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	06/01/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, update, and implement a person-centered care plan (CP) for three of 15 sampled residents (Resident 39, Resident 17, and Resident 5). This failure had the potential for residents' immediate care needs to not be met. Findings: During a record review of Medical Record,Resident 39 was in a persistent vegetative state (appears awake but has no awareness of their environment) and post cranial post flap (surgical procedure removes a section of your skull) surgery. During an interview on 5/28/26 at 9:08 a.m. with Administrative Assistant (AA), AA stated she did not find updated care plan under neurology following the resident's post-surgical procedure. During a concurrent interview and record review on 5/28/26 at 9: 38 a.m. with Registered Nurse (RN) 1, Resident 39's CP was reviewed. RN 1 stated there should be a CP for neuro checks (check for changes in personality and behavior) after residents post cranial surgery. During a concurrent observation, interview, and record review, on 5/28/26 at 2:09 p.m. with RN 1, Resident 17 was in bed and had a bed alarm (a sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) on. Resident 17's Medical Record (MR), [undated] was reviewed. RN 1 stated Resident 17 had a bed alarm for bed and for chair. RN 1 stated there was no care plan for the bed and chair alarm. During a concurrent observation, interview, and record review, on 5/28/26 at 2:52 p.m. with RN 1, Resident 5 was in bed and had a bed alarm on. Resident 5's Medical Record (MR), [undated] was reviewed. RN 1 stated Resident 5 had a bed alarm while in bed and when up in chair. RN 1 stated there was no care plan for the bed or chair alarm. RN 1 stated bed and chair alarm is considered a restraint and there should be a care plan prior to applying bed and chair alarm. During a review of the facility's policy and procedure (P&P) titled, Plan: Activities Assessments And Care Plan, dated 8/25/23, the P&P indicated, The plan is utilized by the nursing staff and nurse assistant to encourage and help the resident to participate in appropriate activities. The plan is updated every three months.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure: 1) Two of two sampled residents (Resident 7 and Resident 2) had physician orders for foley catheter (a hollow tube inserted into the bladder to drain or collect urine) change and a feeding tube (a surgical opening fitted with a device to allow feedings to be) dressing change. These failures had the potential for Resident 7 and Resident 2 to have complications related to foley catheter and feeding tube care. 2) Blood pressure (physical force of circulating blood pushing against the walls of your arteries as your heart pumps through your body) was checked before administering the medication for one of four sampled residents (Resident 44). This failure had the potential not to meet Resident 44's needs.3) To follow its policy and procedure (P&P), tilted Nursing Assessment and Reassessment for Patients, for one of 15 sampled resident (Resident 39) when Resident 39 had no neurological assessments. This failure had the potential for adverse effects for Resident 39. Findings: 1. During a review of Resident 7's Electronic Health Record (EHR), dated 5/1/26, the EHR indicated Resident 7 had his foley catheter changed on 5/1/26. During a review of Resident 7's EHR, dated 4/11/26, the EHR indicated Resident 7 had his foley catheter changed on 4/11/26. During a review of Resident 7's EHR, dated 3/31/26, the EHR indicated Resident 7 had his foley catheter changed on 3/31/26. During a concurrent interview and record review on 5/28/26 at 1:43 p.m. with Registered Nurse (RN) 2, Resident 7's Physician Orders (PO), dated 2/20/26 was reviewed. The PO indicated, Foley Care BID (twice a day) Wound Management. RN 2 stated there was no PO for foley catheter change. RN 2 stated the RN's should get a PO for each foley catheter change for 5/1/26, 4/11/26, and 3/31/26. During a concurrent observation and interview on 5/28/26 at 3 p.m. in Resident 7's room with Licensed Vocational Nurse (LVN) 2, Resident 7 had a split gauze under his feeding tube. LVN 2 stated each resident that does not have any skin issues with their feeding tube gets a split gauze. LVN 2 stated Resident 7 does not have a PO for feeding tube dressing change. During a concurrent interview and record review on 5/28/26 at 3:30 p.m. with RN 2, Resident 7's Care Plan (CP), dated 12/10/25 was reviewed. The CP indicated, Tube feeding Insertion Care, Monitor for Complication. RN 2 stated there was no PO to change the dressing daily. During a review of the facility's policy and procedure (P&P) titled, Physician Services – Physician Orders, dated August 2025, the P&P indicated, All medications and treatments administered to the patient [resident] must be ordered by the attending physician such orders must be in writing and signed and dated by the prescribing. During a review of the facility's P&P titled, Administration of Medication, Feedings, via gastrostomy [feeding tube] . and Tube Site Care, dated August 2025, the P&P indicated, Dress the site per order. 