

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Adventist Health Delano		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Garces Hwy Delano, CA 93215	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>37697</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure (P&P) on abuse for one of 13 sampled residents (Resident 13), when the alleged abuser Licensed Vocational Nurse (LVN) 1 was not removed from the working schedule and/or monitored until cleared from the abuse allegation. This failure had the potential to place Resident 13 at risk for further abuse and had the potential to place other residents at risk for abuse and serious harm.</p> <p>Findings:</p> <p>During a review of Resident 13's CODING SUMMARY (CS), dated 1/13/24, the CS indicated, Resident 13's diagnosis including history of chronic respiratory failure (condition when the lungs cannot get enough oxygen into the blood), dependence on respirator (means of providing oxygen to support or replace breathing), Tracheostomy (an incision into the wind pipe to provide a means for a person to breathe) and myoneural disorder (a disease that affects the nerves that control voluntary muscles).</p> <p>During a review of Resident 13's MDS (Minimum Data Set - an assessment tool) under the section Brief Interview for Mental Status (BIMS - an assessment of cognition [cognition - mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception], dated 1/24/24, the BIMS indicated, Resident 13 was not assessed due to being rarely or never understood, under the section Cognitive Patterns (CP) the CP indicated Resident 13 had problems with her short- and long-term memory. The CP also indicated Resident 13 had severe impairment in her cognitive skills for daily decision making.</p> <p>During an interview on 5/1/24 at 10:52 a.m. with Registered Nurse (RN) 1, RN 1 stated on 4/24/24 at approximately 6:30 p.m. Resident 13's sister called and stated Resident 13 alleged LVN 1 hit and aggressively pushed Resident 13's head. RN 1 stated LVN 1 went home at her regularly scheduled time on 4/24/24 and returned to work on 4/25/24 but was not assigned to Resident 13.</p> <p>During an interview on 5/1/24 at 11:05 a.m. with Social Services Director (SSD), SSD stated LVN 1 was identified as the staff member Resident 13 made an allegation of abuse against. SSD stated LVN 1 was not taken off schedule but continued to work after the abuse allegation. SSD stated LVN 1 worked on 4/25/24 and 4/30/24 but the investigation to the allegation of abuse was unknown since it had not been completed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/24 at 12:15 p.m. with Risk and Regulation Analyst (RRA), RRA stated it is the facility P&P to remove staff accused of abuse from caring for the resident that made the allegation. RRA stated the staff member may be allowed to continue to work while the investigation is ongoing but must be directly monitored. RRA stated LVN 1 was allowed to continue to work while the investigation was ongoing but was not directly monitored. RRA stated the facility investigation to the allegation of abuse was still ongoing as of today 5/1/24.</p> <p>During a review of the facility Time Sheets (TS), the TS indicated, LVN 1 worked on 4/25/24 from 7 a.m. to 7 p.m. and 4/30/24 from 7 a.m. to 7 p.m.</p> <p>During a review of the facility's policy and procedure (P&P) titled, FACILITY POLICY: SUSPECTED CHILD, ADULT, DISABLED PERSON OR ELDERLY ABUSE/NEGLECT/EXPLOITATION, dated 9/28/20, the P&P indicated, Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation. It is the policy of this hospital to protect patients from real or perceived abuse, neglect, or exploitation from anyone, including staff members, students, volunteers, other patients, visitors or family members. All allegations, observations or suspected cases of abuse, neglect, or exploitation that occur in the hospital will be investigated by the hospital. If allegations exist that the patient is experiencing abuse, neglect or exploitation caused by a staff member(s), that staff member will not be assigned to the involved patient. A thorough investigation will be conducted, during which time his or her immediate supervisor will monitor the staff member's performance until the allegations are proven or disproved. At no time will a staff member suspected of improper actions toward a patient be allowed to interact with any patient without a second staff member in attendance.