STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056426	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adventist Health Delano	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 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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on interview and record review, the facility failed to implement their policy and procedure on abuse for one of three sampled residents (Resident 1) when the staff accused was not separated from providing resident care. This failure had the potential for other residents to be abused. Findings: 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) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 7/10/25, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition is), the BIMS score was 15 (cognition intact). During a review of Resident 1's Investigation Report Summary (INRS), dated 8/18/25, the INRS indicated on 8/17/25 Resident 1 made an allegation using a communication/letter board (a tool used to facilitate communication for patients who may have difficulty expressing their needs verbally) that Certified Nursing Assistant (CNA) 1 was, bullying him. The INRS indicated, Per investigation the resident (1) expressed his concern on 8/17/2025. He is alert and able to express wants and needs using a letter board to communicate. During an interview on 8/20/25 at 11:08 a.m. with Nursing Facility Supervisor (NFS) and Quality Assurance Nurse (QAN), NFS stated he was made aware that Resident 1 made an allegation of abuse on 8/17/25 when he arrived at work on 8/18/25. NFS stated he is the abuse coordinator for the facility. NFS and QAN both stated CNA 1 was not removed from the facility nor supervised after the allegation of abuse was made. During a review of the facility's Employee Timecards (ETC), dated 8/17/25 (date allegation of abuse was made), the ETC indicated, CNA 1 worked on 8/17/25 from 6:57 a.m. to 7:28 p.m. During an interview on 8/20/25 at 2:44 p.m. with CNA 1, CNA 1 stated on 8/17/25 she assisted CNA 2 with providing care to Resident 1 sometime in the morning (time not specific). CNA 1 stated around 11:48 a.m. Resident 1 made an allegation of abuse that she was bullying him. CNA 1 stated Registered Nurse (RN) 1 was made aware of the allegation and instructed CNA 1 to no longer go into Resident 1's room. CNA 1 stated she continued to work her shift but did not return to Resident 1's room. CNA 1 stated she was not supervised nor asked to be removed from the facility after the allegation of abuse was made.During an interview on 8/20/25 at 3:27 p.m. with RN 1, RN 1 stated she worked on 8/17/25. RN 1 stated sometime during late morning (specific time not given) CNA 2 reported to her that Resident 1 made an allegation of abuse regarding CNA 1 bullying him. RN 1 stated she spoke with CNA 1 and asked her to stay away from Resident 1's room. RN 1 stated she did not remove CNA 1 from the facility and/or have her supervised.During a review of the facility's policy and procedure (P&P) titled, ,Suspected Child, Adult, Disabled Person or Elderly Abuse/Neglect/Exploitation dated 5/2/24, the P&P indicated, Patients (Residents) have the right to be free from mental, physical, sexual and verbal abuse, neglect and exploitation. It is the policy of this (facility) to protect patients from real or perceived abuse, neglect or exploitation from anyone, including staff members . In instances of investigations concerning a staff member's behavior, it is preferable to assign the involved staff member non-patient care activities, if possible. The (facility) has the obligation and responsibility to protect both the rights of the staff member and the rights of the patient. The staff member's investigation should be conducted fairly and in a confidential manner, involving only those individuals in the investigation that have a need to know. The staff member should not be unjustly accused because an allegation has been rendered. All allegations should be immediately and thoroughly investigated until conclusion. However, the rights and protection of the patient should not be compromised in the essence of fairness toward the staff member. Therefore, it is the responsibility of the hospital to separate the staff member and the patient until conclusion of the investigation. The hospital must also protect other patients from the acts of the staff member should these acts prove true. Therefore, assignment of the involved staff member to non-patient care activities would be optimum. If circumstances do not allow for this option, the staff member's interaction with patients must be monitored at all times during the investigation.