

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Arvin Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>35649</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the physician provided the informed consent (the process in which a health care professional educates a patient about the risks, benefits, and alternatives of a given procedure or medication) on the use of antipsychotic (drugs that treat psychosis [mental distress, mental disorder] and related conditions and symptoms) medication for one of one sampled resident (Resident 43) prior to the verbal consent obtained from Resident 43's representative. This failure had the potential for the resident and/or the resident representative to not receive the appropriate information regarding the drug, its indication, side-effects, and make the right decision. 2. Ensure licensed personnel witness and validate the verbal consent received from the resident representative for one of one resident (Resident 43) and sign the informed consent form to validate the consent and the material information provided. This failure had the potential for the informed consent to be dismissed. <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent interview and record review, on 12/18/24 at 2:28 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 43's Informed Consent -Psychoactive Medication (ICPM), dated 9/23/24, was reviewed. The ICPM indicated, Remeron (medication to treat depression) 15 milligrams (mg) one tablet by mouth at bedtime for depression. MDSC stated verbal consent was obtained from Resident 43's representative on 9/23/24. MDSC stated the physician (MD) 1 signed the ICPM on 9/26/24. MDSC stated the ICPM form was signed prior to the physician providing the informed consent. MDSC stated the doctor signed the ICPM after the verbal consent was obtained. <p>During a concurrent interview and record review, on 12/18/24 at 2:48 p.m. with MDSC, Resident 43's ICPM, dated 4/19/24, was reviewed. The ICPM indicated, Temazepam (sedative [slows down brain activity] and medication to treat insomnia [difficulty falling asleep or staying asleep]) 15 mg one tablet PO (oral) every hs (at bedtime). MDSC stated verbal consent was obtained from the resident's representative on 4/17/24. MDSC stated MD 1 signed the ICPM on 4/19/24. MDSC stated the resident's representative did not receive the informed consent from the physician who prescribed the medication at the time the verbal consent was obtained. MDSC stated the doctor signed the ICPM after the verbal consent was obtained.</p> <p>(continued on next page)</p>		

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a concurrent interview and record review on 12/18/24 at 2:50 p.m. with MDSC, Resident 43's ICPM form for Remeron, dated 9/26/24, was reviewed. The ICPM form did not indicate the licensed nurse signed the ICPM form to verify informed consent was obtained and that the required material information had been provided for the use of Remeron. MDSC stated there was no nurse signature on the form.</p> <p>During a concurrent interview and record review on 12/18/24 at 2:55 p.m. with MDSC, Resident 43's ICPM form for Temazepam, dated 4/19/24, was reviewed. The ICPM form did not indicate the licensed nurse signed the ICPM form to verify informed consent was obtained and that the required material information had been provided for the use of Temazepam. MDSC stated there was no nurse signature on the form.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, [undated], the P&P indicated, 3. Informed Consent: a. Examination and Signature: iii. Prior to administration of a Psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record. iv. A licensed nurse must verify informed consent has been obtained from the resident or the resident's representative prior to administering psychotropic medication. v. A licensed nurse must also sign the consent form, declaring that the required material information has been provided.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>35649</p> <p>Based on interview and record review, the facility failed to ensure advance directives (AD- A legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions) were offered and completed for 15 of 27 sampled residents (Resident 6, Resident 7, Resident 10, Resident 11, Resident 12, Resident 21, Resident 25, Resident 26, Resident 28, Resident 30, Resident 33, Resident 41, Resident 49, Resident 59, and Resident 64). This failure had the potential for residents' healthcare wishes to not be honored.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 12/16/24 at 3:05 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), MDSC was unable to provide documentation that Resident 33 was offered an AD. MDSC stated, I do not see anything on him [Resident 33]. There is no advance directive and there is no acknowledgment.</p> <p>During a concurrent interview and record review on 12/16/24 at 3:07 p.m. with MDSC, MDSC was unable to provide documentation of an AD for Resident 12. MDSC stated Resident 12 did not have an AD.</p> <p>During a concurrent interview and record review on 12/16/24 at 3:52 p.m. with MDSC, MDSC stated, I do not see an advance directive only POLST (physician order for life sustaining treatment).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 9/2022, the P&P indicated, Determining Existence of Advance Directives: 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative.</p> <p>32946</p> <p>During a concurrent interview and record review on 12/17/24 at 2:48 p.m. with SSD, Resident 28's medical record (MR) was reviewed. SSD stated, No [Resident 28] does not have one [an AD].</p> <p>During a concurrent interview and record review on 12/17/24 at 2:49 p.m. with SSD, Resident 6's MR was reviewed. SSD stated, There is no AD in the chart [medical record].</p> <p>During a concurrent interview and record review on 12/17/24 at 2:53 p.m. with SSD, Resident 41's MR was reviewed. SSD stated, No AD, I don't see it, it's not uploaded.</p> <p>During a concurrent interview and record review on 12/17/24 at 2:55 p.m. with SSD, Resident 11's MR was reviewed. SSD stated, No AD in the chart.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on 12/17/24 at 2:56 p.m. with SSD, Resident 21's MR was reviewed. SSD stated, No AD found.</p> <p>During a concurrent interview and record review on 12/17/24 at 2:57 p.m. with SSD, Resident 7's MR was reviewed. SSD stated, No AD in the medical record.</p> <p>During a concurrent interview and record review on 12/17/24 at 2:58 p.m. with SSD, Resident 10's MR was reviewed. SSD stated, No AD in the medical record.</p> <p>SSD stated, I handed them [AD form] out to resident families, but none of the families have returned them.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 9/2022, the P&P indicated, Determining Existence of Advance Directives: 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative.</p> <p>50939</p> <p>During a concurrent interview and record review on 12/17/24 at 10:39 a.m. with Nurse Consultant (NC) 1, Resident 30's medical record, was reviewed. NC 1 was unable to find documentation of an AD for Resident 30.</p> <p>During a concurrent interview and record review on 12/17/24 at 10:40 a.m. with NC 1, Resident 59's medical record, was reviewed. NC 1 was unable to find documentation of an AD for Resident 59.</p> <p>During a concurrent interview and record review on 12/17/24 at 10:42 a.m. with NC 1, Resident 64's medical record, was reviewed. NC 1 was unable to find documentation of an AD for Resident 64.</p> <p>During a review of the facility's P&P titled, Advance Directives, dated 9/2022, the P&P indicated, 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. A. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. B. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>42148</p> <p>Based on interview and record review, the facility failed to ensure confidentiality of Private Health Information (PHI) was maintained for two of two sampled residents (Resident 25 and Resident 58). This failure resulted in Resident 25 and Resident 58's PHI being compromised and seen by unauthorized personnel.</p> <p>Findings:</p> <p>During a review of Resident 25's Clinical Record (CR), The CR contained Resident 58's clinical note titled, Skilled Nursing Progress Note (SNPN), dated 10/18/24.</p> <p>During a concurrent interview and record review on 12/17/24 at 9:53 a.m. with Medical Records Clerk (DMR), Resident 25's CR was reviewed. DMR stated, Resident 58's SNPN was in Resident 25's CR. DMR stated that was the incorrect clinical record.</p> <p>During a review of Resident 58's Admission Agreement (AA), dated 6/21/24, the AA indicated, Resident 58 agreed that she read and understood Resident [NAME] of Rights Section (e) Privacy and confidentiality indicating the resident has the right to personal privacy and confidentiality of his or her personal and clinical records and Section X. Confidentiality of Your Medical Information stating You have a right to confidential treatment of your medical information.