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37697</p> <p>Based on interview and record review, the facility failed to complete an investigation for one of 13 sampled residents (Resident 13) allegation of abuse within five (5) working days. This failure had the potential for the abuse allegation to not be thoroughly investigated and could result in further abuse.</p> <p>Findings:</p> <p>During an interview on 5/1/24 at 10:52 a.m. with Registered Nurse (RN) 1, RN 1 stated on 4/24/24 at approximately 6:30 p.m. Resident 13's sister called and stated Resident 13 alleged Licensed Vocational Nurse (LVN) 1 had hit and aggressively pushed Resident 13's head.</p> <p>During an interview on 5/1/24 at 11:05 a.m. with Social Services Director (SSD), SSD stated an allegation of abuse was made on 4/24/24. SSD stated the investigation for the allegation of abuse had not been completed at this time.</p> <p>During an interview on 5/1/24 at 12:15 p.m. with Risk and Regulation Analyst (RRA), RRA stated the Director of Nursing (DON) had been investigating the allegation of abuse made by Resident 13, but the DON was unavailable due to being at a conference. RRA stated the Patient Care Executive (PCE) is covering for the DON while the DON is at the conference but is unaware of the allegation of abuse. RRA stated she was not sure regarding the timeframe for the facility to complete an investigation for an allegation of abuse.</p> <p>During a review of the facility Investigative Report Summary (IRS), dated 5/7/24, the IRS indicated, the facility completed the investigation on 5/7/24 for allegation of abuse made on 4/24/24 by Resident 13.</p> <p>During an interview on 5/13/24 at 2:53 p.m. with RRA, RRA stated (via email) the 5-day timeframe for an abuse investigation to be completed does not exist in the facility policy and procedure. RRA stated, We [facility] have identified this gap [timeframe not indicated in the policy and procedure] and are working on making some corrections.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to staff appropriately to meet the needs of the residents for 12 of 13 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, and Resident 12). This failure resulted in diminished ability to provide effective care to the residents, had potential to have negative impacts on other residents from lack of staffing and resulted in new skin wounds for two residents (Resident 10 and Resident 12).</p> <p>Findings:</p> <p>During a review of Resident 1's CODING SUMMARY (CS), dated 11/17/23, the CS indicated, Resident 1 diagnosis including functional quadriplegia (complete immobility due to severe disability or frailty) and Guillain Barre Syndrome (a rare disorder in which your body's immune system attacks your nerves).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - an assessment tool) under the section Brief Interview for Mental Status (BIMs - an assessment tool for cognition [the mental processes including perception, memory, and thought]), dated 4/4/24, the BIMs indicated, Resident 1 had a score of 15 (cognition is intact).</p> <p>During a review of Resident 1's MDS under the section Functional Assessment (FS), dated 4/4/24, the FS indicated Resident 1 required the following from facility staff: Dependence (residents who need complete assistance with all aspects of care) on staff for oral hygiene, toilet hygiene, shower/bathing, lower body dressing, putting on/off footwear, personal hygiene, rolling left/right, chair to bed transfers and tub to shower transfers.</p> <p>During an interview on 5/16/24, at 11:41 a.m. with Resident 1, Resident 1 stated the facility does not have enough staff to meet the needs of the residents. Resident 1 stated the issue with not enough staff had been going on for about a month. Resident 1 stated she is incontinent (unable to control) of bowel and bladder and would have to wait 20 to 30 minutes before staff could help her change due to the lack of staff. Resident 1 stated her roommate (Resident 2) is unable to turn herself in bed and cannot speak. Resident 1 stated Resident 2 was only turned twice a day (once in the morning and once at night) instead of every two hours required due to lack of staff.