| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056426 | A. Building<br>B. Wing | 04/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Adventist Health Delano | 1401 Garces Hwy<br>Delano, CA 93215 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident’s assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50409<br><br>Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS - assessment tool) quarterly (every three months) assessments were completed for five of nine sampled residents (Resident 1, Resident 19, Resident 21, Resident 34 and Resident 13). This failure had the potential for the delay in the development and implementation of Resident 1, Resident 19, Resident 21, Resident 34 and Resident 13's individualized care plans.<br><br>Findings:<br><br>During a concurrent interview and record review on 4/8/24 at 9:23 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated, I'm behind with my assessments. MDSC stated quarterly MDS assessments need to be completed within 14 days of the Assessment Reference Date (ARD-the specific end point of look-back periods in the MDS assessment process). The following residents' quarterly MDS assessments were reviewed:<br><br>a) Resident 1's quarterly MDS assessment dated [DATE] indicated the MDS assessment was not completed.<br><br>b) Resident 19's quarterly MDS assessment dated [DATE] indicated the MDS assessment was not completed.<br><br>47153<br><br>c) During a concurrent interview and record review on 4/8/24 at 11:26 a.m. with MDSC, Resident 21's MDS assessment, dated 12/21/23 was reviewed. MDSC stated Resident 21's last MDS was completed 12/21/23. MDSC stated Resident 21 should have had a quarterly assessment completed in March and she did not.<br><br>d) During a concurrent interview and record review on 4/8/24 at 11:29 a.m. with MDSC, Resident 34's MDS assessment, dated 12/26/23 was reviewed. MDSC stated she was behind, but there was no staff to help because nobody else was trained to do MDS assessments. MDSC stated she used to do MDS [AGE] years ago, but had not received any recent training. MDSC stated Resident 34's last quarterly MDS was done in December and was out of compliance.<br><br>(continued on next page) |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e) During a concurrent interview and record review on 4/8/24 at 11:35 a.m. with MDSC, Resident 13's MDS assessment, dated 12/24/23 was reviewed. MDSC stated MDS for Resident 13 was last done 12/24/23, Resident 13's quarterly MDS was overdue.<br><br>During a review of the Resident Assessment Instrument Manual (RAI), dated October 2023, the RAI indicated, The MDS completion date . must be no later than 14 days after the ARD (ARD + 14 calendar days). The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act - quality of care of nursing homes] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD . must be not more than 92 days after the ARD of the most recent OBRA assessment of any type. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>47153<br><br>Based on observation, interview, and record review, the facility failed to ensure professional standards of quality were followed when:<br><br>1. One of one sampled resident's (Resident 18) nephrostomy tube (tube placed directly into the kidney to drain urine) was not secured and maintained in a clean environment. This failure had the potential for Resident 18's nephrostomy tube to be displaced and urine to flow back into the kidney and the potential for infection.<br><br>2. Multiple medications were crushed and administered together through a (G-tube, inserted through the belly, directly into the stomach) for two of four sampled residents (Resident 25 and Resident 17). This failure had the potential to cause a blockage in the G-tube and violated Resident 25 and Resident 17's right to refuse a medication.<br><br>3. One of eight sampled Certified Nursing Assistants (CNA 7) performed work outside of the Certified Nursing Assistant scope of practice when CNA 7 reconnected Resident 28 to Blow By (a method used to deliver humidified air or oxygen to a resident with a tracheostomy[surgical incision in the neck]) oxygen therapy. This failure had the potential to result in improper oxygenation to Resident 28.<br><br>4. Physician order (PO) for psychiatric consult was not followed for one of one sampled resident (Resident 45). This failure resulted in a delay of care for Resident 45.<br><br>Findings:<br><br>1a. During a concurrent observation and interview on 4/8/24 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 18's nephrostomy bag was on the floor next to the bed. LVN 2 stated Resident 18 already had renal impairment (poor function of the kidneys). LVN 2 stated the nephrostomy bag should not be on the floor because it could cause an infection, or the nephrostomy bag or tubing could get stepped on and get pulled out.<br><br>During an interview on 4/9/24 at 10:56 a.m. with IP, IP stated the nephrostomy bag should not have been on the floor. IP stated the nurse should have changed the nephrostomy bag when it became contaminated from being on the floor on 4/8/24.<br><br>1b. During an interview on 4/8/24 at 11:42 a.m. with LVN 4, LVN 4 stated Resident 18's nephrostomy site was on the right side. LVN 4 stated Resident 18's nephrostomy site did not get covered with any dressing and Resident 18 did not have an order for a dressing since she was admitted with it.<br><br>During an interview on 4/10/24 at 3:41 p.m. with LVN 6, LVN 6 stated she had been providing care for Resident 18's nephrostomy, but she had not been trained. LVN 6 stated, I wipe it down, usually with tap water or normal saline. LVN 6 stated she did not realize it was supposed to be a sterile procedure. LVN 6 stated there had been no dressing on Resident 18's nephrostomy site since Resident 18's admission. LVN 6 stated there were no instructions for how to care for the nephrostomy site in Resident 18's physician's order. LVN 6 stated she did not clarify the order for nephrostomy site care and should have.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/10/24 at 3:46 p.m. with LVN 4, LVN 4 stated she did not receive training for nephrostomy site care or how to clean it.<br><br>During an interview on 4/11/24 at 9:08 a.m. with IP, IP stated cleaning the nephrostomy site or changing the nephrostomy bag should be a sterile procedure. IP stated Resident 18 had multiple urinary tract infections (UTIs). IP stated the nephrostomy tube had not been kept sterile which could have led to Resident 18's repeated UTI's. IP stated there had been a lack of communication and training regarding nephrostomy procedure and infections.<br><br>2. During an observation on 4/9/24 at 8:17 a.m. in the hallway, LVN 1 was preparing medications for Resident 25. LVN 1 crushed a multivitamin and fenofibrate (used to treat high cholesterol) together, sprinkled the contents of two Gabapentin (used for numbness and pain) capsules, and mixed all three medications together in the same medicine cup.<br><br>During an observation on 4/9/24 at 8:37 a.m. in Resident 25's room, LVN 1 administered the three previously mixed medications through Resident 25's G-tube. LVN 1 did not flush the G-tube with water before or after medication administration.<br><br>During an observation on 4/9/24 at 8:59 a.m. in the hallway, LVN 1 was preparing medications for Resident 17. LVN 1 crushed amlodipine (used to treat high blood pressure), calcium carbonate (supplement), and losartan (used to treat high blood pressure) and mixed the three medications together in the same medicine cup.<br><br>During an observation on 4/9/24 at 9:08 a.m. in Resident 17's room, LVN 1 administered the three previously mixed medications into Resident 17's G-tube. LVN 1 did not flush the G-tube with water before or after the medication administration.<br><br>During an interview on 4/9/24 at 9:22 a.m. with LVN 1, LVN 1 stated she should have given each medication separately. LVN 1 stated she should have flushed the G-tube with water before and after medication administration.<br><br>During an interview on 4/9/24 at 12:11 p.m. with Charge Nurse (CN), CN stated medications should have been given separately in the G-tube.<br><br>During a review of the facility's policy and procedure (P&P) titled, Medication Administration Through A Feeding Tube, dated 10/2/20, the P&P indicated, Do not mix medications with each other. If giving multiple medications, flush tube with 5-10 mL [milliliters] water in between meds [medications].Flush tube with 15-30 cc [cubic centimeters] warm water before and after all medications are given.<br><br>44134<br><br>3. During a review of Resident 28's Physician Order (PO), dated 4/1/24, the PO indicated, Oxygen Therapy. per Blow By, tit [titrate] to keep sats [saturation] > [greater than] 92% [percent].<br><br>During an observation on 4/8/24 at 11:05 a.m. in Resident 28's room, Two staff members brought Resident 28 back to his room and placed Resident 28 into bed.