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	05/20/2026

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. Based on interview and record review, the facility failed to develop a complete care plan with interventions for one of three sampled residents (Resident 1) when antibiotics was not administered as ordered. This failure had the potential for staff to be unaware of how to care for Resident 1 when the antibiotic was not administered.Findings:During a review of Resident 1's Care Plan (CP) dated 5/13/26, the CP indicated, Focus.Resident had a missed dose of Zosyn (antibiotic) on 5/11/26 Resident made a statement to staff that he felt neglected and fears that he will lose his leg.Goal. IV (intravenous-administered through a vein) antibiotic will be administered as ordered timely.Interventions/Tasks.No description provided (indicating the care plan had no interventions).During a concurrent interview and record review on 5/20/26 at 11:41 a.m., with Director of Nursing (DON), Resident 1's CP was reviewed. DON stated the CP was incomplete and should have included interventions.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans undated, the P&P indicated, The comprehensive care plan will describe, at a minimum, the following.the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow physician orders when an antibiotic was not administered as ordered for one of three residents (Resident 1). This failure resulted in a missed dose of antibiotics and the potential for Resident 1's wound to worsen. Findings:During a review of Resident 1's Physician Order (PO) dated 5/6/26, the PO indicated, Zosyn Intravenous Solution.Use 50 ml (milliliters) intravenously three times a day related to local infection of the skin and subcutaneous tissue.for 14 days.During a review of the Medication Administration Record (MAR), dated 5/2026, the MAR indicated, Zosyn Intravenous Solution.three times a day related to local infection of the skin and subcutaneous (fatty layer under the skin) tissue.14 days.5/11/26.0800 (8 a.m.) .blank (indicating medication was not administered) .During a review of Resident 1's Progress Notes (PN) dated 5/11/26 at 5 p.m., the PN indicated, Followed up with resident regarding concerns about delayed IV antibiotic administration, including missed 0800 (8 a.m.) dose and delayed 1400 (2 p.m.) dose. DON became aware of missed 0800 dose at approximately 1300 (1 p.m.) and discussed continuation of antibiotic therapy with resident. DON later became aware at approximately 1630 (4:30 p.m.) that scheduled 1400 (2 p.m.) dose had not yet been administered.During a review of Resident 1's PN dated 5/11/26 at 7:17 p.m., the PN indicated, At about 7 p.m. SSA (Social Service Assistant) spoke with resident regarding a concern resident has regarding IV medication. Resident complained of missing scheduled 8AM and 2 PM IV medication. Resident stated assigned nurse, assigned CNA (certified nursing assistant), and DON were informed of questions regarding IV medications. Resident stated he was asking all day for medication, and medication was not administered at scheduled times. Resident states he feels neglected and fears that he will lose his leg.During an interview on 5/20/26 at 10:12 a.m. with Resident 1, Resident 1 stated he was being treated for a leg infection and did not receive a dose of his antibiotics on 5/11/26. Resident 1 stated the facility told him it was a miscommunication on their part.During an interview on 5/20/26 at 10:17 a.m. with DON, DON stated on 5/11/26 there was a lack of communication, and she was unaware there was not an RN available to administer Resident 1's IV antibiotic. DON stated Resident 1 missed his 8 a.m. dose of the antibiotic and that was an error on her part.During a review of the facility's policy and procedure (P&P) titled, Medication Administration undated, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so as ordered by the physician and in accordance with professional standards of practice.