2. During a review of Resident 44's Physician Order Review (POR), dated 10/14/24, the POR indicated metoprolol tartrate (used to treat high blood pressure) 25 milligram (mg - unit of measure) two times a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day, hold this dose if heart rate (number of times our heart beats in one minute) less than 50, systolic (first beat) blood pressure less than 90 or diastolic (last beat) blood pressure less than 50. During a concurrent observation and interview on 5/28/26 at 9:32 a.m. with LVN 1, outside of Resident 44's room, LVN 1 was prepping the medication for Resident 44. LVN 1 prepped metoprolol tartrate 25 mg one tablet in the medication cup. LVN 1 stated blood pressure was checked around 8 a.m. by Certified Nursing Assistant. LVN 1 stated he did not recheck the blood pressure before administering the medication. During an interview on 6/1/26 at 8:53 a.m. with Pharmacist 1, Pharmacist 1 stated blood pressure for medication administration should be checked 10-15 minutes prior to administration of medication. 3. During a review of Resident 39's Medical Record (MR), undated, The MR indicated Resident 39 was in a persistent vegetative state (appears awake but has no awareness of their environment) and post cranial post flap (surgical procedure removes a section of your skull) surgery. During a concurrent interview and record review on 5/28/26 at 11:22 a.m. with RN 2, Resident 39's Nursing Progress Notes (NPN), dated 4/23/26 to 4/28/26 were review. The NPN indicated there were no neurological notes. RN 2 stated there were no NPN's. During an interview on 6/1/26 at 9:49 a.m. with Medical Doctor (MD), MD stated residents should get routine neurological checks and be documented by the nurses. During a review of the facility's P&P titled, Nursing Assessment and Reassessment for Patients, Policy #10215 dated 8/1/2019, the P&P indicated, Process of Ongoing Assessment. 3. RN's must perform a focused re-assessment [sic] for the following: C. To assess response to specific treatments/interventions.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify, develop, and implement infection prevention and control action database identified by the survey team (F690). This failure placed all facility residents at risk for a Urinary Tract Infection (UTI-infection in the urine). Findings: During an interview and record review on 5/28/25 at 9 a.m. with Infection Preventionist Director (IPD), The Facility-Level Quality Measure (QM) Report, date 11/1/25 through 4/30/26 was reviewed. The QM indicated, the facility national percentage of UTI was at a 93 percentage. IPD stated the facility does not map UTI's. During an interview on 6/1/26 at 12:08 p.m. with Infection Preventionist (IP), the IP stated she was unaware of how the data is being reported and needs to get better at tracking the urinary catheter and UTI's. During a review of facility's Special Care Unit (SCU) Quality Assurance Meeting Minutes (Meeting Minutes), dated 1/21/26 was reviewed, the Meeting Minutes indicated Infection Preventionist Report denoted antibiotic utilization no action plan. During a review of the facility's Meeting Minutes, dated 4/29/26 was reviewed, the Meeting Minutes indicated Infection Preventionist Report denoted Prevention . [2025-74] UTI's requiring treatment. No action plan. During a review of the facility policy and procedure (P&P) titled, Team Conferences, dated 8/12/25, the P&P indicated, To ensure that the plan of care is appropriate with set goals that are meant to meet residents' needs and geared towards the provision of the highest quality care possible.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure psychotropic (medication to treat mental disorders) medication consents were completed appropriately for two of four (Resident 17, and Resident 19) sampled residents. This failure had the potential for the residents to receive psychotropic medication without knowing all the risks and benefits.Findings:During a review of Resident 17's Psychotherapeutic Drug Informed Consent Form (PDICF), dated 3/27/26, the PDICF indicated, 10. Caution and Warning Summary.c) Black Box Warning Label was checked No. The PDICF was for Risperidone (used for mental disorders) 0.25 milligram (MG).During a review of Resident 17's PDICF, dated 3/27/26, the PDICF indicated, 10. Caution and Warning Summary.c) Black Box Warning Label was checked No. The PDICF was for Risperidone 0.5 MG.During an interview on 6/1/26 at 8:46 a.m. with Pharmacist 1, Pharmacist 1 stated risperidone does have black box warning. Pharmacist 1 stated black box warning label should be checked yes and risk and benefits should be explained to the resident or resident representative. During a concurrent interview and record review on 6/1/26 at 11:40 a.m. with Nurse Manager (NM), Resident 19's Consent for the Administration of Psychotropic Medications (CAPM), dated 9/24/25 was reviewed. NM stated the CAPM was for Zoloft (used to treat mental disorders) 25 mg and there was only one consent that was obtained on 9/24/25 and there was no other consent in Resident 19's chart.During a review of Psychotherapeutic Drug Informed Consent Form Instruction Sheet (PDICFIS), [undated] the PDICFIS indicated, 2. Within six months after the consent form is signed, and every six months thereafter during which the resident receives the psychotherapeutic drug, the facility shall reissue the Informed Consent form.10. Caution and Warning Summary - REQUIRED to select Yes/No for EACH item (a-c).During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Consent, dated 4/13/26, the P&P indicated, General Guidelines 1. All mental health patients have the right to accept or refuse antipsychotic medication and shall be treated with such medication only after completion of the informed consent process.