

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 06/03/2025
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 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>(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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan (a detailed document outlining how the facility staff will provide care to meet the resident's specific needs) interventions as recommended by the Interdisciplinary Team (IDT - a group of healthcare professionals who collaborate to provide comprehensive care to a patient) for one of three sampled residents (Resident 1). This failure resulted in Resident 1 falling on 5/28/25 and sustaining an acute fracture (clean and immediate break in the bone) of her pelvis (bowl-shaped bony structure in the lower part of your body located between your lower back and your legs) S3 and S4 region (third and fourth sacral [triangular bone at the base of the spine] vertebrae [backbone]) and subluxation (when bones are moved out of place resulting in pressure and irritation) of S2 and S3 (second and third sacral bone -area of the pelvis) requiring the resident to be transferred to the acute hospital (from 5/28/25 to 6/1/25). Findings: During a review of Resident 1's admission RECORD (AR), dated 6/4/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of epilepsy (a brain condition that causes recurring seizures [electrical disturbances in the brain]), dementia (a progressive state of decline in mental abilities), muscle weakness, cognitive (the way our brains think, learn, and understand things) or emotional (having to do with feelings) deficit (absence of) following cerebral infarction (loss of blood flow and/or oxygen to part of the brain), and osteoporosis (weak and brittle bones). During a review of Resident 1's Minimum Data Set (MDS) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 5/16/25, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition is. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact. A score of 99 suggest the resident was unable to complete the interview and therefore the assessor is unable to determine the resident's cognition), the BIMS score was 07. Under section GG (assesses functional abilities and goals), Resident 1 was documented to require supervision or touching assistance (staff provides verbal cues and/ or physical contact like touching, steadying as the resident performs an activity) for the following physical movements: A. Move from sitting to standing position B. Transfer from bed to chair or chair to bed C. Transfer on and off toilet D. Walk 10 feet (a unit of measurement) E. Walk 50 feet with two turns F. Walk 150 feet G. Wheel herself in a wheelchair 50 feet with two turns H. Wheel herself 150 feet in a wheelchair. During a review of Resident 1's Morse Fall Scale (MFS - a tool used to assess a patient's risk of falling. A score of 0-24 indicates low fall risk, 25-45 indicates moderate fall risk, and scores above 45 indicates high fall risk), dated 11/27/24 the MSF indicated, Resident 1 had a score of 70. The MSF dated 1/8/25 indicated Resident 1 had a score of 75. The MSF dated 5/23/25 indicated Resident 1 had a score of 75. The MSF dated 5/28/25 indicated Resident 1 had a score of 75. During a review of Resident 1's IDT Fall (IDTF - document used by the IDT during their meetings), dated 11/28/24, the IDTF indicated, on 11/27/24 at 2:30 p.m. Resident 1 was found in the facility outdoor patio on the floor. The IDTF indicated Resident 1 stated, I just fell. IDTF recommendations were for housekeeping to keep the area clean due to Resident 1 wanting to clean up the area by reaching down to the floor from wheelchair to pick up trash. The IDTF dated 1/9/25 indicated, on 1/8/25 at 3:18 p.m., Resident 1 was found on the floor face down in the outdoor facility patio. The IDTF recommendations were to provide Resident 1 with gardening tools and plants on a table to limit her need to reach down and garden around her area. The IDTF dated 5/26/25, indicated on 5/23/25 at 3:14 p.m. Resident 1 fell in the outdoor facility patio. The IDTF recommendations were to encourage and educate Resident 1 about taking medications due to Resident 1 falling after having a seizure. The IDTF on 6/4/25 indicated, on 5/28/25 at 5:20 a.m. Resident 1 was found on the floor in her room and was unable to state what happened. The IDTF indicated Resident 1 had a diagnosis of cognitive social (how we store, process, and use information about other people) or emotional deficit, following cerebral infarction that may have contributed to her fall. The IDTF indicated Resident 1's doctor was informed of Resident 1's fall on 5/28/25 and the physician ordered the licensed nurses to send Resident 1 to the emergency room for further evaluation. The IDTF recommendations were to place non-skid strips (sticky strips placed on surfaces to prevent slips and falls) on the right side of Resident 1's bed on the floor. During a review of Resident 1's acute hospital History and Physicals (H&P), dated 5/28/25, the H&P indicated, Resident 1 was brought into the acute hospital after being found at the facility on the ground in a fetal position (huddled posture where</p>		