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/8/24 at 11:07 a.m. in Resident 28's room, Resident was in bed connected to his Blow By oxygen therapy via his tracheostomy. CNA 7 stated herself and the other staff member in the room were both CNA's. CNA 7 stated they just brought Resident 28 back from the activities room. CNA 7 stated she connected Resident 28 back up to his Blow By oxygen and that she also re-adjusted the tubing when Resident 28 was turned and repositioned. CNA 7 stated this was in her job description and she was trained when she was in orientation.<br><br>During an interview on 4/10/24 at 10:42 a.m. with Respiratory Therapist Manager (RTM), RTM stated to her knowledge CNAs and nursing staff were not connecting and disconnecting residents from their Blow By oxygen. RTM stated the Respiratory Therapists (RT) were responsible to provide this care.<br><br>During an interview on 4/10/24 at 10:43 a.m. with RT 3, RT 3 stated when resident's need to be connected to Blow By oxygen therapy, CNAs were supposed to call for the RT to connect resident. RT 3 stated Registered Nurses (RN) and LVNs were also able to connect resident using Blow By oxygen therapy.<br><br>During an interview on 4/10/24 at 2:42 p.m. with Director of Nursing (DON), DON stated she was unaware of what staff were able to connect and disconnect residents from Blow By oxygen therapy.<br><br>During an interview on 4/10/24 at 2:46 p.m. with DON, DON stated it was not in the CNA's scope of practice to connect or disconnect resident Blow By oxygen tubing. DON stated CNAs should not be touching or repositioning any tubing that was connected to resident tracheostomy. DON stated CNAs should ask an LVN or RT for assistance.<br><br>During a review of the facility's policy and procedure (P&P) titled, Facility Policy: Unlicensed Personnel: CNA Scope Of Practice, dated 1/4/24, the P&P indicated, Unlicensed personnel shall not be assigned to perform nursing functions in lieu of a registered nurse and may not be allowed to perform functions under the direct clinical supervision of a registered nurse that requires a substantial amount of scientific knowledge and technical skills. These include, but are not limited to, the following.invasive procedure including.tracheal suctioning.discontinuing invasive devices.performing sterile procedures. tacheostomy [sic] care.<br><br>Requested policy and procedure for Blow By oxygen therapy, no policy was provided.<br><br>47734<br><br>4. During a concurrent interview and record review on 3/26/24 at 3:17 p.m. with DON, Resident 45's PO, dated 10/1/23 was reviewed. The PO indicated, Resident 45 had a physician order for Psych Consult every 3 months. DON stated no psych consult was done after the physician order in October. DON stated this order was missed and not completed timely.<br><br>During a review of the facility's P&P titled, Physician Services - Physician Orders, dated 3/1/2022, the P&P indicated, All orders will be double-checked by the night nurse every 24 hours to be sure they have been carried out or reviewed. 24-hour Chart Checks are documented in the resident's electronic medical record. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>44134<br><br>Based on interview and record review, the facility failed to implement their policy and procedure (P&P) titled, Pressure Injury or Skin/Wound Conditions- Assessment, Prevention and Management when staff did not turn and reposition one of seven sampled residents (Resident 15) every two hours. This failure had the potential to result in impaired healing or worsening of a pressure injury (PI-localized damage to the skin and/or underlying tissue as a result of prolonged pressure).<br><br>Findings:<br><br>During a review of Resident 15's Clinical Data Flowsheet (CDF) dated 4/1/24, the CDF indicated, Resident 15 was Completely immobile (unable to make even the slightest changes in body or extremity position without assistance) with a Braden Scale Score (an assessment tool used in health care to determine a patient's risk of developing a pressure injury) of 9 (very high risk for skin breakdown).<br><br>During a review of Resident 15's Physician Orders (PO) dated 3/22/24, the PO indicated, Wound Assessment.Q [every] Week, Site Coccyx [small bone at the bottom of the spine], continue to assess and measure coccyx pressure injury.<br><br>During a review of Resident 15's Wound Pressure Injury Photo Note (WPIPN) dated 4/3/24, the WPIPN indicated, Wound Care Consultant (WCC) assessed Resident 15's Pressure injury stage: Stage 4 [full thickness tissue loss with exposed bone, tendon or muscle] to Resident 15's coccyx.Assessment.[Patient 15] was laying on his back.proper placement was not done.education provided to bedside RN [Registered Nurse] on the importance of frequent at least every 2 hours turning and repositioning body to prevent skin breakdown.Recommendations.Reposition every 2 hours using a wedge @ [at] 30 degrees.<br><br>During an interview on 4/10/24 at 11:53 a.m. with WCC, WCC stated the main intervention to help promote healing Resident 15's PI to the coccyx was ensuring Resident 15 was being turned every two hours.<br><br>During a concurrent interview and record review on 4/11/24 at 10:26 a.m. with RN 1, Resident 15's Hourly Rounding Report (HRR), dated 4/1/24 through 4/8/24 was reviewed. The HRR indicated, Resident 15's position on the following dates and times:<br><br>On 4/1/24 at 6:31 a.m., lying on left side, on 4/1/24 at 9:20 a.m., lying on left side, on 4/1/24 at 12:42 p.m., lying on right side. RN 1 stated it was unacceptable for Resident 15 to go six hours without being turned.<br><br>On 4/1/24 at 10:03 p.m., lying supine (lying on back with face upward), on 4/2/24 at 12:04 a.m., lying supine, on 4/2/24 at 4:05 a.m., lying supine, on 4/2/24 at 6:05 a.m., lying on left side. RN 1 stated Resident 15 should be turned Q2 [hours] and not just on his back.<br><br>On 4/3/24 at 9:04 a.m., lying on right side, on 4/3/24 at 11:32 a.m., lying on right side, on 4/3/24 at 2:09 p.m., lying on right side, on 4/3/24 at 5:00 p.m., lying on right side, on 4/3/24 at 6:35 p.m., lying on left side. RN 1 stated Resident 15 should have been turned every two hours.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/3/24 at 8:01 p.m., lying supine, on 4/4/24 at 12:07 a.m., lying supine, on 4/4/24 at 2:22 a.m., lying on left side. RN 1 stated Resident 15 should have been turned every two hours.<br><br>On 4/6/24 at 6:12 a.m., lying on left side, on 4/6/24 at 9:20 a.m., lying on right side. RN 1 stated Resident 15 should have been turned every two hours.<br><br>On 4/7/24 at 6:10 a.m., lying on left side, on 4/7/24 at 9:29 a.m., lying on right side. RN 1 stated Resident 15 should have been turned every two hours.<br><br>On 4/8/24 at 6:29 a.m., lying on left side, on 4/8/24 at 10:30 a.m., lying on left side, on 4/8/24 at 12:53 p.m., lying on right side. RN 1 stated Resident 15 should have been turned every two hours. RN 1 stated Resident 15 not being turned every two hours could compromise the healing process of the wound.<br><br>During a review of the facility's P&P titled, Pressure Injury or Skin/Wound Conditions- Assessment, Prevention and Management, dated 5/4/22, the P&P indicated, Pressure Injury Prevention Involves The Following.implement prevention strategies for all patients identified as being at risk.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. Document all preventative measures in the EHR [electronic health record]. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Provide Restorative Nursing Assistant (RNA) program (provided by RNA to help maintain or improve mobility for the residents) for five of 35 sampled residents (Resident 31, Resident 354, Resident 19, Resident 1, and Resident 27).<br><br>2. Ensure the Director of Nursing (DON) implemented the RNA program.<br><br>These failures had the potential for reduced mobility and range of motion (ROM - limit to which a part of the body can be moved around a joint) for Resident 31, Resident 354, Resident 19, Resident 1, and Resident 27.<br><br>Findings:<br><br>1a. During an interview on 4/8/24 at 3:22 p.m. with Resident 31's Family Member (FM) 1, FM 1 stated Resident 31 was to get RNA care by a CNA three times a week for ROM (Range of Motion) and did not think that was happening. FM 1 stated she came in the evening to keep the Resident 31's movement (ROM) going.<br><br>During an interview on 4/9/24 at 8:29 a.m. with Resident 31, Resident 31 stated no staff have done RNA care.<br><br>During a review of Resident 31's Brief Interview for Mental Status (BIMS, 15 point scale: 0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact) dated 1/9/24, the BIMS indicated, Resident 31 had a total score summary of 15 (cognitively intact).<br><br>During a concurrent interview and record review on 4/9/24 at 8:45 a.m. with Registered Nurse (RN) 1, the facility's Staffing Pink Sheets (SPS), dated 3/1/24 to 4/8/24 were reviewed. The SPS indicated the following on the following dates:<br><br>3/10/24 at 1 p.m., one staff member was assigned as RNA.