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	02/03/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 1) from verbal abuse inflicted by his roommate (Resident 2). This failure resulted in Resident 1 being agitated, noisy, restless and the inability to sleep with the potential for psychosocial harm. Findings: During a review of Resident 1's Minimum Data Set (MDS), dated [DATE], the MDS indicated, Brief Interview for Mental Status (BIMS).05 (severe cognitive impairment). During a review of Resident 2's MDS dated [DATE], the MDS indicated, BIMS.13 (cognition is intact). During a review of Resident 1's Admission Record (AR), dated 3/3/25, the AR indicated, Resident 1 was admitted [DATE] and had the following diagnoses.quadriplegia c-1-c-4 complete (spinal cord injury resulting in total paralysis of both arms and legs), dysphasia (condition that affects the ability to understand, use, or produce language) following cerebral infarction (lack of oxygen causing an area of dead tissue in the brain). During a review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC341), dated 1/23/25, the SOC 341 indicated, It was reported today to Abuse Coordinator/Administrator and designee (Social Services Director) that the alleged aggressor, (Resident 2), displayed angry outbursts toward his roommate, (Resident 1). During a review of Resident 1's and Resident 2's Census List (CL), dated 2/7/25, the CL indicated, Resident 1 and Resident 2 had been roommates since 6/7/23 (approximately one year and 7 months). During an interview on 2/3/25 at 12:30 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated when Resident 1 and Resident 2 shared a room, Resident 2 would call Resident 1 a pedophile (person sexually attracted to children) and cuss at him. CNA 1 stated Resident 1 was unable to talk but would make grunting noises. CNA 1 stated after Resident 1 and Resident 2 were separated (1/23/25), Resident 1 yelled out less, slept more and seemed more comfortable. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Sierra Valley Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 301 West Putnam Porterville, CA 93257	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/3/25 at 12:46 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 would yell at Resident 1 when he was moaning and groaning. LVN 1 stated Resident 2 was verbally aggressive towards Resident 1. LVN 1 stated after Resident 1 was moved to a different room, Resident 1 was resting more. During an interview on 2/3/25 at 12:54 p.m. with Social Service Director (SSD), SSD stated Resident 2 would have angry outburst towards others no matter how much he was redirected. During an interview on 2/3/25 at 1:37 p.m. with Director of Staff Development (DSD), DSD stated on 1/23/24, Resident 2 was telling Resident 1 to shut up you f****** baby. DSD stated it was unfair for Resident 1 to hear those words on a day-to-day basis. DSD stated Resident 2 would say shut the f*** up all the time to Resident 1. DSD stated Resident 2 has always said (bad) words to Resident 1. DSD stated she reported it on 1/23/24 because when she went to ask Resident 2 to stop, Resident 2 told her to get the f*** out and if he was verbally abusive to her, she could only imagine what he said to Resident 1. DSD stated after Resident 1 was moved to a different room, Resident 1 was happier, sleeping more and he could moan without being called names. DSD stated Resident 2's verbally abusive behaviors should have been reported to the Administrator when it was happening in the past to protect Resident 1. During an interview on 2/6/25 at 3:55 p.m. with CNA 1, CNA 1 stated Resident 1 could not talk but was able to moan and yell out. CNA 1 stated Resident 2 would get mad at Resident 1 and tell him to shut up. CNA 1 stated when Resident 1 and Resident 2 shared a room together it was stressful to go in the room to provide care to Resident 1 because Resident 2 would call Resident 1 a dirty Mexican, say racial slurs and tell Resident 1 he was gay. CNA 1 stated Resident 1 and Resident 2 had shared a room together for a year. CNA 1 stated when she would report the verbal altercations to the nurses, they would say they were going to make a note of the behavior and care plan it. CNA 1 stated several CNAs said Resident 2 was verbally abusive to Resident 1. During an interview on 2/20/25 at 3:49 p.m. with Administrator, Administrator stated staff had never reported Resident 1 being verbally abusive to Resident 2. Administrator stated the staff should have reported the verbal abuse to him or the Director of Nursing (DON). During a review of the lesson plan titled Abuse: Reporting Requirement & Procedures.What constitutes Abuse? (ARRPWCA), dated 11/19/24 at 2 p.m., the ARRPWCA indicated, Abuse Reporting & Investigations. What are the 7 types of abuse.verbal abuse.five things to do if you witness an abuse: Protect the victim.call for help.report.Resident Rights.Be free from abuse and neglect. During a review of the facility policy and procedure titled, Behavioral Assessment, Intervention and Monitoring dated 3/19, the P&P indicated, The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. (continued on next page)

