

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 07/03/2025
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)
F 0685 Level of Harm - Actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (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
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<p>F 0685</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to maintain vision for one of three sampled residents (Resident 1) when the facility failed to: 1. Administer Lumigan (prescription medicated eye drops that helps reduce intraocular pressure-the fluid pressure in the eyes. If the pressure is too high, it can cause irreversible vision loss) as ordered by the ophthalmologist (OPHTH - medical doctors who specialize in all aspects of eye care). 2. Arrange the follow-up appointment with OPHTH as ordered for continued eye assessment and care management. These failures resulted in Resident 1 experiencing pain, headaches, photosensitivity (sensitivity to light), blurry vision, increased intraocular pressure, and potential to result in neovascularization (abnormal blood vessel growth that can result in bleeding, swelling, and vision loss) in the left eye due to presumed (suppose that something is the case on the basis of probability) ischemia (lack of blood supply). Findings: 1. During a review of the facility Resident Appointment Calendar (RAC), dated 2/11/25, the RAC indicated Resident 1 was seen by OPHTH on 2/11/25. During a review of Resident 1's OPHTH Notes (OPHTN), dated 2/11/25, the OPHTN indicated Resident 1 was to start Lumigan eye drops at night. During a review of Resident 1's ORDER SHEET (OS), dated 2/11/25, the OS indicated Resident 1 was to start Lumigan one drop to both eyes for 12 months starting on 2/11/25. During a review of the facility Social Services Concern Log (SSCL), dated 4/9/25, the SSCL indicated, Resident 1 wanted all the lights in his room to remain off due to pain in his eyes from the light. The SSCL indicated Social Services Director (SSD) informed Resident 1 that his roommate (Resident 2) had the right to have his side of the room light on. The SSCL indicated Resident 1 requested to be moved to another room where the entire room lights can remain off, but the facility was not able to accommodate. On 6/17/25 the SSCL indicated, Resident [1] attended [OPHTH appointment] on 6/17/25. Found out his [Resident 1] drops (Lumigan) had not been continuous [sic] and did not attend March [2025] f/u [follow up appointment]. During an interview on 7/2/25 at 9:57 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 had a loss of vision to his left eye due to the facility not giving his Lumigan eye drops as ordered by the OPHTH. During a review of Resident 1's CODING SUMMARY (CS), dated 4/10/25, the CS indicated Resident 1 had a diagnosis of Tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] through the front of the neck. This opening allows a tube to be inserted to maintain an airway and allow breathing) status, and cerebral infarction (loss of blood flow to a part of the brain resulting in brain tissue death). During a review of Resident 1's Minimum Data Set (MDS - comprehensive assessment tool), dated 7/10/25, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS - an assessment of how well a person thinks, remembers, and learns) score was 15 (score of 13-15 means mentally intact). During a concurrent observation and interview on 7/15/25 at 2:01 p.m. with Resident 1 in Resident 1's room, Resident 1 was lying in bed in his darkened room with all lights off. Resident 1 had reddened lines to the white portion of his left eye. Resident 1 was using a communication board (a board with letters, symbols, and/or photos that allow a person who cannot speak to communicate) and using his head in a yes or no fashion. Resident 1 stated, I am going blind. Resident 1 stated he had pain in both eyes at a level of 9 out of 10 pain scale (A pain scale score of 9 signifies excruciating, very severe pain that is difficult to bear). During an interview on 7/15/25 at 2:15 p.m. with Registered Nurse (RN) 1, RN 1 stated, she was assigned to Resident 1 and had been assigned to him in the past several months. RN 1 stated Resident 1's room is kept dark because the light bothers his eyes. RN 1 stated there was recently an issue with Resident 1 not getting his medicated eye drops (was not specific on name of medication) for approximately a month and a half. During an interview on 7/15/25 at 2:40 p.m. with SSD, SSD stated during an interdisciplinary meeting (IDT - a gathering of healthcare professionals from various disciplines to discuss and coordinate a patient's care plan) (date not given) with FM 1 regarding Resident 1. SSD stated Resident 1's Lumigan eye drops were stopped after he had to go to the emergency department (ED) for chest pain (date not specific) and when he returned there was a miscommunication (not specified) about the Lumigan eye drop orders, and they (eye drops) were not resumed despite no order to discontinue. During an interview on 7/15/25 at 3:17 p.m. with Nursing Facility Supervisor (NFS), NFS stated Resident 1 was sent to the ED (Emergency Department/Hospital) on 4/10/25 for complaints of chest pain and was admitted to the acute hospital. NFS stated Resident 1 returned to the facility on 4/12/25 but the orders for his Lumigan eye drops were dropped for some unknown reason. NFS stated Resident 1 did not start his Lumigan eye drops again until after his OPHTH appointment on 6/17/25 (two months and five days</p>

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>(continued on next page)</p>

