social Services (DSS), Resident 26's BCPS and AHCD were reviewed. The DSS stated she does not provide the advance directive formulation information to the Resident Representative because they cannot formulate advance directive for the resident. The DSS stated Resident 26 was not capable of formulating an advance directive so she left the boxes indicating the resident received the following information blank: - I have received information regarding my right to make an Advanced Healthcare Directive (AHCD). - I do not have an Advanced Healthcare Directive (AHCD), and I would like to receive more information. - I do not have an Advance Healthcare Directive (AHCD) and I don't not want any information at this time. - Yes, I do have an Advanced Healthcare Directive (AHCD). The DSS also stated they discussed the advanced healthcare directive on Resident BCPS on 11/5/2024, however, the BCPS did not indicate any information if the Resident Representative was provided with advanced healthcare directive information formulation. During a concurrent interview and record review on 12/17/2025 at 1 p.m. with the Director of Nursing (DON), Resident 26's BCPS and AHCD were reviewed. The DON stated the AHCD was incomplete as it does (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

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 12/17/2025
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not indicate whether an advance directive formulation information was provided to the Resident Representative and the BCPS did not indicate whether advance directive formulation information was provided to the Resident Representative. The DON stated the AHCD should have indicated that the information was provided to the Resident Representative to honor their right to formulation of advanced healthcare directive. The DON also stated there will be a potential for the facility to not provide the desired treatment of the resident during end-of-life care. During a review of the facility's recent policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directive, last reviewed on 4/16/2025, the P&P indicated it is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy Explanation and Compliance Guidelines: 1. On, admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advanced directive. In the event the resident is unable to formulate an AD due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) to two of four sampled residents (Residents 24 and 22) reviewed for pressure ulcers by failing to set the low air loss mattress (LALM - a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) according to the resident's weight and per physician's order. These deficient practices had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: 1. During a review of Resident 24's admission Record (AR), the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 12/18/2024, with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (the heart is like a weak pump that cannot keep up with the body's needs, failing to send enough oxygen-rich blood to organs, leading to fatigue, shortness of breath [especially with activity], and fluid buildup causing swelling in legs, ankles, and lungs), and muscle weakness. During a review of Resident 24's History and Physical (H&P), dated 11/17/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 7/27/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person has sharp, clear thinking and full use of their mental abilities, allowing them to function independently in daily life). The MDS indicated the resident required substantial assistance to being independent on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure ulcers/injuries. During a review of Resident 24's Order Summary Report (OSR), dated 11/7/2025, the OSR indicated a treatment order: low air loss mattress for wound management every shift (QS): (2) Monitor for setting accuracy and functionality every shift for skin breakdown prevention. During a review of Resident 24's Braden Score (BS), dated 7/29/2025, the BS indicated the resident was moderate risk for developing pressure injuries. During a review of Resident 24's Care Plan (CP) Report regarding the resident having a low air loss mattress, initiated on 8/5/2025, the CP indicated an intervention to check for proper functioning and monitor air pressure with appropriate setting indicated by weight. During a review of Resident 24's Weights and Vitals Log (WVL), dated 12/2/2025, the WVL indicated the resident's weight was 114 pounds (lbs. - a unit of weight) During a concurrent observation and interview on 12/15/2025 at 9:05 a.m. with Restorative Nurse Assistant (RNA) 1, inside Resident 24's room, observed Resident 24's LALM set to number four (4) or 230 lbs., and the sticker attached to the LALM machine was number two (2). RN 1 stated Resident 24's latest weight was 114 lbs. and should be at setting 2. During a concurrent interview and record review on 12/16/2025 at 2:27 p.m. with Registered Nurse (RN) 1, Resident 24's OSR, WVL, BS, and CP were reviewed. RN 1 stated Resident 24 had an order for low air loss mattress for wound management QS: (2) Monitor for setting accuracy and functionality every shift for skin breakdown prevention. RN 1 stated the resident's latest weight was 114 lbs. and the Braden was moderate risk for developing pressure injury. RN 1 stated the setting should be number 2 (130 lbs.) as per physician's order. RN 1 stated the failure of the staff to set the LALM according to the resident's weight and physician's order had the potential for the resident to develop skin issues such as pressure injuries. During an interview on 12/17/2025 at 1 p.m. with the Director of Nursing (DON), the DON stated the staff should have set the LALM of Resident 24 according to the resident's weight and per physician's order to prevent pressure injuries from getting worse. The DON stated the licensed staff should be checking the setting of the LALM when they do their environmental rounds to ensure the settings is correct and the therapeutic effect of the mattress is achieved. The DON stated the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failure of the staff to ensure Resident 24's bed was set according to weight and per physician's order predisposed the resident for skin breakdown and possible development of pressure injury. 2. During a review of Resident 22's AR, the AR indicated the facility admitted the resident on 8/18/2021, and readmitted the resident on 8/1/2025, with diagnoses including mild-protein calorie malnutrition (a condition where a person is not consistently eating enough protein and calories [energy] to meet their body's needs), pressure ulcer of back, buttock, and hip stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound). During a review of Resident 22's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a person's thinking, memory, or judgment issues are noticeable to others and cause some trouble). The MDS indicated the resident was dependent to needing setup assistance on mobility and ADLs. The MDS indicated the resident was at risk for developing pressure ulcer/injuries, had one stage 2 pressure ulcer, and was on pressure ulcer/injury care. During a review of Resident 22's OSR, dated 11/7/2025, the OSR indicated a treatment order: Low Air Loss Mattress for wound management QS: (3) Monitor for Setting accuracy and functionality every shift. During a review of Resident 22's BS, dated 8/1/2025, the BS indicated the resident was high risk for developing pressure injuries. During a review of Resident 22's WVL, dated 12/2/2025, the WVL indicated the resident weight was 128 lbs. During a review of Resident 22's CP Report titled Documented Pressure Ulcer stage 2 pressure injury to left gluteal, resolved on 12/17/2025, the CP indicated an intervention of LAL mattress as ordered. During a concurrent observation and interview on 12/15/2025 at 9:44 a.