STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555229	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Healthcare Center	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)
F 0837 Level of Harm - Actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763 Based on observation, interview, and record review, the facility failed to implement their policy and procedure (P&P) titled, Pressure Ulcer (or injury is localized damage to the skin and underlying soft tissue usually over a bony prominence) Prevention for one of three sampled residents (Resident 1) when: 1. Resident 1 was not assessed for risk for developing pressure injuries upon admission. 2. Physician was not notified to obtain treatment for Resident 1's left heel redness. 3. A care plan (resident centered health document designed to facilitate communication among members of the care team with the resident) was not developed to address Resident 1's left heel redness. 4. Interdisciplinary team (Team members from different disciplines working collaboratively with a common purpose, to set goals, make decisions and share resources and responsibilities) meeting was not conducted to address Resident 1's left heel redness. These failures resulted in Resident 1 sustaining a facility acquired Stage 3 (Full-thickness loss of skin, in which adipose [fat] is visible) pressure injury to the left heel. Findings: During a review of Resident 1's Admission Record (AR) the AR indicated, Resident 1 was admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (occurs as a result of disrupted blood flow to the brain and you may become paralyzed on one side of the body, or lose control of certain muscles), muscle weakness, and reduce mobility. During a review of Resident 1's Nursing Admission Screening/History (NASH) dated 3/14/24, the NASH indicated Resident 1 was alert and oriented to person, place, time, and situation and Resident 1's cognition (mental action or process) was intact. The NASH indicated, Skin . Face . Dryness . (no other documented skin issues). (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 0837 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's admission Minimum Data Set (MDS-an assessment tool) dated 3/20/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status) a score of 12 (a score of 8 to 12 indicates moderately impaired cognition). The MDS indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), and Resident 1 was dependent (helper does all the effort) for chair/bed to chair transfers (the ability to transfer to and from bed to a chair or wheelchair). 1. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk (Braden-a medical instrument used to measure residents' risk of developing pressure injuries) dated 3/14/24, the document was noted blank. During a concurrent interview and record review on 4/24/24 at 1:30 p.m. with Director of Nursing (DON), Resident 1's Braden Scale for Predicting Pressure Sore Risk dated 3/14/24, was reviewed. DON confirmed Resident 1 was admitted on [DATE]. DON reviewed Resident 1's Braden Scale for Predicting Pressure Sore Risk dated 3/14/24, and DON stated the Braden Scale for Predicting Pressure Sore Risk was not completed. 2. During a review of Resident 1's Skin Observation Tool, (SOT) dated 3/15/24, the SOT indicated redness to Resident 1's left heel (one day after the admission). During a review of Resident 1's Treatment Administration Record, dated 3/2024, the TAR indicated no documented treatment for Resident 1 left heel redness. During a concurrent interview and record review on 4/24/24 at 1:30 p.m. with DON, Resident 1's SOT dated 3/15/24 was reviewed. The SOT indicated Resident 1 left heel redness. DON reviewed Resident 1's medical record and stated the physician was not notified to obtain treatment for Resident 1's left heel redness. 3. During a review of Resident 1's Skin Observation Tool, (SOT) dated 3/15/24, the SOT indicated redness to Resident 1's left heel (one day after the admission). During a concurrent interview and record review on 4/24/24 at 1:30 p.m. with DON, Resident 1's SOT dated 3/15/24 was reviewed. DON confirmed the SOT indicated Resident 1's left heel redness. DON reviewed Resident 1's care plans and stated there was no care plan developed to address Resident 1's left heel redness. During a review of Resident 1's Wound Weekly Observation Tool (WWOT) dated 4/4/24 (20 days after the admission), the WWOT indicated, Resident 1 had a SDTI (suspected deep tissue injury-intact or non-intact skin with localized area of persistent non-blanchable [the skin does not turn white when touched with a finger] deep red, maroon, purple discoloration or epidermal [outer layer of skin] separation revealing a dark wound bed or blood-filled blister [small bubble on the skin filled with serum]) to the left heel. The WWOT indicated the SDTI was intact, measuring 20 mm (millimeters-unit of measure) in length by 20 mm in width. (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's WWOT dated 4/10/24, the WWOT indicated Resident 1's SDTI to the left heel worsened to a Stage 3 pressure injury measuring 25 mm in length by 25 mm in width and 1 cm (centimeter-unit of measure) in depth. The