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 9/22, the P&P indicated If resident abuse, neglect, exploitation, misappropriation of resident property or injury or 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 resulting in serious bodily injury.within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on interview and record review, the facility failed to follow its policy and procedure for one of three sampled residents (Resident 1) when verbal abuse was not reported to the Administrator. This failure resulted in Resident 1 experiencing persistent verbal abuse from his roommate (Resident 2). Findings: During a review of Resident 1's Minimum Data Set (MDS), dated [DATE], the MDS indicated, Brief Interview for Mental Status (BIMS).05 (severe cognitive impairment). During a review of Resident 2's MDS dated [DATE], the MDS indicated, BIMS.13 (cognition is intact). During a review of Resident 1's Admission Record (AR), dated 3/3/25, the AR indicated, Resident 1 was admitted [DATE] and had the following diagnoses.quadriplegia c-1-c-4 complete (spinal cord injury resulting in total paralysis of both arms and legs), dysphasia (condition that affects the ability to understand, use, or produce language) following cerebral infarction (lack of oxygen causing an area of necrotic tissue in the brain). During a review of Resident 1's and Resident 2's Census List (CL), dated 2/7/25, the CL indicated, Resident 1 and Resident 2 had been roommates since 6/7/23 (approximately one year and 7 months). During a review of Resident 1's Psychiatric Consultation (PC), dated 12/9/24, the PC indicated, Patient.seen in room.shows an inability to relax, as evidenced by calling out and episodes of crying. During a review of Resident 2's PC dated 12/9/24, the PC indicated, Patient.seen in room.exhibiting irrational outbursts of anger.Behavior.aggressive.angry.agitated. During an interview on 2/3/25 at 12:30 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated when Resident 1 and Resident 2 shared a room, Resident 2 would call Resident 1 a pedophile (person sexually attracted to children) and cuss at him. CNA 1 stated Resident 1 was unable to talk but would make grunting noises. CNA 1 stated after Resident 1 and Resident 2 were separated (1/23/25), Resident 1 yelled out less, slept more and seemed more comfortable. During an interview on 2/3/25 at 12:46 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 would yell at Resident 1 when he was moaning and groaning. LVN 1 stated Resident 2 was verbally aggressive towards Resident 1. LVN 1 stated after Resident 1 was moved to a different room, Resident 1 was resting more. During an interview on 2/3/25 at 12:54 p.m. with Social Service Director (SSD), SSD stated Resident 2 has angry outburst towards others no matter how much he is redirected. SSD stated when Resident 2 was calling Resident 1 names the staff should have reported it. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/3/25 at 1:37 p.m. with Director of Staff Development (DSD), DSD stated on 1/23/24, Resident 2 was telling Resident 1 to shut up you f****** baby. DSD stated it was unfair for Resident 1 to hear those words on a day-to-day basis. DSD stated Resident 2 says shut the f*** up all the time to Resident 1. DSD stated Resident 2 has always said (bad) words to Resident 1. DSD stated she reported it on 1/23/24 because when she went to ask Resident 2 to stop, Resident 2 told her to get the f*** out and if he was verbally abusive to her, she could only imagine what he says to the roommate. DSD stated after Resident 1 was moved to a different room, Resident 1 was happier, sleeping and he could moan without being called names. DSD stated, Resident 2's verbally abusive behaviors should have been reported to the Administrator when it was happening in the past to protect Resident 1. During an interview on 2/3/25 at 1:55 p.m. with Director of Nursing (DON), DON stated when staff were aware of an abuse allegation it was their responsibility to report it to the administrator. DON stated no allegations of verbal abuse to Resident 1 were reported by staff. During an interview on 2/6/25 at 3:55 p.m. with CNA 1, CNA 1 stated Resident 1 could not talk but was able to moan and yell out. CNA 1 stated, Resident 2 would get mad at Resident 1 and tell him to shut up. CNA 1 stated when Resident 1 and Resident 2 shared a room together it was stressful to go in the room to provide care to Resident 1 because Resident 2 would call Resident 1 a dirty Mexican, say racial slurs and tell Resident 1 he was gay. CNA 1 stated Resident 1 and Resident 2 had shared a room together for a year. CNA 1 stated when she would report the verbal altercations to the nurses, they would say they were going to make a note of the behavior and care plan it. CNA 1 stated several CNAs said Resident 2 was verbally abusive to Resident 1. During an interview on 2/6/25 at 3:54 p.m. with LVN 2, LVN 2 stated Resident 1 would make sounds and wake up Resident 2 at night and Resident 2 would tell Resident 1 to shut the f*** up, you retard. LVN 2 stated Resident 2 was mean, vulgar and verbally abusive to Resident 1 and staff. LVN 2 was unaware if the verbal abuse was reported. LVN 2 stated when Resident 1 was sharing a room with Resident 2 he was up more at night and since the room change, he was resting more. During an interview on 2/6/25 at 4:39 p.m. with CNA 3, CNA 3 stated Resident 2 was verbally abusive to Resident 1 and would tell Resident 1 he was a child predator, baby [NAME] and make fun of his disabilities. CNA 3 stated it had been going on for years and it made Resident 1 feel helpless and upset. CNA 3 stated he had reported the verbal abuse to the nurses and the Director of Staff Development (DSD) in the past. CNA 3 stated since Resident 1 was moved to a different room he had calmed down. During an interview on 2/20/25 at 3:49 p.m. with Administrator, Administrator stated staff had never reported Resident 1 being verbally abusive to Resident 2. Administrator stated the staff should have reported the verbal abuse to him or the Director of Nursing (DON). During a review of the lesson plan titled Abuse: Reporting Requirement & Procedures.What constitutes Abuse? (ARRPWCA), dated 11/19/24 at 2 p.m., the ARRPWCA indicated, Abuse Reporting & Investigations. What are the 7 types of abuse.verbal abuse.five things to do if you witness an abuse: Protect the victim.call for help.report.Resident Rights.Be free from abuse and neglect. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 9/22, the P&P indicated If resident abuse, neglect, exploitation, misappropriation of resident property or injury or 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 resulting in serious bodily injury.within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.