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, dated July 2017, the P&P indicated, 5. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy.</p> <p>During a review of the facility's P&P titled, Protected Health Information (PHI), Management and Protection of. The P&P indicated, 1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release of disclosure.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32946</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Personal Property, for two of two sampled residents (Resident 30 and Resident 21) when:</p> <ol style="list-style-type: none"> 1. Resident 30's belongings were not inventoried and documented on admission. 2. Resident 21's clothing went missing in the facility. <p>These failures had the potential to negatively affect the resident's psychosocial well-being and had the potential to result in lack of reimbursement for lost belongings.</p> <p>Findings:</p> <p>During an interview on 12/16/24 at 3 p.m. with Resident 30, Resident 30 stated he had four pairs of underwear when he was admitted to the facility, and he had two left. Resident 30 stated he reported it to a Certified Nursing Assistant (CNA) few days ago and the CNA looked for them in the laundry and did not find them.</p> <p>During a review of Resident 30's Admission Record (AR), dated 11/27/24, the AR indicated Resident 30 was readmitted to the facility on [DATE].</p> <p>During a concurrent interview and record review on 12/18/24 at 3:12 p.m. with the Social Services Director (SSD), Resident 30's Personal Belonging Inventory (PBI), dated 11/1/24 was reviewed. SSD was unable to provide a personal belonging inventory on Resident 30's readmitted [DATE].</p> <p>During a review of the facility's P&P titled, Personal Property, dated 8/2022, the P&P indicated, 10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary.</p> <p>50939</p> <p>During an interview on 12/18/24 at 3:20 p.m. with CNA 3, CNA 3 stated the resident had some clothing in the closet, but since the remodel of the residents' room his [Resident 21] clothing had not been in the closet.</p> <p>During a concurrent observation and interview on 12/18/24 at 3:23 p.m. with Resident 21, Resident 21 stated he had two flannel shirts (Resident does not remember the color), and two pairs of jeans in his room's closet at one time and when the facility remodeled his room the items of clothing were lost or misplaced. There were no items of clothing found in the closet for Resident 21.</p> <p>During an interview on 12/18/24 at 3:37 p.m. with Treatment Nurse (TN) outside Resident 21's room. TN stated she was not aware of the residents' missing items of clothing.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with Resident 21, Resident 21 reviewed his signed Personal Belonging Inventory (PBI) sheet dated 11/6/24. The personal belonging inventory sheet indicated Resident 21 owed the following personal items of clothing.</p> <ol style="list-style-type: none"> 1. Boxer (underwear) 2. Two long sleeve shirts 3. One pair jean <p>During a review of the facility policy and procedure (P&P), titled, Personal Property, dated 2001, indicated, Policy Statement Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits, unless doing so would infringe on the rights or health and safety of other resident . 2. Resident belongings are treated with respect by facility staff, regardless of perceived value . 3. Residents are encouraged to use personal belongings to maintain a homelike environment and foster independence .</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649</p> <p>Based on interview and record review, the facility failed to ensure a Baseline Care Plan (BCP- outlines a process for development of an initial person-centered care plan within the first 48 hours of admission, that will provide instructions for care of the resident) was completed for one of one sampled resident (Resident 12) within 48-hours of admission and a summary provided to the resident and/or resident representative. This failure had the potential for Resident 12 to not receive the care and the safeguards necessary within the 48-hour of admission.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was admitted on [DATE] with diagnosis including, Diabetes Mellitus (blood sugar is too high) with diabetic neuropathy (nerve damage that is caused by diabetes), End-Stage Renal Disease (ESRD- final, permanent stage of chronic kidney disease).</p> <p>During a concurrent interview and record review on 12/18/24 at 1:58 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 12's BCP, dated 8/16/24, was reviewed. The BCP Summary indicated, the BCP Summary was incomplete. MDSC stated the BCP Summary was not provided to Resident 12 and his representative.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans-Baseline, [undated], the P&P indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .4. The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/ representative can understand) . 5. Provision of the summary to the resident and/or resident representative is documented in the medical record.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35649</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for personal grooming, including care of the fingernails for one of one sampled resident (Resident 12). This failure had the potential for unmet care needs.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 12/16/24 at 2:50 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 12's room, Resident 12 was seated in his wheelchair. Noticed Resident 12's hands were dry. The left-hand fingernails were long and inside the nailbeds were blackish substance. The 5th and 4th fingernails were long, and the nailbeds were black in color. LVN 2 stated Resident 12's fingernails were long and needed trimming.</p> <p>During a concurrent observation and interview on 12/17/24 at 8:50 a.m. with Treatment Nurse (TN) and Resident 12 in Resident 12's room, Resident 12's fingernails remained long and nailbeds black in color. TN stated Resident 12's fingernails have dirt inside the fingernails. TN stated Resident 12's fingernails were long on the left hand; the right hand had some fingernails trimmed on the 3rd and 2nd fingers. TN stated Resident 12 has avulsion (a severe injury where a body structure is torn off by trauma or surgery) on the right thumbnail. Resident 12 stated, I lost my nail. TN measured Resident 12's fingernails. The following were the fingernails measurement:</p> <p>Left Hand</p> <p>Left thumbnail.</p> <p>Length: 1.5 cm</p> <p>Width: 1.5 cm</p> <p>Depth (thickness): 0.1 cm</p> <p>Left Index:</p> <p>L: 1.4 cm</p> <p>W: 1.3 cm</p> <p>D: 0.1 cm</p> <p>Left Middle finger:</p> <p>L: 1.5 cm</p> <p>W: 1.4 cm</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>42148</p> <p>Based on interview and record review, the facility failed to revise a care plan after a change of status for Hospice (end of life care) services for one of two sampled residents (Resident 25). This failure had the potential for Resident 25 to receive Hospice services when no longer needed.</p> <p>Findings:</p> <p>During a record review of Resident 25's Order Summary Report (OSR), dated November 2024, the OSR indicated, Resident is discharged from [Name of Hospice Company] as of 11/15/24 due to extended prognosis.</p> <p>During a record review of Resident 25's Nursing-Weekly Summary (NWS), dated 12/15/24, the NWS indicated, Currently under hospice care.</p> <p>During a review of Resident 25's End of Life: Care Plans (ELCP), dated 11/15/24, the ELCP indicated, Resident requires Hospice care and is at risk for rapid decline in activities of daily living, sudden onset or worsening skin integrity, weight loss, nausea/vomiting, pain, abnormal breathing, impaired psychosocial wellbeing related to terminal illness.</p> <p>During a concurrent observation and interview on 12/17/24 at 8:19 a.m. with Administrator in Resident 25's room, resident was asleep and resting. Administrator stated, [Resident 25] was in Hospice, but now she is not.</p> <p>During a concurrent interview and record review on 12/17/24 at 8:38 a.m. with Director of Nursing (DON), Resident 25's OSR and ELCP were reviewed. DON stated, Resident 25's ELCP should have been revised to indicate Resident 25 is no longer receiving hospice care.</p> <p>During a concurrent interview and record review on 12/18/24 at 2:15 p.m. with Nursing Consultant (NC) 1, Resident 25's OSR and ELCP were reviewed. NC 1 stated, Resident 25's ELCP should have been revised to indicate Resident 25 is no longer receiving hospice care.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.</p>		

