STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555170	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arvin Post Acute	323 Campus Drive Arvin, CA 93203

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to send one of three sampled residents (Resident 1) to the hospital promptly for evaluation and treatment of a left leg injury after Resident 1 reported she had injured her left leg and requested to be taken out to the hospital for X-rays (medical imaging to visualize the inside of the body, particularly bones and dense tissues) and treatment, delayed for six days until Resident 1 was taken to the hospital for evaluation and treatment for the left leg fracture (broken bone). This failure resulted in Resident 1 experiencing continued severe pain in her left leg which required hospitalization and surgical intervention.Findings:During a review of Resident 1's admission Record (AR), undated, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of abnormal posture and need assistance with personal care.During a review of Resident 1's Minimum Data Set (MDS) (a comprehensive assessment tool) dated 11/14/25, the MDS indicated Resident 1had a Brief Interview for Mental Status (BIMS - a mental capacity assessment) score of 15 (score of 13-15 means intact cognition). The MDS indicated Resident 1 used a wheelchair and needed assistance with movement and activities of daily living (eating, dressing, hygiene).During a review of Resident 1's Nurse's Note (NN) dated 1/3/26 at 6:21 p.m., the NN indicated Resident 1 had been out of the facility on 1/3/26 on a family outing and returned at 5 p.m. The NN indicated, [Resident 1] came back to facility with family at 5 p.m. VS [vital signs-clinical measurements, specifically pulse rate (the number of times your heart beats per minute as it pumps blood through your body), temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions] obtained were normal. No pain or discomfort noted.During a review of Resident 1's SBAR Communication Form (Situation, Background, Assessment and Recommendations - a standard form used to document change in conditions of residents) (SBAR), dated 1/3/26 at 8:05 p.m. (three hours later), the SBAR indicated [Resident 1] reported PAIN to nurse, pt [patient/Resident 1] reported while she was with family, on wheel chair her left leg got twisted, nurse assessed, mild swelling noted on left knee and provided PRN [as needed] pain medication for pain, vitals were recorded within normal range. Family/RP [Responsible Party] DR [Doctor] made aware, dr [Doctor] prescribed 5% lidocaine patch [a topical pain medication] for moderate pain and Norco 5mg [milligrams] [a narcotic pain medication] every 6 [hours] as needed. There was no documentation of physician's order to send resident to the hospital.During a review of Resident 1's Care Plan titled Pain (Pain Care Plan), dated 1/3/26, the Pain Care Plan indicated the intervention of, Assess pain every shift and as indicated.During a review of Resident 1's Medication Administration Record (MAR), dated January 2026, the MAR indicated order dated 7/14/25 indicating, Monitor and Record pain assessment level Q [every] shift, -No pain, 1-3 Mild pain, 4-6 Moderate pain, 7-10 Severe pain. 1/4/26: Pain Level of 7. The MAR also contained order dated 12/2/25 for Hydrocodone-Acetaminophen [a pain medication] Oral Tablet 5-325 mg [milligrams]. Give 1 tablet as needed for pain. The pain medication was given on:1/3/26: Pain Level of 81/4/26: Pain Level (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 0684 Level of Harm - Actual harm Residents Affected - Few	of 71/5/26: Pain Level of 71/6/26: Pain Level of 71/7/26: Pain Level of 81/8/26: Pain Level of 7 During a review of Resident 1's NN dated 1/6/26 at 1:36 p.m., the NN indicated, [Resident 1] is complaining of pain left knee. During a review of Resident 1's Radiology Results Report (RR), dated 1/8/26 at 4:31 p.m. (five days later), RR indicated, KNEE EXAM. LEFT. Reason for Study: PAIN IN LEFT KNEE. Conclusion: Nondisplaced [a stable break where the bone cracks but remains properly aligned] distal [away from body center] femur [the longest bone in the leg] fracture appears acute [happened recently] . Medical Doctor (MD) 1 sent a text message to Registered Nurse (RN) 1 on 1/3/26 (five days ago) with a thumbs up emoji to order X-Ray.During a review of Resident 1's SBAR, dated 1/9/26 at 10:44 a.m., the SBAR indicated, X-Ray results came, [Resident 1] has nondisplaced [a bone break where the fragments remain in their proper alignment] distal femur fracture appears acute. notified dr [doctor]/rp [responsible party/family], [Resident 1's son] told his dad was rolling the wheel chair while [Resident 1] got twisted her leg underneath the wheelchair. [Resident 1 sent out to hospital].During a review of Resident 1's hospital record History and Physical (H&P), dated 1/9/26 at 9:53 p.m. (six days later), the H&P indicated, Pt [patient] BIB [[NAME] in by ambulance] EMS [emergency medical services] from [facility] complaining of left knee pain for x6 [six] days. Complains of moderate pain and swelling. XR [r-ray] and CT [computerized tomography, diagnostic imaging procedure that uses rotating X-rays and