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 22's room, observed with LVN 1 Resident 22's LALM was set at number 4 or 175 lbs., and the LALM machine had a number 4 sticker attached. LVN 1 stated the resident's latest weight was 128 lbs. and the bed should be set at number three (3) or 180 lbs. LVN 1 stated the failure of the staff to ensure the LALM was set according to the resident's weight and per physician's order had predisposed the resident to skin breakdown or worsening of skin breakdown if the resident had pressure injury. LVN 1 stated it was the responsibility of all licensed staff to ensure the bed was set accordingly to resident's weight and per physicians order. During concurrent interview and record review on 12/16/2025 at 2:27 p.m. with RN 1, Resident 24's OSR, WVL, BS, and CP were reviewed. RN 1 stated Resident 22 had an order for low air loss mattress for wound management QS: (3) Monitor for setting accuracy and functionality every shift for skin breakdown prevention. RN 1 stated the resident's latest weight was 128 lbs. and the Braden was high risk for developing pressure injury. RN 1 stated the setting should be number 3 (180 lbs.) as per physician's order. RN 1 stated the failure of the staff to set the LALM according to the resident's weight and physician's order had the potential for the resident to develop skin issues such as pressure injuries. During an interview on 12/17/2025 at 1 p.m. with the DON, the DON stated the staff should have set the LALM of Resident 22 according to the resident's weight and per physician's order to prevent pressure injuries from getting worse. The DON stated the licensed staff should be checking the setting of the LALM when they do their environmental rounds to ensure the settings is correct and the therapeutic effect of the mattress is achieved. The DON stated the failure of the staff to ensure Resident 22's bed was set according to weight and per physician's order predisposed the resident for skin breakdown and possible development of pressure injury. During a review of the facility's recent policy and procedure (P&P) titled, Pressure Injury Prevention and Management, last reviewed on 4/16/2025, the P&P indicated this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Policy Explanation and Compliance Guidelines: 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 4. Interventions for Prevention and to Promote Healing b. Interventions will be based on specific factors (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: iii. Provide appropriate, pressure-redistributing, support surfaces. During a review of the facility-provided Operation Manual (OM) for low air loss mattress (LALM) 1, undated, the OM indicated weight/pressure set up. Users can adjust air mattress to a desired firmness according to resident's weight or the suggestion from a health care professional.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of urine received appropriate treatment and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for two of two sampled residents (Resident 25 and 36) by failing to: 1. Ensure indwelling suprapubic catheter (a hollow tube inserted into the bladder to drain urine through a small opening in the lower abdomen) care was provided per physician's orders and facility policy and procedure (P&P) for Resident 25 on multiple dates in 12/2025. 2. Ensure that Registered Nurse (RN) 1 cleaned the urinary catheter tubing during Resident 25's indwelling catheter care per facility P&P during an indwelling catheter care observation on 12/17/2025. 3. Ensure residents urinal bottles (portable container for collecting urine) were labeled with the name, room number, and date it was provided to the residents for Resident 36. These deficient practices had the potential for cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and urinary tract infection. Cross-reference F691. Findings: a.1. During a review of Resident 25's admission Record (AR), the AR indicated the facility admitted the resident on 7/12/2021 and most recently readmitted the resident on 11/18/2025 with diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), UTI, obstructive and reflux uropathy (the flow of urine is blocked and flows backwards from the bladder to the kidneys), encounter for fitting and adjustment of urinary device, and urogenital implants (medical devices surgically placed in the urinary or reproductive systems to restore function). During a review of Resident 25's Minimum Data Set (MDS &ndash; resident assessment tool), dated 7/20/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for moving from sit to stand, bathing, and toileting hygiene. The MDS indicated the resident had an indwelling catheter (including suprapubic catheter). During a review of Resident 25's History and Physical (H&P), dated 1/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, (Resident 25) has suprapubic catheter related to obstructive and reflux uropathy, urinary retention, diseases of the male genital organs., initiated 9/3/2023 and last reviewed 9/26/2025, the CP indicated a goal that the resident would show no signs or symptoms of UTI with interventions including to cleanse the suprapubic catheter ostomy site. During a review of Resident 25's CP titled, (Resident 25) is at risk for UTI related to suprapubic catheter use., initiated 11/9/2021, the CP indicated to provide catheter care as ordered. During a review of Resident 25's Order Summary Report, the Order Summary Report indicated a physician's treatment order to cleanse suprapubic catheter ostomy site daily, dated 11/17/2025. During an observation on 12/15/2025 at 9:15 a.m., observed Resident 25 awake and lying in bed. Resident 25 stated the facility staff does not take care of him. Resident 25 stated the facility staff does not clean his urostomy (a surgically created opening on the abdomen that allows urine to exit the body) catheter. Resident 25 stated he has had UTIs in the past. During a concurrent interview and record review on 12/16/2025 at 10:42 a.m. with Registered Nurse (RN) 1, Resident 25's physician orders, Treatment Administration Record (TAR - a daily (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation record used by a licensed nurse to document medications and treatments given to a resident), for 12/2025, and Progress Notes, for 12/2025, were reviewed. RN 1 stated for the past two weeks she has been the RN Supervisor and acting Treatment Nurse (TN). RN 1 stated she works every Monday to Friday day shift (7 a.m. to 3 p.m.) and administers all the resident treatments for that shift. RN 1 stated the assigned Licensed Nurses (LN) perform resident treatments on the weekends and for the evening (3 p.m. to 11 p.m.) and night shift (11 p.m. to 7 a.m.). RN 1 stated Resident 25 has a suprapubic indwelling catheter, and she provides daily catheter care and documents in the TAR after providing treatments. RN 1 stated daily suprapubic catheter care is important to monitor for signs and symptoms of infection and to cleanse the area to prevent UTIs. RN 1 stated Resident 25's urostomy site makes the resident susceptible to developing UTIs. RN 1 stated that when catheter care is not done, there is the potential for infection in the resident. RN 1 stated Resident 25 never refuses treatments. RN 1 reviewed Resident 25's TAR for 12/2025 and Progress Notes for 12/2025 and noted there was no documented evidence that the resident received treatment per physician's orders on the following dates: - On 12/4/2025 for the day shift (7 a.m. to 3 p.m.), there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 worked on 12/4/2025, but RN 1 could not remember if she provided catheter site care to Resident 25. RN 1 stated if it was not documented then it was not done. - On 12/7/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 did not work on 12/7/2025. RN 1 stated if it was not documented then it was not done. - On 12/8/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 worked on 12/8/2025, but RN 1 could not remember if she provided catheter site care to Resident 25. - On 12/13/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 did not work on 12/13/2025. RN 1 stated if it was not documented then it was not done. During a concurrent interview and record review on 12/17/2025 at 9:36 a.m. with the Director of Nursing (DON), Resident 25's TAR, physician's order, and the facility P&P regarding catheter care were reviewed. The DON stated indwelling catheter care is provided per physician's orders and documented in the TAR to verify that the treatment was completed. The DON stated that even if a resident refuses treatment, the LN will document the refusal in the TAR because it is the standard of practice in nursing to document care provided. The DON stated if the LN does not document care, then the care was not provided. The DON stated the P&P was not followed when there was no documented evidence that indwelling catheter care was provided to Resident 25 potentially resulting in catheter associated UTIs (CAUTI - germs enter the urinary tract through a urinary catheter and cause infection). During a review of the facility P&P titled, Catheter Care, last reviewed 4/16/2025, the P&P indicated it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . Document care and report any concerns noted to the nurse on duty and MD. During a review of the facility P&P titled, Indwelling Catheter Use and Removal, last reviewed 4/16/2025, the P&P indicated if an indwelling catheter is in use, the facility will provide appropriate (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to:.ongoing care.that adhere to professional standards of practice and infection prevention and control procedures. During a review of the facility P&P titled, Documentation in Medical Record, last reviewed 4/16/2025, the P&P indicated, Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. 