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NAME OF PROVIDER OR SUPPLIER Arvin Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 323 Campus Drive Arvin, CA 93203	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649</p> <p>Based on observation, interview, and record review, the facility failed to ensure oral care was rendered for one of one sampled resident (Resident 33) to maintain oral hygiene. This failure had the potential for Resident 33 to acquire oral infections, tooth decay, or gum disease.</p> <p>Findings:</p> <p>During a review of Resident 33's Admission Record (AR), the AR indicated Resident 33 was admitted on [DATE] with diagnosis including Hemiplegia (complete paralysis) and Hemiparesis (weakness on one side) following cerebral infarction (stroke-[bleeding in the brain]).</p> <p>During a concurrent observation and interview on 12/16/24 at 9:46 a.m. with Licensed Vocational Nurse (LVN) 2 in Resident 33's room, Resident 33 was awake sitting in his bed. Resident 33 had weakness on the right side of the body. LVN 2 stated Resident 33 is paralyzed on the right side. Resident 33 was slow in communicating but able to respond to questions. Resident 33's mouth was dry and teeth yellowish in color. Resident 33 stated no one brushes his teeth before or after eating. Resident 33 stated, I do not remember when they [staff] brushed my teeth. LVN 2 stated the resident's toothbrush and toothpaste are stored in the resident's bedside table. LVN 2 opened Resident 33's bedside table and did not find a toothbrush for Resident 33 inside the bedside table. LVN 2 found toothpaste tube that had not been used in a kidney basin (a shallow, kidney-shaped bowl).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal, and oral hygiene.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>42148</p> <p>Based on observation, interview, and record review, the facility failed to implement person center quality care for one of one sampled resident (Resident 10) when Resident 10's fingernails were not trimmed, hand splint was not applied and, physician's order for surgical consultant was not processed. This failure resulted in delayed care for Resident 10 and had the potential for adverse outcomes.</p> <p>Findings:</p> <p>During an observation on 12/16/24 at 10 a.m. in Resident 10's room, Resident 10's left hand was contracted (abnormal bend of the joint) where her middle three fingers were folded in toward her palm. Resident 10's fingernails on her left hand were long, thick, and curled over going into the skin of her left palm. Resident 10 did not have any type of splint on her left arm/hand.</p> <p>During a concurrent observation and interview on 12/18/24 at 10:21 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 10's room, Resident 10's left hand was observed. LVN 3 stated, I do not know if Resident 10 is supposed to have a hand splint on her left hand or not. I have worked the last three days and have not seen Resident 10 wear a hand splint. Staff clipped Resident 10's nails yesterday but it does not look like the fingernails on her left hand were clipped any time recently. They should not be that long and look like they are going into the palm of her hand.</p> <p>During concurrent observation and interview on 12/18/24 at 1:25 p.m. with Treatment Nurse (TN) in Resident 10's room, Resident 10's left hand was observed. TN stated [Resident 10] got her nails clipped yesterday. TN stated her left fingernails looked like they were not clipped and were long, thick, and curled under her fingers. TN stated, It looks like her fingernails are digging into the palm of her hand with the way her fingers are contracted. TN stated she does not know if Resident 10 requires a hand splint or not, that is an RNA (Restorative Nursing Assistant) thing.</p> <p>During a concurrent interview and record review on 12/19/24 at 8:31 a.m. with Director of Nursing (DON), Resident 10's Care Plans (CP) and Order Summary Report (OSR) were reviewed. The CP dated 9/8/23 indicated, Contracted left 3 fingers r/t [Related To] her diagnosis. Interventions include Fingernails need to be short so avoid injury of the skin around the area. Follow up with hand specialist as ordered. Apply splint to hand/finger to prevent rubbing each other, Monitor the site for any changes and informed [sic] MD [Medical Doctor]. The resident has skin injury to left middle finger r/t rubbing of the mis-aligned fingernail. Protect the affected finger by applying dressing to the area. The OSR dated 10/5/23 indicated, Hand Surgeon Consult. DON stated the care plan should have been implemented to include keeping Resident 10's fingernails short on her left hand and Resident 10 is supposed to be wearing a hand splint to keep the fingers from rubbing. [NAME] stated, I see the physician's order for a hand surgeon consult from 10/2023 and I am not sure why it wasn't followed through with.</p> <p>During a concurrent interview and record review on 12/19/24 at 11:54 a.m. with Nursing Consultant (NC) 1, Resident 10's CP and OSR were reviewed. NC stated the care plans should have been implemented and the Hand Surgeon consult should have been followed through with.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of dated February 2018, the P&P indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Preparation. 1. Review the resident's care plan to assess for any special needs of the resident. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.6. Scope and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.</p> <p>During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and 2. Reflects currently recognized standards of practices for problem areas and conditions.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>35649</p> <p>Based on observation, interview, and record review, the facility failed to provide foot care and podiatry (foot specialist) referral for one of one sampled resident (Resident 33). This failure resulted in Resident 33's feet and toenails to be left untreated.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 12/17/24 at 8:11 a.m. with Treatment Nurse (TN) in Resident 33's room, Resident's right big toenail appeared deformed, with abnormal growth, yellowish, and had fungus-like appearance. The right 2nd, 3rd, 4th, and 5th toes had long, thick, yellowish toenails. The right 5th toenail had blackish discoloration. The skin on the top of the right foot was dry and flaky. The left big toenail was yellowish in color and thick. The left 2nd, 3rd, 4th, and 5th toenails were long and the nails were curled inwards. TN stated Resident 33's nails needed trimming. TN stated she just checked around the monitoring bracelet to see if there were any abrasions around the lower extremity. TN stated, I check the feet whenever the resident has no socks on; otherwise, no. TN obtained a measuring tape and measured the length, width, and thickness of the toenails on both Resident 33's feet. The following were the measurements:</p> <p>Left foot</p> <p>Left Great toenail:</p> <p>Length: 1.7 centimeters (cm)</p> <p>Width: 2.5 cm</p> <p>Depth (thickness): 0.3 cm</p> <p>Left 2nd toenail:</p> <p>L:1.4 cm</p> <p>W:1.2 cm</p> <p>D: 0.2 cm</p> <p>Left 3rd toenail:</p> <p>L: 1.1cm</p> <p>W: 1.1 cm</p> <p>D: 0.2 cm</p> <p>Left 4th toenail:</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>L: 1.2 cm</p> <p>W:1 cm</p> <p>D:0.1 cm</p> <p>Left 5th toenail:</p> <p>L:1.3 cm</p> <p>W: 0.8 cm</p> <p>D: 0.1 cm</p> <p>Right Foot:</p> <p>Right Great Toenail</p> <p>L:1.3 cm</p> <p>W:1.7 m</p> <p>D: 0.1 cm</p> <p>great toe, black discoloration to the nail</p> <p>Right 2nd toenail</p> <p>L: 0.7 cm</p> <p>W1.1 cm</p> <p>D: 0.1 cm</p> <p>Right 3rd toenail</p> <p>L: 0.8 cm</p> <p>W: 1.1 cm</p> <p>D: 0.1 cm</p> <p>Right 4th toenail</p> <p>L: 1.2 cm</p> <p>W: 1 cm</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D: 0.1 cm</p> <p>Right 5th toenail:</p> <p>L:0.8 cm</p> <p>W:0.7 cm</p> <p>D: 0.1 cm</p> <p>TN stated [Resident 33] needs podiatry referral. TN stated Resident 33 has not been referred to Podiatry. TN stated each nurse does a nursing weekly assessment.</p> <p>During a concurrent interview and record review on 12/17/24 at 9:11 a.m. with Director of Nursing (DON), DON was unable to find documentation Resident 33 was seen by a podiatrist. DON stated Resident 33 did not have a Podiatry referral.</p> <p>During a concurrent interview and record review on 12/17/24 at 9:29 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 33's Podiatry referral was reviewed. MDSC was unable to find documentation of Resident 33's Podiatry referral. MDSC stated, I do not see a Podiatry referral.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 10/2022, the P&P indicated, Residents receive appropriate care and treatment in order to maintain mobility and foot health. 1. Residents are provided with foot care and treatment in accordance with professional standards of practice .5. Residents with foot disorder or medical conditions associated with foot complications are referred to qualified professionals .