computer technology to produce detailed, cross-sectional, 3D slices of bones, blood vessels, and soft tissues] scan of the left knee performed on arrival to ED [emergency department] showing new nondisplaced fracture of distal femur. Assessment/Plan: Fracture of the distal [farther] end of left femur [thigh]. occurred six days ago. Ortho surgical repair [procedure performed by specialists to fix, reconstruct, or replace damaged components of the bones].During an interview on 2/4/26 at 11:57 a.m. with RN 1, RN 1 stated he was the charge nurse on 1/3/26 during the afternoon shift (3 p.m. to 11 p.m.). RN 1 stated Resident 1 was out of the facility on a day pass on 1/3/26 and returned around 5-6 p.m. RN 1 stated at around 8 p.m. he went to Resident 1's room to check on her. RN 1 stated Resident 1 reported pain in her left knee. RN 1 stated he assessed Resident 1's left knee and noticed it was swollen. RN 1 stated he took pictures of Resident 1's knees using the Nursing Phone and sent the pictures via a text message to MD 1. RN 1 stated the Nursing Phone was a facility cell phone used to communicate with physicians. RN 1 showed the text message and pictures he sent MD 1. RN 1 showed a text message sent to MD 1 on 1/3/26 at 8:05 p.m. as follows, Hey dr, [Resident 1], her left knee hurts and its little swollen. Because she said her leg got twisted on wheelchair when she was out with her family. She didn't report anything after coming back but she is in pain now. She also requesting for X-ray for her knee. Attached to this text message were pictures of Resident 1's knees, showing swelling of her left knee. RN 1 said MD 1 replied with a thumbs up emoji and the following text message, We can do a lidocaine patch [patch with medication for pain] too, 5% q [every] 24 prn [as needed] . if severe can give Norco 5 [mg/milligram] q [every] 6 [hours] prn. RN 1 stated MD 1's response was for him to enter the two pain medication orders and treat Resident 1's pain. RN 1 stated that MD 1 did not order x-rays or for Resident 1 to be sent out to the hospital for evaluation of her leg.During an interview on 2/4/26 at 1:25 p.m. with Resident 1, Resident 1 was alert and oriented and stated she broke her left leg in the facility on 1/3/26 at around 6 p.m. Resident 1 stated on 1/3/26 at around 6 p.m. she was in her room and was going to the bathroom in her wheelchair when she accidently twisted her left leg and felt her left knee pop. Resident 1 stated she felt a sharp pain in her left knee and reported it to her nurse. Resident 1 stated thereafter she had a constant, sharp, moderate intensity pain in her left knee daily until she was taken to the hospital six days later on 1/9/26. Resident 1 asked why it took so long to take her to the hospital to check on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	her leg. Resident 1 stated she should have been taken to the hospital the same day she had injured her leg on 1/3/26.During an interview on 2/4/26 at 2:40 p.m. with MD 1, MD 1 stated she was contacted by RN 1 on 1/3/26 at night via text message. MD 1 stated RN 1 sent her a text message on 1/3/26 at 8:05 p.m. reporting Resident 1 had left knee pain and requesting an x-ray of her left knee. MD 1 stated she replied to RN 1's text message with a thumbs up emoji and a text message with pain medication orders. MD 1 stated the thumbs up emoji meant she approved of Resident 1's request for a left knee x-ray. MD 1 stated her expectation was for RN 1 to send Resident 1 out to the ER that night or the next morning for evaluation and treatment of her left leg pain and swelling. During an interview on 2/4/26 at 3 p.m. with Director of Nursing (DON), DON stated there was a miscommunication between RN 1 and MD 1 on 1/3/26 regarding Resident 1's left leg injury. DON stated emojis were not a professional way for MD 1 to communicate with RN 1 concerning the care of Resident 1. DON stated emojis had the potential for confusion and misunderstanding. DON stated the fact Resident 1 was Spanish speaking only may have contributed to a misunderstanding amongst nursing staff about how Resident 1 injured her leg. DON stated Resident 1 should have been sent earlier to the hospital for evaluation and treatment of her leg pain and injury. DON stated the facility had no policy and procedure on proper communication between the licensed nurse and the doctor.During a review of facility policy and procedure (P&P) titled Quality of Care/Accommodation of Needs, Revised March 2021, the P&P indicated, Our facility's environment and staff behavior are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The resident's individual needs and preferences are accommodated to the extent possible.During a review of facility P&P titled Pain Assessment and Management, dated October 2022, the P&P indicated, .to develop interventions that are consistent with the resident's goals and needs and that address the underlying cause of pain.During a review of facility P&P titled Change in a Resident's Condition or Status, Revised February 2021, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(an):.(a) accident or incident involving the resident. (g) need to transfer the resident to a hospital/treatment center.