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their policy and procedure on, ADVERSE EVENT (an undesirable medical occurrence) REPORTING, for one of three sampled residents (Resident 1) when a medication error resulting in harm was not reported to the California Department of Public Health (CDPH). This failure had the potential for Resident 1 continually experience adverse health outcomes.</p> <p>Findings:During an interview on 7/2/25 at 9:57 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 had a loss of vision to his left eye due to the facility not giving his Lumigan (prescription medicated eye drops) for intraocular pressure (the fluid pressure in the eyes. If the pressure is too high, it can cause irreversible vision loss. Normal pressure is from 10 and 21 mmHg [millimeters of mercury - a unit of measurement]) as ordered by his ophthalmologist (OPHTH - medical doctor who specialize in all aspects of eye care). During a review of Resident 1's ORDER SHEET (OS), dated 2/11/25, the OS indicated, Resident 1 was to start Lumigan one drop to both eyes for 12 months starting on 2/11/25.During an interview on 7/15/25 at 2:15 p.m. with Registered Nurse (RN) 1, RN 1 stated, she was assigned to Resident 1 and had been assigned to him in the past several months. RN 1 stated Resident 1's room is kept dark because the light bothers his eyes. RN 1 stated there was recently in issue with Resident 1 not getting his medicated eye drops (not specified) for approximately a month and a half. During an interview on 7/15/25 at 2:40 p.m. with SSD, SSD stated during an interdisciplinary meeting (IDT - a gathering of healthcare professionals from various disciplines to discuss and coordinate a patient's care plan) (date not given) with FM 1 regarding Resident 1. SSD stated Resident 1's Lumigan eye drops were stopped after he had to go to the emergency department (ED) for chest pain and when he returned there was a miscommunication (not specified) about the Lumigan eye drop orders, and they were not resumed despite no order to discontinue. During an interview on 7/15/25 at 3:17 p.m. with Nursing Facility Supervisor (NFS), NFS stated Resident 1 was sent to the ED on 4/10/25 for complaints of chest pain and was admitted to the acute hospital. NFS stated Resident 1 returned to the facility on 4/12/15 but the orders for his Lumigan eye drops were dropped for some unknown reason. NFS stated Resident did not start his Lumigan eye drops again until after his OPTH appointment on 6/17/25 (two months and five days after his last dose). NFS stated, My opinion is they [acute hospital] dropped the ball [Resident 1's Lumigan eye drop orders] and we should of picked it [Lumigan eye drop] back up. During a review of Resident 1's Medication Administration Record Report ([NAME]), dated 2025, the [NAME] indicated the following:a. April 1st to the 9th - Resident 1 received his Lumigan eye drops to both eyes. b. April 12th to the 30th - After returning from the acute hospital, Resident 1 was not given his Lumigan eye drops.c. May 1st to the 31st - Resident 1 did not receive his Lumigan eye drops. d. June 1st to the 17th - Resident 1 did not receive his Lumigan eye drops.e. June 18th to June 30th - Resident 1 was restarted on Lumigan eye drops to both eyes.During a review of OPTH Specialist Note (OPHTSN), dated 7/29/25, the OPTHSN indicated, On December 19, 2024, [Resident 1] . intraocular pressure was 17 [mmHg-millimeter mercury, unit of pressure measurement] in the right eye and 46 [mmHg] in the left eye. Moderate ptosis [drooping of the upper eyelid] was present as well as cataract [a medical condition in which changes to the lens of the eye causes blurred vision and whitening] changes. Lumigan drop(s) was ordered to the left eye for his elevated intraocular pressure. His next visit was in three to four weeks. On February 11, 2025, he [Resident 1] was seen for a follow up examination. He was not on the eyedrops [Lumigan] that were prescribed. His intraocular pressure was 13 and 34 in the right and left eye respectively. Corneal edema (a condition where the cornea, the clear front surface of the eye, swells due to excess fluid) was present in the left eye. He was reordered the Lumigan to the left eye . His next follow-up was in approximately next month. He was seen on June 17, 2025. The patient relayed a history of pain with headaches, photosensitivity and blurry vision. Ascertained [found out] at 20/400 (mmHg) in the right eye and no light perception [the ability to detect the presence or absence of light, distinguishing it from darkness] in left eye. The examination is noteworthy for dense milky white cataract, left eye much worse than right. He also was not using his prescribed eyedrops. Patient [Resident 1] was also noted to have neovascularization in the left eye due to presumed ischemia. Orders for the Lumigan . to both eyes were prescribed. During a concurrent interview and record review on 7/15/25 at 3:35 p.m. with Quality Assurance Nurse (QAN), the facility's policy and procedure (P&P) titled, ADVERSE EVENT REPORTING, dated 5/9/23 was reviewed. The P&P indicated, This policy ensures complaint with the requirements of applicable federal and state laws and the standards of applicable accrediting</p>		