</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649</p> <p>Based on interview and record review, the facility failed to manage and document pain accurately for one of one sampled resident (Resident 12). This failure had the potential for Resident 12 to not be able to function and perform daily activities and improve quality of life.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was admitted on [DATE] with diagnosis including, Diabetes Mellitus (blood sugar is too high with diabetic neuropathy (nerve damage that is caused by diabetes), End-Stage Renal Disease (ESRD- final, permanent stage of chronic kidney disease).</p> <p>During a review of Resident 12's Wound Evaluation, dated 11/28/24, the Wound Evaluation indicated, 1. Pressure-Deep Tissue Injury (DTI- purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear), right heel: area 10.19 centimeter (cm), length 5.83 cm, and width 4.4 cm. Present on Admission 2. Pressure-DTI, left heel: area 20.26 cm, length 6.18 cm, and width 4.3 cm .4. Pressure-DTI right dorsum, first digit (hallux-big toe) area 1.48 cm, length 1.68 cm and width 1.28 cm. in-house acquired (facility acquired) .8. Pressure-DTI, right lateral malleolus (prominent bone on each side of the ankle), 0.75 cm, length 1.08 cm and width 1 cm. in-house acquired.</p> <p>During a concurrent interview and record review on 12/16/24 at 2:53 p.m. with Resident 12 in Resident 12's room, Resident 12 stated, They (staff) have ignored my pain when I told them that I had pain. I have sores in both my feet. They are very painful. They have not been giving me pain medication.</p> <p>During a review of Resident 12's Physician's Orders (PO), dated 12/16/24, the PO indicated, Acetaminophen tablet 600 milligrams (mg) one tablet every 4 hours as needed for pain. Pain scale 1-3. Hydrocodone-Acetaminophen (narcotic pain medication) oral tablet 5-325 mg, give one tablet by mouth every 4 hours as needed for severe pain; pain scale 7-10. Ultram (pain medication) oral tablet 50 mg, give 50 mg by mouth two times a day for peripheral neuropathy (nerve damage that causes pain, tingling, numbness, or weakness in the extremities).</p> <p>During a concurrent interview and record review on 12/18/24 at 2:44 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 12's Medication Administration Record (MAR) dated 11/6/24, was reviewed. MDSC was unable to find documentation Resident 12 was medicated for pain at pain scale level 6. MDSC stated she could not find any documentation the nurses called the physician to clarify pain medication order for pain scale level 6 since the medications were ordered for pain scale level 1-3 and pain scale level 7-10. The PO, dated 8/14/24 indicated, Monitor and record pain assessment level every shift: 0-no pain, 1-3 mild pain, 4-6 moderate pain, 7-10 severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/18/24 at 2:50 p.m. with MDSC, Resident 12's MAR, dated 12/1/24 to 12/18/24, were reviewed. The MAR indicated Monitor and record pain level every shift 0-3 mild pain, 4-6 moderate pain, and 7-10 severe pan. The MAR indicated, Hydrocodone-Acetaminophen 5/325 mg give one tablet every 4 hours as needed for severe pain, pain scale 7-10. MDSC stated pain monitoring is done every shift: 8 AM, 2 PM, and 10 PM. MDSC stated Resident 12 received Hydrocodone-Acetaminophen 5/325 mg for pain level of 5 without a physician's order. MDSC stated she found the following inaccuracy in Resident 12's pain management:</p> <p>12/1/24 -12/7/24: 0 pain monitoring at 8 AM, 2 PM, and 10 PM</p> <p>12/1/24: Hydrocodone/Acetaminophen 5/325/mg given at 05:32 a.m. for documented pain scale 5</p> <p>12/6/24: Level 0 pain on monitoring at 8 AM, 2 PM, and 10 PM</p> <p>12/6/24: Hydrocodone/Acetaminophen 5/325/mg given at 03:12 a.m. pain scale level 5.</p> <p>12/14/24: Level 3 pain monitoring at 8 AM, 0 at 2 PM and 10 PM</p> <p>12/14/24: Hydrocodone/Acetaminophen 5/325 mg given at 05:57 a.m. for pain scale level 5</p> <p>Policy and Procedure for pain Management was requested; none was provided.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>50939</p> <p>Based on observation, interview, and record review, the Dietary Manager (DM) failed to demonstrate competency to carry out the functions of the food and nutrition service for all the residents residing in the facility when there was a multi-generational cockroach infestation in the kitchen. This failure resulted in no action plan put in place to address and meet the health and safety needs for the residents.</p> <p>Findings:</p> <p>During an observation on 12/16/24 at 8:15 a.m. in the kitchen, there were nine dead cockroaches in a drain above a sink where food is prepared.</p> <p>During an interview on 12/16/24 at 8:16 a.m. with Dietary Manager (DM), DM stated, Those are bugs [dead cockroaches in the drain]. DM stated she has seen ants, pincher bugs, and cockroaches in the kitchen. DM stated she started noticing them (ants, pincher bugs, and cockroaches) when the facility started renovation this year approximately March 2024.</p> <p>During an interview on 12/18/24 at 10:28 a.m. with Registered Dietitian (RD), RD stated she was not made aware by anyone in the facility that there were live cockroaches.</p> <p>During a review of the DM's Job Description: Dietary Manager, (JDDM), dated 1/2019, the JDDM indicated, The primary purpose of your job position is to provide supervision for the Dietary Department ensuring quality food and Nutrition is meet [sic] in accordance with current federal, state, and local standards, guidelines, and regulations governing our facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary condition in the kitchen with known infestation of cockroaches as evidenced by:</p> <ol style="list-style-type: none"> 1. On 12/17/24 and 12/18/24 observed live cockroaches in the kitchen identified as German Cockroaches by the pest control service technician. 2. The kitchen staff do not clean and sanitize the kitchen counters prior to food preparation with known cockroach infestation. This involved nocturnal behavior of cockroaches which are highly likely to be contaminating food contact surfaces during the night. 3. In addition, cockroaches carry germs that can contaminate and had the potential to lead to foodborne illness for highly susceptible residents receiving food from the kitchen. 4. Failed to maintain an effective Pest Control Program. <p>These failures had the potential to place 70 of 72 highly susceptible residents at risk for food borne illnesses in the facility infested with multi-generational German cockroaches which are known to spread 33 kinds of bacteria, six kinds of parasitic worms as well as other kind of human diseases.</p> <p>On 12/18/24 at 11:54 AM, an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has cause, or it is likely to cause, serious injury, harm, impairment, or death to a resident) under Federal tag 812 was declared with the Administrator, Administrator for Bakersfield Post Acute, Director of Nursing (DON), and Nursing Consultant regarding the following identified concerns:</p> <ol style="list-style-type: none"> 1. On 12/17/24 and 12/18/24 observed live cockroaches in the kitchen identified as German Cockroaches by the pest control service technician. 2. The kitchen staff do not clean and sanitize the kitchen counters prior to food preparation with known cockroach infestation. This involved nocturnal behavior of cockroaches which are highly likely to be contaminating food contact surfaces during the night. 3. In addition, cockroaches carry germs that can contaminate and had the potential to lead to foodborne illness for highly susceptible residents receiving food from the kitchen. 4. Failed to maintain an effective Pest Control Program. <p>These failures had the potential to place 70 of 72 highly susceptible residents at risk for food-borne illnesses in the facility infested with multi-generational cockroaches.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arvin Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 12/19/24 at 6:12 PM, the California Department of Public Health (CDPH) notified the Administrator, Administrator for Bakersfield Post Acute, DON, Nursing Consultant, and Registered Dietician (RD), the IJ was abated after verifying and confirming on-site the facility had implemented an acceptable written plan of correction.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 12/16/24 at 8:15 a.m. with Dietary Manager (DM) in the kitchen, there were nine dead cockroaches in a floor drain above the sink where food was prepared. DM stated, those are bugs [dead cockroaches in the drain].</p> <p>During an interview on 12/16/24 at 8:16 a.m. with DM, DM stated she had seen ants, pincher bugs, and cockroaches in the kitchen. DM stated she noticed them (ants, pincher bugs, and cockroaches) during the renovation of the kitchen approximately March 2024.