1.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation can be completed at the time of service, but no later than the shift in which the . care service occurred. 3. Principles of documentation include but are not limited to: . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. a.2. During an indwelling urinary catheter care observation on 12/17/2025 at 8:49 a.m. with RN 1, observed RN 1 gather indwelling catheter care supplies and enter Resident 25's room. Observed RN 1 removed the urostomy site dressing, cleansed the urostomy site, and applied a new dressing. RN 1 did not cleanse Resident 25's indwelling catheter tubing. RN 1 then exited Resident 25's room and documented in the TAR. RN 1 stated she did not clean Resident 25's indwelling catheter tubing. RN 1 stated she cleans Resident 25's catheter tubing when it looks dirty, but she did not notice that the tubing looked dirty and did not clean the tubing. During an interview on 12/17/2025 at 9:18 a.m. with the Infection Preventionist (IP), the IP stated indwelling catheter care is provided because the catheter is an indwelling device that has the potential to introduce bacteria from the catheter tubing into the opening in the patient's body resulting in an infection. The IP stated indwelling catheter care for the urostomy site always includes cleaning the catheter tubing. During a concurrent interview and record review on 12/17/2025 at 9:36 a.m. with the DON and RN 1, Resident 25's TAR, physician's orders, and the facility P&P regarding catheter care were reviewed. RN 1 stated she only cleans Resident 25's indwelling catheter tubing when it is soiled. The DON confirmed RN 1 stated RN 1 only cleans Resident 25's indwelling catheter tubing when it is soiled. The DON stated indwelling catheter care for the urostomy is performed by the LN and includes cleaning the catheter tubing. The DON stated for Resident 25, the catheter tubing should be cleansed during catheter care when the urostomy site is cleaned and not just when the tubing appears dirty. The DON stated RN 1 did not follow the facility P&P when she did not cleanse the catheter tubing during catheter care on 12/17/2025. The DON stated that when the catheter tubing is not cleaned there is the potential to result in CAUTI in Resident 25. During a review of the facility P&P titled, Catheter Care, last reviewed 4/16/2025, the P&P indicated it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . With a new moistened cloth. moving outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. Document care and report any concerns noted to the nurse on duty and MD. During a review of the facility P&P titled, Indwelling Catheter Use and Removal, last reviewed 4/16/2025, the P&P indicated if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to:.ongoing care.that adhere to professional (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standards of practice and infection prevention and control procedures. b. During a review of Resident 36's AR, the AR indicated the facility admitted the resident on 6/18/2013, and readmitted the resident on 10/23/2025, with diagnoses including type 2 DM, spinal stenosis (narrowing of the spinal column that causes pressure on the spinal cord), muscle weakness. During a review of Resident 36's MDS, 1/25/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's overall mental functioning [thinking, memory, attention, etc.] appears normal and satisfactory during a basic, initial examination, without obvious significant problems, even though more subtle issues might exist). The MDS indicated the resident was needing supervision to set up assistance on toileting hygiene and toilet transfers. During a review of Resident 36's Order Summary Report (OSR), dated 10/23/2024, the OSR indicated an order for cranberry oral tablet 450 milligrams (mg - a unit of weight) (Cranberry [Vaccinium Macrocarpon]). Give one (1) tablet by mouth two times a day for supplement. During a review of Resident 36's CP Report regarding Resident 36's potential for urinary tract infection related to presence of dysuria (pain or a burning sensation during urination) and pain in the penile area (the entire male external genitalia) when urinating, last revised on 10/24/2024, the CP indicated the resident was on Cranberry 450 mg, 1 tablet by mouth two times a day and had an intervention to monitor resident every shift time (X) 72 hours for any complications from dysuria or progressing signs of urinary tract infection, increase in pain, presence of hematuria (blood in the urine). During a concurrent observation and interview on 12/15/2025 at 8:57 a.m. with the IP, inside Resident 36's room, observed with the IP Resident 36's urinal hanging on the right lower part of the bed unlabeled. The IP stated Resident 36's urinal bottle should be labeled with the name, room number, and the date it was provided to prevent infection to Resident 36. During an interview on 12/16/2025 at 11 a.m. with RN 1, RN 1 stated Resident 36's urinal bottle should have been labeled with the name of the resident and the date it was provided to prevent UTI. RN 1 stated the infection can set in to the resident if the staff accidentally switch urinals among residents. During an interview on 12/17/2025 at 1 p.m. with the DON, the DON stated the staff should have labeled the urinal bottle of Resident 36 with the initials of the resident and the date it was provided to prevent cross-contamination to Resident 36 that can cause UTI. The DON stated placing the initials of the resident on the urinal prevents switching of urinals among residents and they affix the date of when it was provided to makes sure they do not use the urinal for more than 7 days and if needed (PRN). During a review of the facility's recent P&P titled Disinfection of Bedpans and Urinals, last reviewed on 4/16/2025, the P&P indicated bedpans and urinals are handled in a manner to prevent the spread of infection through personal equipment. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 4/16/2025, the P&P indicated this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and (continued on next page)		

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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 12/17/2025