</p> <p>During a review of Resident 2's CS, dated 11/16/23, the CS indicated, Resident 2 had diagnosis of chronic respiratory failure (a serious condition making it difficult to breathe on your own), anoxic brain injury (brain injury caused by lack of oxygen) and persistent vegetative state (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings).</p> <p>During a review of Resident 2's MDS under the section BIMs, dated 4/24/24, the BIMs indicated, unable to assess.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2's MDS under the section FS, dated 4/24/24, the FS indicated Resident 2 was completely dependent on staff for all aspects of care.</p> <p>During an observation on 5/16/24 at 11:45 a.m. in Resident 2's room, Resident 2 was observed laying on her back with a pillow to each of her sides. Resident 2 does not respond to verbal stimuli; her eyes do not have purposeful movement and she does not show any signs of being able to communicate.</p> <p>During a review of Resident 3's CS, dated 11/15/23, the CS indicated, Resident 3 diagnosis including chronic respiratory failure and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area).</p> <p>During a review of Resident 3's MDS under the section BIMs, dated 4/18/24, the BIMs indicated, Resident 3 had a score of 13 (cognitively intact).</p> <p>During a review of Resident 3's MDS under the section FS, dated 4/18/24, the FS indicated Resident 3 was completely dependent on staff for all aspects of care.</p> <p>During an interview on 5/16/24 at 12:01 p.m. with Resident 3, Resident 3 stated he is turned every two hours, sometimes.</p> <p>During an interview on 5/16/24 at 1 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated over the last few weeks the facility has had issues with staffing to meet the resident needs. LVN 2 stated providing care to the residents in the facility with low staffing is overwhelming.</p> <p>During an interview on 5/16/24 at 1:07 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the facility has been short on staffing over the last few weeks. CNA 1 stated all the residents in the facility were to be checked for incontinence and turned every two hours (check and change). CNA 1 stated the check and change was not getting done as it should be.</p> <p>During an interview on 5/16/24 at 1:14 p.m. with CNA 2, CNA 2 stated staffing had been very short over the last few weeks. CNA 2 stated yesterday (5/15/24) she was assigned 21 residents (not identified) with another CNA (not identified), and they were all total care which required two staff members at a time. CNA 2 stated the way the facility staffed in the past to meet the resident needs was 12 to 13 total care residents for two CNAs.</p> <p>During an interview on 5/16/24 at 1:20 p.m. with CNA 3, CNA 3 stated check and change of the residents was to be done every two hours. CNA 3 stated with staffing being low it was hard to accomplish the check and change every two hours.</p> <p>During an interview on 5/16/24 at 1:26 p.m. with CNA 4, CNA 4 stated the facility is constantly short on staff over the last month. CNA 4 stated all the residents in the facility were total care which requires two staff members to provide care. CNA 4 stated meeting the residents needs was not being done due to the shortage in staffing. CNA 4 stated turning the residents every two hours was not being accomplished as it should be.</p> <p>During an observation on 5/16/24 at 1:37 p.m. in Resident 2's room, Resident 2 was observed continuing to lay on her back with a pillow to each of her sides.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 5/16/24 at 2:19 p.m. with Quality Assurance Professional (QAP) in the Resident 2's room, Resident 2 was observed remaining on her back with a pillow to each of her sides. QAP verbalized that Resident 2 was on her back.</p> <p>During a review of Resident 4's CS, dated 5/8/24, the CS indicated, Resident 4 diagnosis including chronic respiratory failure, traumatic brain injury (an injury that affects how the brain works and is a major cause of death and disability) and bed confinement (unable to get up from bed).</p> <p>During a review of Resident 4's MDS under the section BIMs, dated 3/3/24, the BIMs indicated, Resident 4 was not assessed.</p> <p>During a review of Resident 4's MDS under the section FS, dated 3/3/24, the FS indicated Resident 4 was completely dependent on staff for all aspects of care.</p> <p>During an observation on 5/22/24 at 10:05 a.m. in Resident 4's room, Resident 4 was observed laying on her back. Resident 4 is non-responsive to verbal stimuli.