WWOT indicated slough (yellow, tan, white, or stringy material noted in the wound) and necrotic (dead skin tissue-brown, black, leather, scab-like) tissue. During a concurrent observation and interview on 4/17/24 at 12:39 p.m. with Resident 1, in Resident 1 room, Resident 1 had his left foot elevated on a pillow. Resident 1 stated he was not admitted to the facility with pressure injury to the left heel. Resident 1 stated two weeks ago (4/4/24) a wound care provider took something off the bottom of his left foot, he stated the wound care provider came in today and scrapped and scrapped at my left foot again. Resident 1 stated, I was ready to go home but they won't let me go because of the wound [left heel]. During an interview on 4/24/24 12:32 p.m. with Treatment Nurse (TN), TN stated the facility process for new admitted resident identified with wounds was for the treatment nurse to measure the wounds, contact the physician to obtain treatment orders, develop a care plan, perform weekly wound assessment with the wound specialist, and update the treatment order and care plan as needed. During an interview on 5/15/24, at 11:25 a.m. with DON, DON confirmed Resident 1's SDTI to the left heel was now a Stage 3. 4. During a concurrent interview and record review on 5/20/24 at 11:56 a.m. with DON, Resident 1's medical record was reviewed. There was no IDT meeting noted to address Resident 1's left heel redness. DON stated Resident 1 did not have an IDT meeting to address Resident 1's left heel redness on the month of March 2024. During a review of facility's P&P titled, Pressure Ulcer Prevention, revised 11/1/17, the P&P indicated, Purpose To identify residents at risk for skin breakdown, implement measures to prevent and/or manage pressure ulcers and minimize complications. Policy: The facility will identify residents at risk for pressure ulcers and provide care and services to promote the prevention of pressure ulcer development. Procedure I. Risk Identification and Assessment: A. The Licensed Nurse will complete a Braden Scale Assessment upon admission and quarterly to identify residents at risk for skin breakdown. B. Licensed Nurse will conduct a skin assessment for a resident upon admission, readmission, weekly and as needed. a. If the resident is identified as having wound upon admission, findings will be documented on the Resident Admission Assessment . and a Wound Monitoring Record . will be implemented. c. A Wound Monitoring Record will be implemented for each identified wound. II. Plan of Care: A. The Licenses Nurse will develop a Care Plan specific to the resident's risk factors such as moisture control, pressure reduction, positioning, mobility, and nutrition in consultation with the following: i. Attending Physician ii. Interdisciplinary Team (IDT)- Skin Committee iii. Registered Dietician iv. Director of Rehabilitation Services B. Nursing Staff will monitor interventions for effectiveness and resident tolerance. C. The Care Plan will be revised as indicated. III. Ongoing Monitoring: . C. The Licensed Nurse will document effectiveness of pressure ulcer prevention techniques in the resident's medical record on a weekly basis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39763 Based on interview and record review, the facility failed to ensure one of three sampled resident (Resident 1) medical records were accurate. This failure resulted in inaccurate information in Resident 1's medical record. Findings: During a concurrent interview and record review on 5/15/24 at 11:25 a.m. with Director of Nursing (DON), DON reviewed Resident 1's Wound Weekly Observation Tool, (WWOT) dated 4/4/24. DON confirmed Resident 1 had an SDTI (suspected deep tissue injury-intact or non-intact skin with localized area of persistent non-blanchable [the skin does not turn white when touched with a finger] deep red, maroon, purple discoloration or epidermal [outer layer of skin] separation revealing a dark wound bed or blood-filled blister [small bubble on the skin filled with serum]) to the left heel and skin intact. DON reviewed Resident 1's care plan with the focus on stage 3 (Full-thickness loss of skin, in which adipose [fat] is visible) pressure injury (is localized damage to the skin and underlying soft tissue usually over a bony prominence) to left heel initiated on 4/4/24 and the interventions were initiated on 4/3/24 (one day before the care plan was initiated). DON confirmed Resident 1 had a left heel SDTI on 4/4/24, not a stage 3 pressure injury. DON stated the documentation was not accurate. During a review of the facility's policy and procedure (P&P) titled, Completion &Correction, revised 5/1/19, the P&P indicated, The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. II. Entries will be recorded promptly as the events or observations occur. III> entries will be complete, legible, descriptive, and accurate. V. Entries should be written in chronological sequence. If it is necessary to chart out of sequence during, the appropriate date and time will be entered. A. When adding an entry at a later date, the entry is to be clearly identified as a late entry. XV. An event is never to be documented before it occurs.