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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure residents with a urostomy (a surgically created opening on the abdomen that allows urine to exit the body) received appropriate treatment and services in accordance with professional standards of practice for one of two sampled residents (Resident 25) by failing to ensure suprapubic catheter (a hollow tube inserted into the bladder to drain urine through a small opening in the lower abdomen) and urostomy site care was provided per physician's orders and facility policy and procedure (P&P) for Resident 25 on multiple dates in 12/2025. These deficient practices had the potential for cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and urinary tract infection (UTI - an infection of the urinary system). Cross-reference F690. Findings: a.1. During a review of Resident 25's admission Record (AR), the AR indicated the facility admitted the resident on 7/12/2021 and most recently readmitted the resident on 11/18/2025 with diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), UTI, obstructive and reflux uropathy (the flow of urine is blocked and flows backwards from the bladder to the kidneys), encounter for fitting and adjustment of urinary device, and urogenital implants (medical devices surgically placed in the urinary or reproductive systems to restore function). During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 7/20/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for moving from sit to stand, bathing, and toileting hygiene. The MDS indicated the resident had an indwelling catheter (including suprapubic catheter). During a review of Resident 25's History and Physical (H&P), dated 1/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 25's Care Plan (CP) titled, (Resident 25) has suprapubic catheter related to obstructive and reflux uropathy, urinary retention, diseases of the male genital organs., initiated 9/3/2023 and last reviewed 9/26/2025, the CP indicated a goal that the resident would show no signs or symptoms of UTI with interventions including to cleanse the suprapubic catheter ostomy site. During a review of Resident 25's CP titled, [Resident 25] is at risk for UTI related to suprapubic catheter use., initiated 11/9/2021, the CP indicated to provide catheter care as ordered. During a review of Resident 25's Order Summary Report, the Order Summary Report indicated a physician's treatment order to cleanse suprapubic catheter ostomy site daily, dated 11/17/2025. During a concurrent observation and interview on 12/15/2025 at 9:15 a.m., observed Resident 25 awake and lying in bed. Resident 25 stated the facility staff does not take care of him. Resident 25 stated the facility staff does not clean his urostomy catheter. Resident 25 stated he has had UTIs in the past. During a concurrent interview and record review on 12/16/2025 at 10:42 a.m. with Registered Nurse (RN) 1, Resident 25's physician orders, Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for 12/2025, and Progress Notes, for 12/2025, were reviewed. RN 1 stated for the past two weeks she has been the RN Supervisor and acting as a Treatment Nurse (TN). RN 1 stated she works every Monday to Friday day shift (7 a.m. to 3 p.m.) and administers all the resident treatments for that shift. RN 1 stated the assigned Licensed Nurses (LN) perform resident treatments on the weekends and for the evening (3 p.m. to 11 p.m.) and night shift (11 p.m. to 7 a.m.). RN 1 stated Resident 25 has a suprapubic indwelling catheter, and she provides daily catheter care and documents in the TAR after providing treatments. RN 1 stated daily suprapubic catheter care is important to monitor for signs and symptoms of infection and to cleanse the area to prevent UTIs. RN 1 stated Resident 25's urostomy site makes the resident susceptible to developing UTIs. RN 1 stated that when catheter care is not done, there is the potential for infection in the resident. RN 1 stated Resident 25 never refuses treatments. RN 1 reviewed Resident 25's TAR for 12/2025 and Progress Notes for 12/2025 (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and noted there was no documented evidence that the resident received treatment per physician's orders on the following dates: - On 12/4/2025 for the day shift (7 a.m. to 3 p.m.), there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 worked on 12/4/2025, but RN 1 could not remember if she provided catheter site care to Resident 25. RN 1 stated if it was not documented then it was not done. - On 12/7/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 did not work on 12/7/2025. RN 1 stated if it was not documented then it was not done. - On 12/8/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 worked on 12/8/2025, but RN 1 could not remember if she provided catheter site care to Resident 25. - On 12/13/2025 for the day shift, there was no documented evidence that suprapubic catheter care was completed. RN 1 stated RN 1 did not work on 12/13/2025. RN 1 stated if it was not documented then it was not done. During a concurrent interview and record review on 12/17/2025 at 9:36 a.m. with the Director of Nursing (DON), Resident 25's TAR, physician's order, and the facility P&P regarding catheter care were reviewed. The DON stated indwelling catheter care is provided per physician's orders and documented in the TAR to verify that the treatment was completed. The DON stated that even if a resident refuses treatment, the LN will document the refusal in the TAR because it is the standard of practice in nursing to document care provided. The DON stated if the LN does not document care, then the care was not provided. The DON stated the P&P was not followed when there was no documented evidence that indwelling catheter care was provided to Resident 25 potentially resulting in catheter associated UTIs (CAUTI - germs enter the urinary tract through a urinary catheter and cause infection). During a review of the facility P&P titled, Catheter Care, last reviewed 4/16/2025, the P&P indicated it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . Document care and report any concerns noted to the nurse on duty and MD. During a review of the facility P&P titled, Indwelling Catheter Use and Removal, last reviewed 4/16/2025, the P&P indicated if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: ongoing care that adhere to professional standards of practice and infection prevention and control procedures. During a review of the facility P&P titled, Documentation in Medical Record, last reviewed 4/16/2025, the P&P indicated, Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation can be completed at the time of service, but no later than the shift in which the . care service occurred. 3. Principles of documentation include but are not limited to: . b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for one of one sampled resident (Resident 4) reviewed for respiratory care by failing to ensure Resident 50's oxygen via nasal cannula (NC - a simple, two-pronged device that delivers extra oxygen to the nose) was not touching the floor. The deficient practice had the potential for residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 11/11/2025, with diagnoses of respiratory failure (a serious condition that makes it difficult to breathe), severe sepsis (a life-threatening blood infection), immunodeficiency (a condition where the immune system is weakened, making the body unable to effectively fight off infections, viruses, bacteria, and other diseases, leading to frequent or severe illnesses). During a review of Resident 4's History and Physical (H&P), dated 11/11/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had impaired cognition (having difficulty with thinking skills like memory, attention, learning, reasoning, problem-solving, and decision-making, making it harder to understand the world and handle daily tasks). The MDS indicated the resident was on continuous oxygen therapy (provides extra oxygen for people whose bodies cannot get enough from normal breathing, helping organs function better). During a review of Resident 4's Order Summary Report (OSR), dated 12/15/2025, the OSR indicated an order for oxygen via NC at two (2) liters per minute, may titrate (slowly adjust something to find the perfect, most effective amount or balance) oxygen (O2) to maintain saturation of peripheral oxygen (SPO2, the percentage of oxygenated hemoglobin [hemoglobin containing oxygen] relative to the total amount of hemoglobin in the blood) greater or equal to 92 percent (%) as needed. During a review of Resident 4's Care Plan (CP) Report titled, Resident on monitoring for adverse side effects (an unwanted, harmful, or unpleasant symptom or outcome that happens as a result of a medical treatment, such as a medicine or a surgical procedure) due to oxygen tubing on the floor, initiated on 12/15/2025, the CP indicated an intervention to monitor oxygen tubing during rounds and to remove and discard oxygen tubing that made contact with floor. During a concurrent observation and interview on 12/15/2025 at 9:24 a.m. with Licensed Vocational Nurse (LVN) 2, inside Resident 4's room, observed with LVN 2 Resident 4's oxygen tubing via nasal cannula attached to the resident touching the floor. LVN 2 stated the tubing should not be touching the floor due to infection control. LVN 2 was observed coiling the extra tubing that was touching the floor and hung them on the oxygen concentrator (a medical machine