STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555053	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	729 Browning Road Delano, CA 93215

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 37697 Based on interview and record review, the facility failed to treat one of three sampled residents (Resident 1) with dignity and respect. This failure had the potential for negative self-esteem, lack of self-worth and other negative consequences. Findings: During a review of Resident 1's ADMISSION RECORD (AR), dated 12/13/21, the AR indicated, Resident 1 diagnosis including anxiety disorder (involves persistent and excessive worry that interferes with daily activities) and paraplegia (inability to move lower part of the body). During a review of Resident 1's Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought], dated 4/25/24, the BIMS indicated, Resident 1 had a score of 13 (cognition intact). During an interview on 8/1/24 at 10:31 a.m. with Resident 1, Resident 1 stated staff (not identified) placed a towel in her rectal area, and she screamed out (could not give exact date). Resident 1 stated when she screamed out Licensed Vocational Nurse (LVN) 2 came to her room, told her (in an irritated manner) to stop yelling and closed the door to her room. Resident 1 stated this incident had happened at least three or four times (could not give dates) where she would yell out and LVN 2 would close the door to her room. Resident 1 stated the door to her room is re-opened (unable to identify who opened the door) after about two or three hours or when LVN 2 is no longer working her shift. During a review of Resident 1's Progress Notes (PN), dated 5/24 to 7/24, the PN indicated, on 7/9/24 at 10:05 p.m. LVN 2 entered a note that stated, Noted resident [1] yelling out at 2030 [8:30 p.m.] saying that someone had placed a piece of towel and chili in her anus. I [LVN 2] went to check and told resident [1] that there in [sic] nothing in her perineum [area between the thighs]. [Resident 1] continue to make noises. She [Resident 1] requested for a bed bath at 2100 [9 p.m.]. While she [Resident 1] was being prepared, she [Resident 1] continues to yell out insisting that she has chili in her butt and said that she wants to call the ambulance to take her to ER [emergency room]. I asked her if she wants a bed bath, she needs to calm down and allow the CNAs (Certified Nursing Assistant) to start because its already 2130 [9:30 p.m.]. She refused to listen. I told the resident [Resident 1] that I [LVN 2] need to close [the] door and when she decides to stop, she needs to call so she can have the bed bath. Situation is endorsed to the incoming shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 10:53 p.m. with LVN 2, LVN 2 stated her shift is from 2 p.m. to 11 p.m. LVN 2 stated over the last two years Resident 1 has made allegations the staff were putting chili and towels in her anus. LVN 2 stated when Resident 1 makes these allegations and will yell out despite LVN 2 reassuring her there was nothing in her anus. LVN 2 stated, I tell her that there is nothing in her anus but she (Resident 1) yells more and more. She screams very loud. LVN 2 stated she will close the door to Resident 1's room when she is having this behavior. During an interview on 8/1/24 at 11 a.m. with Director of Nursing (DON), DON stated she was never informed by staff or LVN 2 of Resident 1's yelling out. DON stated the intervention of closing the door on Resident 1 during episodes of yelling was not care planned and had not been discussed by facility leadership. DON stated she should have been informed of Resident 1's yelling out so a proper investigation and interventions could be done. DON stated simply closing Resident 1's door was not appropriate. DON stated an appropriate response/intervention to Resident 1's screaming would be to attempt to redirect Resident 1 and speak to Resident 1 in a calm manner. DON stated if redirection and speaking in a calm manner were not effective then Resident 1's roommates should be asked if it is ok to close the door and the neighboring resident rooms should be asked if they want their doors closed as well. DON stated none of these interventions were done prior to LVN 2 closing the door on Resident 1. During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity, undated, the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37697 Based on interview and record review, the facility failed to follow its policy and procedure on reporting allegations of abuse for one of three sampled residents (Resident 1). This failure resulted in placing Resident 1 at risk for further abuse and had the potential to place other residents at risk for abuse. Findings: During a review of Resident 1's ADMISSION RECORD (AR), dated 12/13/21, the AR indicated, Resident 1 diagnosis including anxiety disorder (involves persistent and excessive worry that interferes with daily activities) and paraplegia (inability to move lower part of the body). During a review of Resident 1's Minimum Data Set (MDS- an assessment tool) under the section BIMS (Brief Interview for Mental Status - an assessment of cognition [mental processes including perception, memory, and thought], dated 4/25/24, the BIMS indicated, Resident 1 had a score of 13 (cognition intact). During a review of Resident 1's MDS under the section GG (an assessment of the level a care a resident requires), dated 4/25/24, the GG indicated, Resident 1 required maximum assistance from staff to conduct personal hygiene and was dependent on staff for showering, lower body dressing and toileting. During an