</p> <p>During a review of Resident 5's CS, dated 11/16/23, the CS indicated, Resident 5 diagnosis including respiratory failure, unspecified coma (state of deep unconsciousness) and persistent vegetative state (chronic state of brain dysfunction in which a person shows no signs of awareness).</p> <p>During a review of Resident 5's MDS under the section BIMs, dated 5/3/24, the BIMs indicated, Resident 5 was not assessed.</p> <p>During a review of Resident 5's MDS under the section FS, dated 5/3/24, the FS indicated Resident 5 was dependent on staff for all aspects of care.</p> <p>During an observation on 5/22/24 at 10:06 a.m. in Resident 5's room, Resident 5 was observed laying on her back with one pillow under her right arm.</p> <p>During a review of Resident 6's CS, dated 11/15/23, the CS indicated, Resident 6 diagnosis including chronic respiratory failure and epilepsy (a brain disorder).</p> <p>During a review of Resident 6's MDS under the section BIMs, dated 5/2/24, the BIMs indicated, Resident 6 was not assessed.</p> <p>During a review of Resident 6's MDS under the section FS, dated 5/2/24, the FS indicated Resident 6 was dependent on staff for all aspects of care.</p> <p>During an observation on 5/22/24 at 10:10 a.m. in Resident 6's room, Resident 6 was observed laying on her back with a pillow to each side of her body and a pillow under her knees. Resident 6 is non-responsive to verbal stimuli.</p> <p>During a review of Resident 7's CS, dated 11/16/23, the CS indicated, Resident 7 diagnosis including chronic respiratory failure, anoxic brain injury (injury to brain due to no oxygen), cardiac arrest (heart attack) and chronic obstructive pulmonary disease (COPD - disease of the lungs that obstructs airflow).</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 7's MDS under the section BIMs, dated 4/12/24, the BIMs indicated, Resident 7 was not assessed.</p> <p>During a review of Resident 7's MDS under the section FS, dated 4/12/24, the FS indicated Resident 7 was completely dependent on staff for all aspects of care.</p> <p>During an observation on 5/22/24 at 10:17 a.m. in Resident 7's room, Resident 7 was observed laying on her back with a pillow to each side of her body and one pillow under her knees. Resident 7 is non-responsive to verbal stimuli.</p> <p>During a review of Resident 8's CS, dated 11/16/23, the CS indicated, Resident 8 diagnosis including chronic respiratory failure, history of falling and pulmonary edema (excess fluid in the lungs).</p> <p>During a review of Resident 8's MDS under the section BIMs, dated 3/30/24, the BIMs indicated, Resident 8 was not assessed.</p> <p>During a review of Resident 8's MDS under the section FS, dated 3/30/24, the FS indicated Resident 8 was dependent on staff for all aspects of care.</p> <p>During an observation on 5/22/24 at 10:20 a.m. in Resident 8's room, Resident 8 was observed laying on his back with a pillow to each side of his body and a wedge type pillow to under his knees. Resident 8 is non-responsive to verbal stimuli.</p> <p>During a review of Resident 9's CS, dated 11/17/23, the CS indicated, Resident 9 diagnosis including pulmonary edema, chronic respiratory failure, COPD and anoxic brain damage.</p> <p>During a review of Resident 9's MDS under the section BIMs, dated 5/9/24, the BIMs indicated, Resident 9 had a score of zero.</p> <p>During a review of Resident 9's MDS under the section FS, dated 5/9/24, the FS indicated Resident 9 was dependent on staff for all aspects of care with the exception of upper body dressing and rolling left/right in which he required substantial/maximal assistance.</p> <p>During an observation on 5/22/24 at 10:22 a.m. in Resident 9's room, Resident 9 was observed laying on his back with a pillow to each side of his body.</p> <p>During a review of Resident 10's CS, dated 11/17/23, the CS indicated, Resident 10 diagnosis including pulmonary edema, chronic respiratory failure and quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso).</p> <p>During a review of Resident 10's MDS under the section BIMs, dated 3/22/24, the BIMs indicated, Resident 10 had a score of 15.