that takes ordinary air from the room, removes the nitrogen, and provides a continuous supply of highly purified oxygen for a person to breathe). LVN 2 did not change the tubing. During an interview on 12/16/2025, at 11 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 4's oxygen tubing should not be touching the floor to prevent respiratory infection to set in. RN 1 stated LVN 2 should have removed and discarded the oxygen tubing that touched the floor as it was contaminated. RN 1 stated the failure of the licensed staff to discard and change the oxygen tubing predisposed Resident 2 to respiratory infections. During an interview on 12/17/2025 at 1 p.m. with the Director of Nursing (DON), the DON stated Resident 4's oxygen tubing that touched the floor should have been replaced by LVN 2 instead of coiling the extra tubing and securing them on the oxygen concentrator because the tubing is already contaminated and can cause respiratory infections to Resident 4. During a review of the facility's recent policy and procedure (P&P) titled, Oxygen Administration, last reviewed on 4/16/2025, the P&P indicated oxygen us administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goal and preferences. Policy (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Explanation and Compliance Guidelines: 4. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: b. Change oxygen tubing and mask/cannula weekly and as needed it becomes soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 4/16/2025, the P&P indicated this facility has established and maintains 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 as per accepted national standards and guidelines.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of four sampled residents (Resident 19) reviewed during the Medication Administration task, by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 1 administered medication per the physician prescribed orders when LVN 1 omitted (did not administer) folic acid (a dietary supplement that helps the body make red blood cells) 400 micrograms (mcg - a unit of measurement) on 12/16/2025 during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely). 2. Ensure LVN 1 administered the cranberry 400 milligrams (mg - a unit of measurement) tablet (dietary supplement taken for urinary tract health) per physician's orders on 12/16/2025 during the 9 a.m. medication pass observation when LVN 1 administered a 450 mg tablet. These deficient practices had the potential to result in a delay of care and treatment, mismanagement of the resident's care for anemia (low levels of healthy red blood cells), and urinary tract infection (UTI - an infection in the bladder/urinary tract) prevention. Cross-reference F759. Findings: During a review of Resident 19's admission Record (AR), the AR indicated the facility originally admitted the resident on 7/13/2022 and most recently admitted the resident on 10/30/2025 with diagnoses that included adult failure to thrive (a state of overall physical and mental decline), severe protein - calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), anemia, osteoporosis (weak and brittle bones), and essential (primary) hypertension (HTN - high blood pressure [BP] with an unknown cause). During a review of Resident 19's Minimum Data Set (MDS - resident assessment tool), dated 10/31/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for toileting, bathing, lower body dressing, and mobility. During a review of Resident 19's Physician Order Summary, the Physician Order Summary indicated the following orders: 1. Cranberry Oral Tablet 400 mg, give 400 mg by mouth one (1) time a day for supplement, dated 12/15/2025. 2. Folic Acid Oral Tablet 400 mcg, give one tablet by mouth one time a day for supplement, dated 10/30/2025. During a review of Resident 19's Care Plan (CP) titled, [Resident 19] has anemia. Folic Acid Oral Tablet 400 mcg, give 1 tablet by mouth one time a day, initiated 9/18/2024, the CP indicated a goal that the resident would remain free of signs or symptoms or complications related to anemia. The CP indicated an intervention to give medications as ordered. During a review of Resident 19's CP titled, [Resident 19] is at risk for UTI related to incontinence (lack of voluntary control over urination or defecation), dementia (a progressive state of decline in mental abilities), advanced age.cranberry oral tablet., initiated 9/18/2024, the CP indicated a goal that the resident will show no signs or symptoms of infection. During a Medication Administration Observation on 12/16/2025 at 8:34 a.m. with LVN 1, LVN 1 stated he would prepare Resident 19's 9 a.m. medications at Medication Cart 1. Observed LVN 1 prepared Resident 19's medications including one tablet from a bottle labeled Cranberry Dietary Supplement 450 mg. The surveyor also observed that LVN 1 did not prepare a 400-mcg folic acid tablet. LVN 1 then entered Resident 19's room and administered the medications including the 450 mg cranberry tablet. Observed LVN 1 did not administer a 400-mcg folic acid tablet. LVN 1 exited Resident 19's room and documented in the medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) the administration of the medications. LVN 1 then reviewed Resident 19's physician orders and stated he administered to Resident 19 one 450 mg cranberry tablet, but the physician's order indicated to give one 400 mg cranberry tablet. LVN 1 stated he should have checked the Cranberry order and clarified the correct dosage prior to administering the supplement, but he did not. LVN 1 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated clarifications of dosage should always be done with the physician to ensure the correct dosage is administered. LVN 1 further stated LVN 1 did not administer a 400-mcg folic acid tablet because LVN 1 did not have the medication in the med cart. During a follow-up interview on 12/16/2025 at 10:19 a.m. with LVN 1, LVN 1 stated Resident 19's folic acid had not been delivered, and the medication would be administered late because the 9 a.m. medications should be administered before 10 a.m. and folic acid was not administered. During a concurrent interview and record review on 12/16/2025 at 11:45 a.m. with Registered Nurse (RN) 1, Resident 19's physician orders and MAR, for 12/2025, were reviewed. RN 1 stated the facility process is to call the pharmacy and re-order medications and supplements at a minimum of three days before the medication and supplements run out. RN 1 stated the licensed nurse (LN) needs to make sure all of a resident's medications are on hand for administration to meet the resident's needs. RN 1 stated Resident 19's folic acid should have been in the medication cart and when it was not administered on 12/16/2025 during the scheduled 9 a.m. medication pass, it was considered a medication error. RN 1 stated cranberry tablets are administered to prevent UTIs. RN 1 stated the administered dose of cranberry tablets must match the physician's order because the physician determines the dose the resident needs. RN 1 stated when Resident 19's order dose did not match the dose on the bottle, LVN 1 should have clarified the order prior to administering the tablet. RN 1 stated it was considered a medication error to administer a different dose of cranberry tablet than the prescribed dose in the physician's order. During a concurrent interview and record review on 12/17/2025 at 10:11 a.m. with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding medication administration was reviewed. The DON stated the facility process for medication administration is to follow the physician's orders including the right dose and the right time of medication and supplements administration. The DON stated medications and supplements scheduled for the 9 a.m. medication pass are administered up to one hour before and after the scheduled time. The DON stated all routine medications and supplements are ordered before the supply runs out to ensure the medication is available in the medication cart for administration. The DON stated the facility P&P was not followed when folic acid was not available for administration to Resident 19 during the scheduled 9 a.m. medication pass. The DON stated it was considered a medication error when folic acid was not administered with the potential that the resident would not have their needs met for folic acid supplementation. The DON further stated it was also a medication error when Resident 19 was not administered the prescribed dose for the cranberry tablet. The DON stated the physician determines the dose and when the correct dose is not administered there is the potential that the resident would not have their needs met for cranberry supplementation. The DON stated the P&P was also not followed when Resident 19 was administered the wrong dose of cranberry tablet. During a review of the facility P&P titled, Medication Administration, last reviewed 4/16/2025, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: .1. Keep medication cart clean, organized, and stocked with adequate supplies. 