<br><br>3/11/24 at 7 a.m. to 7 p.m., two staff members were assigned as RNA.<br><br>3/12/24 at 7 a.m. to 7 p.m., two staff members were assigned as RNA.<br><br>3/15/24 at 7 a.m. to 7 p.m., two staff members were assigned as RNA.<br><br>3/16/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>3/19/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>3/25/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3/26/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>3/27/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>3/28/24 at 7 a.m. to 7 p.m., two staff members were assigned as RNA.<br><br>3/29/24 at 7 a.m. to 7 p.m., one staff member was assigned as RNA.<br><br>4/1/24 through 4/8/24, there were no staff assigned as RNA.<br><br>RN 1 stated if a Licensed Vocational Nurse or CNA was assigned to do RNA duties for the day that would be their assignment and not resident care on the floor.<br><br>During a review of Resident 31's Range of Motion Order Sheet ([NAME]), dated 10/1/23, the [NAME] indicated, Daily, RNA to provide Passive ROM to BLE for 15-30 minutes or as tolerated.<br><br>During an interview on 4/10/24 at 9:04 a.m. with CNA 2, CNA 2 stated he does RNA care with ROM with the residents during care. CNA 2 stated he had not been scheduled a full day of care or seen a CNA scheduled for RNA care only.<br><br>During an interview on 4/10/24 at 9:06 a.m. with CNA 7, CNA 7 stated ROM was done by CNAs in between getting the resident up for the day, going to activities or coming back from activities or getting a shower.<br><br>50409<br><br>1b. During a concurrent observation and interview on 4/7/24 at 11:29 p.m. with Resident 354 in Resident 354's room, Resident 354 had limited range of motion on both of her arms and legs. Resident 354 stated, I don't get my exercises.<br><br>During a review of Resident 354's MDS (Minimum Data Set - an assessment tool), dated 10/3/23, the MDS indicated, Resident 354 had a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact).<br><br>During a review of Resident 354's Orders, dated 10/1/23, the Orders indicated, RNA to do daily PROM [passive range of motion - assistance is provided for the resident to perform the ROM]/AAROM [assisted active range of motion - resident performs the ROM but may require some help] to BUE [bilateral upper extremities - part of the body that includes the arm, forearm, wrist, and hand] x [for] 15 minutes daily.<br><br>During a review of Resident 354's Flowsheet, dated April 2024, the Flowsheet indicated no ROM exercises documented for the following dates: 4/1/24, 4/2/24, 4/5/24, 4/7/24, 4/8/24, and 4/10/24.<br><br>1c. During a concurrent observation and interview on 4/8/24 at 9:58 a.m. with Resident 19 in Resident 19's room, Resident 19 had limited range of motion on both of his arms and legs. Resident 19 stated, They're [facility] using CNAs to take up that slack of the therapists. Before, they [nursing staff] ask me to do range of motion exercises almost every day but now they just ask once or twice a week sometimes.<br><br>(continued on next page) |

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| 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.

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had a BIMS of 14 (cognitively intact).<br><br>During a review of Resident 19's Orders, dated 10/1/23, the Orders indicated, RNA to do daily BUE passive ROM exercises x 15 min [minutes] and positioning.<br><br>During a review of Resident 19's Orders, dated 10/16/23, the Orders indicated, Restorative Program Splint/Brace Assist. [assistance] Nursing staff to apply AFO [ankle foot orthoses - used on lower limbs to stabilize joints] to BLE [bilateral lower extremities - part of the body that includes the hip, thigh, knee, leg, ankle, and foot] for 6 hours twice a day or as tolerated.<br><br>During a review of Resident 19's Flowsheet, dated March 2024, the Flowsheet indicated, no ROM exercises documented for the following dates: 3/2/24 and 3/5/24. The Flowsheet also indicated no AFO applied for the following dates: 3/2/24, 3/3/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/11/24, 3/12/24, 3/13/24, 3/19/24, 3/20/24, 3/21/24, 3/24/24, 3/28/24, and 3/29/24.<br><br>1d. During an observation on 4/7/24 at 10:30 a.m. in Resident 1's room, Resident 1 had limited range of motion on both hands.<br><br>During a review of Resident 1's Orders, dated 10/1/23, the Orders indicated, ROM daily by RNA to do AAROM ex [exercises] to BUE x 15 min daily.<br><br>During a review of Resident 1's Flowsheet, dated March 2024, the Flowsheet indicated, no ROM exercises documented for the following dates: 3/5/24, 3/6/24, and 3/26/24.<br><br>During an interview on 4/8/24 at 11:33 a.m. with CNA 1, CNA 1 stated, They make us do the RNA exercises. I was trained only one time, but I need more training. I told them I need to be trained again but they told me the team leader will help me. It's hard because sometimes we get 16 patients.<br><br>1e. During an interview on 4/10/24 at 10:47 a.m. with Regulatory Specialist (RS) 2, RS 2 stated, There is no March 2024 RNA [Flowsheet] for [Resident 27].<br><br>During a concurrent interview and record review on 4/10/24 at 10:51 a.m. with Minimum Data Set Coordinator (MDSC), Resident 27's Orders, dated 3/25/24 were reviewed. Resident 27's Orders indicated, RNA to do PROM exercises x 15 min to BUE and provide proper positioning of UE (support on pillows). MDSC stated the PROM exercises were started on 4/1/24. MDSC stated the nursing staff should have started the RNA program on 3/25/24.<br><br>During a review of the facility's policy and procedure (P&P) titled, SPLINT AND HAND ROLLS ASSESSMENT OF SPECIAL CARE PATIENTS, dated 1/25/24, the P&P indicated, Provide range of motion to affected hand/hands. Record the use and effectiveness of assistive devices in the electronic medical record.<br><br>During a review of the facility's Patient Oriented Council (POC), dated 2/23/24, the POC indicated, NEW CONCERNS AND SUGGESTIONS. Support for Range of Motion & turning and repositioning pts [residents]. Pt. [resident] concerned about when other RNA comes back.<br><br>During an interview on 4/9/24 at 10:49 a.m. with Risk and Regulatory Analyst (RRA), RRA stated they do not have a policy that speaks to CNA doing RNA care.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/10/24 at 2:48 p.m. with CNA 2, CNA 2 stated, We do RNA exercises, but we have a lot of work, getting up the resident, showers, repositioning. We can only do the RNA exercises after when we're free, so we just prioritize those alert residents.<br><br>During an interview on 4/11/24 at 9:56 a.m. with RN (Registered Nurse) 1, RN 1 stated CNAs don't have access on the computer to view the residents' orders for RNA exercises.<br><br>During an interview on 4/11/24 at 9:57 a.m. with CNA 3, CNA 3 stated, They just gave it [providing RNA program for the residents] to us out of nowhere. We don't know how to chart it [RNA program]. We can't get into the computer to check their RNA orders. At the same time, we are busy we don't have time to do the exercises. Some are daily. [For] some residents, it takes an hour to do the exercises. I was not trained with charting and doing the RNA exercises.<br><br>2. During an interview on 4/10/24 at 12:06 p.m. with DON, DON stated she attended the Patient Oriented Council (POC), on 2/23/24. DON stated she was aware of the residents' concerns regarding the range of motion exercises and RNA.<br><br>During an interview on 4/11/24 at 2:26 p.m. with DON, DON stated, The RNAs we did have are no longer here. DON stated there was no plan to replace the RNAs at this time.<br><br>During a review of the facility's Director, RN Job Summary, dated 3/2/24, the Director, RN Job Summary indicated, Maintains responsibility for coordinating services of departments including staffing, operational policies and procedures, systems, and programs. Supervises the quality and effectiveness of patient care delivered by assigned employees in the patient care units in consultation with other members of the management and exerts influence and gives direction to employees for patient teaching and other activities as needed. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>45654<br><br>Based on observation, interview and record review, the facility failed to follow their Policy and Procedure (P&P) titled Tracheostomy [surgical opening in the neck] Tube and inner Cannula [flexible tube] Changing, for one of one sampled resident (Resident 24) did not have a spare tracheostomy tube at the bedside. This failure had the potential to result in a delay in care in the event of an emergency.<br><br>Findings:<br><br>During an observation on 4/7/24 at 10:24 a.m., in Resident 24's room, Resident 24 had no ambu bag (manual breathing bag), no emergency blow by (method to supply oxygen) and no spare tracheostomy tube or supplies at bedside.