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	03/26/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop and implement a care plan for the prevention and treatment of pressure injuries (a localized injury to the skin and/or underlying issue usually over a bony prominence, as a result of pressure, or pressure in combination with a shear) for two of three sampled residents (Resident 6 and Resident 28). This failure placed Resident 6 and Resident 28 at risk for developing pressure injuries.Findings: RESIDENT 6 During a review of Resident 6's admission RECORD (AR), dated 3/23/19, the AR indicated, Resident 6's diagnosis includes Diabetes Mellitus (a group of disease that result in too much sugar in the blood), need for assistance with personal care, and vitamin deficiency. During a review of Resident 6's BRADEN SCALE [a tool used to assess a residents risk for skin breakdown] FOR PREDICTING PRESSURE SORE RISK (BSPS), dated 9/23/25 the BSPS indicated, Resident 6 had score of 13 (a score of 15 to 18 is a mild risk, 13 to 14 is a moderate risk, 10 to 12 is high risk, and any score less than 9 is considered a severe risk) which indicated Resident 6 was a moderate risk for pressure injury. During a concurrent interview and record review on 3/25/26 at 1:15 p.m. with Director of Nursing (DON), Resident 6's Weekly Summary (WS), dated 9/28/25 was reviewed. The WS indicated, Resident 6's skin assessment was blank. DON stated skin assessment is part of WS and should be completed with WS. DON stated on 9/28/26 skin assessment was not completed. During a review of Resident 6's Shower/Bed Bath Sheet (BBS), dated 9/29/25, the BBS indicated no wound on the left leg was documented. During a review of Resident 6's SBAR Communication Form (SBAR), dated 10/1/2025, the SBAR indicated, unstageable pressure wound to lateral left leg L [length] 1.5cm x W[width] 1.5 cm x D [depth] 0.1 cm w/ [with] mild serous drainage. During a review of Resident 6's Omni Wound Physician Progress Note (OMNIPN), dated 10/3/25, the OMNIPN indicated, Patient [Resident 6] and nursing staff were educated on the importance of adhering to the treatment plan, including offloading, repositioning every two hours, proper use of a low air-loss mattress, and maintaining an appropriate diet to support wound healing. During a review of Resident 6's Minimum Data Set (MDS- an assessment tool), dated 9/26/25, the MDS indicated, Resident 6's BIMS (Brief Interview for Mental Status) score was 9 (a score of 13 to 15 (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	means resident is cognitively [mental process that involves knowledge and comprehension] intact, 8 to 12 suggest moderate impairment, 0 to 7 suggest severe impairment). During a review of Resident 6's MDS, dated [DATE], the MDS section GG indicated, Resident 6 required: A. Eating - Setup clean-up assistance (Helper sets up or clean up) B. Oral hygiene – Dependent (Helper does all the efforts) C. Toileting hygiene – Dependent F. Upper body dressing – Dependent G. Lower body dressing – Dependent H. Put on/taking off footwear – Dependent I. Personal Hygiene – Dependent During a concurrent interview and record review on 3/26/26 at 11:18 a.m. with Assistant Regional Director Clinical Services (ARDCS) Resident 6's Care Plan (CP), was reviewed. The ARDCS stated the left leg pressure wound was identified on 10/1/25 and there was no care plan initiated until 10/27/25. ARDSC stated CP's are created to direct the care for the resident and start the departmental communication and to reflect the current care and any changes in the resident's condition. ARDSC stated CP created on 10/27/25 did not address resident's needs. During a review of Resident 6's BSPS, dated 10/23/25 the BSPS indicated, Resident 6 had score of 10. During a review of facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated 4/2020, the P&P indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered. RESIDENT 28 During a review of Resident 28's admission Record (AR), undated, the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care, hemiplegia (total paralysis of one side of the body) and hemiparesis (partial weakness in one side of the body) following cerebral infarction (when blood flow to part of the brain is blocked or a blood vessel bursts, starving brain cells of oxygen) affecting the right dominant side (the stronger side of the body), difficulty in walking, muscle spasms (abnormal involuntary movement of muscles) and fatigue. During a review of Resident 28's BSPS dated 12/26/25 at 5:16 p.m., the BSPS indicated Resident 28 had a MODERATE RISK for pressure injuries. The BSPS indicated Resident 28 had the following risk factors for pressure injuries: (1) SENSORY PERCEPTION (ability to respond meaningfully to pressure-related discomfort): Very Limited; (2) MOISTURE (degree to which skin is exposed to moisture): Occasionally Moist; (3) ACTIVITY (degree of physical