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	06/01/2026

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 and implement care plan interventions for one of three sampled residents (Resident 1) when Resident 1's gastrostomy tube (G-tube- a tube which delivers liquid, nutrition, and medications, through a flexible tube that goes directly into the stomach) was repeatedly dislodged. This failure resulted in Resident 1 being sent to the acute hospital two times in a 24-hour period and potential for complications including severe pain and infections. Findings:During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 3/13/26, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status-standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 6 (0-7 points indicates the resident severely impaired cognition). The MDS indicated Resident 1 was dependent (helper does all the effort) for upper body dressing (the ability to dress and undress above the waist: including fasteners if applicable) and lower body dressing (the ability to dress and undress below the waist, including fasteners; does not include footwear).During a review of Resident 1's Change in Condition, (CIC) dated 5/16/26 at 1:55 p.m., the CIC indicated, GT [G-tube] dislodgement/balloon deflated . 3. Recommendation of Primary Clinician(s): send out to ER (emergency room) for replacement.During a review of Resident 1's Change in Condition, dated 5/20/26 at 6:05 p.m., the CIC indicated, [Resident 1] was found with G-Tube chewed off and pulled out . [Resident 1] had abdominal binder on and was also removed by himself. [Resident 1] was sent out for g-tube replacement.During a review of Resident 1's Change in Condition, dated 5/20/26 at 10:40 p.m., the CIC indicated, Gtube (sic) dislodged . 3. Recommendation of Primary Clinician(s): Transfer to [acute hospital] for gtube (sic)replacement.During a concurrent interview and record review, on 6/1/26 at 2:30 p.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), Resident 1's Change in Condition, dated 5/16/26 and 5/20/26 were reviewed. DON and ADON confirmed Resident 1 was sent out to the acute hospital on 5/16/26, 5/20/26 at 6:05 p.m. and 10:40 p.m. for G-tube dislodgement and being pulled out. Resident 1's G-tube s care plans were reviewed. DON and ADON stated no new intervention were developed or implemented for Resident 1 for CIC on 5/16/26. ADON stated there should have been new interventions put in place to prevent Resident 1 from pulling out his G-tube.During a review of the facility's policy and procedure (P&P) titled, Care Planning, revised 6/2020, the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. II. The Care Plan serves as a course of action where the resident (resident's family and /or guardian or other legally authorized representatives), resident's Attending Physician, IDT work to help the resident move towards resident-specific goals that address the resident's medical, nursing, mental and psychological needs. VIII. A comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs. B. Changes may be made to Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. IX. Each resident's Comprehensive Care Plan will describe the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; (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	B. Any services that would be required, but are not provided due to the resident's exercise of rights. Which includes the right to refuse treatment . X. The Comprehensive Care Plan must be completed . and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments. V. The IDT will revise the Comprehensive Care Plan as needed at the following intervals: .B. As Dictated by changes in the resident's condition; . D. Ta address changes in behavior and care; and E. Other times as appropriate or necessary.