interview on 7/18/24 at 11:27 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on Monday (7/15/24) Resident 1 stated staff (not identified) were placing chili in her rectum and poking it. CNA 1 stated Resident 1 was asking if she felt the staff (not identified) were enjoying doing that to her. CNA 1 stated she did not report the allegations made by Resident 1 because, Oh everyone knows she does that. CNA 1 stated during the time the allegations were made (on 7/15/24) Licensed Vocational Nurse (LVN) 1 had entered Resident 1's room and Resident 1 had a facial expression of wanting to cry when she told LVN 1 staff were poking her in the rectum. During an interview on 7/18/24 at 11:42 a.m. with Activities Director (AD), AD stated Resident 1 no longer likes to get out of bed and prefers to stay in her room. AD stated Resident 1 had been yelling out allegations that staff (not identified) are putting chili and towels in her rectum. AD stated she could not recall when the last time Resident 1 made the allegation. During an interview on 7/18/24 at 11:48 a.m. with LVN 1, LVN 1 stated he was assigned as Resident 1's nurse. LVN 1 stated on Monday 7/15/24, Resident 1 had been yelling out allegations the staff (not identified) had put chili in her rectum. LVN 1 stated he had heard from other staff (not identified) Resident 1 had been making allegations of someone placing chili into her rectum. LVN 1 stated he was not sure if a report was made regarding the allegation of abuse. LVN 1 stated he did not report the allegation of abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 11:54 a.m. with CNA 2, CNA 2 stated over the last month (July 2024) staff (not identified) had been aware Resident 1 was accusing staff of inserting chili into her rectum. CNA 2 stated all the CNAs were aware Resident 1 made the allegation of someone inserting chili into her rectum because it was discussed during change of shift. CNA 2 stated if it was any other resident making the same allegation, she would immediately report it. During an interview on 7/18/24 at 12:09 p.m. with Social Services Director (SSD), SSD stated on 7/11/24, she spoke with Resident 1 and Resident 1 informed her on 7/9/24, LVN 2 was verbally aggressive with her. SSD stated she could not recall if she had reported this allegation to anyone and could not recall what she had done after the allegation of verbal aggression was made. During a review of Resident 1's Progress Notes (PN), dated 5/24 to 7/24, the PN indicated: 1. On 5/12/24 at 11:16 p.m. LVN 3 entered a note indicated, Resident [1] was shouting that chili peppers were shoved into her rectum. Attempted to redirect resident [1] but she continued to shout. Message sent to DON [Director of Nursing]. 2. On 5/15/24 at 1:17 a.m. LVN 4 entered a note indicated, Resident [1] had episodes of screaming and stating staff putting something in her rectum. 2 [two] CNA's [not identified] provided patient care and after they left her room, that's when resident started to scream. 3. On 5/15/24 at 6:34 a.m. LVN 4 entered a note indicated, Resident [1] had the same episodes of screaming and accusing staff putting something to her rectum. 4. On 5/18/24 at 5:50 a.m. LVN 5 entered a note indicated Resident 1 was observed to have blood in her stool. 5. On 5/18/24 at 8:47 p.m. LVN 5 entered a note indicated, At approximately [11:40 p.m.] had assigned CNA [not identified] interpret what resident [1] was complaining about. Resident [1] stated in spanish ' Check my bottom for a towel because a staff member during pm shift stuck a towel into my rectum.' Assessed resident [1] and explained to her that there was no towel stuck in her rectum. She then replied ' If there is blood in my stool later in the morning it's because there was a towel shoved in there earlier.' 6. On 7/9/24 at 10:05 p.m. LVN 2 entered a note indicated, Noted resident [1] yelling out at 2030 [8:30 p.m.] saying that someone had placed a piece of towel and chili in her anus. I [LVN 2] went to check and told resident [1] that there in [sic] nothing in her perineum [area between the thighs]. [Resident 1] continue to make noises. She [Resident 1] requested for a bed bath at 2100 [9 p.m.]. While she [Resident 1] was being prepared, she [Resident 1] continues to yell out insisting that she has chili in her butt and said that she wants to call the ambulance to take her to ER [emergency room]. I asked her if she wants a bed bath, she needs to calm down and allow the CNAs to start because its already 2130 [9:30 p.m.]. She refused to listen. I told the resident [Resident 1] that I [LVN 2] need to close [the] door and when she decides to stop, she needs to call so she can have the bed bath. Situation is endorsed to the incoming shift. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 1:03 p.m. with Administrator, Administrator stated he was the facility abuse coordinator. Administrator was made aware of Resident 1's several allegations. Administrator stated he was made aware of Resident 1 alleging staff had placed chili into rectum twice. Administrator stated the first time was in May of 2024. Administrator stated all allegations of abuse are reportable but with Resident 1 it was not done due to her history of false allegations. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, undated, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to . Responding immediately to protect the alleged victim and integrity of the investigation. The facility will have written procedures that include . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or . Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.