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to follow its policy and procedure (P&P), tilted Advanced Healthcare Directive, Surrogate Decision Maker, for two of 15 sampled residents (Resident 44 and Resident 7) who were unable to sign an Advance Directive (AD - legal document indicating resident preference on end-of-life treatment decisions). This failure had the potential for Resident 44 and Resident 7 wishes not to be honored.Findings:During a review of Resident 44's California Standard admission Agreement For Skilled Nursing Facilities and Intermediate Care Facilities (admission Agreement), dated 11/17/23, the admission Agreement indicated, the box on the admission and readmission Agreement Signature Sheet, which was meant to be checked or left blank for All signed Advance Directive, was left unmarked.During a review of Resident 44's Physician Orders for Life-Sustaining Treatment (POLST), dated 11/17/23, the POLST indicated, no advance directiveDuring a review of Resident 44's Social Services Evaluation (SSE), dated 5/13/26, the SSE indicated, Advance Directive .Pt [patient/resident] wishes to receive info [information] .Unable to obtain response from patient.During an interview on 5/27/26 at 2:01 p.m. with Family Member (FM) 1, and Registered Nurse (RN) 1, in Resident 44's room. FM 1 stated he told the facility he would sign for Resident 44 but did not sign any AD paperwork.During an interview on 5/27/26 at 4:11 p.m. with Social Services (SS), SS stated Resident 44 was incapacitated and unable to sign the admission Agreement that is why it is left blank. SS stated she did not have Resident 44's family or responsible party (RP) sign for the AD.During a review of Resident 7's admission Agreement, dated 3/17/26, the admission Agreement indicated, the box on the admission and readmission Agreement Signature Sheet, which was meant to be checked or left blank for All signed Advance Directive, was left unmarked.During a review of Resident 7's SSE, dated 5/20/26, the SSE indicated, Advance Directive .Pt wishes to receive info .Unable to obtain response from patient.During an interview on 5/28/26 at 2:36 p.m. with SS, SS stated Resident 7 was incapacitated and unable to sign the admission Agreement that is why it is left blank. SS stated she did not have Resident 7's family or responsible party (RP) sign for the AD During a review of the facility's P&P titled, Advanced Healthcare Directive, Surrogate Decision Maker, Policy # 13509, dated 9/17/24, the P&P indicated, 4. When a patient [resident] who lacks present decision making capacity (as determined by the admitting physician in consultation with family members and or close friends of the patient) is admitted to the hospital, the person responsible for documenting the admission shall provide information regarding advanced directives and direct questions regarding the existence of advanced directive to a relative or friend accompanying the patient. Regarding advanced directives, an inquiry into the existence of advanced directives shall be directed to the patient surrogate decision maker once the surrogate decision maker has been identified by the attending physician or licensed care provider.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to obtain physician's orders prior to the application of bed alarm (a sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) for one of three sampled residents (Resident 5). This failure had the potential to result in violation of residents' rights.Findings:During a concurrent observation, interview, and record review, on 5/28/26 at 2:52 p.m. with Registered Nurse (RN) 1, Resident 5 was in bed and had a bed alarm on. During a review of Resident 5's Medical Record (MR), [undated] was reviewed. RN 1 stated Resident 5 had a bed alarm while in bed and when up in chair. RN 1 stated there was no physician order for the bed or chair alarm. RN 1 stated bed and chair alarm is considered a restraint and there should be a physician order prior to applying bed and chair alarm.During a review of facility's policy and procedure (P&P) titled, Physical Restraint and Reduction, dated 5/30/26, the P&P indicated, A physician's order is required before reducing restraints.9. A physical or Occupational Therapist shall be required to assess the following when restraint reduction is indicated: a. Kind of restraint used and time applied. B. Reason for reduction. C. Time released or removed and the length of time off.