activity): Chairfast (ability to walk (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely limited or non-existent); (4) MOBILITY: Very Limited. [Resident]. unable to make frequent or significant changes independently); (5) NUTRITION (usual food intake pattern): probably inadequate; (6) FRICTION AND SHEAR (surface rubbing and internal deformation of skin when shifting in bed): Potential Problem. During a review of Resident 28's Care Plan Report (CPR) (a record of all care plans initiated for the resident), undated, the CPR indicated care plan titled, [Resident 28] has impaired skin integrity as evidenced by skin blister on his right thigh and multiple scratch on his both legs related to trauma, lower dryness legs and sever[e] dryness feet pt have old scabbed wound on his back bone and is at risk for other, pain or discomfort, dated 12/27/26. This care plan did not indicate Resident 28 was at risk for pressure injuries or contained interventions to mitigate the risk factor of limited mobility identified in the BSPS dated 12/26/25, such turning and repositioning Resident 28. During a review of Resident 28's SBAR Summary for Providers Note (SBAR Note) dated 12/27/25 at 9:10 p.m., the SBAR Note indicated Resident 28 was sent to the hospital on [DATE] for shortness of breath. During a review of Resident 28's Admission/re-admission Summary Note (ARSN) dated 1/1/26 at 6:16 p.m., the ARSN indicated Resident 28 was readmitted to the facility on [DATE]. During a review of Resident 28's BSPS dated 1/1/26 at 7:38 p.m., the BSPS indicated Resident 28 was at VERY HIGH RISK of pressure injuries. The BSPS indicated Resident 28 had the following risk factors for pressure injuries: (1) SENSORY PERCEPTION: Very Limited; (2) MOISTURE: Constantly Moist; (3) ACTIVITY: Bedfast (confined to bed); (4) MOBILITY: Very Limited, (5) NUTRITION: probably inadequate; (6) FRICTION AND SHEAR: Problem. During a review of Resident 28's CPR, the CPR indicated no care plan for the prevention of pressure injuries with interventions to mitigate the pressure injury risk factors identified in the BSPS dated 1/1/26. During a review of Resident 28's Nurse's Note (NN) dated 1/5/26 at 1:33 p.m., the NN indicated [Resident 28] found unresponsive in the dining room. 911 called. [Resident 28] sent to [hospital] for further evaluation. During a review of Resident 28's NN dated 1/8/26 at 8:06 p.m., the NN indicated, [Resident 28] re-admitted to facility today from hospital. During a review of Resident 28's BSPS dated 1/8/26 at 8:32 p.m., the BSPS indicated Resident 28 was at HIGH RISK of pressure injuries. The BSPS indicated Resident 28 had the following risk factors for pressure injuries: (1) SENSORY PERCEPTION (ability to respond meaningfully to pressure-related discomfort: Very Limited; (2) MOISTURE: Very Moist; (3) ACTIVITY: Bedfast; (4) MOBILITY: Very Limited; (5) NUTRITION: probably inadequate; (6) FRICTION AND SHEAR: Problem. During a review of Resident 28's CPR, the CPR indicated the care plan titled Resident is at risk for skin breakdown related to impaired mobility, wheelchair bound dated 1/10/26. This care plan contained the following interventions initiated on 1/10/26: (1) administer medications and treatments as ordered; (2) check skin during daily care provisions and notify the physician of abnormal findings; (3) diet and supplements as ordered and (4) educate on avoiding skin injuries and encourage fluids. This care plan did not contain interventions to address Resident 28's immobility, such as frequent (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	turning and repositioning. During a review of Resident 28's CPR, the CPR indicated the care plan title Skin . Resident at risk for further breakdown . related to decreased mobility dated 1/12/26 with the intervention of Turning/repositioning program During a concurrent interview and record review on 3/26/26 at 8:15 a.m. with Director of Staff Development (DSD), the clinical record of Resident 28 was reviewed. DSD stated Resident 28 was at risk for pressure injuries as indicated in the BSPS dated 12/26/25, 1/1/26, and 1/8/26. DSD stated Resident 28 had very limited mobility and needed frequent turning and repositioning. DSD stated the first care plan for prevention of pressure injuries including the intervention of turning and repositioning for Resident 28 was developed on 1/12/26. During an interview on 3/26/26 at 11:28 a.m. with Regional Director of Clinical Services (RDCS), RDCS stated pressure injury prevention care plans should be created for all residents assessed to be at risk for pressure injuries and should contain interventions to address the risk factors identified in the BSPSs. RDCS stated pressure injury prevention care plans should be created as soon as residents are assessed to be at risk for pressure injuries. During a review of facility 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 objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. During a review of facility's P&P titled Prevention of Pressure Injuries, dated 4/2020, the P&P indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1. Expired and opened sterile (processed to prevent infection) wound treatment supplies were removed from storage and disposed of. This failure had the potential to result in expired and opened wound treatment supplies being used for residents' care and preventing wound healing and causing infection.2. One of three sampled residents (Resident 28) at risk of falls had fall risk assessments completed after falls. This failure placed Resident 28 at risk of falls and injuries. Findings: 1. During a concurrent observation and interview on [DATE] at 11:03 a.m. with Licensed Vocational Nurse (LVN) 1, in the medication storage room cabinet, there were two expired sterile wound treatment supply packages and one opened sterile wound treatment supply. LVN 1 stated the sterile foam dressing expired on [DATE] (one year ago). LVN 1 stated the sterile canister supply expired on [DATE] (approximately four months ago). LVN 1 stated the opened cannister supply package was no longer sterile and needed to be thrown away. LVN 1 stated the supplies were used in the treatment of resident wounds. During an interview on [DATE] at 3:26 p.m. with Administrator, Administrator stated expired and opened wound treatment supplies should be disposed of and if used for care of residents could cause an infection or delayed wound healing. On [DATE] at 3:42 p.m. policy and procedure for storage of sterile supplies was requested, none was provided. 2. During a review of Resident 28's admission Record (AR), undated, the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care, hemiplegia (total paralysis of one side of the body) and hemiparesis (partial weakness in one side of the body) following cerebral infarction (when blood flow to part of the brain is blocked or a blood vessel bursts, starving brain cells of oxygen) affecting the right dominant side (the stronger side of the body), difficulty in walking, muscle spasms (abnormal involuntary movement of muscles) and fatigue. During a review of Resident 28's Nursing – Fall Risk Observation/Assessment (Fall Risk Assessment), dated [DATE] at 6:07 p.m., the Fall Risk Assessment indicated Resident 28 was at a HIGH RISK for falls. During a review of Resident 28's SBAR (Situation Background Assessment and Recommendation) Note (SBAR Note) dated [DATE] at 2:50 p.m., the SBAR Note indicated Resident 28 had a fall. During a review of Resident 28's clinical record, there was no fall risk assessment completed for Resident 28 after his fall on [DATE]. During a review of Resident 28's SBAR Note dated [DATE] at 2:30 p.m., the SBAR Note indicated Resident 28 had another fall. During a review of Resident 28's clinical record, there was no fall risk assessment completed for Resident 28 after his fall on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 8:15 a.m. with the Director of Staff Development (DSD), the clinical record of Resident 28 was reviewed. DSD stated Resident 28 did not have fall risk assessments completed after the falls on [DATE] and [DATE]. DSD stated there were only three fall risk assessments completed for Resident 28, on [DATE], [DATE] and [DATE]. During an interview on [DATE] at 11:28 a.m. with Regional Director of Clinical Services (RDCS), RDCS stated fall risk assessments should be completed for residents after each fall. During a review of facility P&P titled, Falls Risk Assessment dated [DATE], the P&P indicated, The nursing staff, in conjunction with the attending physician, consulting pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility:1. Failed to ensure the ice machine was sanitized (disinfected) according to manufacturer's instructions.2. Failed to ensure a visitor wore a hair net while in the kitchen. These failures placed residents at risk of consuming contaminated food and beverages. Findings: 1. During an interview on 3/24/26 at 10:02 a.m. with the Director of Maintenance (DM) in the kitchen, DM stated he was responsible for cleaning the ice machine. DM stated he cleaned the ice machine using a cleaner which he poured into the machine's water reservoir and let the cleaner to run through the machine's ice-making cycle. DM provided the cleaner he used which read Nickel-Safe Ice Machine Cleaner. DM stated this was the only product he used to clean the ice machine. During a concurrent interview and record review on 3/24/26 at 11:35 a.m. with DM, the ice machine's Installation, Use & Care Manual (Ice Machine Manual), dated 10/13 was reviewed. The Ice Machine Manual, under Section 4 Maintenance, indicated the cleaning of the ice machine should be followed by sanitizing it, which comprised running a sanitizer solution through the ice machine in the same way as the cleaner. The Ice Machine Manual indicated, Ice machine cleaner is used