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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop and implement a care plan to prevent elopement (leaving the facility without authorization or a discharge order) for one of one sampled resident (Resident 1) who was at risk for elopement. This failure had the potential for Resident 1 to elope from the facility and sustain injury. Findings:During a review of Resident 1's admission Record (AR), dated 8/1/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis (paralysis and severe weakness of one side of the body after a stroke).During a review of Resident 1's Care Plan (CP), dated 7/22/25, the CP indicated, Resident 1 had a BIMs [Brief Interview for Mental Status - a cognitive assessment] score of 3 [scores of 0-7 indicated severe cognitive impairment]. During a review of Resident 1's Progress Note (PN), dated 7/23/25 at 1:28 pm, the PN indicated, Resident 1 was oriented x2 (Resident 1 knew who he was and where he was but did not know the current date/time or his current circumstances).During a review of Resident 1's PN dated 7/24/25 at 6:45 pm, the PN indicated, [Resident 1] was angry and yelling at staff.and spoke to a family member asking her to get him out of this place.and stated you're trying to lock me up.During a review of Resident 1's PN dated 7/29/25 at 5:20 pm, the PN indicated, [Resident 1] has been having behaviors of shouting and yelling in the hallway. claims he wants to go home. wanted to go live with his 'homeboy'.During a review of Resident 1's PN dated 7/30/25 at 3:31 pm, the PN indicated, [Resident 1] repeatedly stated I am going to leave, or sign the AMA [Against Medical Advice - a form residents/patients sign when they self-discharge from a healthcare facility] or I'll just walk out of here.During a review of Resident 1 PN dated 7/31/25 at 10:55 am, the PN indicated, [Resident 1] stated I'm going home. I don't care, I'm going home. I don't care who you tell, I'm going home.During a review of Resident 1 PN dated 7/31/25 at 1:38 pm, the PN indicated, [Resident 1] noted with repeatedly stating he wants to leave [the facility].During a review of Resident 1's SBAR [Situation Background Assessment & Recommendation] Summary for Providers (SBAR) note, dated 7/31/25 at 7:09 p.m., the SBAR indicated, [Resident 1] stated I'm going to start walking out, I don't care you call the cops.During a review of Resident 1's Q (every)15 Minutes Visual Observation Form (VOF), dated 7/31/25, the VOF indicated Resident 1 was placed on direct observation by staff every 15 minutes starting at 3 pm. The VOF indicated at 7:15 pm, Resident 1 walked out of facility.During a review of Resident 1's CP dated 7/31/25, the CP indicated, Resident [1] noted to have increased in behavior and tried to leave the facility. Resident [1] was placed on staff supervision every 15 minutes and then 1:1 [one on one , one staff monitoring] continuous supervision on 7/31/25. There were no previous care plans addressing Resident 1's risk for elopement. During a review of Resident 1's IDT (interdisciplinary, group of management staff) Notes (IDTN), dated 8/1/25 at 2:42 p.m., the IDTN indicated, [Resident 1] noted to have increased behaviors for the past days. Resident [1] was attempting to elope with staff member and was in the neighborhood. Staff were with the resident near the church close to facility until Law Enforcement and EMS [Emergency Medical Services, is a system that provides emergency medical care] arrived.During an interview on 8/7/25 at 11:30 am with Licensed Vocational Nurse 1 (LVN) 1, LVN 1 stated he was at the facility on 7/31/25 and witnessed Resident 1 leaving the facility. LVN 1 indicated that on 7/31/25 at around 6 p.m. he (LVN 1) was at the nurse's station and observed Resident 1 in the hallway agitated and yelling at staff. LVN 1 stated Resident 1 then exited the facility through the front door. LVN 1 stated he followed Resident 1 to the parking lot where Resident 1 remained for a period. LVN 1 stated Resident 1 then left the parking lot and strolled through the neighborhood until he stopped in front of a house where he was picked up by ambulance and taken to Hospital. LVN 1 stated he stayed with Resident 1 the whole time he was out of the facility. LVN 1 stated Resident 1 had indicated several times in the days before his elopement that he (Resident 1) wanted to leave the facility. During an interview on 8/7/25 at 10:50 am with Director of Nursing (DON), DON stated Resident 1 was at risk for elopement and an elopement care plan was only created on 7/31/25, the day Resident 1 eloped from the facility. DON stated an elopement care plan should have been created prior to his elopement when Resident 1 first started to say he wanted to leave the facility.During a review of facility policy and procedure (P&P) titled Elopements and Wandering Residents, dated 2025, the P&P indicated, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.During a review of facility