10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify . dose . b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. 14. Administer medication as ordered . During a review of the facility P&P titled, Medication Errors, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Definitions: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; . or accepted professional standards and principles which apply to professionals providing services. 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but not limited to: . i. Incorrect dose, ., time of administration; .ii. Medication omission.7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right . dose, . and time of administration. During a review of the facility P&P titled, Medication Reordering, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident.2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications, the nurse will observe how many doses are left, that nurse will reorder the medication.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 28 total opportunities contributed to an overall medication error rate of 7.14%, affecting 2 of four (4) residents observed for medication administration (Resident 19 and 5). The medication errors resulted when the facility failed to: 1. Ensure Licensed Vocational Nurse (LVN) 1 administered medication per the physician prescribed orders when LVN 1 omitted (did not administer) folic acid (a dietary supplement that helps the body make red blood cells) 400 micrograms (mcg - a unit of measurement) on 12/16/2025 during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely) to Resident 19. 2. Ensure LVN 2 administered the crushed thiamine HCl oral tablet (an essential, water-soluble nutrient that the body needs daily to turn the food eaten into energy) 100 milligrams (mg - a unit of weight) mixed with water from the piston syringe (used for injecting, withdrawing, and especially for irrigating/flushing wounds, catheters, and feeding tubes to clear blockages, debris, or deliver medication/flushing solutions) barrel that was set aside to manage the clogged gastrostomy tube (g-tube - a soft feeding tube surgically placed through the belly wall directly into the stomach, creating a shortcut to deliver liquid food, medicine, and fluids when someone can't eat or drink enough by mouth, ensuring they get vital nutrients and hydration) for Resident 5. These deficient practices had the potential to result in a delay of care and treatment to Residents 19 and 5, and mismanagement of Resident 19's care for anemia (low levels of healthy red blood cells). Cross-reference F755. Findings: a. During a review of Resident 19's admission Record (AR), the AR indicated the facility originally admitted the resident on 7/13/2022 and most recently admitted the resident on 10/30/2025 with diagnoses that included adult failure to thrive (a state of overall physical and mental decline), severe protein & calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), anemia, osteoporosis (weak and brittle bones), and essential (primary) hypertension (HTN - high blood pressure [BP] with an unknown cause). During a review of Resident 19's Minimum Data Set (MDS & resident assessment tool), dated 10/31/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required substantial / maximal assistance from staff for toileting, bathing, lower body dressing, and mobility. During a review of Resident 19's Physician Order Summary, the Physician Order Summary indicated the following orders: 1. Folic Acid Oral Tablet 400 mcg, give one tablet by mouth one time a day for supplement, dated 10/30/2025. During a review of Resident 19's Care Plan (CP) titled, [Resident 19] has anemia. Folic Acid Oral Tablet 400 mcg, give one tablet by mouth one time a day, initiated 9/18/2024, the CP indicated a goal that the resident would remain free of signs or symptoms or complications related to anemia. The CP indicated an intervention to give medications as ordered. During a Medication Administration Observation on 12/16/2025 at 8:34 a.m. with LVN 1, LVN 1 stated he would prepare Resident 19's 9 a.m. medications at Medication Cart 1. Observed LVN 1 prepared Resident 19's medications. The surveyor observed that LVN 1 did not prepare a 400-mcg folic acid tablet. LVN 1 entered Resident 19's room and administered the prepared medications. Observed LVN 1 (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not administer a 400-mcg folic acid tablet. LVN 1 exited Resident 19's room and documented in the medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) the administration of the medications. LVN 1 then stated LVN 1 did not administer a 400-mcg folic acid tablet because LVN 1 did not have the medication in the med cart. During a follow-up interview on 12/16/2025 at 10:19 a.m. with LVN 1, LVN 1 stated Resident 19's folic acid had not yet been delivered, and the medication would be administered late because the 9 a.m. medications should be administered before 10 a.m. and folic acid was not administered. During a concurrent interview and record review on 12/16/2025 at 11:45 a.m. with Registered Nurse (RN) 1, Resident 19's physician orders and MAR, for 12/2025, were reviewed. RN 1 stated the facility process is to call the pharmacy and re-order medications and supplements at a minimum of three days before the medication and supplements run out. RN 1 stated the licensed nurse (LN) needs to make sure all of a resident's medications are on hand for administration to meet the resident's needs. RN 1 stated Resident 19's folic acid should have been in the medication cart and when it was not administered on 12/16/2025 during the scheduled 9 a.m. medication pass, it was considered a medication error. During a concurrent interview and record review on 12/17/2025 at 10:11 a.m. with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding medication administration was reviewed. The DON stated the facility process for medication administration is to follow the physician's orders including the right time of administration. The DON stated medications and supplements scheduled for the 9 a.m. medication pass are administered up to one hour before and one hour after the scheduled time. The DON stated all routine medications and supplements are ordered before the supply runs out to ensure the medication is available in the medication cart for administration. The DON stated the facility P&P was not followed when folic acid was not available for administration to Resident 19 during the scheduled 9 a.m. medication pass. The DON stated it was considered a medication error when folic acid was not administered with the potential that the resident would not have their needs met for folic acid supplementation. During a review of the facility P&P titled, Medication Administration, last reviewed 4/16/2025, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Policy Explanation and Compliance Guidelines: .1. Keep medication cart clean, organized, and stocked with adequate supplies. 10. Review MAR to identify medication to be administered. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. During a review of the facility P&P titled, Medication Errors, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Definitions: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; . or accepted professional standards and principles which apply to professionals providing services. 'Medication error rate' is determined by calculating the percentage of errors observed during a medication administration observation. 