<br><br>During a concurrent observation and interview on 4/9/24 at 8:37 a.m. with Licensed Vocational Nurse (LVN) 6, in Resident 24's room, there were no emergency supplies: ambu bag, blow by or spare tracheostomy tube and supplies. LVN 6 stated the supplies are supposed to be hanging at bedside or the hook at the closet area.<br><br>During an interview on 4/9/24 at 10:49 a.m. with Respiratory Therapist (RT) 2, RT 2 stated when the resident got moved, they did not move the emergency tracheostomy supplies for the Resident 24.<br><br>During a review of the facility's policy and procedure (P&P) titled, Facility Procedure: Tracheostomy Tube and inner Cannula Changing, of Special Care Unit Patients, dated 2/22/23, the P&P indicated, Always keep a second trach [tracheostomy tube] at the bedside. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654<br><br>Based on observation, interview, and record review, the facility failed to provide enough direct care staff to ensure the daily needs were met for four of four sampled residents (Resident 21, Resident 18, Resident 34, and Resident 31) when:<br><br>1. Resident 21, Resident 18, Resident 34, and Resident 31 were not turned every two hours. This failure had the potential for Resident 21, Resident 18, Resident 34, and Resident 31 to develop pressure injuries (damage that can occur as a result of being in the same position for extended periods of time).<br><br>2. Resident 21's call light was not answered timely. This failure had the potential for Resident 21 to feel devalued and helpless.<br><br>3. Resident 21 face and hands were not cleaned before meals without asking. This failure had the potential for Resident 21 to feel helpless and neglected.<br><br>4. Resident 21, Resident 34, and Resident 19's Restorative Nursing Assistant (RNA) program (provided by RNA to help maintain or improve mobility for the residents) was not performed as ordered. This failure had the potential for residents to develop contractures (permanent tightning of muslces that cause joint to shorten and become stiff).<br><br>Findings:<br><br>1. During an interview on 4/7/24 at 10:30 a.m. with Resident 21, Resident 21 stated the care had gotten worse recently. Resident 21 stated she told the Director of Nursing (DON), the CNAs are not turning her every two hours.<br><br>During an interview on 4/8/24 at 11:09 a.m. with CNA 4, CNA 4 stated the facility started assigning each CNA eight residents, a total of 16 residents per team. CNA 4 stated recently the facility gave the CNAs the additional responsibility for the RNA exercises. CNA 4 stated there was not enough time to complete the RNA exercises and turn the residents every two hours.<br><br>During an interview on 4/8/24 at 11:47 a.m. with CNA 5, CNA 5 stated the workload was too much, she did her best to turn the residents every two hours but sometimes it was longer than two hours because there was not enough time.<br><br>During a concurrent interview and record review on 4/11/24 at 10:12 a.m. with RN 1, Resident 18's Hourly Rounding Report (HRR), dated 4/1/24 through 4/10/24 were reviewed. Resident 18's HRR indicated the following on:<br><br>4/2/24 12:05 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 2:11 a.m. Indicate resident's position: Lying on the left side<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4/3/24 10:01 a.m. Indicate resident's position: Lying on the left side<br><br>4/3/24 12:47 p.m. Indicate resident's position: Lying on the left side<br><br>4/3/24 2:21 p.m. Indicate resident's position: Lying on the right side<br><br>4/3/24 4:53 p.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 8:28 a.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 11:40 a.m. Indicate resident's position: Supine<br><br>4/7/24 8:45 a.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 10:49 a.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 11:55 a.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 4:41 p.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 8:19 p.m. Indicate resident's position: Lying on the right side<br><br>4/9/24 4:11 a.m. Indicate resident's position: Lying on the right side<br><br>4/9/24 6:01 a.m. Indicate resident's position: Lying on the right side<br><br>4/9/24 8:31 a.m. Indicate resident's position: Lying on the right side<br><br>RN 1 stated according to the HRR documentation Resident 18, was not always turned every 2 hours. RN 1 stated the policy for turning was not followed.<br><br>During a concurrent interview and record review on 4/11/24 at 10:12 a.m. with RN 1, Resident 34's HRR, dated 4/1/24 through 4/10/24 were reviewed. Resident 34's HRR indicated the following on:<br><br>4/1/24 3:09 a.m. Indicate resident's position: Lying on the right side<br><br>4/1/24 4:51 a.m. Indicate resident's position: Lying on the right side<br><br>4/1/24 10:11 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 12:08 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 2:12 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 6:06 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 9:07 a.m. Indicate resident's position: Lying on the right side<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4/3/24 2:30 p.m. Indicate resident's position: Lying on the right side<br><br>4/3/24 4:56 p.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 8:39 a.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 11:41 a.m. Indicate resident's position: Sitting in chair<br><br>4/7/24 10:52 a.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 5:28 p.m. Indicate resident's position: Lying on the right side<br><br>4/7/24 8:03 p.m. Indicate resident's position: Lying on the right side<br><br>RN 1 stated according to the HRR documentation Resident 34, was not always turned every 2 hours. RN 1 stated the policy for turning was not followed.<br><br>During a concurrent interview and record review on 4/11/24 at 10:12 a.m. with RN 1 Resident 21's HRR, dated 4/1/24 through 4/10/24 were reviewed. Resident 21's HRR indicated the following on:<br><br>4/1/24 4:03 a.m. Indicate resident's position: Lying on the right side<br><br>4/1/24 6:23 a.m. Indicate resident's position: Lying on the right side<br><br>4/1/24 8:27 a.m. Indicate resident's position: Lying on the right side<br><br>4/1/24 10:09 p.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 12:05 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 2:11 a.m. Indicate resident's position: Lying on the left side<br><br>4/2/24 8:41 a.m. Indicate resident's position: High Fowlers<br><br>4/2/24 12:19 p.m. Indicate resident's position: High Fowlers<br><br>4/3/24 6:11 a.m. Indicate resident's position: Lying on the left side<br><br>4/3/24 9:59 a.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 8:29 a.m. Indicate resident's position: Lying on the right side<br><br>4/5/24 11:40 a.m. Indicate resident's position: Sitting in chair<br><br>4/7/24 12:37 p.m. Indicate resident's position: Supine<br><br>4/7/24 5:25 p.m. Indicate resident's position: Lying on the right side<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4/8/24 6:19 a.m. Indicate resident's position: Lying on the left side<br><br>4/8/24 9:02 a.m. Indicate resident's position: Lying on the right side<br><br>RN 1 stated according to the HRR documentation Resident 21 was not always turned every 2 hours. RN 1 stated the policy for turning was not followed. RN 1 stated the turning chart on wall was the turning schedule and the turning schedule did not account for when residents were on their back.<br><br>During an interview on 4/11/24 at 10:29 a.m. with CNA 2, CNA 2 stated the CNAs were instructed to follow turning schedule hung in the hallways which allow for left and right only, no back. CNA 2 stated they (CNAs) try to get the RNA exercises done but multiple residents require total assistance with care, and it was hard to get all of their (CNA/RNA) tasks completed. CNA 2 stated, We prioritize the alert patients [residents], or they [residents] will just keep complaining.<br><br>During a concurrent interview and record review on 4/11/24 at 10:38 a.m. in Resident 18's room with LVN 4, the turning chart on the wall was reviewed. The turning chart indicated, Resident 18 should have been turned onto her left side. LVN 4 stated the CNAs had just turned Resident 18 to 30 minutes ago. LVN 4 stated they [the CNAs] are behind because they do not have time. Resident 18 was on the right side but according to the turning chart should have been turned onto the left side. LVN 4 stated the CNAs do not have time to turn the residents every two hours, especially during first rounds.<br><br>During a review of facility's policy and procedure (P&P) titled, Turning Schedule, dated 10/2/20, the P&P indicated, All residents on the unit will be turned every (2) hours.Each staff member altering the resident's position in bed for routine and necessary activities is to consult turning schedule and reposition the resident accordingly.