to remove lime scale and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime. DM stated he did not know he was supposed to sanitize the ice machine. DM stated he did not sanitize the ice machine. During an interview on 3/24/26 at 11:47 a.m. with the Dietary Director (DD), DD stated ice from the ice machine was placed in residents' water bottles, drinks, and used for food preparation for residents. During a review of facility policy and procedure (P&P) titled Ice Machines and Ice Storage Chests dated January 2012, the P&P indicated, Ice-making machines, ice storage chests/containers, and ice can all become contaminated by . colonization by microorganisms . Our facility has established procedures for cleaning and disinfecting ice machines . which adhere to manufacturer's instructions. 2. During observations on 3/24/26 at 10:33 a.m., 10:43 a.m., 10:46 a.m. and at 10:47 a.m., a haired food delivery worker entered the kitchen without a hair net and placed food boxes in front on the refrigerators. In each instance the food delivery worker passed a few feet away from trays of bread rolls and from a food preparation table where [NAME] 1 was preparing lunch for residents. During an interview on 3/24/26 at 4:20 p.m. with the Registered Dietician (RD), RD stated everyone entering the kitchen should wear a hair net, including non-staff and delivery people. During a review of facility policy and procedure (P&P) titled, Food Preparation and Service, dated November 2022, the P&P indicated, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices . Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, for one of two sampled residents (Resident 12) when his informed consent for psychotropic (medication to treat mental disorders) medication was not completed. This failure had the potential for Resident 12 to receive psychotropic medication without knowing the risks and benefits of the medication.Findings:During a concurrent interview and record review on 3/25/26 at 1:37 p.m. with Assistant Regional Director Clinical Services (ARDCS), Resident 12's admission Record (AR), [undated] was reviewed. Resident 12 was on Prozac (used to treat mental disorder) 20 mg by mouth every day started on 1/9/26. ARDCS stated there was no informed consent obtained prior to administering this medication.During a review of facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, [undated], the P&P indicated, The prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a psychotropic medication.1. General Guidelines: .g. 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.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 34) was provided enough electrical outlets when Resident 34 was unable to plug in her television and refrigerator at the same time. This failure resulted in Resident 34 not being able to use her television. Findings:During a concurrent observation and interview on 3/23/26 at 9:53 a.m. with Resident 34 in Resident 34's room, a small refrigerator was plugged into an electrical outlet on the wall at the foot of Resident 34's bed. The cord for the television was unplugged. Resident 34 stated the facility would not allow her to have an extension cord with multiple outlets. Resident 34 stated she had only two single outlet plugs to use to charge her phone, use a lamp, plug in her refrigerator and use the television. Resident 34 stated she had to ask staff for assistance for plugging and unplugging her devices. Resident 34 stated she has not been able to watch television for a while since there were not enough outlets. During a review of Resident 34's Minimum Data Set (MDS - a comprehensive assessment tool), Section C, dated 6/2/25, the MDS indicated Resident 34's BIMS (Brief Interview for Mental Status) score was 14 (score of 13-15 means cognition is intact). During an interview on 3/26/26 at 11:45 a.m. with Administrator, Administrator stated the facility leadership team did rounds in resident rooms and remove items not allowed such as extension cords with concern for fire hazard. Administrator stated the expectation was that if an extension cord was removed, staff would replace it with a facility approved electrical outlet device. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Accommodation of Needs, (undated), the P&P indicated, 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis as needed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on interview and record review, the facility failed to inform and/or obtain Advance Directive (AD - written statement of person's wishes regarding medical treatment and end of life decisions, made to ensure those wishes are carried out should the person become unable to communicate their wishes) options for three of 24 sampled residents (Resident 11, Resident 72, and Resident 6). This failure had the potential for residents' end of life wishes to not be honored.Findings:During a review of Resident 11's Medical Record (MR), the MR contained no documentation the facility provided written information showing whether Resident 11 had formulated an advance directive, whether Resident 11 wished to do so, or if assistance was offered.During a review of Resident 72's MR, the MR contained no documentation the facility provided written information showing whether Resident 72 had formulated an AD, whether Resident 72 wished to do so, or if assistance was offered.During a review of Resident 6's MR, the MR contained no documentation the facility provided written information showing whether Resident 6 had formulated an AD, whether Resident 6 wished to do so, or if assistance was offered.During an interview on 3/25/26 at 12:40 p.m. with Director of Regional Clinical Services (DRCS), DRCS stated there were no Advance Directive Acknowledgement forms completed for Resident 11, Resident 72, and Resident 6.During a review of facility's Policy and Procedure (P&P) titled, Advance Directives dated 9/2022, the P&P indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify ombudsman (representatives who assist residents in long-term care facilities with issues related to day-day care, health, safety, and personal preferences) of four of four sampled residents (Resident 11, Resident 12, Resident 6, and Resident 80) planned transfers and discharges. This failure had the potential to result in Resident 11, Resident 12, Resident 6, and Resident 80 not having an advocate who could inform them of their admission, transfer, and discharge rights and options.Findings:During a concurrent interview and record review on 3/25/26 at 9:47 a.m. with Assistant Regional Director Clinical Services (ARDCS), Resident 11's Medical Record (MR), [undated] was reviewed. ARDCS stated Resident 11 was transferred to hospital on 3/21/25, 8/26/25, and 3/15/26. ARDCS stated there was no ombudsman notification completed for 3/21/25, 8/26/25, and 3/15/26. ARDCS stated Ombudsman should have been notified after each transfer out to hospital.During a review of Resident 6's MR, [undated], the MR indicated Resident 6 was transferred to hospital on 9/10/25 and 10/3/25. There was no indication in Resident 6's MR that Ombudsman was notified.During a review of Resident 80's MR, [undated], the MR indicated Resident 80 was transferred to hospital on 3/15/25 and 3/2/26. There was no indication in Resident 80's MR that Ombudsman was notified.During an interview on 3/25/26 at 11:19 a.m. with Director of Regional Clinical services (DRCS), DRCS stated Ombudsman notifications for Resident 80 and Resident 6 were not completed. DRCS stated Ombudsman should be notified when transfer to hospital. DRCS stated Ombudsman is only being notified when residents were being discharged to home.During a concurrent interview and record review on 3/25/26 at 1:47 p.m. with ARDCS, Resident 12's MR [undated] was reviewed. ARDCS stated Resident 12 was transferred to hospital 1/3/26 and 2/19/26. ARDCS stated there was no Ombudsman notification completed for 1/3/26 and 2/19/26.During a review of facility's policy and procedure (P&P) titled, Transfer or Discharge Notice, dated 3/2021, the P&P indicated, Residents and/or representatives are notified in writing, and in language and format they understand, at least thirty (30) days prior to a transfer or discharge.

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	555170	A. Building B. Wing	03/26/2026

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the complete Baseline Care Plan (BCP-initial instructions for care of the residents) for two of six sampled residents (Resident 3 and Resident 11). This failure had the potential to result in staff being unaware of residents' needs.Findings:During a concurrent interview and record review on 3/25/26 at 9:31 a.m. with Assistant Regional Director Clinical Services (ARDCS), Resident 3's Medical Record (MR), [undated] was reviewed. Resident 3 was admitted on [DATE]. ARDSC was unable to find documentation for BCP. ARDSC stated BCP should be initiated within 48 hours. During a concurrent interview and record review on 3/25/26 at 9:47 a.m. with ARDCS, Resident 11's MR, [undated] was reviewed. Resident 11 was admitted on [DATE]. ARDSC stated she was unable to find documentation for BCP.During a review of facility's policy and procedure (P&P) titled, Care Plans - Baseline, dated 5/2024, the P&P indicated, A baseline plan of care should be developed for each resident within forty-eight (48) hours of admission.