</p> <p>During a review of Resident 10's MDS under the section FS, dated 3/22/24, the FS indicated Resident 10 was dependent on staff for all aspects of care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/24 at 10:42 a.m. with Resident 10, Resident 10 stated the facility over the last month had not staffed to meet the needs of the residents. Resident 10 stated she had not been changed or turned since six in the morning until just a few minutes ago and on most days, she would not have been changed or turned until two or three in the afternoon. Resident 10 stated she was not turned every two hours as she should be but turned every four to five hours. Resident 10 stated, I am starting to get wounds on my bottom because of it (not being turned or changed every two hours). I have been here five and a half years, and this is the first time I have ever started to get a wound. The staff keep telling me they are understaffed, and they are doing the best they can. I know it is not the CNAs fault it is the facility for not staffing us appropriately, we are all [residents] that are in need of large levels of care.</p> <p>During an interview on 5/22/24 at 10:58 a.m. with Family Member (FM) 1, FM 1 stated staffing had worsened in the facility over the last month. FM 1 stated she observed CNAs providing care by themselves on total care residents when it should be two staff members. FM 1 stated her sister (Resident 11) was frequently noted with a brief (adult diaper) full of bowel movement and urine. FM 1 stated she comes to visit Resident 11 every day at nine or 10 in the morning, stay for approximately 45 minutes and then return in the evening at 4:30 or 5 PM. FM 1 stated when she returns to the facility, she observed Resident 11 in the same position she was left in in the morning.</p> <p>During an interview on 5/22/24 at 11:47 a.m. with Wound Nurse (WN), WN stated staffing in the facility had been bad since March 2024 but has worsened over the last month. WN stated there were two new wounds recently acquired in the facility. WN stated Resident 10 had a sore on her buttocks found yesterday (5/21/24), Resident 12 had a large blister to his left foot due to pressure and a wound to the coccyx (lower portion of the spine) due to incontinence (inability to control bowel or bladder). WN stated these new wounds were preventable but occurred due to lack of staffing to meet residents needs. WN stated, it is really important that the resident(s) be turned every two hours and it is not happening. [wound] issues are caused by lack of staffing and inability to turn the residents. WN stated Despite the check and change not being done every two hours staff are still charting that it is done so that when they get audited, they won't get in trouble.</p> <p>During a review of the facility NON-DECUB WEEKLY REPORT (NDWR), dated 4/28/24 to 5/22/24, the NDWR indicated the following:</p> <ul style="list-style-type: none"> a. Resident 10 on 5/21/24 had acquired a pimple like sore to her left upper buttock. b. Resident 12 on 5/16/24 had acquired a blister to the left first metatarsal (bone of the foot) plantar (sole of the foot). c. Resident 12 on 5/21/24 had an abrasion (skin worn away from the surface due to friction) to the coccyx. <p>During an observation on 5/22/24 at 12:39 p.m. in Resident 4's room, Resident 4 was observed laying on her back and with no change in her body position or her pillows from earlier.</p> <p>During an observation on 5/22/24 at 12:41 p.m. in Resident 5's room, Resident 5 was observed laying on her back and with no change in her body position or her pillows from earlier.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/22/24 at 12:43 p.m. in Resident 6's room, Resident 6 was observed laying on her back and with no change in her body position or her pillows from earlier.</p> <p>During an observation on 5/22/24 at 12:45 p.m. in Resident 7's room, Resident 7 was observed laying on her back and with no change in her body position or her pillows from earlier.</p> <p>During an observation on 5/22/24 at 12:47 p.m. in Resident 8's room, Resident 8 was observed on his back and with no change in his body position or his pillows from earlier.</p> <p>During an observation on 5/22/24 at 12:49 p.m. in Resident 9's room, Resident 9 was observed on his back and with no change in his body position or his pillows from earlier.</p> <p>During an interview on 5/22/24 at 12:50 p.m. with CNA 5, CNA 5 stated she had not turned Resident 9 since 8:30 a.m. CNA 5 stated she had not had time to turn Resident 9 because she had been busy with other residents and did not have anyone else to help her.