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to obtain a physician order for foley catheter (a flexible tube passed through the urethra and into the bladder to drain urine) change for one of two sampled resident (Resident 2). This failure had the potential to result in Resident 2 having a Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) with the possibility of sepsis (a life-threatening blood infection).Findings:During a review of Resident 2's Care Plan (CP), dated 8/6/25, the CP indicated, Eval [Evaluate] for Symptoms of UTI.Plan Removal of Indwelling Cath [foley catheter].During a review of Resident 2's Flowsheet (FS), dated 5/16/26, the FS indicated, Resident 2 was running a 101.1 Fahrenheit (normal range from 97 - 100.4) temperature. During a review of Resident 2's Clinical Note Nursing (CNN), dated 5/21/26, the CNN indicated, Therapy for Sepsis. During a concurrent interview and record review on 5/28/26 at 3:36 p.m. with Registered Nurse (RN) 2, Resident 2's Physician Orders (PO), dated 2/17/26 was reviewed. The PO indicated, Resident 2 had no PO for a foley catheter change. RN 2 stated there should be a PO for foley catheter change. The PO dated 5/21/26 indicated ceftriaxone (Rocephin [antibiotic]) was ordered for a UTI. RN 2 stated Resident 2 had a UTI.During a concurrent interview and record review on 5/28/26 at 3:38 p.m. with RN 2, Resident 2's Urinary Catheter group (UC), dated 2/20/26 was reviewed. The UC indicated, Resident 2's last foley catheter change was on 2/20/26. RN 2 stated the process is foley catheters are changed every three months.During an interview on 5/28/26 at 3:45 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the process is foley catheters are changed every three months.During an interview on 5/28/26 at 3:47 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated foley catheter is changed two to four weeks by the LVN or RN that is the process with the order. CNA stated but the RN gets the order. During an interview on 5/28/2026 at 3:51 p.m. with LVN 3, LVN 3 stated the foley catheter is changed every 3 months. LVN 3 stated if there is sediment in the catheter, the catheter is not properly draining, or if it is clogged, then we (nursing) change it.During an interview on 6/1/26 at 10:11 a.m. with Infection Preventionist (IP), IP stated she expects the nurse to call the physician after the resident has had a foley catheter in for a long time and ask the physician if a foley change is needed. IP stated there is no length on time for the physician notification. IP stated the length of time Resident 2's foley catheter was not changed could have been the source of the infection.During a review of the facility's policy and procedure (P&P) titled, Performing Urinary Catheter Care, undated, the P&P indicates, Monitoring of signs/symptoms of catheter-associated UTI (CAUTI).monitor for fever.During a review of the facility's P&P titled, CAUTI Prevention Urinary Catheter Insertion and Maintenance, dated 5/16/25, the P&P indicated, Daily review of catheter necessity and prompt removal of unnecessary catheters is vital to CAUTI prevention.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure two of seven sampled residents (Resident 44 and Resident 14) maintain a medication error rate of less than five percent (5%) during the medication pass observation. This failure resulted in a medication error rate of 16% consisting of four medication errors in a sample size of 25 opportunities for error. Findings:During a concurrent observation and interview on 5/28/26 at 9:32 a.m. with Licensed Vocational Nurse (LVN) 1, outside of Resident 44's room, LVN 1 was prepping the medication for Resident 44. LVN 1 poured valproic acid (medication used to control seizures) 250 milligram (mg)/ml (milliliter -unit of measure), poured 5 ml in the medication cup. LVN 1 stated there was 5 ml of medication in the medication cup.During a concurrent interview and record review on 5/28/26 at 10:14 a.m. with LVN 1, Resident 44's Physician Order Review (POR), dated 5/20/26, was reviewed. The POR indicated valproic acid give 1500 mg (30ml) two times a day. LVN 1 stated wrong dose of medication was administered and not full dose of medication was administered.During a observation and interview on 5/28/26 at 10:43 a.m. with LVN 1, outside of Resident 14's room, LVN 1 was preparing the medication for Resident 14. LVN 1 prepared omeprazole (used to decrease the amount of acid in stomach) 40 mg capsule, losartan (treat high blood pressure) 25 mg 1 tablet, and amlodipine (to treat high blood pressure) 5 mg 1 tablet in medication cup. LVN 1 stated these medications were due at 9 a.m. LVN 1 stated time frame of giving medications was an hour before and an hour after. LVN 1 stated, I am little late today.During a review of facility's policy and procedure (P&P) titled, Medication Dosing Times, dated 4/28/26, the P&P indicated, Medications prescribed more frequently than daily but less frequently than every 4 hours - 2 hour window for medication administration.