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and interview, the facility failed to ensure one of three residents (Resident 105) was offered and provided showers when requested. This failure resulted in Resident 105 only showering once during a seven day period. Findings: During a review of Resident 105's admission Record (AR), undated, the AR indicated Resident 105 was admitted on [DATE]. During an interview on 3/23/26 at 3:32 p.m. with Resident 105, Resident 105 stated she was not receiving enough showers. Resident 105 stated she wanted more showers. Resident 105 stated she requested a shower yesterday but was denied. During a concurrent interview and record review on 3/25/26 at 10:05 a.m. with the Director of Staff Development (DSD), Resident 105's shower flowsheets were reviewed. DSD opened Resident 105's Bathing log in the computer which indicated Resident 105 had a total of four showers since admission, on 3/17/26, 3/19/26, 3/20/26 and 3/24/26. DSD stated there were no shower refusals documented in Resident 105's Bathing log. DSD stated the facility's policy was for residents to be offered showers twice a week but residents could have showers as frequently as they wanted. DSD stated Resident 105's shower days were Tuesday and Thursdays. During an interview on 3/25/26 at 10:20 a.m. with Resident 105, Resident 105 stated she wanted showers every other day not only twice a week. During a review of facility policy and procedure (P&P) titled Shower/Tub Bath, dated October 2010, the P&P indicated showers/tub baths promote cleanliness, provided comfort to the resident and to observe the condition of the resident's skin.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure one of three residents (Resident 43) receiving tube feedings was kept with his head elevated at least 30 degrees while receiving tube feedings. This failure placed Resident 43 at risk of aspiration (food or liquid going into the lungs causing disease and respiratory problems). Findings: During a concurrent observation and interview on 3/23/26 at 12:37 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 43's room, Resident 43 was receiving tube feedings while lying flat in his bed. LVN 1 stated Resident 43's head of bed should be elevated 45 degrees when receiving tube feedings. During a concurrent observation and interview on 3/25/26 at 3:35 p.m. with the Director of Nursing (DON) in Resident 43's room, Resident 43 was receiving tube feedings while lying flat in his bed. DON stated Resident 43's head of bed should be elevated 30 degrees when receiving tube feedings. During a review of Resident 43's care plan (CP) titled Resident requires tube feeding ., dated 3/20/26 with the objective, Resident will remain free of side effects or complications related to tube feeding . the CP indicated, Resident's HOB [head of bed] elevated 45 degrees during and thirty minutes after tube feed. During an interview on 3/26/26 at 11:28 a.m. with Regional Director of Clinical Services (RDCS), RDCS stated residents receiving tube feeding should be kept with their heads elevated at 45 degrees to prevent aspiration. During a review of facility policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions dated 2001, the P&P indicated, Elevate the head of bed (HOB) at least 30 degrees during tube feeding .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty eight hours a day, seven days a week. This failure had the potential for resident care to be negatively impacted.Findings:During a concurrent interview and record review on 3/24/26 at 3:18 p.m. with Director of Staff Development (DSD), the Detail Time and Job (clock in log) dated 1/10/26, 2/22/26, 3/14/26, and 3/15/26 was reviewed. DSD stated there was no RN present in the building for 8 hours a day during those days.During a review of facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent nursing, dated 8/2022, the P&P indicated, 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure Performance Evaluation (PE - a process to give employees feedback on their job performance) for five of five sampled employees (Certified Nursing Assistant [CNA] 1, CNA 2, CNA 3, CNA 4, CNA 5) were completed. This failure had the potential for the staff not to be aware of their need for improvement in certain areas, which could affect resident care.Findings:During a concurrent interview and record review on 3/25/26 at 8:13 a.m. with Director of Staff Development (DSD), CNA 1's Personnel File (PF) was reviewed. The PF indicated CNA 1 was hired on 2/1/18 and last PE was done on 7/5/24 and there was no PE found after 7/5/24. DSD stated PE should be completed annually.During a concurrent interview and record review on 3/25/26 at 8:27 a.m. with DSD, CNA 2's PF was reviewed. The PF indicated CNA 2 was hired on 5/7/24 and there was no PE found in their PF. DSD stated PE should be completed annually.During a concurrent interview and record review on 3/25/26 at 8:29 a.m. with DSD, CNA 3's PF was reviewed. The PF indicated CNA 3 was hired on 5/22/24 and there was no PE found in their employee file. DSD stated PE should be completed annually.During a concurrent interview and record review on 3/25/26 at 8:33 a.m. with DSD, CNA 4's PF was reviewed. The PF indicated CNA 4 was hired on 4/28/22 and there was no PE found in their employee file. DSD stated PE should be completed annually.During a concurrent interview and record