</p> <p>During an interview on 5/22/24 at 1:03 p.m. with CNA 6, CNA 6 stated she had not had time to turn Resident 5 since before 10 a.m. and had not been able to turn Resident 6 since 8 a.m. because she was busy with other residents. CNA 6 stated staffing had not been appropriate to meet the needs of the residents for over a month. CNA 6 stated there were four CNAs typically assigned to 44 total care residents in the facility which is not possible to meet the residents' needs.</p> <p>During an interview on 5/22/24 at 1:12 p.m. with CNA 7, CNA 7 stated It is not possible to turn the residents every two hours due to being short on staff. CNA 7 stated he was assigned nine residents on his own at this time that were total care, and he has to wait until another employee gets a chance to help him provide the care which requires two people. CNA 7 stated the staffing issues had been going on for almost two months.</p> <p>During an interview on 5/22/24 at 1:21 p.m. with Director of Nursing (DON), DON stated she believed approximately 98 percent of the residents in the facility were total care. DON stated one CNA cannot handle a total care resident on their own, it needs to be the CNA and another staff member. DON stated the facility had been short on staff over the last few weeks. DON stated the number of CNAs assigned to residents does not meet the needs of the residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, MODEL POLICY: PRESSURE INJURY OR SKIN/WOUND CONDITIONS -ASSESSMENT, PREVENTION AND MANAGEMENT, dated 5/4/22, the P&P indicated, POLICY/SUMMARY INTENT . To assess and document patient skin risk, develop a plan of care for prevention and/or management of skin condition, wound or pressure injury . Pressure Injury Prevention Involves The Following . If appropriate, offload bony prominence and utilize redistribution devices and protective dressings in high risk patients. Unless contraindicated, reposition the patient at least every 2 hours if they are unable to reposition themselves. This can be accomplished through but not limited to repositioning in the bed, bed to chair, chair to bed, sit to stand, etc.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Adventist Health Delano		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Garces Hwy Delano, CA 93215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, PLAN: PLAN FOR THE PROVISION OF CARE AND SCOPE OF SERVICE-SCU, dated 6/2/23, the P&P indicated, The Unit only serves adults that require intensive skilled services and or sub-acute level of care [a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility]. [The facility] is supported by a License Administrator, Charge Nurses, House Supervisor, eight (8) hours clerical, MOS Coordinator, Activity Director, Staff Development Coordinator, Social Services, Rehabilitation Therapist and Respiratory Therapy. The max census is fifty-one (51), staffing needs are projected shift by shift. The staffing is regulated by state and federal regulations.</p> <p>During a review of the facility's P&P titled, MODEL POLICY: STAFFING ASSIGNMENT BY ACUITY, dated 2/14/23, the P&P indicated, [The facility] adopts the following system wide Adventist Health policy to standardize the process of defining patient acuity and need as they are used for determining staffing assignments, in addition to any state mandated ratio requirements and collective bargaining agreements. Demand - is a component of the electronic staffing solution that calculates workload based on patient turnover and when combined with Outcomes-Driven Acuity, factors in the patient's clinical condition and fluctuating staffing needs. CNA- means any person who holds himself or herself out as a certified nurse assistant and who, for compensation, performs basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients, and is certified as having completed the requirements of this article. These services shall not include any services which may only be performed by a licensed person and otherwise shall be performed under the supervision of a registered nurse. Acuity levels are based on the patient's clinical condition and care needs. Factors that are taken into consideration when developing staffing plans include . Staffing solution provided Demand hours based on the patient's acuity.</p>		