<br><br>2. During an interview on 4/7/24 at 10:30 a.m. with Resident 21, Resident 21 stated sometimes there were not enough CNAs, and she has had to wait up to 30 minutes for someone to answer her call light. Resident 21 stated, I already feel so helpless, I can't move any part of my body.<br><br>During a review of Resident 21's BIMS, dated 12/18/23, the BIMS indicated, Resident 1 had a BIMS Summary Score 14. (indicated cognition intact).<br><br>3. During an interview on 4/7/24 at 10:30 a.m. with Resident 21, Resident 21 stated the care had gotten worse recently and she told the Director of Nursing (DON) the CNAs are not cleaning her face and hands for meals. Resident 21 stated, I already feel so helpless, I can't move any part of my body.<br><br>During an interview on 4/9/24 at 2:02 p.m. with Resident 21, Resident 21 stated, My understanding is our CNAs had eight patients [residents] each but now they have 16 patients [residents]. They are always in a hurry. They do not fix my hair or wipe my face. They do it only if I ask.<br><br>During a review of Resident 21's MDS, dated [DATE], the MDS indicated, Resident 21 had a BIMS of 14 (indicated cognitively intact).<br><br>4. During an interview on 4/7/24 at 10:30 a.m. with Resident 21, Resident 21 stated the care had gotten worse recently and she told the Director of Nursing (DON) the CNAs are not doing her RNA exercises.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/7/24 at 11:45 a.m. with FM 2, FM 2 stated she was not sure if Resident 34 was getting her RNA exercises. FM 2 stated the facility had been short staffed.<br><br>During an interview on 4/8/24 at 9:58 a.m. with Resident 19, Resident 19 stated, They pull in CNAs and LVNs to cover and do those job duties that the therapists are supposed to do. Before they ask me to do range of motion [limit to which a part of the body can be moved around a joint] exercises almost every day but now, they just ask once or twice a week.<br><br>During a review of Resident 19's MDS (Minimum Data Set - an assessment tool), dated 10/3/23, the MDS indicated, Resident 19 had a BIMS of 14 (indicated cognitively intact).<br><br>During an interview on 4/8/24 at 11:09 a.m. with CNA 4, CNA 4 stated recently the facility gave the CNAs the additional responsibility for the RNA exercises. CNA 4 stated there was not enough time to complete the RNA exercises.<br><br>During an interview on 4/8/24 at 11:47 a.m. with CNA 5, CNA 5 stated a week ago the DON told all CNAs they were now responsible for RNA exercises. CNA 5 stated the workload was too much.<br><br>During an interview on 4/11/24 at 10:15 a.m. with Charge Nurse (CN), CN stated when there are only three teams the CNAs were not able complete all duties required of them. CN stated the CNAs had come to the RNs and LVNs stating they did not know how to complete or chart RNA tasks. CN stated DON had been made aware of staffing concerns and was already aware CNAs were having trouble completing their assigned duties.<br><br>During an interview on 4/11/24 at 10:19 a.m. with CN, CN stated they are currently short one LVN. CN stated when they are short an LVN, CNAs cannot utilize LVNs to assist with completing residents' care.<br><br>During an interview on 4/8/24 at 11:33 a.m. with CNA 1, CNA 1 stated, Sometimes there are only 3 teams, and we get 16 patients [for each CNA].<br><br>During a review of the facility's Patient Oriented Council (POC - resident council meeting minutes), dated 2/23/24, the POC indicated, NEW CONCERNS AND SUGGESTIONS. Support for Range of Motion & turning and repositioning. Pt [resident] concerned about when other RNA comes back. Pts [Residents] feel that there isn't enough staffing support .<br><br>During a review of the facility's POC, dated 3/27/24, the POC indicated, NEW CONCERNS AND SUGGESTIONS. CNA are overload c [with] pts [residents]. They [CNAs] don't have time to give us [residents] quality care. CNA been call out to assist other resident while they are not finish what they're doing they rushing all the time. CNA make only 3 rounds a day and NOC [night shift].<br><br>During an interview on 4/10/24 at 2:48 p.m. with CNA 2, CNA 2 stated, It started in February when we did the RNA exercises and the three teams with 16 patients for one CNA, also sometimes they make us leave early.<br><br>47153<br><br>50409 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>47153<br><br>Based on observation, interview and record review, the facility failed to ensure 41 of 41 licensed nurses were competent to:<br><br>1. Care and manage the nephrostomy (tube placed directly into the kidney to drain urine) tube for one of one sampled resident (Resident 18). This failure had the potential for the urine to flow backwards into Resident 18's kidney and may have contributed to multiple infections.<br><br>2. Administer medications through a gastrostomy (G-tube, tube inserted into stomach for nutrition and medication) tube for two of two sampled residents (Resident 25 and Resident 17). This failure had the potential for medication reactions, blockage of the G-tube, and insufficient water provided to Resident 25 and Resident 17.<br><br>Findings:<br><br>1a. During a concurrent observation and interview on 4/8/24 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 18's nephrostomy bag was on the floor next to the bed. LVN 2 stated Resident 18 already had renal impairment (decreased kidney function). LVN 2 stated the nephrostomy bag should not be on the floor because it could cause an infection, or the bag or tubing could get stepped on and get pulled out.<br><br>During an interview on 4/9/24 at 10:56 a.m. with Infection Preventionist (IP), IP stated the nephrostomy bag should not have been on the floor. IP stated the nurse should have changed the nephrostomy bag when it became contaminated from being on the floor on 4/8/24.<br><br>1b. During an interview on 4/8/24 at 11:42 a.m. with LVN 4, LVN 4 stated Resident 18's nephrostomy site is on the right side. LVN 4 stated Resident 18's nephrostomy site did not get covered with any dressing. LVN 4 stated Resident 18's did not have an order for a dressing since she was admitted with it.<br><br>During an interview on 4/10/24 at 3:41 p.m. with LVN 6, LVN 6 stated she had been providing care for Resident 18's nephrostomy. LVN 6 stated she had not been trained in nephrostomy care. LVN 6 stated, I wipe it down, usually with tap water or normal saline. LVN 6 stated she did not realize it was supposed to be a sterile procedure. LVN 6 stated there had been no dressing on Resident 18's nephrostomy site since resident's admission. LVN 6 stated there were no instructions for how to care for the nephrostomy site in Resident 18's physician's orders. LVN 6 stated she did not clarify the order for nephrostomy site care and should have.<br><br>During an interview on 4/10/24 at 3:46 p.m. with LVN 4, LVN 4 stated she did not receive training for a nephrostomy site care or how to clean it.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Adventist Health Delano | 1401 Garces Hwy<br>Delano, CA 93215 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/11/24 at 9:08 a.m. with IP, IP stated cleaning the nephrostomy site or changing the nephrostomy bag should be a sterile procedure. IP stated Resident 18 had multiple urinary tract infections (UTIs). IP stated she did not know Resident 18 had a nephrostomy until a few days ago. IP stated the nephrostomy tube had not been kept sterile which could have led to Resident 18's repeated UTI's. IP stated there had been a lack of communication and training regarding nephrostomy procedure and infections.<br><br>During an interview on 4/10/24 at 2:39 p.m. with Director of Nursing (DON), DON stated there were no competencies in place for nephrostomy tube management for any of the licensed nurses. DON stated the nurses should have had a competency before being required to provide nephrostomy care.<br><br>2a. During an observation on 4/9/24 at 8:17 a.m. in the hallway, LVN 1 was preparing medications for Resident 25. LVN 1 crushed a multivitamin and fenofibrate (used to treat high cholesterol) together, sprinkled the contents of two Gabapentin (used for numbness and pain) capsules, and mixed the three medications together in the same medicine cup.<br><br>During an observation on 4/9/24 at 8:37 a.m. in Resident 25's room, LVN 1 administered the three previously mixed medications through Resident 25's G-tube. LVN 1 did not flush the G-tube with water before or after medication administration.<br><br>2b. During an observation on 4/9/24 at 8:59 a.m. in the hallway, LVN 1 was preparing medications for Resident 17. LVN 1 crushed amlodipine (used to treat high blood pressure), calcium carbonate (supplement), and losartan (used to treat high blood pressure) and mixed the three medications together in the same medicine cup.