review on 3/25/26 at 8:37 a.m. with DSD, CNA 5's PF was reviewed. The PF indicated CNA 5 was hired on 4/12/22 and annual PE was completed on 6/25/24 and there was no PE found in their employee file. DSD stated PE should be completed annually.During a review of facility's policy and procedure (P&P) titled, Performance Evaluations, dated 9/2020, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the safe administration of medications when medications were found at Resident 33's bedside table without a medication self- administration assessment or a physician order for one of 24 sampled resident (Resident 33). This failure had the potential for medications to be administered incorrectly and unsafely.Findings:During a concurrent observation and interview on 3/23/26 at 9:20 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 33's room, Resident 33 had a medication cup on the bedside table with five pills and three capsules in the medication cup and no nurse was present in the room. LVN 2 stated in the medication cup there were pantoprazole (medication used for stomach acid), aspirin (to prevent blood clots), cresemba (medication to treat fungal infections), metformin (medication used to treat high blood sugar), multi-vitamin, vitamin C, Vitamin B12 (used for vitamin deficiency) and senna (stool softener). LVN 2 stated nurses should wait and watch until residents swallow all the medications.During a concurrent interview and record review on 3/26/26 at 1:49 p.m. with Assistant Regional Director Clinical Services (ARDCS), Resident 33's Medical Record (MR), [undated] was reviewed. ARDCS stated there was no physician order to keep medications at bedside. ARDCS stated there was no self-administer assessment in Resident 33's MR. ARDCS stated there was no care plan to keep medications at bedside. ARDCS stated nurses should ensure Resident 33 swallowed the medication before leaving the room.During a review of facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 56 and Resident 43) were provided care using Enhanced Barrier Precautions (EBP - use of gowns and gloves to reduce transmission of multi-drug resistant organisms). This failure had the potential to result in Resident 56 and Resident 43 developing an infection. Findings: During an observation on 3/23/26 at 8:57 a.m. in the doorway of Resident 56's room, Certified Nursing Assistant (CNA) 6 was at Resident 56's bedside wearing gloves (no gown) while giving care to Resident 56. A sign on the name plate outside of Resident 56's room indicated Resident 56 was on EBP. During a concurrent observation and interview on 3/23/26 at 9:03 a.m. in the doorway of Resident 56's room, CNA 6 was at Resident 56's bedside wearing gloves (no gown) tying a trash bag then exited the room. CNA 6 stated Resident 56 had a wound on his groin but was not sure what EBP means. CNA 6 stated she was only wearing gloves while providing care to Resident 56. During a review of Resident 56's Order Summary (OS) dated 2/24/26, the OS indicated, Resident [56] requires Enhanced Barrier Precautions (EBP) during high contact care activities r/t [related/to]: Surgical Wound RT [right] groin. During an observation on 3/25/26 at 9:16 a.m. with Licensed Vocational Nurse (LVN) 1 at Resident 43's bedside, LVN 1 donned gloves (no gown) and checked Resident 43's gastrostomy tube (g-tube - a tube inserted into the stomach through the abdominal wall used to administer medications and nutrition) placement and residual (how much liquid was in the stomach). LVN 1 attached a syringe to the g-tube and flushed with 30 milliliters of water. During a concurrent observation and interview on 3/25/26 at 10:03 a.m. with LVN 1 outside of Resident 43's room, a sign on the nameplate indicated Resident 43 was on EBP. LVN 1 was unable to verbalize what EBP meant and why Resident 43 was on EBP. LVN 1 stated she only wore gloves while caring for Resident 43's g-tube but because Resident 43 was on EBP she also needed to wear a gown when providing care. During a review of Resident 43's OS, dated 12/4/25, the OS indicated, Resident [43] requires Enhanced Barrier Precautions (EBP) during high contact care activities r/t: G-Tube. During an interview on 3/26/26 at 2:13 p.m. with Infection Preventionist (IP), IP stated residents who have been colonized (presence of germs without causing disease symptoms) with MDRO (Multi Drug Resistant Organisms - germs immune to antibiotic drugs), have an indwelling device (medical instruments inserted into the body including g-tube), or have an open wound will be placed on EBP. IP stated staff have to wear a gown and gloves when providing care and touching the environment of residents on EBP to help prevent infections. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 2/2025, the P&P indicated, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. a. Gloves and gown are applied prior to performing the high contact resident care activity.