STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055568	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Valley Rehab Center	301 West Putnam Porterville, CA 93257

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38993 Based on interview and record review, the facility failed to follow their policy and procedure when a resident-to-resident allegation of abuse was not reported to California Department of Public Health (CDPH-state agency) per facility policy and procedure for two of two sampled residents (Resident 4 and Resident 5). This failure resulted in the allegation of abuse not being reported to CDPH timely. Findings: During a review of the Initial Facility Reported Event (IFRE), (undated), the IFRE indicated, Date/Time Reported: 12/16/24 approx. (approximately) 5 p.m. CDPH.Obtained knowledge 12/16/24 of incident on 12/14/24 at approx. 5:44 p.m. (approximately 48 hours prior to the abuse being reported) .Type of Incident. resident-to-resident physical contact.An incident of resident-to-resident mistreatment occurred between (Resident 5) and (Resident 4). Per staff witness, both residents were initially arguing when (Resident 4) kicked (Resident 5). During a review of Resident 4's Minimum Data Set (MDS-resident assessment tool) dated 12/8/24, the MDS indicated, Brief Interview for Mental Status (BIMS).12 (moderately impaired cognitively). During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool) dated 12/7/24, the MDS indicated, Brief Interview for Mental Status (BIMS). 03 (severe cognitive impairment). During an interview on 12/16/24 at 4:22 p.m. with Administrator (prior to the facility reporting the incident), Administrator stated he was not aware of the resident-to-resident (Resident 4 and Resident 5) altercation on 12/14/24, but it should have been reported to CDPH. During an interview on 12/30/24 at 2:28 p.m. with Social Services Director (SSD), SSD stated when the resident-to-resident (Resident 4 and Resident 5) altercation occurred, the staff should have notified the abuse coordinator right away and it should have been reported to CDPH per facility policy. During a review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating the P&P indicated If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.Immediately is defined as. within two hours of an allegation involving abuse or result in serious bodily injury.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38993 Based on observation, interview, and record review, the facility failed to ensure the care plan was followed for one of three sampled residents (Resident 3) when the mesh stop sign on Resident 3's door was not in use. This failure had the potential for residents to wander into Resident 3's room. Findings: During a review of Resident 3's Care Plan (CP), (undated), the CP indicated, 12/3/24 Alleged receiver of inappropriate touching from another resident.Interventions/Tasks.Place a bright colored stop sign at the entrance to deter wandering residents. During a concurrent observation and interview on 12/30/24 at 3:29 p.m. with Certified Nursing Assistant (CNA) 1 in the hallway, the mesh stop sign on Resident 3's door was not in use. CNA 1 confirmed the findings and stated the mesh stop sign was used to keep wandering resident's out of Resident 3's room and it should have been in use. During an interview on 12/30/24 at 3:45 p.m. with Social Service Director (SSD), SSD stated Resident 3's stop sign should always be used to deter the wandering residents from entering the room. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 3/22, the P&P indicated, The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38993 Based on interview and record review, the facility failed to ensure the physician orders were implemented for one of three sampled residents (Resident 3). This failure resulted in Resident 3 not receiving the medication as ordered by the physician and had the potential for adverse health outcomes. Findings: During a review of Resident 3's Physician's Orders (PO), dated 12/11/24, the PO indicated, 12/11/24 Increase Xanax (medication used to treat anxiety) 1mg (milligram-a unit of measurement) TID (three times a day). During a review of Resident 3's Order Summary Report (OSR), dated 12/30/24, the OSR indicated, Resident 3 had a physician order for Alprazolam (also known as Xanax) oral tablet 1 mg give 1 tablet by mouth two times a day.start date 10/24/24. During a review of Resident 3's Medication Administration Record (MAR), dated 12/24, the MAR indicated, Alprazolam.1 mg. two times a day was being administered daily. During an interview on 12/30/24 at 2:34 p.m. with Social Service Director (SSD), SSD stated she was the one who received Resident 3's PO from the psychologist. SSD stated she did not provide nursing with the PO and she should have. SSD stated Resident 3 should have been receiving Xanax 1 mg TID and not the Xanax two times daily. During a review of the facility's policy and procedure (P&P) titled Administering Medications dated 4/19, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 38993 Based on interview and record review, the facility failed to ensure one of three sampled staff Licensed Vocational Nurses (LVN 1) competencies were completed. This failure had the potential for LVN 1 to be incompetent when providing care for the residents'. Findings: During a review of LVN 1's L.V.N. Competency Skills Checklist (LVNCSC) (undated), the LVNCSC indicated, Competency 2.Communicates effectively in professional relationships.Competency 3.Utilizes the nursing process in providing nursing care to residents.Competency 5.Provides nursing care based on scientific principles and sound theoretical knowledge.Competency 6.Demonstrates knowledge of emergency procedures.Competency 7.Demonstrates knowledge of unit rounds and nursing documentation.Competency 8.Transcribes and administers medications according to policy and procedures.Competency 9.Demonstrates knowledge of principles of Pain Management Program.Competency 10.Demonstrates knowledge of discharge process.Competency 11.Verbalizes the importance of acting as a resident advocate.Competency 12.Verbalizes accountability for one's own professional practice.Competency 13.Participates in the Quality Improvement/Risk Management process at the unit level. The above competencies were noted to be incomplete. During a concurrent interview and record review on 12/4/24 at 3:47 p.m. with Director of Staff Development (DSD), LVN 1's competencies were reviewed. DSD stated LVN 1's competencies were incomplete. During an interview on 12/18/24 at 2:42 p.m. with LVN 1, LVN 1 stated he had been assigned and worked in all three stations in the facility providing medications to the residents. During an interview on 12/19/24 at 1:02 p.m. with Administrator, Administrator stated he would have expected LVN 1's competencies to be completed prior to passing medications independently. During a review of the facility's policy and procedure (P&P) titled, Licensed Nurse Competency Evaluation Guidelines dated 12/31/15, the P&P indicated, Onboarding is the introductory period of employment, generally the first 90 days. Competencies required during on-boarding must be validated prior to the nurse performing the skill independently.Until the nurse meets the competency required, the nurse may not perform the skill, unless done so under direct supervision of a competent nurse.

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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. 38993 Based on interview and record review, the facility failed to ensure medication was documented when administered for one of three sampled residents (Resident 1). This failure had the potential for Resident 1's medical record to be inaccurate. Findings: During an interview on 12/16/24 at 1:05 p.m. with Resident 1, Resident 1 stated she does not receive her medications that are scheduled at 6 a.m. on time. During a concurrent interview and record review on 12/30/24 at 2:30 p.m. with Assistant Director of Nursing (ADON) 2, Resident 2's Administration History (AH), dated 12/30/24 was reviewed. The AH indicated, Levothyroxine Sodium (thyroid medication) oral tablet 150 mcg (micrograms-a unit of measurement) . scheduled for 6 am on 12/9/24. The AH indicated, Administration by (ADON 2) .Documented 12/19/24 (10 days after administration) 1:19 p.m. ADON 2 stated she administered Resident 2's Levothyroxine Sodium on 12/9 (no time given) but did not document it until 12/19. ADON 2 stated when the medication was administered it should have been documented as soon as it was given. During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated 4/19, the P&P indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.