</p> <p>During an observation on 12/17/24 a.m. at 11:19 a.m. in the kitchen, there was peeling paint and a hole under the skink near the dish washer.</p> <p>During a concurrent observation and interview on 12/17/24 at 11:20 a.m. with DM, in the staff bathroom, there was a hole in the staff bathroom. DM stated there was a leak in the ceiling of the staff bathroom in the kitchen in September 2024. DM stated the Maintenance Director (MD) was aware of the hole and was supposed to fix it but did not make the kitchen department a priority. DM stated she had put in a maintenance request to the maintenance department about the peeling paint and the hole on the ceiling of the staff bathroom in the kitchen.</p> <p>During a review of the facility's [NAME] COUNTY PUBLIC HEALTH SAFE DINER-Inspection Violations Report (KCPHSDIVR) dated 5/24/24, the KCPHSDIVR indicated, OBSERVED A HOLE IN THE CEILING IN THE RESTROOM LOCATED IN KITCHEN DIE [SIC] TO A WATER LEAK. PLEASE REPAIR TO PREVENT VERMIN INFESTATION.</p> <p>During an observation on 12/17/24 at 11:25 a.m. in the kitchen, there was a live cockroach crawling on the wall above the dishwasher.</p> <p>During an interview on 12/17/24 at 11:26 a.m. with Dietary Aide (DA) 1, DA 1 stated that looks like a cockroach. DA 1 stepped on it and killed the live cockroach. DA 1 stated, I've only been seeing pests since the facility's renovation.</p> <p>During a concurrent observation and interview on 12/17/24 at 11:28 a.m. with Administrator, in the kitchen, Administrator stated he was aware of the hole in the kitchen staff bathroom and the hole on the wall under the sink in the kitchen. Administrator stated they have Pest Control Company come every month. Administrator stated the holes were entrance for pests to come into the kitchen. Administrator saw a cockroach crawling on top of the counter near the dishwashing machine and a small brown cockroach crawling on the wall above the handwashing sink.</p> <p>During an interview on 12/17/24 at 2:44 p.m. with DA (2), DA 2 stated he had seen two cockroaches in the kitchen near the dish washer floor today.</p> <p>During an observation on 12/18/24 at 8:34 a.m. in the kitchen staff bathroom, the hole on the ceiling got bigger.</p> <p><i>(continued on next page)</i></p>

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an observation on 12/18/24 at 8:42 a.m. in the kitchen, was a glue trap with one dead cockroach under the sink of the food preparation counter.</p> <p>During an observation on 12/18/24 at 8:43 a.m. in the kitchen, a cabinet lined with a silicone-type material where assortment of food utensils was stored, there was one small dead cockroach under the lining.</p> <p>During an observation on 12/18/24 at 8:44 a.m. in the kitchen, across the counter where food preparation is done, there was a hole in a pipe connected to the sink used for cleaning.</p> <p>During an interview on 12/18/24 at 8:45 a.m. with DM, DM stated, I saw live roaches [cockroaches] yesterday crawling from the ceiling down to the bulletin board. The bulletin board was hanging on the wall by the entrance wall in the kitchen. DM stated pest control did the treatment last week due to "live roaches[cockroaches]. DM stated, they were dark brown, little ones. DM stated she saw 2-4 live roaches[cockroaches], little one's crawling. DM stated she saw bigger in size, dark brown in color yesterday. DM stated she saw more roaches (cockroaches) on Monday (12/16/24) morning. DM stated she came to the dining room; she saw more dead cockroaches. DM stated sometime in November, I saw live roaches (cockroaches) little ones, in the dish area. DM stated, I mentioned to the Administrator and Maintenance about the live and dead roaches in the kitchen every week. I gave verbal report during the stand-up meeting.</p> <p>During an observation on 12/18/24 at 8:47 a.m. in the kitchen behind the oven, there was one glue trap with one tiny (unable to determine size) dead cockroach and one live, dark brown cockroach.</p> <p>During an interview on 12/18/24 at 8:57 a.m. with Cook, [NAME] stated she came in to work at 4:30 a.m. today. When she turned the light on, she saw one live small cockroach as she opened the door. [NAME] stated, I have noticed cockroaches the first two days I've worked. [NAME] stated alive small black and small brown cockroaches. [NAME] stated in the cabinet under the food preparation counter she saw a live cockroach in the morning, last week.</p> <p>During an observation on 12/18/24 at 8:59 a.m. at the kitchen sink beverage station, there was a large hole in the wall near the sink drainage under the sink. There was a dead cockroach under the kitchen beverage sink.</p> <p>During a concurrent observation and interview on 12/18/24 at 9 a.m. with DA 3 in the Janitorial Closet, there was one live medium dark brown cockroach, one dead medium brown cockroach in the hole near mop sink, two cockroach carcasses on the mop sink, one dead cockroach medium brown behind the janitorial door. DA 3 stated she saw a live roach on the preparation counter last weekend on 12/14/24 and 12/15/24 around 5:45 a.m. and she saw dead roaches in the janitorial room last month.</p> <p>During an observation on 12/18/24 at 9:05 a.m. in the kitchen, there was one small live brown cockroach crawling on the ceiling above the dishwasher sink.</p> <p>During an observation on 12/18/24 at 9:07 a.m. in the kitchen, there was a glue trap with five dead medium dark brown cockroaches behind a rack with plate covers.</p> <p>During an observation on 12/18/24 at 9:09 a.m. in the kitchen, there was a mesh-like metal material on the hole with a small dead cockroach under the sink near the dishwasher.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/18/24 at 9:10 a.m. with DA 1, DA 1 stated she saw roaches, one alive and two dead five days ago around the area where staff wash the dishes and saw three dark brown live roaches in the kitchen dishwashing area.</p> <p>During an observation on 12/18/24 at 9:11 a.m. in the kitchen, there was a leaking water pipe connected to the dishwasher found underneath the dishwashing counter.</p> <p>During an observation on 12/18/24 at 9:13 a.m. in the dry storage room, there was a glue trap behind the refrigerator with 7 small brown dead cockroaches and one small dead cockroach on the floor.</p> <p>During a concurrent observation and interview on 12/18/24 at 9:35 a.m. with Activities Assistant (AA) in the dining room, there was two dead roaches on the floor. AA stated she saw one small, brown, dead roach in the dining floor.</p> <p>During an interview on 12/18/24 at 9:38 a.m. with Housekeeper (HK), HK stated she saw roaches in the dining room, some dead, some alive last week.</p> <p>During an observation on 12/18/24 at 9:40 a.m. in the dining room, there was 10 dead cockroaches in a cabinet under the sink.</p> <p>During an interview on 12/18/2024 at 9:50 a.m. with Environmental Specialist (ES), ES stated because of the different sizes of roaches described, the facility has a problem with multi-generational infestation. During the day, so many of them in hiding places to scavenge for food. ES stated even if they (facility) had sprayed they still have live infestation of roaches.</p> <p>During a concurrent observation and interview on 12/18/24 at 9:58 a.m. with DM in the dry storage room, a live brown cockroach was inside a bin which contained sponges. DM stated that is a live cockroach and killed it with a sponge. There was a dead tiny cockroach in a bin with approximately a dozen scoopers. There was a live small cockroach crawling into a silver rectangular tin box, one dead cockroach under a rack with pitchers, and a small dead cockroach under an empty rack.</p> <p>During an interview on 12/18/24 at 10:30 a.m. with Pest Control Company Owner (PCCO), PCCO stated he was aware of the situation. PCCO stated he went out at night and made a thorough inspection of the kitchen on Wednesday [12/11/24]. PCCO stated he found infestation of German Cockroaches.</p> <p>On 12/18/24 at 11:54 AM, an Immediate Jeopardy (IJ-a situation in which the facility's non-compliance with one or more requirements of participation has cause, or it is likely to cause, serious injury, harm, impairment, or death to a resident) under Federal tag 812 was declared with the Administrator, Administrator for Bakersfield Post Acute, Director of Nursing (DON), and Nursing Consultant regarding the following identified concerns:</p> <ol style="list-style-type: none"> 1. On 12/17/24 and 12/18/24 observed live cockroaches in the kitchen identified as German Cockroaches by the pest control service technician. 2. The kitchen staff do not clean and sanitize the kitchen counters prior to food preparation with known cockroach infestation. This involved nocturnal behavior of cockroaches which are highly likely to be contaminating food contact surfaces during the night. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>3. In addition, cockroaches carry germs that can contaminate and had the potential to lead to foodborne illness for highly susceptible residents receiving food from the kitchen.</p> <p>4. Failed to maintain an effective Pest Control Program.</p> <p>These failures had the potential to place 70 of 72 highly susceptible residents at risk for food-borne illnesses in the facility infested with multi-generational cockroaches.</p> <p>During an interview on 12/19/24 at 2:01 p.m. with Infection Preventionist Nurse Consultant (IPNC), IPNC stated kitchen staff does not have a designated kitchen sanitation schedule or kitchen sanitation log.</p> <p>According to Dr. [NAME], an advisor for the National Pest Management Association, German cockroaches can spread 33 kinds of bacteria, six kinds of parasitic worms, as well as other kind of human diseases. https://www.pestworld.org/news-hub/pest-articles/german-cockroaches-101/#:~:text=These%20germs%20are%20then%20transferred,least%20seven%20other%20human%20pathogens. Accessed 12.26.24</p> <p>On 12/19/24 at 6:12 PM, the California Department of Public Health (CDPH) notified the Administrator, Administrator for Bakersfield Post Acute, DON, Nursing Consultant, and Registered Dietician (RD), the IJ was abated after verifying and confirming on-site the facility had implemented an acceptable written plan of correction.</p> <p>During a review of the facility's Pest Control Invoice (PCI), dated 12/3/24, the PCI indicated, INSPECTION FOR GERMAN ROACHES.</p> <p>During a review of the facility's PCI, dated 12/9/24, the PCI indicated, SERVICE FOR ROACHES IN THE KITCHEN.</p> <p>During a review of the facility's MAINTANENCE REQUEST (MR), dated 12/18/24, the MR request by DM, Pipe (black) from garbage disposal leaking.</p> <p>During a review of the facility's policy and procedure (P&P) titled, GENERAL CLEANING OF FOOD & NUTRITION SERVICES DEPARTMENT, dated 2023, the P&P indicated, Drains.1. FNS staff should remove large debris as it accumulates and are encouraged to clean drains weekly.</p> <p>During a review of the facility's P&P titled, WALLS, CEILINGS, AND LIGHT FIXTURES, dated 2023, the P&P indicated, Walls and ceilings must be free of chipped and/or peeling paint.</p> <p>During a review of the facility's P&P titled, JANITOR'S CLOSET, dated 2023, the P&P indicated, The janitor's closet must be kept clean and orderly. 4. Cleaning of the janitor's closet must be done on a scheduled routine.</p> <p>During a review of the facility's P&P titled, SANITATION, dated 2023, the P&P indicated, 1.The FNS Director is responsible for instructing employees in the fundamentals of sanitation in food service and for training employees to use appropriate techniques. 11. All utensils, counters, shelves, and equipment shall be kept clean .</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>35649</p> <p>Based on interview and record review, the facility failed to ensure the Admissions Coordinator (AC) had the full understanding of the Binding Arbitration Agreement (BAA-the parties waive their right to a trial and agree to accept the arbitrator's decision as final) to be able to explain the content of the BAA for three of 47 sampled residents (Resident 7, Resident 8, and Resident 64) in the manner, form, and language understood by the resident and/or resident representative. This failure had the potential for Resident 7, Resident 8, and Resident 64 and/or their representatives to be misinformed and not fully understand the terms and conditions stipulated in the arbitration agreement.</p> <p>Findings:</p> <p>During an interview on 12/19/24 at 8:21 a.m. with AC, AC stated there were 47 residents who had participated and signed the BAA. AC stated the BAA is part of the admissions packet. AC stated the expectation of the Administrator and Leadership was to ensure the arbitration agreement was signed. AC stated, I inform the resident and/or the resident representative they will go to a mediator meeting and try to resolve the dispute rather than going to court. By not going to arbitration, you pay for your own lawyer and the case can take longer, thus causing you more money. Arbitration is less expensive and quicker way to resolve the dispute. AC stated, I do not explain the 'Articles' in the BAA. I do not know what the Articles in the Agreement meant. I inform the resident or resident representative that arbitration is the cheaper alternative rather than going to court. AC stated he did not discuss the Articles (actual contract of the agreement) included in the Arbitration Agreement.</p> <p>The Articles of the Agreement included:</p> <p>Article 1 - Medical Malpractice Claims</p> <p>Article 2 - Other Claims</p> <p>Article 3 -Scope of Agreement</p> <p>Article 4 - Delegation of Authority</p> <p>Article 5 - Retroactive Effect: (covers services prior to signing the agreement, making the agreement effective on the first day of admission)</p> <p>Article 6 - Right to Rescind (may be canceled)</p> <p>Article 7 - Applicable Law</p> <p>Article 8 - Selection of Arbitrator</p> <p>Article 9 - Convenient Venue</p> <p>Article 10 - Costs of Arbitration</p> <p>(continued on next page)</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Article 11 - Severability (contract independent of one another)</p> <p>During a concurrent interview and record review on 12/19/24 at 8:57 a.m. with AC, Resident 7's BAA, dated 5/3/23, was reviewed. Resident 7's BAA indicated, the section that explained the resident or the resident representative acknowledged the agreement was explained by the facility staff in a manner, form, and language the resident and/or representative understood was not signed by the resident or Resident 7's representative. AC stated the forms were electronically signed and he saw Resident 7's representative signature. AC stated he assumed all the forms were signed.</p> <p>During a concurrent interview and record review on 12/19/24 at 8:59 a.m. with AC, Resident 8's BAA, dated 5/4/23, was reviewed. Resident 8's BAA indicated; Resident 8 signed the BAA herself. A review of Resident 8's Brief Interview of Mental Status (BIMS - a tool used to screen and identify the cognitive condition of the residents upon admission using a point system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact) score indicated 5 (severe cognitive impairment). AC stated he sometimes go to the resident's room. AC stated sometimes the residents' hands have tremors so he would hold the residents' hands and guide them push the signature button in the iPad (a small computer controlled by touch rather than a keyboard) to get the residents' signature.</p> <p>During a concurrent interview and record review on 12/19/24 at 9 a.m. with AC, Resident 64's BAA, dated 5/31/24, was reviewed. Resident 64's BAA indicated, the section that explained the resident or the resident representative acknowledged the agreement was explained by the facility staff in a manner, form, and language the resident and/or representative understood was not signed by the resident or Resident 64's representative. AC stated the forms were electronically signed and he saw Resident 64's representative signature. AC stated he assumed all the forms were signed.</p> <p>During an interview on 12/19/24 at 9:09 a.m. with AC, AC was unable to explain the process in the event a dispute occurred with any of the residents who signed the BAA. AC did not know where the venue for the arbitration would be held. AC stated, It's lack of knowledge on my end. Clearly, I was not given the proper information. AC was not aware the facility has a policy and procedure on Binding Arbitration Agreement. AC stated he had no method or measure if the resident or the resident representative fully understood his explanation of the binding arbitration agreement.</p> <p>During a review of the facility's policy ad procedure (P&P) titled, Binding Arbitration Agreements, dated 11/2023, the P&P indicated, 7. After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the documents: a. A signature alone is not sufficient acknowledgement of understanding. b. The resident or representative must verbally acknowledge understanding, and the verbal acknowledgment documented by the staff member who explained the agreement .Arbitrator/Venue Selection: 6. Arbitration agreements provide for the selection of a venue that is convenient to and suitably meets the needs of both parties .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649</p> <p>Based on observation, interview, and record review, the facility failed to follow and implement nationally recognized infection prevention and control practices for seven of seven sampled residents (Resident 12, Resident 30, Resident 33, Resident 43, Resident 49, Resident 183, and Resident 379) as evidenced by:</p> <ol style="list-style-type: none"> 1. Linens stored for two of two sampled residents (Resident 33 and Resident 183) on the bedside table inside Resident 33 and Resident 183's room. 2. Resident 12 and Resident 43's hands were not cleansed prior to eating lunch. 