<br><br>During an observation on 4/9/24 at 9:08 a.m. in Resident 17's room, LVN 1 administered the three previously mixed medications into Resident 17's G-tube. LVN 1 did not flush the G-tube with water before or after the medication administration.<br><br>During an interview on 4/9/24 at 9:22 a.m. with LVN 1, LVN 1 stated she should have given each medication separately. LVN 1 stated she should have flushed the G-tube with water before and after medication administration.<br><br>During a concurrent interview and record review on 4/10/24 at 12:12 p.m. with Clinical Nurse Educator (CNE), LVN 1 and LVN 2's 2023 Annual Skills Checklist (2023 ASC), dated 3/13/23 were reviewed. 2023 ASC indicated, Medications. Administration via PO (by mouth), IM (injection into muscle), IV (injected into a vein), TPN (nutrition given through a vein). CNE stated the competency did not cover the administration of medications through a G-tube.<br><br>During an interview on 4/10/24 at 2:39 p.m. with DON, DON stated there were no competencies in place for administration of medications through a G-tube for any of the licensed nurses. DON stated the nurses should have had a competency before being required to administer medications through a G-tube.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Adventist Health Delano | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Garces Hwy Delano, CA 93215 | |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of the facility's policy and procedure (P&P) titled, Medication Administration Through A Feeding Tube, dated 10/2/20, the P&P indicated, Do not mix medications with each other . If giving multiple medications, flush tube with 5-10 mL [milliliters] water in between meds [medications] . Flush tube with 15-30 cc [cubic centimeters] warm water before and after all medications are given.<br><br>During a review of the facility's P&P titled, Employee Competency Process, dated 8/10/23, the P&P indicated, Compliance-Key Elements . Adequately orient employees for specific job duties and responsibilities . Evaluate employees routinely to ensure competent performance on the job.<br><br>During a review of the facility's P&P titled, Competency, Clinical Staff, dated 1/24/23, the P&P indicated, the content of the competency will be based on current information and standards. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>47734<br><br>Based on interview and record review, the facility failed to ensure one of six sampled resident's (Resident 48) on a psychotropic (used to treat mental health disorders) medication, behavior was monitored consistently. This failure had the potential for staff to not be able to identify when changes occurred in Resident 48's mood/behavior.<br><br>Findings:<br><br>During a review of Resident 48's Physician Orders (PO), dated 1/13/24, the PO indicated, Sertraline (a psychotropic medication) daily for depression.<br><br>During an interview on 4/9/24 at 9:30 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 48 expressed signs of frustrations when she could not communicate her needs. LVN 3 stated Resident 48 was also sad because she was homesick and wanted to go home.<br><br>During an interview on 4/9/24 at 9:53 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated she did not regularly document Resident 48's behavior or mood.<br><br>During a concurrent interview and record review on 4/9/24 at 11:26 a.m. with Pharmacist Supervisor (PS), Resident 48's Drug Regimen Review (DRR), dated 3/27/24 was reviewed. The DRR indicated Resident 48's behaviors were not reviewed. PS stated he could not tell if the DRR was reviewed correctly; there was no documentation the pharmacist reviewed the behaviors. PS stated behaviors should have been reviewed to make a recommendation.<br><br>During an interview on 4/9/24 at 2:08 p.m. with Director of Nursing (DON), DON stated there was a paper monitoring sheet titled Anti-Depressant Medication Sheets (ADMS) to monitor behaviors for the month of January but there were no paper monitoring sheets for the months of February and March 2024.<br><br>During a concurrent interview and record review on 4/10/24 at 12:15 p.m. with DON, Resident 48's ADMS, dated January 2024 was reviewed. The ADMS indicated, there was no documentation on sign & symptoms of behavior for Resident 48 on 1/15/24, 1/16/24, 1/18/24, 1/19/24, 1/22/24, 1/28/24, 1/29/24, and 1/31/24. DON stated her expectation was to have correct documentation. DON stated the behaviors were not monitored daily for January, and no monitoring sheets for February 2024, and March 2024.<br><br>During a review of the facility's policy and procedure (P&P) titled, Monthly Drug Regimen Review - SCU, dated 10/19/2021, the P&P indicated, 2. The drug regimen review will include a review of unnecessary medication. Unnecessary medications are defined based upon: .d. Inadequate monitoring. C. The Pharmacist will review that the following are monitored: 1. Behavioral expressions 2. Indications of distress 3. Onset or worsening of signs and symptoms. D. The Pharmacist will request:. 3. Signs, symptoms, or related causes are persistent or clinically significant enough (causing functional decline) to warrant initiation or continuation of medication therapy. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47734<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 45) was provided with gradual dose reduction (GDR - reduce dose gradually over time) of an anti-depressant medication (medication used to reduce depressed mood). This failure had the potential for Resident 45 to continue taking a medication unnecessarily.<br><br>Findings:<br><br>During a concurrent interview and record review on 4/9/24 at 11:46 a.m. with Pharmacist Supervisor (PS), Resident 45's Medical Record (MR) was reviewed. PS stated Resident 45 was admitted on [DATE] and was prescribed Sertraline (medication for depressed mood) on 10/25/23. PS stated the start of review should have been November 2023. PS stated there was no documentation for a GDR. PS stated pharmacy review was suppose to every 3 months. PS stated it can be potentially an unnecessary medication.<br><br>During a review of the facility's policy and procedure (P&P) titled, Monthly Drug Regimen Review - SCU, dated 10/19/21, the P&P indicated, 6. Gradual dose reduction (GDR) a. Within the first year of residency or after initiation of medication, at least 2 attempts in separate quarters with at least one month between attempts. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>47153<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Label and date an Intravenous (IV, in the vein) solution (fluid) and tubing (carries fluid from bag to the vein) for one of three sampled residents (Resident 13). This failure had the potential of medication being administered to the wrong resident and the potential for Resident 13 to acquire an infection due to increased time of use.<br><br>2. Date the glucose (sugar) Quality Control (QC) testing strips vial (small container) upon opening on one of four sampled medication carts (Cart 3).<br><br>Findings:<br><br>1. During an observation on 4/7/24 at 10:09 a.m. in Resident 13's room, an IV solution was being administered to Resident 13. The IV solution did not have a patient identifier label or date. The IV tubing did not have a label with a date of first use.<br><br>During an interview on 4/7/24 at 10:16 a.m. with Registered Nurse (RN) 1, RN 1 stated the IV bag was changed this morning, but she did not get a chance to date it or put a label on it. RN 1 stated the IV bag should have been labeled and the tubing should have been dated.<br><br>During an interview on 4/9/24 at 12:09 p.m. with Director of Nursing (DON), DON stated if there was no label RN 1 would have been unable to complete triple check procedure. DON stated the IV bag and tubing should have been labeled.<br><br>During a review of the facility's policy and procedure (P&P) titled, IV Labeling, dated 9/24/20, the P&P indicated, the following labeling process will be done to validate the appropriate medication is administered to the appropriate patient. The nurse will .Affix a patient identification sticker to the product .Fill in on the sticker the following information .Date and time hung on patient.<br><br>2. During a concurrent observation and interview on 4/9/24 at 10:09 a.m. with LVN 3, the vial containing the QC test strips was not dated. LVN 3 stated they [test strips] are supposed to be dated when opened.<br><br>During an interview on 4/10/24 at 9:20 a.m. with Charge Nurse (CN), CN stated when QC strips were opened, they should be dated. QC strips were only good for six months after opening, if used beyond, the QC strips could give an inaccurate QC reading.<br><br>During a review of the Manufacturers Guidelines (MG) for Stat Strip Glucose Hospital Meter Test Strips, (undated), the MG indicated, The expiration date is printed on the vial of test strips. Once opened .Test strips are stable when stored as indicated for up to 6 months or until the expiration date, whichever comes first. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44134<br><br>Based on observation, interview, and record review, the facility failed to maintain safe and sanitary food handling practices for:<br><br>1. One of three sampled freezers (Freezer #6)<br><br>2. One of three sampled refrigerators (Refrigerator #5)<br><br>when food items were not dated after opening.<br><br>These failures had the potential to result in decreased palatability (tastiness) and foodborne illnesses for residents.<br><br>Findings:<br><br>1. During a concurrent observation and interview on 4/7/24 at 10:06 a.m. with Dietary Aide (DA) 1 in the kitchen, Freezer #6 had one open four-pound bag of frozen mixed peas and carrots without an open date, one open four-pound bag of sliced carrots without an open date, and one open large half empty bag of tater tots (bite size portions of shredded potatoes) without an open date. DA 1 stated there should have been an open date on all open food items.<br><br>2. During a concurrent observation and interview on 4/7/24 at 10:08 a.m. with DA 1 in the kitchen, Refrigerator #5 had a one-gallon jar of mayonnaise that was half empty without an open date, and a one-gallon jar of dill pickle relish that was half empty without an open date. DA 1 stated there should have been an open date on all open containers of food.<br><br>During an interview on 4/9/24 at 10:22 a.m. with Certified Dietary Manager (CDM), CDM stated all food items should be labeled with a use by date and opened date per policy.<br><br>During a review of the facility's policy and procedure (P&P) titled, MODEL POLICY: FOOD STORAGE, (undated), the P&P indicated, B. Food Labeling and Dating.1. All stored food must be properly labeled and dated with: a. Product name.b. Date product was opened or prepared. c. Use-by-date. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>44134<br><br>Based on observation and interview, the facility failed to create a policy and procedure (P&P) to ensure safe food handling/storage guidelines were being followed for food brought to residents by family/visitors from outside of the facility. This failure had the potential to result in foodborne illness for residents.<br><br>Findings:<br><br>During a concurrent observation and interview on 4/10/24 at 8:28 a.m. with Activities Director (AD) in the activities room, AD stated the refrigerator was for resident use. Resident refrigerator had ice cream and orange juice, dated with patient labels. AD stated if residents want to store food in the refrigerator, she would store it for them. AD stated she was responsible for cleaning the refrigerator and checking the temperature daily. AD stated she was not sure if the facility had a P&P to ensure safe food handling/storage for food brought to residents from family/visitors.<br><br>During an interview on 4/10/24 at 3:57 p.m. with Regulatory Specialist (RS), RS stated the facility did not have a P&P regarding food handling/storage of food brought to residents from family/visitors.<br><br>During an interview on 4/11/24 at 10:03 a.m. with Registered Nurse (RN) 2, RN 2 stated residents were allowed to have food brought in by family. RN 2 stated there was a resident refrigerator in the activities room if residents would like to store perishable food items. RN 2 stated she was not sure if the facility had a P&P to ensure safe food handling/storage for food brought to residents from family/visitors.<br><br>During an interview on 4/11/24 at 11:04 a.m. with RN 1, RN 1 stated she was not sure what the process was for outside food that was brought to residents by family/visitors. RN 1 stated the activities room had a refrigerator for resident use. RN 1 stated she was not sure if the facility has a P&P to ensure safe food handling/storage for food brought to residents from family/visitors.<br><br>During an interview on 4/11/24 at 11:08 a.m. with Director of Nursing (DON), DON stated outside food brought to residents from family/visitors can be labeled and stored in the resident refrigerator that was in the activities room. DON stated it was the AD's responsibility to monitor the resident refrigerator. DON stated the facility does not have a P&P to ensure safe food handling/storage for food brought to residents from family/visitors. DON stated the facility should have had a P&P. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>47734<br><br>Based on interview and record review, the facility failed to implement and maintain an effective Quality Assurance Performance Improvement Program (QAPI- a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes). This failure had the potential to result in facility issues not identified, recognized, addressed, and corrected appropriately.<br><br>Findings:<br><br>During a review of the facility's Special Care Unit (SCU) Quality Assurance Meeting Minutes (QAPI), dated 10/19/23 and 1/30/24, the QAPI indicated, the final survey findings during the onsite visit from 3/13/24 - 3/16/23.2. F658: Service provided meet professional standards. 3. F686: Treatment & services to prevent & heal pressure ulcers. 4. F688: Increase/prevention in ROM/mobility.6. F695: Respiratory/tracheostomy care and suctioning 7. F725: Sufficient nursing staff.11. F761: Label/store drugs & biologicals 12. F880: Infection prevention & control.Action column: blank.<br><br>During a concurrent interview and record review on 4/11/24 at 1:59 p.m. with Quality Manager (QM), the facility's QAPI dated 10/19/23 and 1/31/24 was reviewed. The QAPI indicated the 2023 Survey Action column was blank. QM stated QAPI was not collaborative before. QM stated there was no data provided to present in QAPI because she was unable to pull reports.<br><br>During an interview on 4/11/24 at 2:34 p.m. Director of Nursing (DON), DON stated, It [QAPI] wouldn't be effective if we don't have data to support.<br><br>During a review of the facility's Quality Assurance and Performance Improvement Plan (QAPI) Special Care Unit (SCU) (QAPI), dated 2023-2024, the QAPI indicated, Performance Improvement Model.Identify opportunities for improvement. Develop a plan for improvement that can be tested . Identify how improvement will be measured.Collect date identified in the plan.Document observations and input from front line staff.organize and analyze data.determine if the change resulted in the expected outcome.F.ensure that data and other information necessary to monitor and improve performance is consistently gathered and assessed at the department level and in collaboration with other departments.G.The Quality/Risk Coordinator.shall be responsible for the overall management and coordination of the performance improvement activities within the hospital. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>50409<br><br>Based on interview and record review, the facility failed to:<br><br>1. Conduct infection control surveillance that included collection of data, analysis, tracking and trending, and follow up of outcomes of infections for 46 of 46 residents.<br><br>2. Ensure the Infection Preventionist (IP) and Director of Infection Prevention (DIP) performed their duties to complete infection control surveillance for 46 of 46 residents.<br><br>3. Store and label oxygen tubing to prevent contamination for one of three sampled residents (Resident 201).<br><br>4. Ensure nephrostomy (tube placed directly into the kidney to drain urine) was secured and maintained in a clean environment to prevent infections for one of one sampled resident (Resident 18).<br><br>5. Ensure hand hygiene was performed after administration of medications through a gastrostomy (G-tube, tube inserted into stomach for nutrition and medication) and before staff provided oral care and suctioning of a tracheostomy (surgical opening in the neck) for two of three sampled residents (Resident 25 and Resident 6).<br><br>These failures had the potential for serious infections to develop and spread to all residents, staff, and visitors in the facility.<br><br>Findings:<br><br>1. During a review of the facility's Infection Surveillance Log (ISL), dated March 2024, the ISL indicated, the following residents had missing information:<br><br>a. For Resident 19 - Organism, re-cultured date, date resolved<br><br>b. For Resident 27 - Onset date, organism, re-cultured date, date resolved<br><br>c. For Resident 20 - Onset date, organism, re-cultured date, date resolved<br><br>During an interview on 4/9/24 at 9:43 a.m. with IP, IP stated she did not complete the ISL.<br><br>During a review of the facility's policy and procedure (P&P) titled, SURVEILLANCE, dated 3/28/24, the P&P indicated, Policy: Compliance - Key Elements: .3. To trace source(s) of infections . 5. To provide a system for evaluating the results of new control measures or policies. 6. To accurately trend surveillance data over time within the facility and compare rates between facilities.<br><br>2. During an interview on 4/11/24 at 9:08 a.m. with IP, IP stated Resident 18 had multiple urinary tract infections (UTIs). IP stated she did not know Resident 18 had a nephrostomy until a few days ago. IP stated she had limited access to residents' medical record and relied only on communication from nursing staff.<br><br>(continued on next page) |

