

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 8th Street Bakersfield, CA 93304	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to provide oxygen per physician's orders for one of three sampled residents (Resident 1). This failure had the potential for negative outcomes.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/22/24 at 2:07 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1 was observed with oxygen being given via nasal canula (a flexible tube with two protruding tips that sit inside the nostrils to deliver oxygen) at six liters (a unit of measurement). LVN 1 stated Resident 1 had the oxygen set at six liters, but it was supposed to be set at two liters.</p> <p>During a review of Resident 1's Order Summary Report (OSR), dated 4/22/24, the OSR indicated, Resident 1 diagnosis including Chronic Obstructive Pulmonary Disease (COPD - a common lung disease causing restricted airflow and breathing problems), Pneumonia (infection of the lung) and Respiratory failure (a serious condition that makes it difficult to breathe on your own). The OSR indicated Resident 1 had a physician's order to receive oxygen at 5 liters via nasal canula as needed for oxygen saturation (the amount of oxygen circulating in the blood) less than 93 percent (%).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 11/1/17, the P&P indicated, Purpose . To prevent or reverse hypoxemia [low oxygen levels] and provide oxygen to the tissues. Procedure . Check the physician's order. turn on the oxygen at the prescribed rate.</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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>37697</p> <p>Based on observation, interview, and record review, the facility failed to ensure the air mattress (a pressure-relief device that is constantly being inflated with air to prevent skin breakdown, wounds and/or assist with the healing of wounds) for three of three sampled residents (Resident 1, Resident 2 and Resident 3) was in safe operating condition. This failure had the potential to impact the safety of the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/22/24 at 2:07 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1 was observed laying on an air mattress in bed. LVN 1 observed the air mattress setting and stated it was set at 290 pounds (lbs.).</p> <p>During a review of Resident 1's Weights and Vitals Summary (WAVS), dated 3/3/24, the WAVS indicated, Resident 1 weighed 110 lbs.</p> <p>During an interview on 4/22/24 at 2:17 p.m. with Treatment Nurse (TN), TN stated the facility maintenance sets up the air mattresses for the residents. TN stated she has not been educated nor does she know how to set up an air mattress or its settings for the residents.</p> <p>During a concurrent observation and interview on 4/22/24 at 2:23 p.m. with TN in Resident 2's room, Resident 2 was observed laying on an air mattress in bed. Resident 2 stated to TN her mattress was uncomfortable. TN looked at Resident 2's air mattress settings and stated it was set at 350 lbs.</p> <p>During a review of Resident 2's WAVS, dated 4/3/24, the WAVS indicated, Resident 2 weighed 158 lbs.</p> <p>During a concurrent observation and interview on 4/22/24 at 2:27 p.m. with TN in Resident 3's room, Resident 3 was observed laying on an air mattress in bed. TN looked at Resident 3's air mattress settings and stated it was set at 1000 lbs.</p> <p>During a review of Resident 3's WAVS, dated 4/5/24, the WAVS indicated, Resident 3 weighed 448 lbs.</p> <p>During an interview on 4/22/24 at 2:34 p.m. with Facility Maintenance Worker (FMW), FMW stated he does not set up the air mattresses for residents. FMW stated he brings in the air mattresses when requested by the nurse, cleans them, sets them on the bed and turns the machine on. FMW stated he thought the facility nurses set the settings on the resident air mattresses.</p> <p>During an interview on 4/22/24 at 2:41 p.m. with Director of Staff Development (DSD), DSD stated she does not provide training to the facility nurses on how to set up the air mattress settings. DSD stated the facility Director of Nursing (DON) was supposed to provide any type of Inservice training to the licensed nurses. DSD stated she had not received any type of training on how to set up an air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/22/24 at 2:46 p.m. with DON, DON stated air mattresses were to be set up according to resident weight. DON stated if the air mattresses were set up to be too high or to be too low in weight, it could cause more damage to the resident's skin. DON stated the facility had not provided any training on how to set up an air mattress to any of the licensed nurses.</p> <p>During a review of the facility Licensed Nurse List (LNL), undated, the LNL indicated, the facility had 28 nurses (LVN 1, TN, DSD, Registered Nurse (RN) 1, RN 2, RN 3, RN 4, RN 5, RN 6, LVN 2, LVN 3, LVN 4, LVN 5, LVN 6, LVN 7, LVN 8, LVN 9, LVN 10, LVN 11, LVN 12, LVN 13, LVN 14, LVN 15, LVN 16, LVN 17, LVN 18, LVN 19 and LVN 20) in the facility that had not received training on resident air mattresses.</p> <p>On 5/7/24 at 4:02 p.m. a request was made for facility policy and procedures regarding licensed nurse training and/or competencies and DON stated the facility did not have any policies for licensed nurses training and/or competencies.</p>		