3. The treatment nurse (TN) did not wear proper Personal Protective Equipment (PPE- refers to gowns, gloves, masks, goggles, face shields to protect the wearer from injury or infection) during wound treatment and dressing change for one of one resident (Resident 49) on Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO-bacteria that have become resistant to multiple antibiotics) that employs targeted gown and glove use during high contact resident care activities). 4. TN did not perform hand hygiene during wound dressing and treatment for one of one resident (Resident 49). 5. A shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER] had feces under the toilet and smeared feces on the sink. 6. There were no PPE supplies for Resident 30 and Resident 379 on EBP. <p>These failures had the potential to transmit infectious diseases.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 12/16/24 at 11:51 a.m. with Dietary Manager (DM) in Resident 33's room, several linens, such as sheets, blankets, and pull sheets were piled up on top of the bedside table. DM stated the linens should not be stored in the rooms unless the staff were changing and making the residents' beds. <p>During a concurrent observation and interview on 12/16/24 at 11:55 a.m. with DM in Resident 183's room, linens, sheets, blankets were stored on top of the bedside table. DM stated the linens are not supposed to be in the residents' rooms unless brought in to change or make the bed.</p> <ol style="list-style-type: none"> 2. During a concurrent observation and interview on 12/16/24 at 12:27 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 43's room, Resident 43's lunch tray was delivered and placed on the overbed table. Resident 43 was served Puree (cooked foods ground finely), regular texture, thin liquids with 4 ounces (oz) of house shake. CNA 1 stated Resident 43 was a feeder and waiting to be fed. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on 12/16/24 at 12:31 p.m. with CNA 2 in Resident 43's room, CNA 2 was sitting at Resident 43's bedside and started preparing to feed Resident 43. CNA 2 placed a towel over Resident 43's chest but did not wash Resident 43's hands before eating.</p> <p>During a concurrent observation and interview on 12/16/24 at 12:57 p.m. with CNA 1 in Resident 12's room, Resident 12's lunch tray was delivered and placed on the bedside table. It was noted the individual who delivered the tray left the meal tray on the overbed table and did not offer Resident 12 any hand wipes to clean his hands before meals. CNA 1 stated the nursing assistants were supposed to provide the residents with rags to clean their hands.</p> <p>3. During a concurrent observation and interview on 12/18/24 at 10:35 a.m. with TN in Resident 49's room, TN entered Resident 49's room to do wound treatment and dressing change. Resident 49 was in his bed and lying on supine position. TN put on a new pair of gloves without performing hand hygiene. TN laid a blue pad (barrier between the table and the medical supplies for dressing and wound treatment) on Resident 49's overbed table and placed the scissors, the kerlix roll, the gauze, the non-adherent pad, and the cream on the blue pad. TN cut the kerlix roll wrapped around Resident 49's right ankle and heel. It was observed the right heel had a wound with a scab and was yellowish in color. The bottom of the right foot was wrinkled, and the skin and the surrounding tissue were peeling off the right heel. The bottom of the right foot was wrinkled, dried, and had a small necrotic (black dead skin) area on the heel. TN described the wound as deep tissue injury (DTI- caused by damage to the soft tissue beneath the skin from pressure or shear forces). TN removed the used gloves and changed into a new pair of gloves without performing hand hygiene. TN cleansed the right heel with a gauze wet with normal saline, pat-to dry, and applied a Xeroform dressing (non-adhesive dressing) on the heel. TN rewrapped the right ankle and heel with a kerlix dressing and secured it with tape.</p> <p>4. During a concurrent observation and interview on 12/17/24 at 10:50 a.m. with TN in Resident 49's room, TN continued to do wound treatment. TN put on gloves and turned Resident 49 to his right side. TN was not wearing a gown or a mask except for gloves. TN realized she did not have the appropriate PPE prior to wound treatment. TN stated, I forgot to gown up and wear mask.</p> <p>TN stated Resident 49 has a moisture-associated skin dermatitis (MASD- a condition that occurs when the skin is repeatedly exposed to moisture from bodily fluids, such as urine, stool, perspiration, saliva, mucus, and wound exudate).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Handwashing, dated 10/2023, the P&P indicated, 2. All personnel are expected to adhere to hand hygiene policies and procedures to help prevent the spread of infections to other personnel, residents, and visitors .Indications for hand hygiene: a. immediately after touching a resident, .c. after contact with blood, body fluid, or contaminated surfaces, .d. after touching a resident, .g. immediately after glove removal .</p> <p>During a review of the facility's P&P titled, Enhanced Barrier Precautions (EBP), dated 11/2024, the P&P indicated, Enhanced Barrier Precautions are utilized to reduce the transmission of multi-drug resistant organisms (MDRO) to residents .2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities .a. Gloves and gown are applied prior to performing the high contact resident care activity .3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include a. dressing .h. wound care (any skin opening requiring dressing).</p> <p>(continued on next page)</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>50939</p> <p>Findings:</p> <p>5. During an observation on 12/16/24 at 8:49 a.m. in shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], there were seven, small, black round circles under the toilet and two brown smears on the bathroom sink. The bathroom had a foul odor.</p> <p>During an interview on 12/16/24 at 9:09 a.m. with CNA 2, CNA 2 stated, black small, round things looks like poop.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, dated 8/19, the P&P indicated, policy Statement. Environmental surfaces will be cleaned and disinfected .</p> <p>6a. During an observation on 12/16/24 at 9:12 a.m. in Resident 30's room, there was an EBP sign and no PPE supplies in the room or outside Resident 30's room.</p> <p>During a concurrent observation and interview on 12/16/24 at 10:48 a.m. with Nurse Consultant (NC) 2 outside of Resident 30's room, there was PPE supplies in a plastic, three-tiered drawer in front of Resident 30's room. NC 2 stated resident has a history of methicillin resistant staphylococcus aureus (MRSA-bacteria that is resistant to many antibiotics). NC 2 stated staff put the container with PPE in the resident's room and there should have been PPE supplies in the resident's room upon admission.</p> <p>During a review of Resident 30's Physician Order (PO), dated 12/16/24, the PO indicated, Resident is placed on EBP d/t [due to] MDRO [Multi-drug-Resistant Organisms-bacteria that have become resistant to multiple antibiotics]: Hx [history] of MRSA & Surgical Site to left foot.</p> <p>During a review of Resident 30's Care Plan CP, dated 12/16/24, the CP indicated, Utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities (e.g., dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care).</p> <p>6b. During an observation on 12/16/24 at 8:30 a.m. in Resident 379's room, Resident 379 had an indwelling urinary catheter (a tube that goes into the patient's bladder to drain urine) with catheter bag (a collection bag) hanging on the side of the bed. There was no EBP sign posted outside of Resident 329's room.</p> <p>During an observation on 12/17/24 at 8:25 a.m. in Resident 379's room, there was an EBP sign posted and no PPE supplies in Resident 379's room. IP stated resident went three days without EBP precaution.</p> <p>During a concurrent observation and interview on 12/17/24 at 8:30 a.m. with NC 2 outside of Resident 379's room. NC 2 stated there should have been PPE supplies in the resident's (Resident 379) room upon admission.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 379's PO, dated 12/16/14, the PO indicated, Resident to be placed on Enhanced Barrier Precaution d/t Device: Indwelling Catheter.</p> <p>During a review of Resident 379's CP, dated 12/16/24, the CP indicated, Place EBP notification/signage near resident room doorway to alert staff/visitors of precautions.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhance Barrier Precaution, dated 11/24, the P&P indicated, EBPs [sic] are indicated .for residents with wounds and/or indwelling medical devices .b. Indwelling medical devices include central lines, urinary catheters .