| 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 04/11/2024 |
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| 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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 4/9/24 at 9:43 a.m. with IP, IP was unable to provide tracking and trending of infection control surveillance and overall data analysis. IP stated, When I took over, it's [ISL] been left out like that. That's my mistake it should be documented all the time. The floor map [facility floor map used for tracking and mapping the patterns of the facility's cases of infection] is not updated every month. Only if they [residents] move rooms, I update my map. I never change the map unless there are major changes. It was last updated in January 2024 and before that, was December 2023. It was the new year that's why.<br><br>During an interview on 4/11/24 at 9:43 a.m. with DIP, DIP stated, I don't review that [ISL]. The IP should complete the [ISL].<br><br>During a review of the facility's job description for Infection Preventionist, dated 3/2/24, the job description indicated, Essential Functions: Conducts ongoing surveillance investigation and follow up of infections through review of. culture results, isolation orders, patient records, consultation requests, post-discharge surveillance. Analyzes trends and risk factors and designs and evaluates prevention and control strategies. Compiles and interprets surveillance reports for committees and specialty areas on a regular basis.<br><br>During a review of the facility's job description for Director, Infection Prevention, dated 3/2/24, the job description indicated, Essential Functions: Conducts ongoing surveillance investigation and follow up of infections through review of. culture results, isolation orders, patient records, consultation requests, post-discharge surveillance. Analyzes trends and risk factors and designs and evaluates prevention and control strategies. Reviews all mandated infection data on a monthly basis and determines what qualifies as reportable to the California Department of Public Health.<br><br>45654<br><br>3. During an observation on 4/7/24 at 11:05 a.m., in Resident 201's room Resident 201's oxygen tubing was undated on wall connected to water filter, hanging on a metal hook.<br><br>During a concurrent observation and interview on 4/7/24 at 11:46 a.m. with Licensed Vocational Nurse (LVN) 7 in Resident 201's room, Resident 201's oxygen tubing had no label and was hanging from a metal hook with no plastic bag. LVN 7, stated respiratory therapist was usually the one who changes the tubing.<br><br>During an interview on 4/7/24 at 11:49 a.m. with Respiratory Therapist (RT) 1, RT 1 stated the oxygen tubing was to change every 7 days. RT stated if the tubing falls on the floor or gets dirty it should be changed.<br><br>During a review of Respiratory Therapist Skills Checklist (RTSC), dated 4/23/23, the RTSC indicated, demonstrates safety, keeping respiratory equipment clean, bagged, and properly labeled.<br><br>Requested a policy and procedure guide for storage, labeling oxygen supplies, no policy was provided.<br><br>47153<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4a. During a concurrent observation and interview on 4/8/24 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 18's nephrostomy bag was on the floor next to the bed. LVN 2 stated Resident 18 already had renal impairment (decreased kidney function). LVN 2 stated the nephrostomy bag should not be on the floor because it could cause infection, could get stepped on and get pulled out.<br><br>During an interview on 4/9/24 at 10:56 a.m. with Infection Preventionist (IP), IP stated the nephrostomy bag should not have been on the floor. IP stated the nurse should have changed the nephrostomy bag when it became contaminated from being on the floor on 4/8/24.<br><br>4b. During an interview on 4/8/24 at 11:42 a.m. with LVN 4, LVN 4 stated Resident 18's nephrostomy site did not get covered with any dressing. LVN 4 stated Resident 18 did not have an order for a dressing since Resident 18 was admitted with a nephrostomy.<br><br>During an interview on 4/10/24 at 3:41 p.m. with LVN 6, LVN 6 stated she had been providing care for Resident 18's nephrostomy, but she had not been trained. LVN 6 stated, I wipe it down, usually with tap water or normal saline. LVN 6 stated she did not realize it was supposed to be a sterile procedure. LVN 6 stated there had been no dressing on Resident 18's nephrostomy site since resident's admission.<br><br>During an interview on 4/10/24 at 3:46 p.m. with LVN 4, LVN 4 stated she did not receive training for nephrostomy site care or how to clean it.<br><br>During an interview on 4/11/24 at 9:08 a.m. with IP, IP stated cleaning the nephrostomy site or changing the nephrostomy bag should be a sterile procedure. IP stated Resident 18 had multiple urinary tract infections (UTIs). IP stated she did not know Resident 18 had a nephrostomy until a few days ago. IP stated the nephrostomy tube had not been kept sterile which could have led to Resident 18's repeated UTI's.<br><br>5. During an observation on 4/9/24 at 8:43 a.m. LVN 1 administered medications through Resident 25's G-tube, but did not change her gloves, or perform hand hygiene before providing oral care to Resident 25.<br><br>During an interview on 4/9/24 at 9:21 a.m. with LVN 1, LVN 1 stated she should have changed gloves and performed hand hygiene before moving to the oral care.<br><br>During an interview on 4/9/24 at 10:59 a.m. with IP, IP stated the nurses should change gloves and perform hand hygiene between administering medications through the G-tube and performing oral care. IP stated the nurses are supposed to perform hand hygiene when moving from one area of the body to another.<br><br>During an observation on 4/10/24 at 8:51 a.m. LVN 5 administered medications through Resident 6's G-tube and then suctioned resident 6's tracheostomy without changing gloves or performing hand hygiene.<br><br>During an interview on 4/10/24 at 8:53 a.m. with LVN 5, LVN 5 stated she should have performed hand hygiene and changed her gloves before moving to the next task and suctioning Resident 6's tracheostomy.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of the facility's P&P titled, Administration On Medications Via Gastrostomy and Jejunostomy [inserted through the belly, directly into the small intestine] Tubes, dated 9/11/20, the P&P indicated, Flush tube with 100ml warm water after all medications are given or water per physician's order. Wash hands after procedure. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>50409<br><br>Based on interview and record review, the facility failed to perform the antibiotic stewardship program (a program that promotes the appropriate use of antibiotics) for three of three sampled residents (Resident 19, Resident 20, and Resident 27) when the surveillance data collection form and infection surveillance log was not completed. This failure had the potential to result in unmonitored and unnecessary use of antibiotics for Resident 19, Resident 20, and Resident 27.<br><br>Findings:<br><br>During a concurrent interview and record review on 4/9/24 at 9:43 a.m. with Infection Preventionist (IP), the facility's Infection Surveillance Log (ISL), dated March 2024 was reviewed. The ISL indicated the following residents had missing information:<br><br>a. For Resident 19 - Date of onset of symptoms, criteria for antibiotic use, organism, re-cultured (laboratory test used to check for bacteria or germs) date, and date resolved.<br><br>b. For Resident 27 - Results of culture, start date of antibiotic treatment, onset date, organism, re-cultured date, and date resolved.<br><br>c. For Resident 20 - Date of onset of symptoms, criteria for antibiotic use, culture, onset date, organism, re-cultured date, and date resolved<br><br>IP stated, That's my mistake, it [missing information on the ISL] should be documented all the time.<br><br>During an interview on 4/11/24 at 9:23 a.m. with Director of Infection Prevention (DIP), DIP stated, I don't review that [ISL]. I don't look at the log [ISL].<br><br>During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Committee (ASC) - SCU [Special Care Unit] Medication Orders, dated 12/16/22, the P&P indicated, Procedure Summary/Intent: To optimize clinical outcomes and improve the appropriate use of antimicrobials for residents of SCU. To identify opportunities to optimize clinical outcomes, assess appropriate antimicrobial use, and minimize antimicrobial resistance. |