2. The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: a. Medication administered not in accordance with the prescriber's order. Examples include but not limited to: . i. Incorrect . time of administration; .ii. Medication omission. During a review of the facility P&P titled, Medication Reordering, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident.2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications, the nurse will observe how many doses are left, that nurse will reorder the medication. b. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 8/18/2025, and readmitted the resident on 9/27/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following a cerebral infarction (a type of stroke where a blood clot blocks a brain artery, cutting off oxygen and nutrients, causing brain cells to die) and metabolic encephalopathy (a change in how the brain works due to an underlying condition). During a review of Resident 5's History and Physical (H&P), dated 8/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment (a significant decline in thinking, memory, judgment, and other mental skills, making it hard to perform daily activities like eating, dressing, or managing finances, often leading to a loss of independence, with conditions like dementia being a common manifestation of this severity). The MDS indicated the resident had a feeding tube. During a review of Resident 5's Order Summary Report (OSR), dated 10/15/2025, the OSR indicated an order of thiamine HCl tablet 100 mg (thiamine HCl). Give one tablet via g-tube one time a day for supplement. During a concurrent observation and interview on 12/16/2025 at 8:16 a.m. with LVN 2, during Medication Administration Facility Task, inside Resident 5's room, observed LVN 2 administer thiamine HCl tablet 100 mg to Resident 5. LVN 3 checked the placement of the g-tube and flushed the g-tube with 30 ml of water prior to administering the crushed thiamine HCl 100 mg tab in a medication cup mixed with 30 ml water. LVN 2 poured the contents of the medication cup with crushed thiamine HCl 100 mg with 30 ml water to the piston syringe to administer the medication. LVN 2 noticed the medication would not go into the g-tube despite tube manipulation, milking of the tubing, and slight plunger push of the medication in the barrel of the piston syringe. LVN 2 decided to empty the medication in a clean drinking cup, so he could do the trouble shooting to unclog the g-tube. LVN 2 flushed the g-tube with more water and the clog was removed. LVN 2 proceeded with the medication administration flushing 30 ml of water in between. LVN 2 discarded the thiamine HCl 100 mg crushed tablet mixed with water that was set aside on a clean drinking cup. LVN 2 stated that he should not have discarded the thiamine HCl 100 mg crushed tablet mixed with water in a clean drinking water and administered them instead to Resident 5 to administer the complete dose as ordered by the physician. LVN 2 stated the resident did not get the correct dose of the medication and it was (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	considered as a medication error. LVN 2 stated the medication will not be effective as the dose was not given as ordered. During a concurrent interview and record review on 12/16/2025 at 11 p.m., with Registered Nurse (RN) 1, Resident 5's Medical Diagnosis, OSR, and Medication Administration Record (MAR) were reviewed. RN 1 stated Resident 5 had a g-tube and had an order of thiamine HCl 100 mg tablet via g-tube, once daily. RN 1 stated LVN 2 should not have discarded the crushed thiamine HCl 100 mg tablet that was mixed with 30 ml of water that was already poured to the piston syringe that was set aside in a clean drinking cup to unclog the g-tube as it contains the medication needed by Resident 5. RN 1 stated the resident did not get the complete dose of the thiamine as it was discarded by LVN 2. RN 1 stated the failure of LVN 2 to administer the complete dose of the medication constituted as a medication error. During an interview on 12/17/2025 at 1 p.m. with the DON, the DON stated LVN 2 should not have discarded the crushed thiamine HCl 100 mg tablet that was mixed with 30 ml of water that was already poured to the piston syringe that was set aside in a clean drinking cup to unclog the g-tube as it contains the medication needed by Resident 5. The DON stated LVN 2 should have administered the medication back to complete the dose. The DON stated the medication will not be effective as the complete dose was not given. The DON stated not administering the complete dose of medication as a medication error. During a review of the facility's recent P&P titled Medication Administration, last reviewed on 4/16/2025, the P&P indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify name, medication name, form, dose, route, and time. 14. Administer medication as ordered in accordance with manufacturer's specifications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to discard from use one opened, expired insulin (a medication used to control high blood sugar levels) Lantus (brand name glargine, a long -acting insulin) Solostar (type of insulin injection device) pen stored at room temperature for Resident 4, in accordance with manufacture's requirements and facility policy and procedures, in one of one medication carts (Medication cart 2). This failure increased the risk for Resident 4 to receive insulin that was compromised (decreased) in efficacy and potency (strength of a medication) for treating Resident 4's blood sugar levels potentially resulting in high or uncontrolled blood sugar levels and diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels). Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on [DATE], with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) respiratory failure (a serious condition that makes it difficult to breathe), and severe sepsis (a life-threatening blood infection). During a review of Resident 4's History and Physical (H&P), dated [DATE], the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 4 rarely to never had the ability to make self-understood and understand others and had impaired cognition (having difficulty with thinking skills like, ^attention, ^learning, ^reasoning, ^problem-solving, and ^decision-making, making it harder to understand the world and handle daily tasks). During a review Resident 4's Medication Administration Record (MAR), dated 12/2025, the MAR indicated insulin glargine was administered to Resident 4 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During a concurrent observation on [DATE] at 10:36 a.m. with Licensed Vocational Nurse (LVN) 2, in Medication Cart 2 an open Lantus Solostar pen for Resident 4 was found stored at room temperature, on the pen a pharmacy label indicated Start: [DATE] and expired: [DATE]. There were no staff initials or documentation on the pen noting when the pen was opened. During an interview with LVN 2 on [DATE] at 10:36 a.m. LVN 2 stated there was no date open on the pen and stated his guess would be it was opened on [DATE], the date it arrived from pharmacy making it expired on [DATE]. LVN 2 stated the Insulin pen was expired and should have been discarded on [DATE] per facility policy. During an interview on [DATE] at 10:45 a.m. with the Director of Nursing (DON), the DON stated expired insulin could be ineffective and the dose could cause a reaction in the resident. The DON stated the insulin should not be in the medication cart and should have been discarded. During a review of the Lantus Solostar pen manufacture's product labeling, opened Lantus Solostar pens should be stored at room temperature up to 86 degrees Fahrenheit (a unit of measure for temperature) and used or discarded within 28 days of opening or once storage at room temperature began. During a review of the facility's policy and procedure (P&P) titled, Insulin pen, dated [DATE], the P&P indicated, insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to keep updated vaccination (medications used to prevent diseases usually given by injection or by mouth) documentation and administer the 2025/2026 influenza (flu) vaccine (medication used to prevent a highly contagious respiratory illness, which spreads easily through the air or when people touch contaminated surfaces) for one of five sampled residents (Resident 13) reviewed during the Infection Control task. This deficient practice had the potential to result in the spread of influenza among residents, visitors, and staff. Findings: During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 2/18/2025 with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), immunodeficiency (decreased ability of the body to fight infections and other diseases), and infection at the surgical site following a procedure. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 13 had the ability to understand others and the ability to be understood. The MDS further indicated the resident required substantial / maximal staff assistance with toileting, bathing, dressing, personal and oral hygiene, and mobility. During a review of Resident 13's Physician Orders, dated 11/7/2025, the Physician Orders indicated an order that Resident 13 may have the flu vaccine. During a review of Resident 13's Influenza Vaccine Consent Form, dated 10/1/2025, the Influenza Vaccine Consent Form indicated Resident 13 gave verbal consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits) to receive the influenza vaccine. During a concurrent interview and record review on 12/16/2025 at 12:33 p.m. with the Infection Preventionist (IP), Resident 13's physician orders, for 10/2025, Influenza Vaccine Consent Form, dated 10/1/2025, and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were reviewed. The IP stated the flu vaccine prevents or minimizes infection from the flu. The IP stated residents are screened for vaccination upon admission, readmission, and annually for seasonal vaccines. The IP stated when a resident receives a vaccine, consent is obtained, the resident is administered the vaccine, and the vaccine administration is documented in the MAR. The IP stated she was hired two weeks prior and was in the process of getting updated regarding the facility residents' vaccination status. The IP stated she did not have access to California Immunization Registry (CAIR - a database that stores the immunization records of children and adults). The IP stated without access to CAIR, she could not determine some of the resident's vaccine status. The IP stated Resident 13 consented to receiving the flu vaccine on 10/1/2025 and there was a flu vaccine clinic on 10/2/2025, but there was no documented evidence that Resident 13 received the flu vaccine. During a follow-up concurrent interview and record review on 12/17/2025 at 7:40 a.m. with the IP, Resident 13's Progress Note, dated 10/1/2025, was reviewed. The IP stated the progress note indicated Resident 13 consented to receiving the flu vaccine and the vaccine should have been administered on 10/2/2025 during the vaccine clinic. The IP stated there was no documentation indicating whether or not the resident received the flu vaccine. The IP stated it was important to document if a resident received or refused a vaccine to ensure the facility is up to date with all the information regarding a resident's vaccination status. The IP stated she was not sure if Resident 13 had received the flu vaccine. The IP stated when Resident 13 consented but there was no documented evidence that the resident received the vaccine, there was the potential for the resident to contract the flu resulting in oxygenation issues that would most likely lead to hospitalization of the resident. During a concurrent interview and record review on 12/17/2025 at 1:20 p.m. with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding vaccine administration and infection control was reviewed. The DON stated the facility is responsible for maintaining documentation regarding residents' vaccine status and administering vaccinations as needed. The DON stated the IP followed up with the flu clinic from (continued on next page)		

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/2/2025 and Resident 13 was not administered the flu vaccine but should have been. The DON stated the importance of receiving the flu vaccine is to prevent the spread of flu and respiratory infections. The DON stated the facility policy regarding vaccine administration was not followed for Resident 13 when the resident did not receive the flu vaccine and there was no documentation on the resident's current flu vaccine status. During a review of the facility P&P titled, Infection Prevention and Control Program, last reviewed 4/16/2025, the P&P indicated, This facility has established and maintains 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 as per accepted national standards and guidelines. 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases. 7. Influenza and Pneumococcal Immunization: a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations. During a review of the facility P&P titled, Influenza Vaccination, last reviewed 4/16/2025, the P&P indicated, It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. 4. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved standing orders. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' bedrooms meet the requirement of 80 square feet (a unit of measure) per resident in multiple resident bedrooms for 18 of 20 rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 24, 16, 17, 18, 19, and 20). 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. Findings: During a general observation tour of the facility on 12/15/2025 at 8:58 a.m., 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. During an interview on 12/16/2025 at 9:17 a.m. with Registered Nurse (RN) 1, RN 1 stated most of the rooms at the facility does not meet the 80 square feet federal regulation space per resident but there was enough space for staff to provide care. During an interview on 12/17/2025 at 1 p.m. with the Director of Nursing (DON), the DON stated they have issues with room size affecting the placement of equipment and furniture in the rooms. During a concurrent interview and record review on 12/17/2025 at 1:30 p.m. with the Administrator (Adm), a letter dated, 12/5/2025, indicated a request for a waiver for room size and beds per room was reviewed. The Adm stated a request for room waiver was made for all rooms except rooms [ROOM NUMBERS]. The Adm stated there was no clutter and all residents were happy. The Adm stated if the residents had any concerns, they would try to accommodate their needs. During the recertification survey between 12/15/2025 and 12/17/2025, the evaluator observed the following rooms had sufficient space for the residents' freedom of movement, nursing staff had enough space to provide nursing care, privacy during care, ability to maneuver residents' care equipment within the room, and the room size did not present any adverse effect on the residents' personal space, nursing care, and comfort: - room [ROOM NUMBER], two beds, 138.88 square feet (unit of measurement), 69.45 square feet per resident. - room [ROOM NUMBER], two beds, 141.38 square feet, 70.69 square feet per resident. - room [ROOM NUMBER], two beds, 141.55 square feet, 70.78 square feet per resident. - room [ROOM NUMBER], two beds, 138.06 square feet, 69.03 square feet per resident. - room [ROOM NUMBER], two beds, 138.97 square feet, 69.48 square feet per resident. - room [ROOM NUMBER], two beds, 138.9 square feet, 69.45 square feet per resident. - room [ROOM NUMBER], two beds, 139.28 square feet, 69.64 square feet per resident. - room [ROOM NUMBER], two beds, 138.28 square feet, 69.14 square feet per resident. - room [ROOM NUMBER], two beds, 136.88 square feet, 68.88 square feet per resident. - room [ROOM NUMBER], two beds, 136.6 square feet, 68.3 square feet per resident. - room [ROOM NUMBER], two beds, 138.9 square feet, 69.45 square feet per resident. - room [ROOM NUMBER], two beds, 139.66 square feet, 69.83 square feet per resident. - room [ROOM NUMBER], two beds, 139.65 square feet, 69.82 square feet per resident. - room [ROOM NUMBER], four beds, 275.55 square feet, 68.88 square feet per resident. - room [ROOM NUMBER], four beds, 276.8 square feet, 69.2 square feet per resident. - room [ROOM NUMBER], four beds, 272.43 square feet, 68.1 square feet per resident. - room [ROOM NUMBER], four beds, 277.76 square feet, 69.44 square feet per resident. - room [ROOM NUMBER], four beds, 281.89 square feet, 70.47 square feet per resident. During a review of the facility's recent policy and procedure (P&P) titled Resident Rooms, last reviewed on 4/16/2025, the P&P indicated resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. Policy Explanation and Compliance Guidelines: 1. Resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in single resident bedrooms.		