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 11/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their intervention to turn and reposition one of three sampled residents (Resident 1) every two hours to prevent pressure ulcers (damage to the skin and underlying tissue from constant pressure, often on bony areas like the tailbone or heels, reducing blood flow, which can cause redness, blisters, and open sores, especially in people who can't move easily). This failure had the potential to cause further skin damage and/or prevent healing for Resident 1.Findings: During a review of Resident 1's PHYSICIAN FACE SHEET (PFS), 7/5/25, the PFS indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including severe sepsis (a life-threatening medical emergency where the body's extreme response to an infection triggers a chain reaction, causing widespread inflammation that can damage tissues, lead to organ failure [a group of different tissues working together to perform a specific job in a living thing], and potentially death) with septic shock (a life-threatening stage of sepsis where a severe infection triggers an extreme immune response, causing widespread inflammation, dangerously low blood pressure, and organ dysfunction, meaning organs aren't getting enough blood and oxygen, leading to potential organ failure), ALS (Amyotrophic Lateral Sclerosis- a progressive brain and spinal cord disease that attacks nerve cells controlling voluntary muscles, causing them to weaken, waste away, and eventually stop working, leading to paralysis [inability to move] and difficulty with walking, talking, swallowing, and breathing, but typically leaves the mind and senses unaffected), and ventilator dependence (a machine that helps a person to breathe because they are unable to on their own). 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 9/3/25, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns]), the BIMS score was 0 (severe memory/thinking problems). Under section GG (assesses functional abilities and goals), Resident 1 was assessed to be completely dependent on staff for all aspects of care. Under section H (Bladder and Bowel), Resident 1 was documented to be always incontinent (unable to control bowel or bladder) of bowel and bladder. Under section M (Skin Conditions), Resident 1 was assessed to be at risk for developing pressure ulcers and was required to be on a turning/repositioning program. During a review of Resident 1's Wound Picture (WP), dated 10/15/25, the WP indicated, Resident 1 was assessed and found to have sacrum (a triangular bone shaped area at the base of the spine) shearing (a wound/injury that occurs when skin layers slide in opposite directions). The wound measured 3.5 by 5 by 0.2 cm (centimeters - a unit of measurement). During a review of Resident 1's Wound Pressure Injury Photo Note (WPIPN), dated 11/5/25, the WPIPN indicated, Resident 1 was identified to have a stage 3 pressure ulcer (skin has broken down that the fatty tissue underneath is visible and is prone to infection) to the sacrum. The WPIPN indicated, Pressure Injury (ulcer) NOT present on admit . (Resident 1) is complete assist in repositioning. Today's (11/5/25) wound assessment showed (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deterioration as evidenced by increased measurements and now with undermining (the tissue underneath the skin's surface has broken down, creating a ‘pocket' or ‘shelf' under the intact skin around the wound's edges, making the wound much larger and deeper than it looks). Please still continue interventions such as repositioning every two hours left and right . Reeducated staff about repositioning left and right . The WPIPN indicated the wound measured 3.3 x 4 x 1.5 cm with 1.5 cm of undermining. During a review of Resident 1's Resident Care Team Meeting (RCTM), dated 11/10/25, the RCTM indicated, Resident 1 had a sacral (sacrum) acute (a condition that started suddenly) skin failure full thickness wound (a wound that passes the two layers of the skin and exposes the fat underneath) with MASD (moisture associated dermatitis - inflammation of the skin caused by being continually moist, typically from bowel movements and urine) . Continue turning and repositioning (every) 2 hours . During an observation on 11/19/25 in Resident 1's room, the following was observed:On 11/19/25 at 11:25 a.m. - Resident 1 was lying on his left side with pillows to his backOn 11/19/25 at 1 p.m. - Resident 1 was lying on his left side with pillows to his backOn 11/19/25 at 1:15 p.m. - Resident 1 was lying on his left side with pillows to his backOn 11/19/25 at 2 p.m. - Resident 1 was lying on his left side with pillows to his back During an interview on 11/19/25 at 11:52 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was assigned to Resident 1 for the day. LVN 1 stated his concerns with Resident 1 was his pressure ulcer. LVN 1 stated the Certified Nursing Assistants (CNAs) should be turning and repositioning Resident 1 every two hours. During an interview on 11/19/25 at 12:41 p.m. with CNA 1, CNA 1 stated Resident 1 is to be turned and repositioned every two hours but sometimes the facility is short staff and CNAs could not turn and reposition the residents every two hours. CNA 1 could not explain how staff know when it is time to turn and reposition Resident 1. During an interview on 11/19/25 at 12:53 p.m. with CNA 2, CNA 2 could not answer how she knew when it was time to turn and reposition residents every two hours. CNA 2 stated most days residents wait more than two hours to be turned and repositioned. CNA 2 stated it possibly goes up to three hours before residents were turned and repositioned. During an interview on 11/19/25 at 1 p.m. with CNA 3, CNA 3 could not answer how she knew it was time to turn and reposition residents every two hours. CNA 3 stated she would try to remember when to turn and reposition the residents. CNA 3 stated residents at times have to wait to be turned and repositioned more than two hours when facility staff are busy. During an interview on 11/19/25 at 1:05 p.m. with Registered Nurse (RN) 1, RN 1 stated she was assigned to Resident 1. RN 1 stated Resident 1 is to be strictly turned and repositioned every two hours due to his stage 3 pressure ulcer. RN 1 stated she was not sure but believed Resident 1 was last turned at 11 a.m. During an interview on 11/19/25 at 1:16 p.m. with CNA 4, CNA 4 stated she attempts to turn and reposition her residents every two hours but at times it can go up to more than 30 minutes past due to not having enough staff. CNA 4 stated there was no organized method for staff to know when it is time to turn and reposition residents. During an interview on 11/19/25 at 1:21 p.m. with Wound Nurse (WN), WN stated Resident 1 had a stage 3 pressure ulcer to his sacrum. WN stated CNAs are to turn and reposition Resident 1 every two hours and she believed they (CNAs) know when it is time to turn. During a review of Resident 1 Electronic Medical Chart (EMC) under the section activity dated 11/19/25, the EMC indicated Resident 1 was last turned to his left side at 10:05 a.m. During a concurrent observation and interview on 11/19/25 at 1:47 p.m. with WN in Resident 1's room, WN stated Resident 1 was on his left side with pillows to his back and he should have been turned and reposition around 12 p.m. During an interview on 11/19/25 at 1:53 p.m. with Risk Manager (RM), RM stated the facility does not have a set process when it comes to knowing when it is time to turn and reposition a resident. During a review of the facility's policy and procedure (P&P) titled, PRESSURE INJURY OR (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SKIN/WOUND CONDITIONS -ASSESSMENT, PREVENTION AND MANAGEMENT, dated 5/4/22, the P&P indicated, For the purposes of this policy, a pressure injury refers to previous terminology used for pressure and decubitus ulcers. 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. Stage 1 Recommendations . Turn and reposition patient every 2 hours unless contraindicated . Offload (relieve pressure) affected area as much as possible. Stage 3 or 4 Recommendations . Follow Stage 1 nursing recommendations.