</p> <p>During a review of the facility's P&P titled, Personal Protective Equipment, dated 10/18, the P&P indicated, 4 . PPE required for transmission-based precautions is maintained outside and inside the resident's room .</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective Pest Control Program when live cockroaches were repeatedly found in the kitchen. This failure placed 70 of 72 highly susceptible sampled residents, at risk for foodborne illnesses when receiving food from the kitchen infested with cockroaches.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 12/16/24 at 8:15 a.m. with Dietary Manager (DM) in the kitchen, there were nine dead cockroaches in a floor drain above the sink where food was prepared. DM stated, those are bugs [dead cockroaches in the drain].</p> <p>During an interview on 12/16/24 at 8:16 a.m. with DM, DM stated she had seen ants, pincher bugs, and cockroaches in the kitchen. DM stated she noticed them (ants, pincher bugs, and cockroaches) during the renovation of the kitchen approximately March 2024.</p> <p>During an observation on 12/17/24 at 11:25 a.m. in the kitchen, there was a live cockroach crawling on the wall above the dishwasher.</p> <p>During an interview on 12/17/24 at 11:26 a.m. with Dietary Aide (DA) 1, DA 1 stated that looks like a cockroach. DA 1 stepped on it and killed the live cockroach. DA 1 stated, I've only been seeing pests since the facility's renovation.</p> <p>During a concurrent observation and interview on 12/17/24 at 11:28 a.m. with Administrator, in the kitchen, Administrator stated he was aware of the hole in the kitchen staff bathroom which was 2 cm x 2 cm (centimeter, unit of measurement) and the hole on the wall under the sink in the kitchen. Administrator stated they have Pest Control Company come every month.</p> <p>Administrator stated the holes were entrance for pests to come into the kitchen. Administrator saw a cockroach crawling on top of the counter near the dishwashing machine and a small brown cockroach crawling on the wall above the handwashing sink.</p> <p>During an interview on 12/17/24 at 2:44 p.m. with DA (2), DA 2 stated he had seen two cockroaches in the kitchen near the dish washer floor today.</p> <p>During an observation on 12/18/24 at 8:42 a.m. in the kitchen, was a glue trap with one dead cockroach under the sink of the food preparation counter.</p> <p>During an observation on 12/18/24 at 8:43 a.m. in the kitchen, a cabinet lined with a silicone type material where assortment of food utensils was stored, there was one small dead cockroach under the lining.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/18/24 at 8:45 a.m. with DM, DM stated, I saw live roaches [cockroaches] yesterday crawling from the ceiling down to the bulletin board. The bulletin board was hanging on the wall by the entrance wall in the kitchen. DM stated pest control did the treatment last week due to "live roaches[cockroaches]. DM stated, they were dark brown, little ones. DM stated she saw 2- 4 live roaches[cockroaches], little one's crawling. DM stated she saw bigger in size, dark brown in color yesterday. DM stated she saw more roaches (cockroaches) on Monday (12/16/24) morning. DM stated she came to the dining room; she saw more dead cockroaches. DM stated sometime in November, I saw live roaches (cockroaches) little ones, in the dish area. DM stated, I mentioned to the Administrator and Maintenance about the live and dead roaches in the kitchen every week. I gave verbal report during the stand-up meeting.</p> <p>During an observation on 12/18/24 at 8:47 a.m. in the kitchen behind the oven, there was one glue trap with one tiny (unable to determine size) dead cockroach and one live, dark brown cockroach.</p> <p>During an interview on 12/18/24 at 8:57 a.m. with Cook, [NAME] stated she came in to work at 4:30 a.m. today. When she turned the light on, she saw one live small cockroach as she opened the door. [NAME] stated, I have noticed cockroaches the first two days I've worked. [NAME] stated alive small black and small brown cockroaches. [NAME] stated in the cabinet under the food preparation counter she saw a live cockroach in the morning, last week.</p> <p>During an observation on 12/18/24 at 8:59 a.m. at the kitchen sink beverage station, there was a large hole in the wall near the sink drainage under the sink. There was a dead cockroach under the kitchen beverage sink.</p> <p>During a concurrent observation and interview on 12/18/24 at 9 a.m. with DA 3 in the Janitorial Closet, there was one live medium dark brown cockroach, one dead medium brown cockroach in the hole near mop sink, two cockroach carcasses on the mop sink, one dead cockroach medium brown behind the janitorial door. DA 3 stated she saw a live roach on the preparation counter last weekend on 12/14/24 and 12/15/24 around 5:45 a.m. and she saw dead roaches in the janitorial room last month.</p> <p>During an observation on 12/18/24 at 9:05 a.m. in the kitchen, there was one small live brown cockroach crawling on the ceiling above the dishwasher sink.</p> <p>During an observation on 12/18/24 at 9:07 a.m. in the kitchen, there was a glue trap with five dead medium dark brown cockroaches behind a rack with plate covers.</p> <p>During an observation on 12/18/24 at 9:09 a.m. in the kitchen, there was a mesh like metal material on the hole with a small dead cockroach under the sink near the dishwasher.</p> <p>During an interview on 12/18/24 at 9:10 a.m. with DA 1, DA 1 stated she saw roaches, one alive and two dead five days ago around the area where staff wash the dishes and saw three dark brown live roaches in the kitchen dishwashing area.</p> <p>During an observation on 12/18/24 at 9:11 a.m. in the kitchen, there was a leaking water pipe connected to the dishwasher found underneath the dishwashing counter.</p> <p>During an observation on 12/18/24 at 9:13 a.m. in the dry storage room, there was a glue trap behind the refrigerator with 7 small brown dead cockroaches and one small dead cockroach on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on 12/18/24 at 9:35 a.m. with Activities Assistant (AA) in the dining room, there was two dead roaches on the floor. AA stated she saw one small, brown, dead roach in the dining floor.</p> <p>During an interview on 12/18/24 at 9:38 a.m. with Housekeeper (HK), HK stated she saw roaches in the dining room, some dead, some alive last week.</p> <p>During an observation on 12/18/24 at 9:40 a.m. in the dining room, there was 10 dead cockroaches in a cabinet under the sink.</p> <p>During an interview on 12/18/2024 at 9:50 a.m. with Environmental Specialist (ES), ES stated because of the different sizes of cockroaches identified, the facility has a problem with multi-generational infestation of cockroaches. ES stated during the day, so many of them in hiding places to scavenge for food. ES stated even if the pest control company had sprayed, they still have live infestation of cockroaches.</p> <p>During a concurrent observation and interview on 12/18/24 at 9:58 a.m. with DM in the dry storage room, a live brown cockroach was inside a bin which contained sponges. DM stated that is a live cockroach and killed it with a sponge. There was a dead tiny cockroach in a bin with approximately a dozen scoopers. There was a live small cockroach crawling into a silver rectangular tin box, one dead cockroach under a rack with pitchers, and a small dead cockroach under an empty rack.</p> <p>During an interview on 12/18/24 at 10:30 a.m. with Pest Control Company Owner (PCCO), PCCO stated he was aware of the cockroaches in the kitchen. PCCO stated we went out on Wednesday night and made a thorough inspection of the kitchen. PCCO stated he found infestation of German cockroaches in the kitchen.</p> <p>According to Dr. [NAME], an advisor for the National Pest Management Association, German cockroaches can spread 33 kinds of bacteria, six kinds of parasitic worms, as well as other kind of human diseases. https://www.pestworld.org/news-hub/pest-articles/German-cockroaches101/#:~:text=These%20germs%20are%20then%20transferred,least%20seven%20other%20human%20pathogens. Accessed 12.26.24</p> <p>During a review of the facility's Pest Control Invoice (PCI), dated 12/3/24, the PCI indicated, INSPECTION FOR GERMAN ROACHES.</p> <p>During a review of the facility's PCI, dated 12/9/24, the PCI indicated, SERVICE FOR ROACHES IN THE KITCHEN.</p> <p>During a review of the facility's P&P titled, JANITOR'S CLOSET, dated 2023, the P&P indicated, The janitor's closet must be kept clean and orderly. 4. Cleaning of the janitor's closet must be done on a scheduled routine.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pest Control, dated May 2008, the P&P indicated, Policy Statement. Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.</p>		